

The Maternal and Newborn Health Thematic Fund

Business Plan Phase III
(2018-2022)





UNFPA is the United Nations sexual and reproductive health agency. Our mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

The MHTF Business Plan for Phase III has been jointly developed by UNFPA Headquarters (Technical Division/Sexual and Reproductive Health Branch) and UNFPA Regional Offices (Arab States - ASRO / Asia & the Pacific - APRO / Eastern & Southern Africa - ESARO / Latin America & the Caribbean - LACRO / West & Central Africa - WCARO).

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Table of Contents

1	Executive Summary	5
2	Introduction	7
3	Strategic Direction and Goal	9
3.1	Goal of the MHTF in Phase III	9
3.2	Relevance of the MHTF	11
3.3	Comparative Strengths of the MHTF	12
4	Expanded Scope	15
4.1	Expanding support to women and adolescent girls in their pathway to sexual and reproductive health	16
4.2	Strengthening both the supply and demand sides of care, and empowering women and adolescent girls to exercise their sexual and reproductive rights	18
4.3	Focusing on the most vulnerable and disadvantaged	18
5	Theory of Change and Strategic Interventions	20
5.1	Theory of Change	20
5.2	Strategic Interventions	26
6	Operating model	44
6.1	Modes of Engagement	44
6.2	Countries designated for support	46
6.3	Governance and Management	48
6.4	Monitoring and Evaluation	49
6.5	Budget and Resource Mobilization	50
7	Annexes	53

Acronyms

B-EmONC	Basic Emergency Obstetric and Newborn Care
DHIS2	District Health Information System
C-EmONC	Comprehensive Emergency Obstetric and Newborn Care
EmONC	Emergency Obstetric and Newborn Care
GIS	Geographic Information System
H6 (formerly H4+)	Partnership of UNAIDS, UNFPA, UNICEF, UN Women, World Bank Group, WHO
HMIS	Health Management Information System
HRH	Human Resources for Health
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
MPDSR	Maternal and Perinatal Death Surveillance and Response
MHTF	Maternal and Newborn Health Thematic Fund
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
QoC	Quality of Care
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child, Adolescent Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

1. Executive Summary

The third phase of UNFPA's Maternal and Newborn Health Thematic Fund (MHTF), from 2018 to 2022, lays out a roadmap for providing maternal and newborn health through a people-centered, human rights-based approach. Fully aligned to UNFPA's Strategic Plan (2018-2021), the MHTF directly contributes to UNFPA's transformative result of "ending preventable maternal deaths." For Phase III, the MHTF has broadened its scope to further contribute to achieve universal access to sexual and reproductive health and rights, and accelerating progress towards the International Conference on Population and Development (ICPD) Programme of Action. Its focus on maternal health includes support to newborn health, which is explicitly reflected in Phase III as maternal and newborn health are indivisible.

The MHTF's commitment and vision for Phase III is one where women and girls have equitable and accountable access to quality sexual and reproductive health services. These must allow them to be healthy and thrive, transforming their lives and societies, and driving the realization of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs). Specifically, Phase III aims to contribute to the global target of having fewer than 70 maternal deaths per 100,000 live births by 2030 (Goal 3, Target 1). While globally, maternal mortality has dropped by two-thirds in the last 25 years, reaching the global SDG target by 2030 will require substantial additional efforts and funds, both domestic and international, to tackle the persistently high number of 303,000 preventable maternal deaths per year.

This Business Plan builds on evidences and lessons learned from previous phases of the MHTF to support countries to strengthen their health system to improve maternal and newborn health through technical guidance and strategic interventions in the MHTF's four focus areas: midwifery, emergency obstetric and neonatal care, maternal and perinatal death surveillance and response, and obstetric fistula and other obstetric morbidities. The MHTF supports women, newborns, and adolescent girls across their lifespan in 32 countries with high burden of maternal and newborn mortality and morbidity and puts a specific focus on indigenous women, and women and girls who are most disadvantaged, including those in fragile settings, and who are displaced. In Phase III, the four focus areas of MHTF will be further integrated and linked with other sexual and reproductive health programmes, including post-partum and post-abortion family planning, comprehensive sexuality education and prevention and treatment of HIV/STIs. Finally, reproductive health morbidities will be addressed in a more focused manner with access to cervical cancer screening and treatment, and safe abortion (where legal) and post-abortion care strengthened.

The Result and Indicator Framework for Phase III is fully aligned with UNFPA's Strategic Plan and is based on a menu of strategic interventions from which countries can select based on their needs. The strategic interventions of the MHTF complement and reinforce efforts under other funding streams, including other UNFPA's resources, to increase maternal and newborn health and realize sexual and reproductive health and rights for all. MHTF in Phase III will facilitate sustainable change in countries through its catalytic effect and strength in leveraging partnerships

at the global, regional and national levels, including through H6 partnership and technical support in countries.

Strengthening resource mobilization efforts to increase its funding base, and further exploring public and private partnerships and innovations will be a priority. These measures will aim at supporting MHTF interventions to realize more sustainable long-term results in advancing sexual and reproductive health and rights for women and girls, across the continuum of care, with no women or newborn left behind.

2. Introduction

The Maternal and Newborn Health Thematic Fund (MHTF) is UNFPA's flagship programme for improving maternal and newborn health and well-being. Launched in 2008 to boost global funding and attention to maternal health, the MHTF is now entering its third phase, from 2018 to 2022,¹ after having completed Phase I (2008-2013) and Phase II (2014-2017). Its focus on maternal health has included support to newborn health, which is explicitly reflected in the third phase, as maternal and newborn health are indivisible.

Although maternal mortality has fallen by 44 per cent since 1990, and tangible progress has been made over the last decades, globally maternal mortality is still unacceptably high. An estimated 830 women die from pregnancy or childbirth-related complications every day while most of them are preventable.² Almost all maternal deaths (99 per cent of global maternal deaths) occur in low- and middle-income countries. In addition, for every woman who dies of pregnancy-related causes, 20 to 30 others experience acute or chronic maternal morbidity, often with permanent sequelae that can affect women's physical, mental and/or sexual and reproductive health.³

Every year, 2.6 million babies die before turning one month old, with about 40 per cent dying on the day they are born. Another 2.6 million are stillborn. More than 80 per cent of newborn deaths are the result of premature birth, complications during labour and delivery, and infections such as sepsis, meningitis and pneumonia. Similar causes, particularly complications during labour, account for a large share of stillbirths.⁴

The MHTF is set up to provide catalytic support to improve maternal and newborn health in high-mortality countries. It provides upstream strategic directions, technical assistance and capacity-building for the development, implementation and monitoring of maternal and newborn health interventions aligned with country-owned and driven processes.

With the transition from the Millennium Development Goals (MDGs) to Agenda 2030 and the SDG, and based on experience in implementing Phases I and II, the MHTF has broadened its scope of work in reducing maternal and newborn mortality and morbidity to a more comprehensive approach to women's and adolescent girls' sexual and reproductive health and rights.

The MHTF is a key building block towards the achievement of UNFPA's new Strategic Plan (2018-2021), particularly its transformative result of zero preventable maternal deaths by 2030. It leads

1. 2018 is a transition year between Phase II and Phase III.

2. L. Alkema, D. Chou, D. Hogan, S. Zhang, A. B. Moller, A. Gemmill, et al., 2016, "Global, regional and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group," *The Lancet* 387 (10017): 462-74.

3. T. Firoz, et al, 2013, "Measuring maternal health: focus on maternal morbidity," *Bulletin of the World Health Organization* 2013.

4. UNICEF, 2018, "Every Child Alive – the urgent need to end newborn deaths."

UNFPA's maternal and newborn health agenda, complements and further strengthens maternal and newborn health interventions supported by UNFPA's core and non-core resources, and contributes to leveraging resources from other strategic partners at the country and regional levels. All of its efforts are aimed at accelerating progress on the Programme of Action of the ICPD, and at improving the lives of women, newborns, adolescents and youths.

This Business Plan for Phase III lays out the foundations of the MHTF's support to countries to operationalize the 2030 Agenda, based on the principles of equity in access to sexual and reproductive health and rights information and services, quality of care and human rights-based accountability. The plan specifically describes changes to position the MHTF to better support countries in achieving the global goals of ending preventable maternal and newborn deaths.

3. Strategic Direction and Goal

3.1 Goal of the MHTF in Phase III

The goal of the MHTF in Phase III is to support countries to ensure that every woman, adolescent girl, and newborn has equitable and accountable access to quality sexual, reproductive, maternal and newborn health and rights by strengthening health systems in countries with high burden of maternal morbidity and mortality.

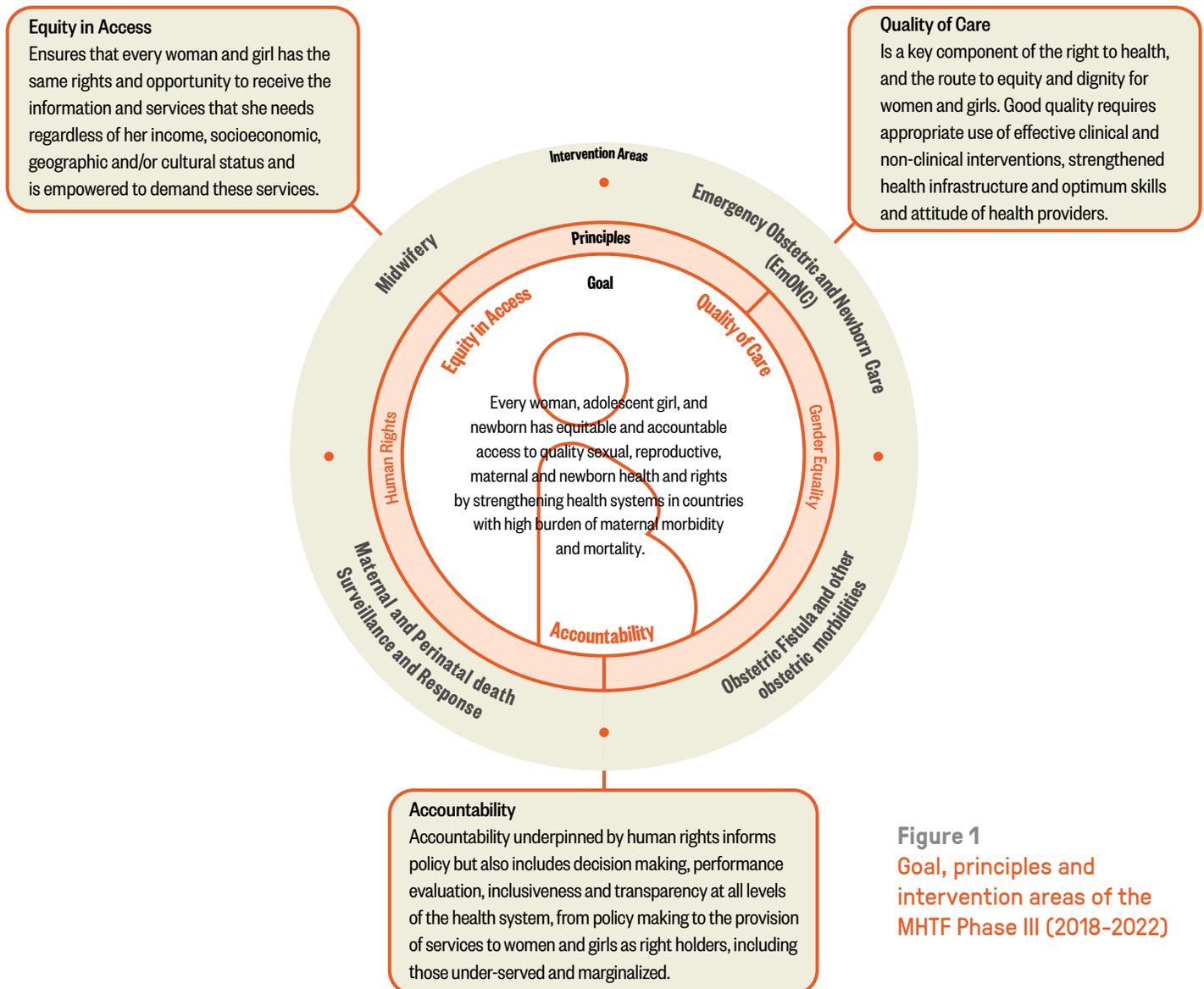


Figure 1
Goal, principles and intervention areas of the MHTF Phase III (2018-2022)

The MHTF operates on three core human rights principles (Figure 1): equity in access, quality of care and accountability. Human rights and gender equality are principles central to realizing the 2030 Agenda. The MHTF in Phase III will emphasize these as essential drivers and contributors to improved health and well-being, in accordance with the ICPD Programme of Action. Its four key intervention areas comprise (1) midwifery; (2) comprehensive sexual and reproductive health in Emergency Obstetric and Newborn Care (EmONC) facilities; (3) obstetric fistula and other obstetric morbidities; (4) Maternal and Perinatal Death Surveillance and Response (MPDSR).

MHTF intervention areas have been strategically selected based on experiences and lessons learned about what works for countries to accelerate action and scale up evidence-based, cost-effective strategies and innovations for maternal and newborn health. Interventions reinforce each other in strengthening national health systems.

As highlighted in Box 1, the new vision of the MHTF contributes to the broader sexual and reproductive health and rights agenda: to enable every woman and adolescent girl to make fundamental decisions about their own bodies, attain the highest possible standard of sexual and reproductive health, and exercise their sexual and reproductive rights. In conjunction with other UNFPA programmes, the MHTF will support women and adolescent girls across their lifespan and along the continuum from sexual and reproductive health through pregnancy and the postnatal period. It will also address 'proximate determinants' to maternal health, including gender equality, geographic access to health-care services, health-care utilization and quality, and co-morbidities.

In line with UNFPA's Strategic Plan (2018-2021) and Agenda 2030, Phase III of the MHTF will increasingly focus on those left furthest behind. It is an established fact that inequalities in realizing sexual and reproductive health and rights block progress in maternal health, and keep women and girls caught in vicious cycles of poverty, diminished capabilities and unfulfilled human rights. Women in the poorest 20 per cent of households may find themselves with little or no access to sexual and reproductive health care, including contraception, leading to unintended pregnancies and childbirth, and higher risk of death or morbidity.⁵

Box 1

MHTF Phase III will:

- Continue its support for health system strengthening, focusing on midwifery, EmONC, MPDSR and obstetric fistula;
- Broaden its support to addressing obstetric morbidities, including genital prolapse, severe anaemia and chronic pelvic inflammatory disease;
- Further focus on post-partum and post-abortion family planning as well as on access to safe abortion (where legal) and post-abortion care;
- Support access to a broader, more holistic package of sexual and reproductive health services for adolescents and youths;
- Expand its support to screening, treatment and prevention of cervical cancer; and
- Strengthen accountability for quality of care through integrated patient-centric care, including based on patient experiences of care.

5. UNFPA, 2017, *Worlds Apart. Reproductive health and rights in an age of inequality*

3.2 Relevance of the MHTF

Since the adoption of the ICPD Programme of Action in 1994, sexual and reproductive health and rights have been recognized by the international community as necessary for women's and girls' overall health and empowerment, and for their ability to benefit from education, training and work as well as to participate in social, political and economic life, and to enjoy their human rights. UN Member States have further recognized that the disempowerment of women and girls; other abuses of their human rights, especially violence and sexual coercion; and social and economic disadvantages severely inhibit achievement of their sexual and reproductive health and rights. There has been remarkable progress towards universal access to sexual and reproductive health and rights. Maternal mortality has declined by 44 per cent since 1990⁶, and so has newborn mortality of 49 per cent⁷. Contraceptive prevalence has reached 64 per cent among married women of reproductive age.⁸

The MHTF has contributed to this success since its creation. UNFPA estimates that 66,400 maternal deaths have been averted from 2010 to 2015 in the 39 countries supported by the MHTF.⁹

This figure, however, represents only 16 per cent of the 411,350 women who could have been saved between 2010 and 2015 in these 39 countries if the MDG 5 targets for maternal health had been achieved. Only three countries supported by the MHTF achieved the MDG 5a target of a 75 per cent reduction in the Maternal Mortality Ratio (MMR).⁹

Remaining challenges include the lack of investment in maternal health,¹⁰ gender inequality, violations of human rights and weak health systems, leading to a lack of equity in access, quality of care and accountability. There is also a lack of commitment and support to prevent abortion-related deaths. Recent studies estimate that 4.7 per cent to 13.4 per cent of all maternal deaths worldwide are due to unsafe abortion. The number of abortion-related deaths in 2014 ranged from 22,000 to 47,000.¹¹ The uncertainty in the numbers relates to the stigmatization of abortion and unwillingness to report on abortion-related cause of death. Around 7 million women are admitted to hospitals every year in developing countries as a result of unsafe abortion.¹²

While newborn mortality rates have fallen in recent decades, these still lag behind the impressive gains made for children from 1 month to 5 years old, who have seen a 62 per cent reduction in mortality, compared to a 49 per cent decline for newborns of less than 1 month. Progress in reducing the deaths of newborns requires strong health systems and a concerted global focus.¹³

6. Trends in maternal mortality: 1990 to 2015 – Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, November 2015.

7. Levels and Trends in Child Mortality Report 2017, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation.

8. Trends in Contraceptive Use Worldwide 2015, Department of Economic and Social Affairs, Population Division. ST/ESA/SER.A/349

9. MHTF, 2017, "Phase II (2014-2017) – Progress Report, Towards Equality in Access, Quality of Care and Accountability."

10. J. J. Dielman, et al. 2016, "Development assistance for health: past trends, associations, and the future of international flows for health," *The Lancet* 387(10037): 2536-2544.

11. L. Say, D. Chou, A. Gemmill, Ö. Tunçalp, A. B. Moller, J. Daniels, A. M. Gülmezoglu, M. Temmerman and L. Alkema, 2014, "Global causes of maternal death: a WHO systematic analysis," *The Lancet Global Health* 2(6): e323-33.

12. S. Singh and I. Maddow-Zimet, 2015, "Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries." *BJOG*, published online on 19 August. DOI:10.1111/1471-0528.13552.

13. UNICEF, 2018, "Every Child Alive – the urgent need to end newborn deaths."

With its technical expertise, catalytic and innovative nature, global reach and focus on country-led interventions in countries with a high burden of maternal and newborn mortality, the MHTF is uniquely positioned to support the realization of access to quality sexual and reproductive health services for all women and adolescent girls. This will help them to survive and thrive, transform their lives and their societies, and drive realization of the 2030 Agenda, particularly SDG 3. The MHTF will support countries in reducing national MMRs to reach the global target of fewer than 70 maternal deaths per 100,000 live births by 2030.¹⁴

The fund will also assist countries to end preventable deaths of newborns and children under five, and to reduce neonatal mortality to no more than 12 per 1,000 live births and under-five mortality to no more than 25 per 1,000 live births.

The 2030 Agenda and the related SDGs, the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), and UNFPA's new Strategic Plan (2018-2021) all present a powerful opportunity for the MHTF to reaffirm and adjust its vision, and align with these global initiatives to end preventable maternal and newborn deaths.

3.3 Comparative Strengths of the MHTF

The MHTF is a unique global programme in the United Nations. On the frontline of improving the health and quality of life of women, newborns and adolescent girls, it offers the following comparative advantages:

- **Country focused:** The MHTF offers tailored assistance to high burden countries in strengthening health systems. These countries supported account for 78 per cent of maternal deaths globally; a number are affected by humanitarian and fragile contexts.¹⁵ The MHTF embraces a flexible and adaptive approach to sexual and reproductive health and rights in humanitarian and conflict settings. It enhances the nexus between humanitarian and development assistance through capacity-building aimed at resilient health systems.

In addition to supporting the development of evidence-based national strategies and plans, the MHTF has a specific focus on assisting countries to implement and monitor them at a national scale. For example, during Phase II, the MHTF developed an approach for countries to strengthen their national network of EmONC facilities and to leverage the evidence generated by the field of implementation research to drive quality improvement processes in EmONC facilities. Since 2016, six countries have developed the capacity to monitor the availability and quality of EmONC (and broader sexual and reproductive health) services on a regular basis, and to respond to identified gaps. The MHTF also supports countries to regularly track implementation of their MPDSR framework by measuring the notification and review rates of maternal deaths.

- **People-centered with a rights-based approach to maternal and newborn health, and to sexual and reproductive health across the lifespan:** Building on the ICPD, MHTF interventions work to ensure priority attention to the human rights of women, newborns and adolescent girls. Phase III will take a targeted approach by reinforcing attention to the most vulnerable and disadvantaged women and adolescent girls. This includes further supporting the generation of

14. WHO, UNICEF, UNFPA, USAID, FIGO, White Ribbon Alliance, Family Care International, ICM, World Bank Group, Maternal Health Task Force, Maternal and Child Integrated Program, 2015, "Strategies toward ending preventable maternal mortality (EPMM)."

15. Nine MHTF-supported countries are classified by the Office for the Coordination of Humanitarian Affairs (OCHA) as countries with "very high risk" of continuing severe humanitarian needs in 2018: Afghanistan, Central African Republic, Chad, Democratic Republic of the Congo, Niger, Somalia, South Sudan, Sudan and Yemen.

evidence and data to support demand for sexual and reproductive health and rights information and services, for example, through patient satisfaction surveys, and anthropological approaches to better address the needs of indigenous women and adolescent girls.

- **Technical expertise and thought leadership:** The MHTF will continue to serve as a technical lead in maternal and newborn health. It plays leading roles in global technical working groups such as Ending Preventable Maternal Mortality (EPMM), Every Newborn Action Plan (ENAP), the Quality of Care Network, EmONC, MPDSR and midwifery inter-agency working groups. The MHTF complements UNFPA's core resources by enhancing the evidence base in maternal and newborn health, promoting best practices, and backing integration across the continuum of sexual and reproductive health care from prevention to care. MHTF strategic interventions, close monitoring of results and contribution to the maternal and newborn health research agenda have influenced the UNFPA Strategic Plan (2018-2021) and contribute to strategic investments of other UNFPA resources (core and non-core), increasing effectiveness, efficiency and scale.
- **Promotion of innovation:** Innovation is a core component of the MHTF, with an emphasis on transformational initiatives in health system approaches and technology, particularly at the country level. During Phase III, the MHTF will consolidate learning from current innovations (Box 2) to support scaling up those that have proven effective. Across its four focus areas, it will promote additional country-driven innovations and research through exploratory grants.

Box 2

MHTF innovations

- **Use of Geographic Information Systems (GIS) to optimize coverage of EmONC:** In Phase II, the MHTF supported the use of GIS/AccessMod (<https://www.accessmod.org>) to measure geographic accessibility to national network of EmONC facilities and help countries plan the facility network to maximize population coverage. This approach has been implemented in Burundi, Guinea, Madagascar, Senegal, Sudan, and Togo, and more countries are planning to implement it in Phase III (e.g., Côte d'Ivoire).
- **E-learning modules for midwifery:** In 2015, innovative multimedia e-learning modules on lifesaving skills and family planning were widely disseminated in 25 countries, and converted to allow midwives to use them on mobile phones and tablets. To stem the growing medicalization of female genital mutilation/cutting (FGM/C), the MHTF supported the development and implementation of a training module for midwives on the human rights violations and health complications of FGM/C, helping to strengthen their capacity as champions of prevention.
- **Driven by evidence and data:** the MHTF supports countries in strengthening the monitoring of maternal and newborn health programmes through routine data collection and analysis. It also helps bolster the use of sexual and reproductive health data, particularly at facility and district levels to stimulate locally driven efforts to improve the availability and quality of care. While primarily focusing on routine data collection and health management information systems, the MHTF also assists with surveys to complement routine data if needed, such as EmONC needs assessments, midwifery workforce assessments, and surveys on obstetric fistula prevalence and incidence.
- **Catalytic in nature:** The MHTF is strategic and synergetic in driving action on maternal and newborn health and sexual and reproductive health and rights at the global, regional and national levels. At the global level, it is a catalyst for change and innovation, sustaining momentum around globally agreed goals for universal access to sexual and reproductive health, the realization of sexual and reproductive rights, and ending preventable maternal and newborn mortality. It kick-starts strategic interventions at the national level through upstream and technical support for the development, implementation and monitoring of national policies and costed plans to achieve equitable access to quality information and services. To accelerate national implementation of strategic interventions, the MHTF leverages coordination mechanisms in

sexual, reproductive, maternal, newborn, child and adolescent health, with an example being the H6 partnership.¹⁶ Many indicators in the MHTF Results Framework are national level indicators, which contributes to sustainability as interventions are embedded in national strategies and plans. By systematically documenting results, best practices, lessons learned and emerging issues, the MHTF has a multiplier effect, including through mobilizing additional funding from domestic and international sources, with the latter comprising the governments of Belgium, Canada, France, Sweden, and the United Kingdom.

16. This partnership of UNAIDS, UNFPA, UNICEF, UN Women, the World Bank Group and WHO provides joint technical support to high-burden countries to operationalize the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030).

4. Expanded Scope

In support of the 2030 Agenda and the UNFPA Strategic Plan (2018-2021), and based on the vision and comparative strengths of the MHTF, Phase III includes new elements and a refined focus. Three major changes of MHTF scope are described below, with specific programmatic implications summarized in Box 3.

Box 3

Summary of the expanded scope of the MHTF

In Phase III, the MHTF will:

- Be guided by the core principles of equity in access, quality of care and accountability, and by human rights and gender equality.
 - Strengthen health systems through four integrated areas of focus: midwifery, EmONC, MPDSR, as well as obstetric fistula and other morbidities.
 - Support women and adolescent girls across their lifespan and along the continuum of care from sexual and reproductive health through to pregnancy and the postnatal period, in conjunction with other UNFPA programmes. MHTF will specifically:
 - Further strengthen the integration between maternal health and sexual and reproductive health, especially family planning, focusing on access to immediate post-partum and post-abortion family planning;
 - Broaden the focus on obstetric morbidities, including obstetric fistula, uterine prolapse, severe anaemia and chronic pelvic inflammatory disease;
 - Increase its focus on access to safe abortion (where legal) and post-abortion care. In countries where abortion is illegal or highly restricted, the MHTF will provide evidence of the public health consequences of the criminalization of abortion, and support governments in developing national standards and guidelines for comprehensive abortion care, in partnership with civil society organizations. It will also support universal access to post-abortion care and contribute to addressing access issues (e.g., clinical, management and other logistical issues) at all levels of the health system. It will train/inform service providers on the rights of women and on when abortions can be performed.
- In countries where abortion is legal, the MHTF will also support policy advice, technical assistance and training of staff (midwives, nurses and other mid-level health-care workers) to improve the quality and availability of safe abortion services. It will support the provision of direct technical assistance to EmONC facilities for abortion-related services.
- Address cervical cancer as a prevalent reproductive health issue for women and adolescent girls. In 2012, approximately 270,000 women died from cervical cancer; more than 85% of these deaths occurring in low-and middle-income countries¹⁷ where 95 per cent of women never have a pap test. The MHTF will support early screening, treatment and vaccination against the human papillomavirus, which can lead to cervical cancer.
 - Improve both the supply and demand sides of sexual and reproductive health and rights by implementing strategic interventions primarily addressing four health system components (the health workforce, service delivery, health information systems, and leadership and governance), and by empowering women and adolescent girls.
 - Address rising inequities in access to sexual and reproductive health information and services. This will require a new way of doing business to increase the focus on reaching those furthest behind, including women, adolescent girls and newborns in the two lowest wealth quintiles, living in hard to reach areas, facing discrimination based on their identity, ethnicity and faith, and living with disabilities.

17. WHO fact sheet dated 15 February 2018

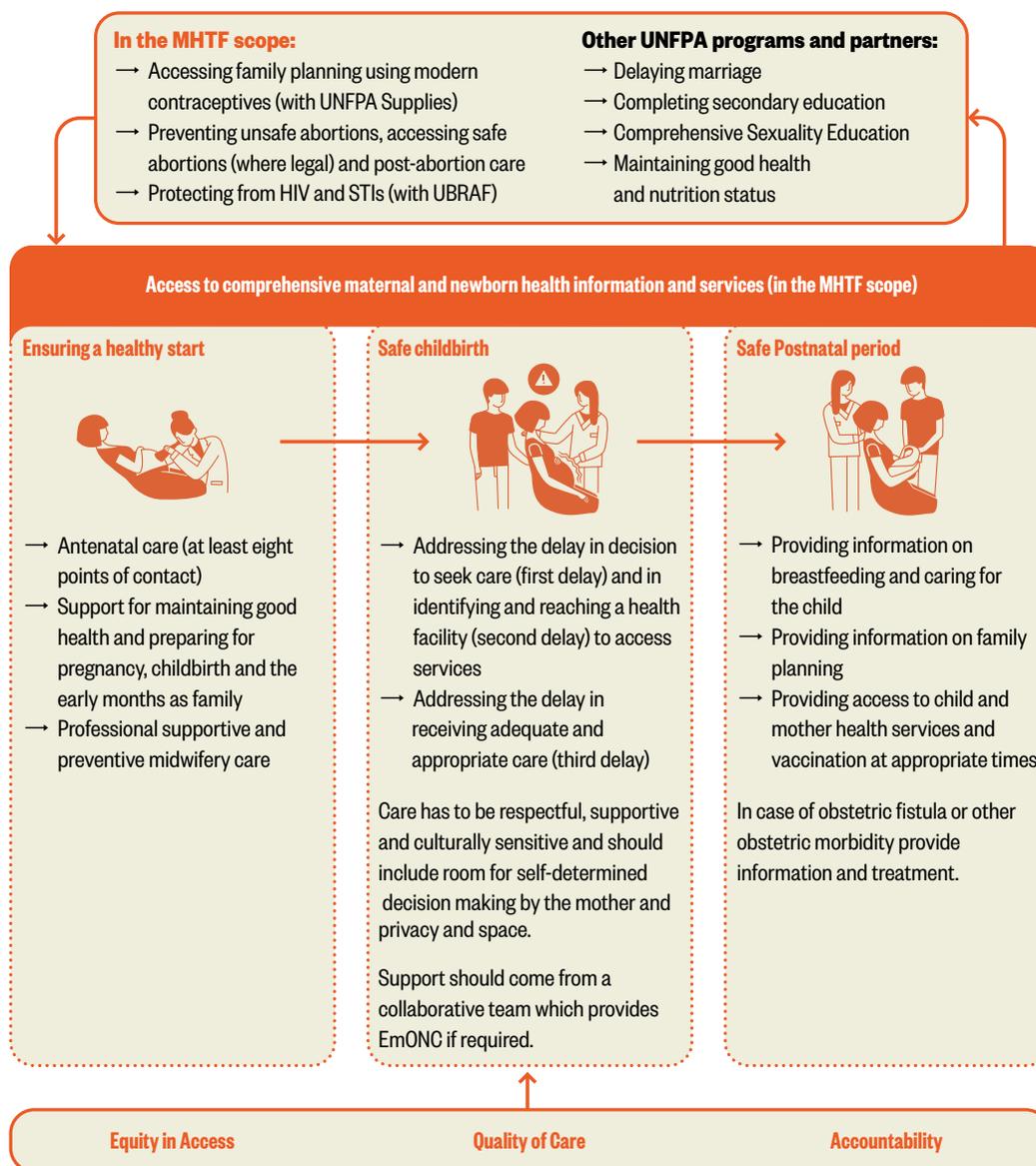


Figure 2
The MHTF scope of work: ensuring access to sexual, reproductive and maternal health throughout a lifetime

4.1 Expanding support to women and adolescent girls in their pathway to sexual and reproductive health

Phase III aims to support women and adolescent girls across their lifespan and along the continuum of care from sexual and reproductive health through to pregnancy and the postnatal period, in conjunction with other UNFPA programmes (Figure 2). As women and newborns are at highest risk of death and morbidity during labour, childbirth and the first week after birth, the MHTF is particularly supporting countries to address the “three delays” in accessing quality maternity care, and improving the post-partum or post-abortion period.

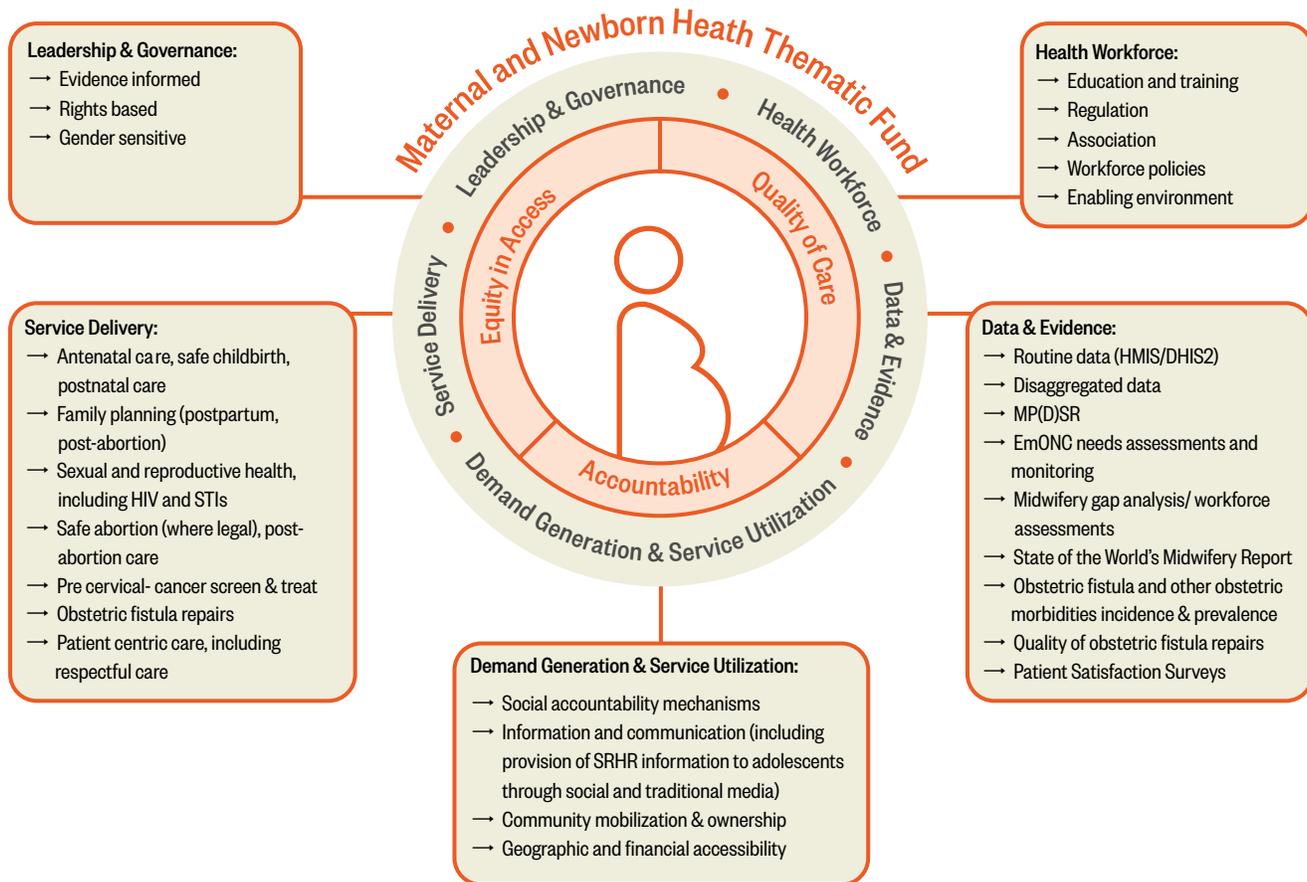


Figure 3
The MHTF's strategic support to strengthen health-care supply and demand

Based on the 2016 World Health Organization (WHO) guidelines, the MHTF will support countries to strengthen access to and the quality of antenatal care, with special attention to adolescent girls and youths. The antenatal care package includes essential sexual and reproductive health information and services, such as for the prevention of unsafe abortion, access to safe abortion (where legal) and the prevention of mother-to-child transmission of HIV. The MHTF will promote the use of birth plans and institutional delivery with a skilled attendant at birth as well as “group antenatal care,” which brings together a health-care provider, preferably a midwife, and a group of women in the same stage of pregnancy to receive care. This model of care solves several problems. It allows a provider to have up to two hours with a group of patients, providing rich content driven by the needs of pregnant women, not the objectives of the provider. It also helps form a peer support group for women throughout their pregnancy and the post-partum period, reducing feelings of isolation. Group care is scheduled, allowing predictable appointments and time for the midwife to prepare content-rich sessions.

Countries that piloted interventions supporting “first-time young mothers” over the last two years – one of the MHTF workstreams for Phase II – will be assisted to evaluate and document the results and encouraged to scale up best practices. This process will promote South-South collaboration, such as by sharing a counselling package tested in Bangladesh with positive results.

4.2 Strengthening both the supply and demand sides of care, and empowering women and adolescent girls to exercise their sexual and reproductive rights

In Phase III, the MHTF will support evidence-based interventions in countries to strengthen four main health system building blocks: leadership/governance, the health workforce, data and evidence, and service delivery. These will help guarantee the supply side of care. Measures to empower adolescent girls and vulnerable and disadvantaged women to access sexual and reproductive health and realize their sexual and reproductive rights will aim at boosting the demand side (Figure 3).

The MHTF will particularly address proximate determinants to maternal health, such as gender equality and the status of women, including midwives; the geographic accessibility, quality and utilization of health-care services; and comorbidities as well as “distal determinants” (such as financial and transport barriers to health care, socio-economic inequalities, education, community awareness, sexual and gender-based violence and harmful practices).

4.3 Focusing on the most vulnerable and disadvantaged – particularly adolescent girls, and women and adolescent girls in the lowest wealth quintiles, in hard-to-reach areas, facing discrimination based on their identity, ethnicity, race, residential and legal status, and living with disabilities

The ICPD Programme of Action and the 2030 Agenda reaffirm the centrality of universal access to sexual and reproductive health and rights to sustainable development, leaving no one behind. Inequalities in sexual and reproductive health and rights have tragic consequences for the health and education outcomes of individuals as well as implications for entire nations. Ending these disparities is an important driver for addressing related economic, social, racial, political and institutional inequalities.¹⁸

Globally, maternal mortality is the second largest cause of deaths among **adolescent girls** aged 15 to 19. Of all births globally each year, around 16 million (11 per cent) are among girls in this age range; about 2 million are among girls under the age of 15. Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. Health systems have to be more responsive to their needs. Building on its expertise in supporting first-time young mothers, the MHTF will support countries to improve access among adolescent girls to broader sexual and reproductive health services. It will, for example, focus on developing the capacity of health workers, especially midwives, in adolescent-friendly integrated sexual and reproductive health services; on documenting the experience of care among adolescents and youths in EmONC facilities; and on auditing reviews of maternal deaths among adolescent girls and youths. Outreach and non-facility-based services are critical to reach adolescents, so the MHTF will also support stronger links between EmONC facilities and peripheral health facilities and communities.

Since poor women in rural and urban areas have less access to quality maternal health care than wealthier women in urban areas, the MHTF will support their equitable access to maternal and newborn health care and broader sexual and reproductive health and rights. Using GIS, the MHTF will help develop national network of EmONC facilities to maximize physical accessibility, and to strengthen referral links within networks and with peripheral maternity services and communities. It will also work with countries to improve the quality of services, including through respectful care.

18. UNFPA, 2017, *Worlds Apart: Reproductive health and rights in an age of inequality*.

This will entail strengthening the capacities of health providers, especially midwives, and empowering facility and district/regional staff to drive quality improvement using data and patients' experiences of care. Capacity-building will continue to target the prevention and treatment of obstetric fistula, a condition mostly affecting the poorest women and girls.

Finally, the MHTF will support countries to identify the best approaches to achieving equitable access to sexual and reproductive health and rights among **women from minority groups**, including through anthropological studies. In 2017, for example, the MHTF supported the Government of the Republic of Congo to implement a systematic initiative in the Sangha Department, which has a concentration of indigenous populations. Over 10 per cent of all reported mortality cases are linked to pregnancy. The programme is being conducted with Médecins d'Afrique, a national non-governmental organization, in partnership with the Ministry of Health. It provides culturally sensitive services to indigenous women in 13 delivery rooms, working with community health workers and indigenous leaders, and reinforces the collection of health statistics and maternal death surveillance. Special attention to teenage mothers enables the provision of comprehensive care, including encouragement to attend or remain in school. Lessons and good practices will be used as key recommendations for the upcoming national health plan (2018-2021). With many MHTF-supported countries being in the Sahel region, where parts of populations are nomadic, the MHTF will also support specific approaches to improve their access to sexual and reproductive health information and services.

5. Theory of Change and Strategic Interventions

5.1 Theory of Change

The theory of change presents the causal conditions that must be in place to achieve results. It also outlines, with evidence, the causal linkages between conditions and results, and spells out the risks and assumptions that may impede the results chain from occurring.

Phase III of the MHTF will support UNFPA's Strategic Plan (2018-2021), which is the first of three strategic plans leading to 2030. Similarly, this MHTF Business Plan is the first of three business plans.

UNFPA's Strategic Plan is based on the ICPD Programme of Action and supports the 2030 Agenda, which has a renewed focus on and commitment to improving maternal, newborn and child health, and sexual and reproductive health and rights. The work of UNFPA to ensure universal access to sexual and reproductive health and rights is critical and catalytic to realizing the SDGs. UNFPA focuses on three transformative results: ending preventable maternal deaths, ending the unmet need for family planning, and ending gender-based violence and harmful practices, including child marriage. The MHTF is at the heart of UNFPA's efforts to end preventable maternal deaths. (Figure 4)

Towards realizing these transformative results, the goal of the UNFPA Strategic Plan 2018-2021 is to **“achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality.”**

While the Strategic Plan contributes to all 17 SDGs, it most directly aligns to: Goal 3 (ensure healthy lives and promote well-being for all at all ages); Goal 5 (achieve gender equality and empower all women and girls); Goal 10 (reduce inequality within and among countries); Goal 16 (promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels) and Goal 17 (strengthen the means of implementation and revitalize the global partnership for sustainable development).

In Phase III, the MHTF will contribute mainly to the first and second outcomes of the Strategic Plan. The first outcome is: **“Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.”** The second outcome is: **“Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts (Figure 5)”**.

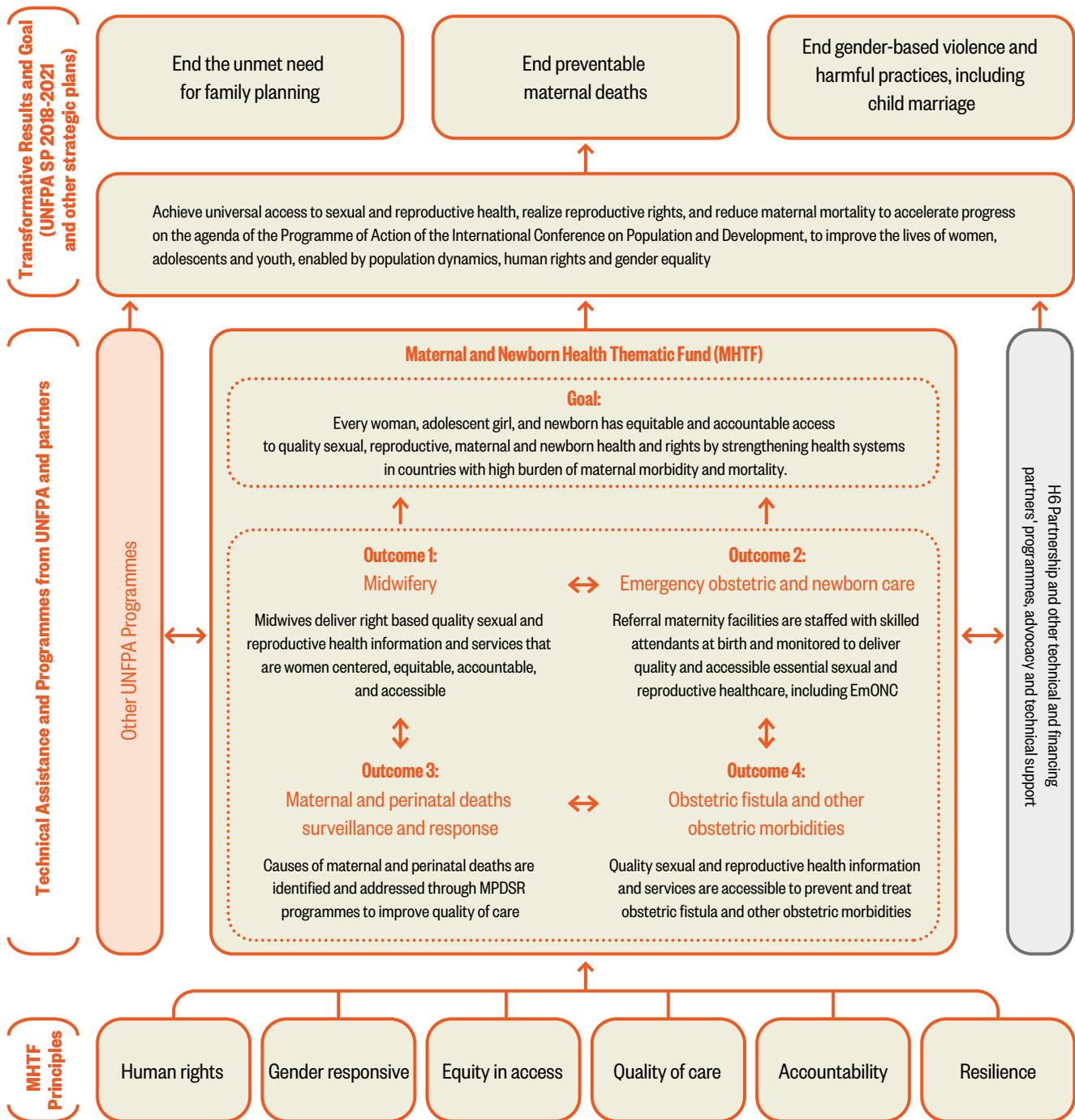


Figure 4
MHTF Phase III overall change model - central to achieving UNFPA's transformative results under the new Strategic Plan (2018-2021)

The MHTF specifically focuses on strengthening health systems to provide equitable and accountable access to quality sexual, reproductive, maternal and newborn health care. Evidence shows that ensuring access to sexual and reproductive health and rights unleashes numerous benefits, including realizing gender equality and fundamental human rights, and reducing maternal and newborn deaths and stillbirths, unintended pregnancies, and the burden of disabilities related to childbirth and pregnancy. Furthermore, investments in universal access to sexual and reproductive health and

rights promote broader, long-term benefits for women, adolescents, children, partners and families, economies and societies. They are also cost-effective. The cost of preventing unintended pregnancies; improving antenatal, childbirth and newborn care; and preventing mother-to-child transmission of HIV is significantly less than the financial cost and social impact of such pregnancies and adverse health outcomes. Each dollar spent on contraceptive services reduces the cost of pregnancy-related care (for unintended pregnancy) by \$1.47.¹⁹ Additional investments of \$5 per person per year in 74 countries with 95 per cent of the global maternal and child mortality burden would yield up to nine times the initial investment in terms of economic and social benefits by 2035.²⁰

The MHTF is one of UNFPA's five large non-core funding streams. The others are: UNFPA Supplies, working on reproductive health commodity security and family planning; the UNICEF/UNFPA Joint Programme to End Female Genital Mutilation and Cutting; the UNICEF/UNFPA Joint Programme to End Child Marriage; and the Unified Budget, Results and Accountability Framework (UBRAF), which focuses on HIV prevention. The strategic interventions of the MHTF complement and reinforce efforts under these funding streams, and support the use of UNFPA's core and non-core resources to improve maternal and newborn health, and realize sexual and reproductive health and rights for all.

The implementation of the MHTF Business Plan Phase III is subject to the following potential risks:

- **A changing political landscape** results in growing opposition and resistance towards sexual and reproductive health and rights. Proposed mitigation strategies include:
 - Consistently highlight the substantial impact on the health of women, adolescents and youth that comes from investing in sexual and reproductive health and rights, which benefits their development and well-being, and that of society more broadly (with economic, social and political returns).
 - Demonstrate the significant risks of not investing in sexual and reproductive health and rights, as reflected in higher rates of maternal mortality, unsafe abortion, maternal morbidity, HIV infection and gender-based violence, and the wider ramifications for society, including potential restrictions on economic growth.
- **Funding constraints limit resources required for the MHTF** to have both a substantive and sustained impact on the lives of women, newborns and adolescent girls. Proposed mitigation strategies include:
 - Identify new funding opportunities and funding streams (including private sector) that can be tapped to support the MHTF.
 - Support countries to prioritize maternal and newborn health (and broadly sexual and reproductive health and rights) through the mobilization of domestic resources.
 - Demonstrate value for money for MHTF-supported interventions through efficiency and effectiveness as well as the fund's catalytic role in driving national maternal and newborn health and the broader sexual and reproductive health agenda.
- **Limitations in human and institutional capacity (skills, ability, expertise, systems)** at all levels adversely impact the implementation of the MHTF. The decline of UNFPA's core resources threatens MHTF activities, as some country office do not have the required staff to support interventions or exclusively use their MHTF resources for staffing. Proposed mitigation strategies include:
 - Review, update and strengthen the required skill sets and operating systems of UNFPA country offices, including integration opportunities, to ensure that they can be effectively harnessed to deliver the identified results.

19. S. Singh, J. E. Darrochand and L. S. Ashford, 2014, *Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014*, New York: Guttmacher Institute.

20. D. T. Jamison et al., 2013, "Global Health 2035: A world converging within a generation," *The Lancet* 382(9908): 1898-1955.

- Ensure a balance between MHTF budgets for staff (required for the implementation of strategic interventions) and supporting activities.
- **Diverse country contexts constrain the ability to effectively address and respond to needs.** Proposed mitigation strategies include:
 - Recognize differing country contexts to ensure sufficient flexibility and adaptability in MHTF-supported activities, in line with the MHTF strategic interventions and results indicator framework;
 - Focus on countries with a high burden of maternal and newborn mortality and morbidity that have the context and capacity to implement MHTF strategic interventions.
- **UNFPA's cost reduction policies and administrative limitations (e.g. on travel) impair the capacity of global and regional MHTF teams to provide needed technical support and to build capacity for innovative approaches.** Proposed mitigation strategies include:
 - Strengthen the collaboration between MHTF teams at global and regional levels to ensure coordinated, effective and efficient technical support to countries.
 - While keeping a focus on cost reduction at all levels of the organization, ensure that the needed skill mix of technical assistance, capacity-building and South-South collaboration can still be provided to drive results and innovation.
- **Addressing those furthest behind will require substantive investment, new approaches and partnerships that may not demonstrate results, at least in the short to medium term.** Proposed mitigation strategies include:
 - Be clear about how this will be operationalized in different country contexts, including by establishing realistic and measurable targets; timelines (short, medium and long term); resource needs (financial, human and material) and measures to address any potential effects on existing programmes.

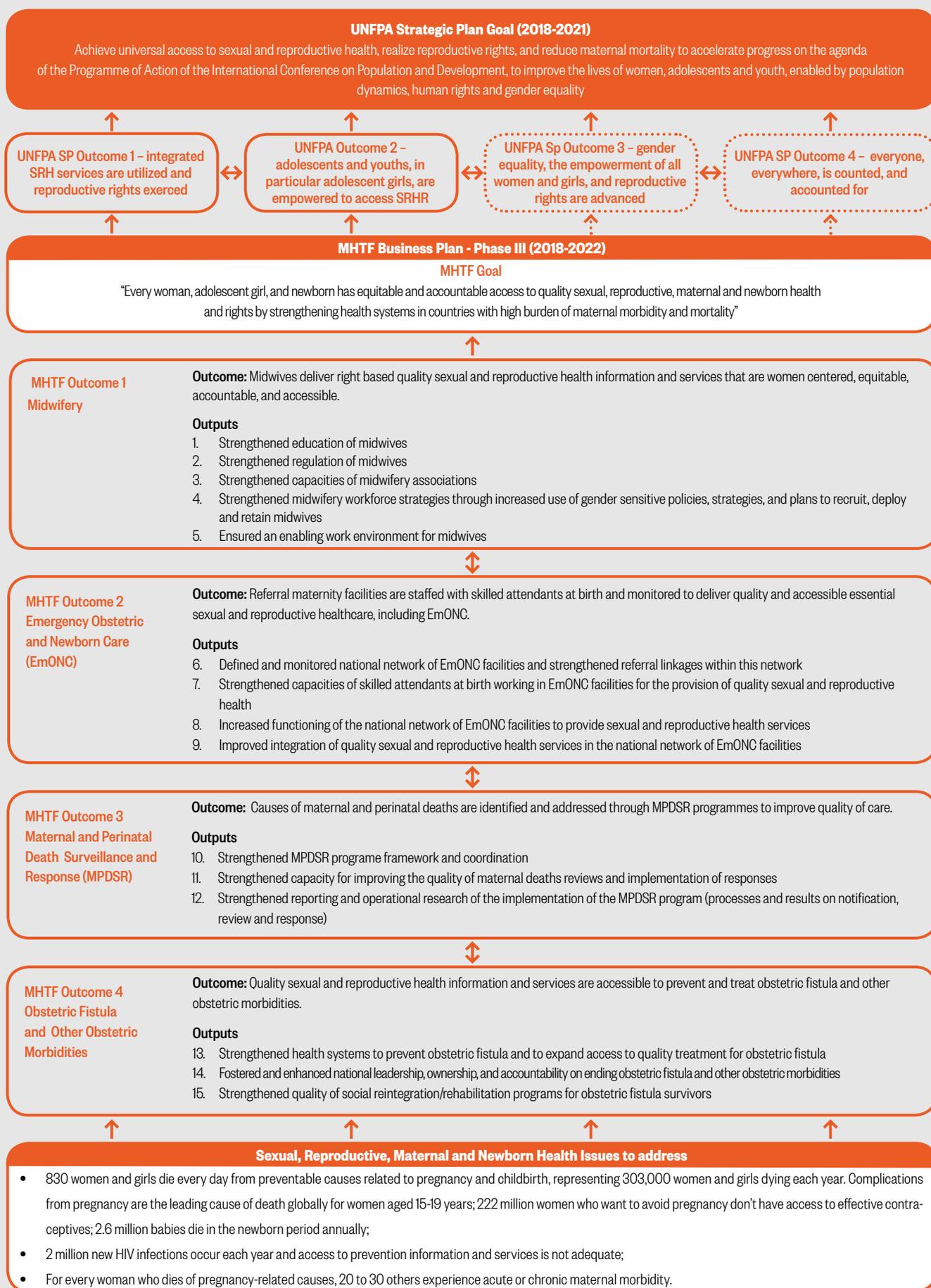
UNFPA has included these risks and mitigation measures in the MHTF theory of change.

To support countries with a high burden of maternal and newborn mortality and morbidity to strengthen their health systems to provide equitable and accountable access to quality sexual, reproductive, maternal and newborn health care, the MHTF specifically contributes to four outcomes (Figure 5):

- **Outcome 1 – midwifery: Midwives deliver right based quality sexual and reproductive health information and services that are women centered, equitable, accountable, and accessible.** Evidence shows that midwives, when educated and regulated based on international standards, have the competencies to deliver 87 per cent of all essential sexual, reproductive, maternal and newborn health services. They can help avert two-thirds of all maternal and newborn deaths.²¹ Building on the previous phases of the MHTF, this outcome aims to further accelerate the delivery of quality midwifery care by expanding the scope of work from a focus on strengthening midwifery education, regulation and associations to also bolstering midwifery workforce strategies, including through the deployment of midwives and improvements in their work environment (in line with the new UNFPA Midwifery Strategy 2017-2030). In addition, Phase III will support midwives to address the sexual and reproductive health needs of the most vulnerable and disadvantaged women and adolescent girls.
- **Outcome 2 – emergency obstetric and newborn care: Referral maternity facilities are staffed with skilled attendants at birth and monitored to deliver quality and accessible essential sexual and reproductive healthcare, including EmONC.** As women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth, investing in improved access to and quality of care, especially EmONC, is essential. Despite a global increase in the coverage of skilled birth attendance, associated declines in maternal and newborn mortality and morbidity have been modest, and for stillbirths, virtually non-existent. One major reason is the lack of access to quality EmONC. Countries therefore need effective

21. State of the World's Midwifery Report 2014.

Figure 5: MHTF Phase III detailed change model



plans and monitoring systems to strengthen their national network of referral facilities to ensure access to quality basic and comprehensive EmONC services. Building on lessons learned from MHTF Phase II, this outcome is moving from technical support for conducting baseline surveys on EmONC to the provision of strategic support on how to use available data on EmONC for defining national networks of facilities. There will be an emphasis on implementing a monitoring and quality improvement process for EmONC and sexual and reproductive health more broadly. This approach was initiated during Phase II in six countries and will be scaled up to more countries during Phase III. In addition, Phase III will offer further support to post-partum and post-abortion family planning in EmONC facilities in terms of access and monitoring. Other objectives will be to strengthen national capacities for and access in EmONC facilities to the screening and treatment of precancerous lesions for cervical cancer prevention.

- **Outcome 3 – maternal and perinatal death surveillance and response: Causes of maternal and perinatal deaths are identified and addressed through MPDSR programmes to improve quality of care.** A key intervention for improving maternal, perinatal and neonatal survival is understanding the number and causes of deaths. Systematic analyses of overall mortality trends, as well as events and contributing factors leading to individual deaths can identify health system barriers, and inspire local solutions to prevent such deaths in the future. MPDSR aims to provide notification of maternal and perinatal deaths, and to review and analyse them to address gaps in the availability and quality of care. Building on previous phases, work under this outcome will further support the implementation of the MPDSR programme framework (guidelines and tools, mandatory notification, a costed national plan included in the maternal and newborn health plan and a functioning MDSR committee) set up by most countries during Phase II. The objectives of Phase III are to improve notification of maternal deaths, increase the number and quality of maternal death reviews, and implement multisectoral responses to address root causes of maternal and perinatal deaths.
- **Outcome 4 – obstetric fistula and other obstetric morbidities: Quality sexual and reproductive health information and services are accessible to prevent and treat obstetric fistula and other obstetric morbidities.** For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that undermine their normal functioning.^{22,23} These sequelae can affect women’s physical, mental and/or sexual health, their ability to function in certain domains (e.g., cognitive, mobility, participation in society), their body image, and their social and economic status.²⁴ The burden of maternal morbidity is estimated to be highest in low- and middle-income countries, especially among the poorest women.²⁵ Building on the previous phases, this outcome will entail further focus on strengthening national programmes for ending fistula. The MHTF will specifically support improving data on obstetric fistula, providing upstream technical support to help countries develop and implement costed national strategies for ending fistula, and expanding evidence-based advocacy to boost national ownership. A focus on strengthening national capacities for ending fistula will support the UNFPA-led global Campaign to End Fistula,²⁶ and will complement the work done by other UNFPA

22. L. Ashford, 2002, “Hidden suffering: disabilities from pregnancy and childbirth in less developed countries,” Population Reference Bureau.

23. M. E. Reichenheim, F. Zylbersztajn, C. L. Moraes and G. Lobato, 2009, “Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators.” *Archives of Gynecology and Obstetrics* 280: 337-43.

24. R. C. Pacagnella, J. G. Cecatti, R. P. Camargo, C. Silveira, D. T. Zanardi, J. P. Souza, et al. “Rationale for a long-term evaluation of the consequences of potentially life-threatening maternal conditions and maternal ‘near-miss’ incidents using a multidimensional approach.”

25. K. T. Storeng, S. F. Murray, M. S. Akoum, F. Ouattara and V. Filippi V, 2010, “Beyond body counts: a qualitative study of lives and loss in Burkina Faso after ‘near-miss’ obstetric complications,” *Social Science and Medicine* 71: 1749-1756. Review of the relative use of its diagnostic indicators.” *Archives of Gynecology and Obstetrics* 280: 337-43.

26. www.endfistula.org

funds and partners on prevention, treatment (including campaigns) and socioeconomic rehabilitation. This outcome will also help improve data on other obstetric morbidities to inform national maternal health strategy and programmes.

These four outcomes are themselves driven by 15 outputs. As part of its Results Indicators Framework, the MHTF has defined indicators and strategic interventions to contribute to the achievements of the four outcomes as described in the next section.

5.2 Strategic Interventions

The MHTF's four interventions areas reinforce each other across the focused health system building blocks. The MHTF will support improving capacities and workforce strategies for midwives. They should be primarily deployed in EmONC facilities and should get continuous support, as part of a team of health-care providers, to ensure quality care. Midwives are also key actors of the MPDSR process, and they are central for the prevention and treatment (with surgeons and others) of obstetric fistula and other obstetric morbidities.

The MHTF strategic interventions for Phase III will be common for all supported countries, but countries will related activities to respond to their specific needs.

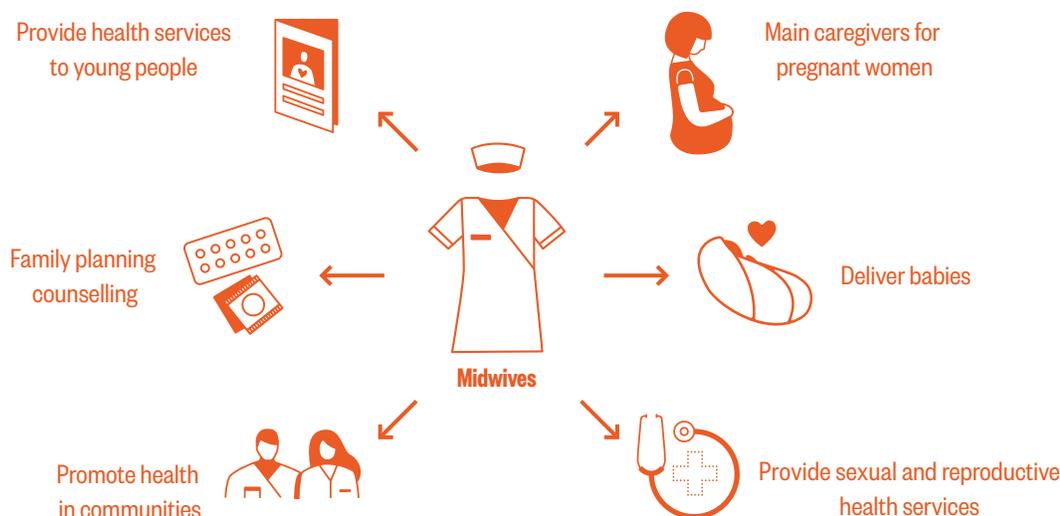
OUTCOME 1 – midwifery: Midwives deliver right based quality sexual and reproductive health information and services that are women centered, equitable, accountable, and accessible.

This outcome takes into account the central role that midwives play as caregivers for women and their newborns throughout the continuum of care from pre-pregnancy to the post-partum period. It is aligned with UNFPA's new global Midwifery Programme Strategy 2017-2030.

As illustrated in Figure 6, a midwife can provide comprehensive sexual and reproductive health information and services – including family planning, antenatal care, safe normal deliveries, basic EmONC, essential newborn care, prevention of sexually transmitted infections and transmission of HIV from mother to child, prevention of fistula and other morbidities, and prevention of FGM/C.

Figure 6

The central role of midwives in integrated sexual and reproductive health information and services



Midwives are also essential in providing culturally sensitive and age-appropriate adolescent sexual and reproductive health care, and comprehensive sexuality education.

The MHTF Phase III will continue supporting countries to strengthen the quality of midwifery education and training, particularly in the areas of safe abortion (where legal), post-abortion care, adolescent health friendly services, comprehensive sexuality education, non-communicable diseases like cervical cancer, and respectful maternity care in dealing with marginalized populations such as adolescent girls, persons with disabilities and Lesbian, Gay, Bi-Sexual, Transgender and Intersex (LGBTI) communities.

In addition, the MHTF will support countries in strengthening workforce policies to ensure the deployment, equitable distribution and retention of midwives, and to create a work environment that empowers midwives. This includes, for example, access to medical equipment and supplies, referral mechanisms and conducive working conditions. Empowering midwives (who are mainly women themselves) improves gender equality by reducing financial and other gaps between men and women.

Linkages between midwifery, fistula prevention and elimination of FGM/C (through linkages with the UNFPA/UNICEF joint programme to eliminate FGM/C) will be further expanded and strengthened. The engagement of midwives in collecting, analysing and using data as part of MPDSR and the deployment of midwives in EmONC facilities will be other priorities.

Five outputs and nine strategic interventions support the outcome on midwifery.

Output 1: Support countries to strengthen the education of midwives.

This output entails building a fully skilled and competent midwifery workforce, educated according to global standards set by the International Confederation of Midwives (ICM) and the WHO. The workforce should meet national needs, depending on the population and the number of pregnancies each year. The MHTF will support countries to ensure that midwives are educated in accredited schools linked to accredited EmONC facilities. It will also support countries to have an adequate number of competent tutors with the required ICM/WHO competencies, and to ensure the availability of continuous professional development and access to career progression pathways for midwives. To achieve this output, the MHTF proposes the following strategic interventions.

- **Intervention 1.1 Improving the capacity of midwifery schools to provide quality pre-service midwifery education** by harmonizing the curriculum to ICM/WHO standards (ensuring that it is gender-sensitive, and that adolescent health friendly services and issues of safe abortion and post-abortion care are adequately covered), equipping the schools with necessary materials (including e-learning), training educators and ensuring compliance with national accreditation mechanisms. This entails the revisions of curriculums to ICM/WHO standards (ensuring that the curriculum is gender sensitive and midwives are educated in providing adolescent-friendly health services, respectful care and safe abortion –where legal- and post abortion care), training of educators, equipping schools with necessary materials (e.g. books, training equipment and materials - including e-learning modules), and ensuring compliance of schools with national accreditation mechanism (based on recommended international standards). Quality of care covers both the provision and experience of care. This intervention will therefore also ensure that respectful and women-centered maternity care are included in the pre-service education of midwives, and that midwives are trained to meet the special needs of the most vulnerable and marginalized women and adolescent girls.
- **Intervention 1.2 Developing national education programmes for bachelor of science degrees in midwifery, and masters and/or doctorate levels to support career progression options for midwives.** This aims at improving the motivation of midwives, and provides midwifery tutors with the opportunity to have higher education levels than their students.

- **Intervention 1.3** Developing and supporting a standardized competency-based midwifery bridging education programme and competency development trainings for midwives and tutors. In-service bridging education refers to competency-based midwifery training programmes for nurses or other health care professionals for 12 to 18 months. In-service competency development training refers to shorter trainings focusing on skills in basic EmONC, safe abortion (where legal), post-abortion care, cervical cancer screenings, family planning and essential newborn care. This intervention also includes training of tutors in teaching skills, clinical skills and mentorship.

Output 2: Support countries to strengthen the regulation of midwives.

This output involves strengthening the midwifery regulatory body (midwifery council or nursing and midwifery council/board, or other body regulating midwifery). It also aims to support countries to develop the regulatory framework to ensure that midwifery is an autonomous profession, and that midwives are able to provide quality sexual and reproductive health services, and be held accountable for their performance. To achieve this output, the MHTF proposes the following intervention.

- **Intervention 2.1** Strengthening midwifery regulatory bodies to support the development and implementation of a midwifery act, midwifery scope of practice, (re)licensing, examination, school accreditation standards, grievance/complaint redressal mechanisms, and regular monitoring data on midwifery workforce availability, capacity, distribution, deployment and retention.

Output 3: Support countries to strengthen the capacities of midwifery associations.

This output includes strengthening the organizational, communication, advocacy and leadership capacities of national midwifery associations. Strong midwifery associations help raise the profile of midwifery, represent the professional needs of midwives, and provide professional support and continuous professional development. Associations also enable the profession to become autonomous, strengthen the engagement of midwives in policy making, and help secure an enabling environment for midwives to practice. To achieve this output, the MHTF will support the following strategic intervention.

- **Intervention 3.1** Strengthening national midwifery associations through supporting:
 - Implementation of a costed strategic action plan that is no more than five years old;
 - Leadership capacity, including engagement of young midwifery leaders;
 - Communication, advocacy and resource mobilization capacities;
 - Organizational capacity (e.g., membership);
 - Capacity to provide continuous professional development of midwives; and
 - Improved access to quality sexual and reproductive health information by adolescents, such as through social and traditional media and other means, including so-called “green lines” where young people remain anonymous for getting information.

Output 4: Support countries to strengthen the midwifery workforce through increased use of gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives.

Conducive workforce policies are essential to ensure that educated and trained midwives are properly and equitably recruited, deployed and retained. This output will ensure that midwifery gaps and needs are properly assessed, that there is continuous generation and tracking of relevant midwifery workforce data, and that evidence-based human resources for health policies have midwifery adequately mainstreamed in them. To achieve this output, the MHTF will support the following strategic interventions.

- **Intervention 4.1** Supporting an updated midwifery gap analysis or workforce needs assessment or midwifery services framework that can feed into health-care human resource strategies.
- **Intervention 4.2** Supporting governments to develop a midwifery workforce policy and strategy. This should include, for example, defining equitable, gender-sensitive recruitment, placement and retention strategies; support for career pathways for midwives, bridging education, timely deployment and adequate remuneration packages.
- **Intervention 4.3** Generating and using midwifery-specific workforce data on a continuous basis.

Output 5: Support countries to ensure an enabling work environment for midwives.

This output comprises fostering an enabling environment for midwives, including but not limited to midwifery students, faculty, mentors, practicing midwives, and midwives in leadership, management and policy positions. To achieve this output, the MHTF will support the following strategic intervention.

- **Intervention 5.1** Supporting governments to develop policies that regulate the work environment for midwives, including supportive supervision mechanisms, mentorship programmes and capacity-building opportunities. This would include advocacy for legal and policy frameworks ensuring a conducive and safe work environment.

Table 1

MHTF Phase III (2018-2022) overview of strategic interventions for Outcome 1 – midwifery

Outputs (and related country level indicators)	Strategic interventions	Mostly contributing to
MHTF OUTCOME 1 – midwifery		
Midwives deliver right based quality sexual and reproductive health information and services that are women centered, equitable, accountable, and accessible		
Output 1: Strengthened education of midwives		
Output 1 indicator: Number of midwifery schools (public and private) accredited by the government based on the recommended international standards	Intervention 1.1 Improve the capacity of midwifery schools to provide quality pre-service midwifery education by harmonizing the curriculum to ICM/WHO standards (ensuring that it is gender-sensitive, and that adolescent health friendly services and issues of safe abortion and post-abortion care are adequately covered), equipping the schools with necessary materials (including e-learning), training educators and ensuring compliance with national accreditation mechanisms (based on the recommended international standards)	'quality of care'
	Intervention 1.2 Develop national education programmes for bachelor of science degrees in midwifery, and masters and/or doctorate levels to support career progression options for midwives	'quality of care'
	Intervention 1.3 Develop and support a standardized competency-based midwifery bridging education programme and competency development trainings for midwives and tutors	'quality of care'
Output 2: Strengthened regulation of midwives		
Output 2 indicator: A regulatory body for midwifery that regulates midwifery practice for quality care and client safety and satisfaction is in place	Intervention 2.1 Strengthen midwifery regulatory bodies to support the development and implementation of a midwifery act, midwifery scope of practice, (re)licensing, examination, school accreditation standards, grievance/complaint redressal mechanisms, and regular monitoring data on midwifery workforce availability, capacity, distribution, deployment and retention	'accountability'
Output 3: Strengthened capacities of midwifery associations		
Output 3 indicator: Midwifery associations provide continuous professional development for midwives	Intervention 3.1 Strengthen national midwifery associations through supporting: <ul style="list-style-type: none"> • Implementation of a costed strategic action plan that is no more than five years old • Leadership capacity, including engagement of young midwifery leaders • Communication, advocacy and resource mobilization capacities • Organizational capacity (e.g., membership) • Capacity to provide continuous professional development of midwives • Improved access to quality sexual and reproductive health information by adolescents, such as through social and traditional media and other means, including so-called "green lines" where young people remain anonymous 	'accountability'
Output 4: Strengthened midwifery workforce through increased use of gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives		
Output 4 indicator: A Human Resources for Health Policy that covers midwifery is available	Intervention 4.1 Support an updated midwifery gap analysis or workforce needs assessment or midwifery services framework that can feed into health-care human resource strategies	'accountability'
	Intervention 4.2 Support governments to develop a midwifery workforce policy and strategy	'accountability'
	Intervention 4.3 Generate and use midwifery-specific workforce data on a continuous basis	'accountability'
Output 5: Ensured an enabling work environment for midwives		
Output 5 indicator: Measures (e.g. policies, incentives) to create an enabling environment for midwives are taken	Intervention 5.1 Support governments to develop policies that regulate the work environment for midwives, including supportive supervision mechanisms, mentorship programmes and capacity-building opportunities	'accountability'

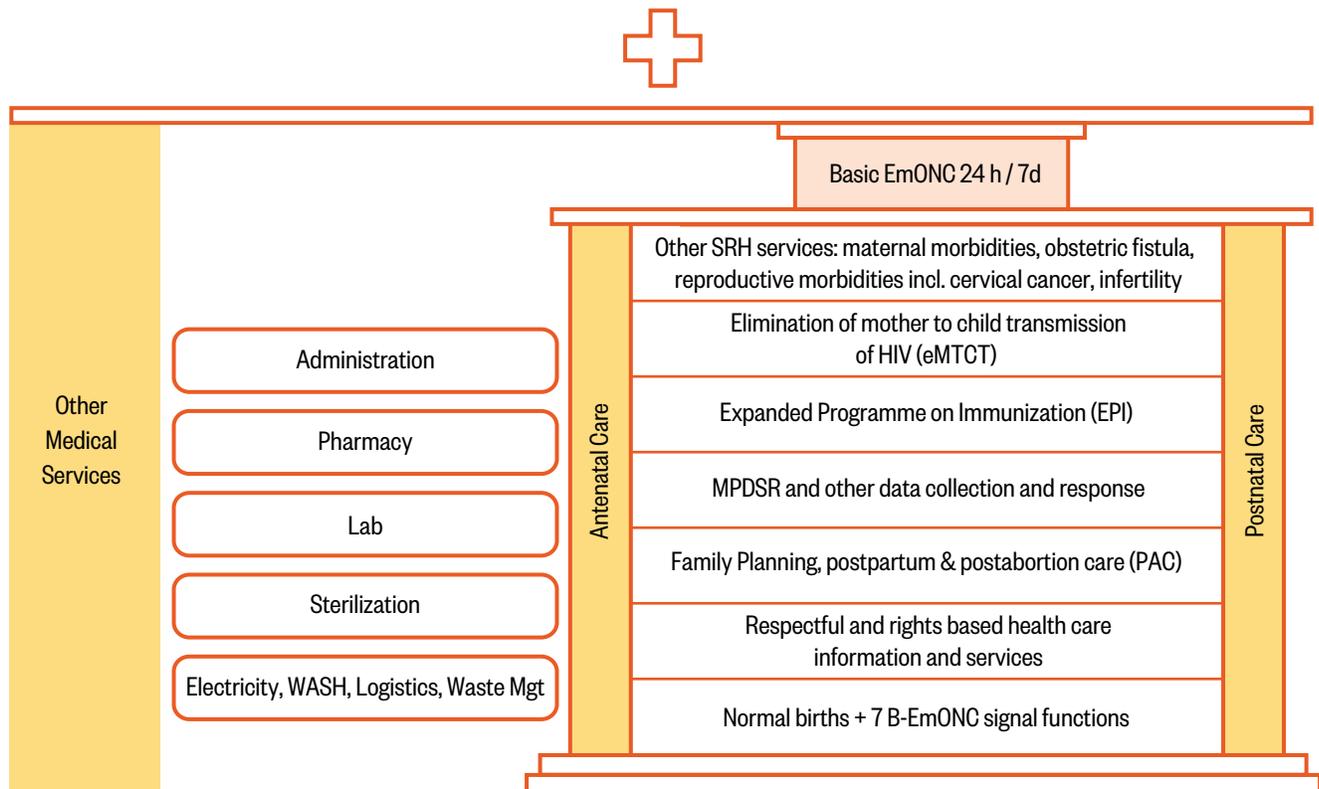
OUTCOME 2 – EmONC: Referral maternity facilities are staffed with skilled attendants at birth and monitored to deliver quality and accessible essential sexual and reproductive healthcare, including EmONC.

Most countries with a high burden of maternal mortality and morbidity made little progress in reaching the MDG maternal mortality target by 2015. This shortfall has drawn the attention of many governments to the need for strengthening maternal health, providing an opportunity to review maternal and newborn health interventions. A particular focus is on referral facilities (EmONC facilities) where the full set of maternal and newborn services are expected to be provided. MHTF is supporting health ministries in addressing maternal and newborn health gaps and issues at a national scale.

With an estimated 15 per cent of pregnancies likely to develop an obstetric complication that can lead to disability or death, health systems should ensure that all pregnant women can access a functioning EmONC facility providing respectful and quality care. In most countries with a high burden of maternal mortality and morbidity, however, access is challenging for the majority of the population. On average, only 30²⁷ per cent of obstetric complications are managed in functioning EmONC facilities. Access to EmONC is even more challenging for the poorest women, adolescent girls and indigenous women, among other excluded groups who face socioeconomic discrimination in terms of access to health care.

Figure 7

The missions of a basic EmONC facility in providing essential sexual and reproductive health services



27. UNFPA annual MHTF-supported country survey, 2017

The MHTF in Phase III will support health ministries to strengthen or design their national network of referral maternity facilities to manage emergency situations and deliver comprehensive and basic EmONC²⁸.

As illustrated by Figure 7, in addition to providing good quality services to manage basic obstetric and neonatal complications 24 hours a day, 7 days a week, B-EmONC facilities are key contributors to the integration of sexual and reproductive health information and services. They provide immediate post-partum family planning (including long-term methods), ante- and postnatal care, safe abortion (where legal), post-abortion care, prevention of mother-to-child transmission of HIV, immunization and cervical cancer prevention. They also perform maternal death reviews.

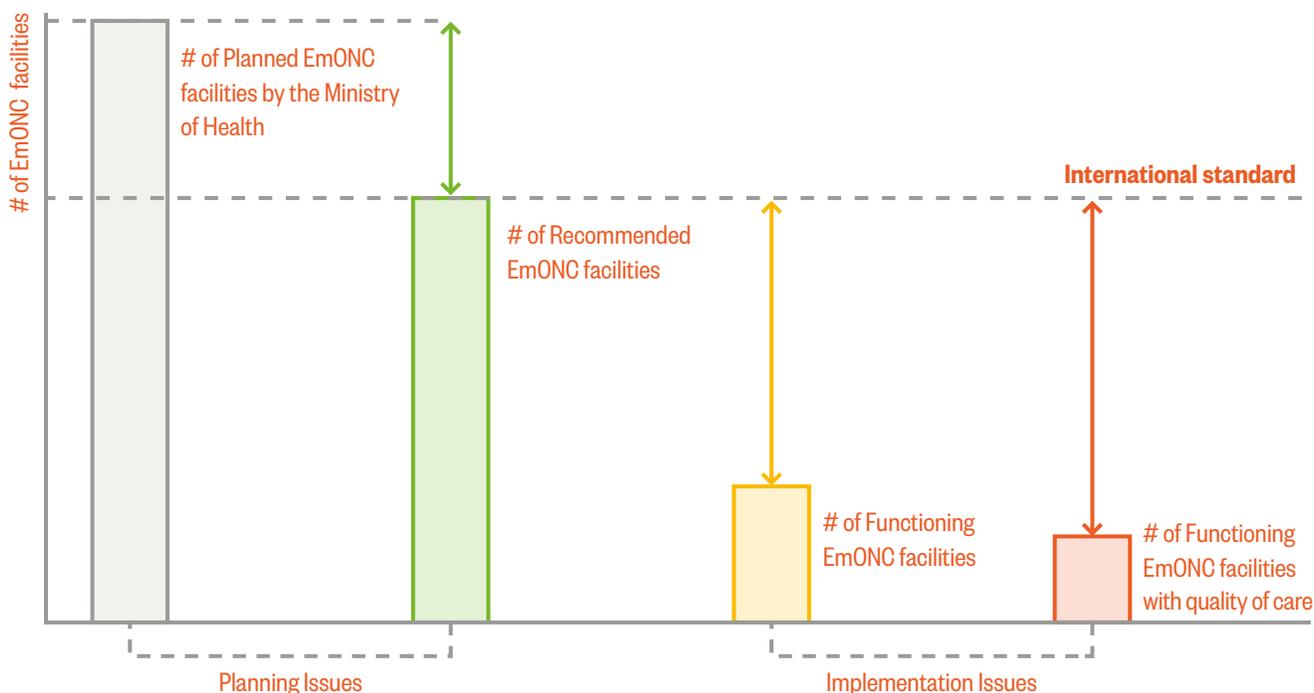
The EmONC referral system needs to be equitably distributed throughout the country to cover the majority of the population. It needs to be linked with peripheral health facilities and communities. Facilities should be staffed with skilled health workers (in particular midwives, obstetricians and anaesthetists), and monitored regularly to ensure quality services.

Improving the quality of care has proven to significantly reduce maternal mortality and morbidity. But this strongly depends on the quality of the pre-service education of midwives, and their careful deployment as part of a team in EmONC facilities.

Figure 8

Network of EmONC facilities face planning and implementation issues

Source: Adapted from Lynn Freedman, *Averting Maternal Death and Disability*, Columbia University, New York (based on EmONC Needs Assessments of 15 countries)



28. AMDD, WHO, UNFPA and UNICEF, 2009, *Monitoring emergency obstetric care: a handbook*. A basic EmONC facility is one in which all seven basic EmONC signal functions are performed. A comprehensive EmONC facility is one in which all seven basic EmONC signal functions are performed as well as caesarean sections and blood transfusions.

As illustrated by Figure 8, the referral network of EmONC facilities in most countries, whenever it exists, is not functioning due to a lack of strategic vision. This is mainly a “planning issue” – where too many designated facilities are planned compared to the international standard of five facilities per 500,000 people (green arrow). Other gaps involve the lack of data for programme management, skilled attendants at birth, anaesthetists deployed in facilities and referral capacity for emergencies. These are “implementation issues” – where scarce resources are spread across too many facilities for them to function well, while there is no regular monitoring to catch lapses in the quality of care (yellow and red arrows).

The MHTF has developed a six-step approach to address planning and implementation issues. On planning, it supports countries in using GIS to ensure that facilities are strategically distributed to optimize access by pregnant women within at most two hours of travel time. The proposed approach supports regular monitoring of key sexual and reproductive health indicators by facility and district/regional staff, and the establishment of quality improvement cycles. With MHTF support, six countries in sub-Saharan Africa have already moved in this direction. Four outputs and 12 strategic interventions support the MHTF outcome on EmONC.

Output 6: Support countries to define and monitor the national network of EmONC facilities, and to strengthen referral linkages within this network.

This output encompasses assisting countries to define and support their national network of EmONC facilities, set up regular (e.g., quarterly) monitoring mechanisms, and strengthen evidence-based analysis for improving the availability and quality of care. To achieve this output, the MHTF will support the following strategic interventions.

Specifically, to address the “planning issues” in EmONC development, the MHTF will assist with:

- **Intervention 6.1 Conducting a national EmONC needs assessment (or rapid assessment).** This consists of supporting (co-)financing an assessment of all facilities with obstetric activities (census of maternities). Such assessment provides an updated baseline of the availability, coverage, and quality of maternal and newborn health services to improve strategic planning of the national network of EmONC facilities.
- **Intervention 6.2 Designing the national EmONC facility network using GIS technology to prioritize facilities and analyse referral links between basic and comprehensive facilities.** This helps countries identify or refine their national network, based on the data of the needs assessment, using objective prioritization criteria and a GIS tool (AccessMod). It supports the strategic selection of a limited number of designated EmONC facilities, preferably corresponding to the international standard of five EmONC facilities per 500,000 inhabitants. The aim of such prioritization is to focus efforts and resources on making selected facilities function well and provide quality care.

To address the “implementation issues” in EmONC development, the MHTF will aid in:

- **Intervention 6.3 Monitoring the national network of EmONC facilities.** This should be done on a regular basis (e.g., quarterly), using national tools, procedures and systems. It should focus on obstetric and newborn activity, staff availability and referral links. Special attention will be given to strengthening the capacities of health providers in data analysis to improve the quality of care.
- **Intervention 6.4 Providing technical assistance for addressing referral links between comprehensive and basic EmONC facilities, and with peripheral facilities.** This comprises strengthening and monitoring the capacity of the health system to refer a woman with obstetric complications to the adequate level of care. It is critical for the network of EmONC facilities, as a functioning basic facility depends on timely referrals to a comprehensive facility. At the community level, the MHTF will advocate for individual birth plans to include scenarios for referral in case an obstetric complication occurs. A GIS approach combined with community sensitization in the catchment area of an EmONC facility can strengthen the capacity of the health system and communities to manage these situations.

Output 7: Support countries to strengthen the capacities of skilled birth attendants in EmONC facilities to provide quality sexual and reproductive health services.

This output guides interventions to strengthen the capacities of graduated midwives to manage obstetric and newborn care (including basic EmONC), and to provide sexual and reproductive health care. Supportive supervision and mentorship programmes for midwives will be supported at work sites. The MHTF will also support strengthening national capacity in anaesthesia through technical support to pre-service training for nurse anaesthesiologists and their deployment in comprehensive EmONC facilities, which also provides other surgical benefits. To achieve this output, the MHTF will support:

- **Intervention 7.1 Strengthening clinical and educational capacities in functioning EmONC facilities used by the ministry of health as pre-service training centres for midwifery students.** This intervention will help countries to upgrade functioning EmONC facilities into accredited pre-service education centres. Through high educational and scientific standards, and practice training, these centres will focus on capacity-building for the provision of quality sexual and reproductive health care. Midwifery students will have the opportunity to practice obstetric care, learn about management of emergency obstetric and newborn care, and provide sexual and reproductive health care in an integrated manner, including family planning; cervical cancer prevention; the prevention, diagnosis and treatment of sexually transmitted infections; and the clinical management of gender-based violence. They will also be trained in the management of maternal death reviews. Priority will be given to EmONC pre-service education centres that are linked to midwifery schools.
- **Intervention 7.2 Strengthening on-site supportive supervision and mentorship programmes for the midwifery workforce in targeted EmONC facilities.** This intervention will consist in supporting countries to design and implement evidence-based in-service training, such as formative supervision and mentorship programmes. With regional support, the MHTF will encourage partners in orienting investment to programmes shown to improve skills in a sustainable way. The MHTF will also focus on supporting countries to provide solid reports on mentorship programmes, including quantitative and qualitative analysis and data on achievements.
- **Intervention 7.3 Supporting pre-service education of anaesthetists (including nurse anaesthetists) and monitoring their deployment in hospitals and comprehensive EmONC facilities.** This intervention will help strengthen the ability of comprehensive EmONC facilities to perform surgery. Similar to the planned MHTF support in midwifery, this includes support for situation analysis, regulation of education and elaboration of a pre-service curriculum in anaesthesia, combined with specific support to national schools for nurse anaesthesiologists.

Output 8: Support countries to strengthen the functioning of the national network of EmONC facilities to provide quality sexual and reproductive health services.

This output involves supporting countries to strengthen the capacities of providers in using maternal and newborn health data monitored in EmONC facilities to upgrade designated facilities and improve the quality of sexual and reproductive health care. To achieve this output, the MHTF will support the following strategic interventions.

- **Intervention 8.1 Encouraging coordination mechanisms to upgrade designated basic EmONC facilities to fully functioning facilities.** This will support coordination mechanisms among stakeholders assisting health ministries in developing national EmONC networks. All stakeholders should ensure that gaps in EmONC signal functions are documented and addressed at the national level, leveraging coordination mechanisms to ensure national scale. The MHTF will also specifically focus on the reduction of gaps in signal functions in the EmONC facilities located in UNFPA's regions of focus (identified in collaboration with the health ministry). For countries that have not yet defined their national network, MHTF support will be provided only to a few maternity facilities with the potential to be upgraded to basic EmONC facilities, serving advocacy purposes, or to become basic EmONC pre-service education centres for midwives. Another possibility will be to support to basic EmONC facilities in areas with high proportions of indige-

nous peoples. Coordination mechanisms are critical to ensure that the needed investments in the infrastructure of the designated EmONC facilities are made, including investments to improve availability of electricity and Water, Sanitation and Hygiene (WASH). The monitoring of the national network of EmONC facilities will enable the identification of infrastructure gaps and can help drive required investments.

- **Intervention 8.2** Supporting the work of midwives (as a team) in providing sexual and reproductive health services in EmONC facilities. This intervention aims at advocating and providing technical support for compliance with national human resources standards, in particular for midwives, to ensure effective team work in designated EmONC facilities that function 24 hours/7 days.
- **Intervention 8.3** Supporting coordinated bottom-up approaches using EmONC facility data to improve the quality of care in sexual and reproductive health. This intervention helps improve quality of care in designated EmONC facilities. The MHTF will promote implementation of national protocols and standards in sexual and reproductive health, and support facility staff to produce, collect and analyse data to improve their work. This effort will include support for developing or updating health facility registers related to sexual and reproductive health to ensure that national protocols and standards are used. Subnational workshops will encourage sharing indicators and best practices between districts and EmONC facilities, with workshop results and recommendations synthesized in national reports on the functioning of the EmONC facility national network. In addition of collecting, analyzing, and using quantitative data and Maternal and Newborn Health (MNH) indicators, the MHTF will also support the organization of patient satisfaction surveys on the provision and experience of care in the national network of EmONC facilities.

Output 9: Support countries to improve the integration of quality sexual and reproductive health services in the national network of EmONC facilities.

This output will support countries to strengthen the integration of sexual and reproductive health and rights. The MHTF will assist and monitor integration of care in the national EmONC facility network, where integration processes are more likely to be higher in quality. To achieve this output, the MHTF will support the following strategic interventions.

- **Intervention 9.1** Supporting the availability and utilization of family planning methods in maternity wards. This intervention will entail advocating the inclusion of immediate post-partum family planning and post-abortion care contraception in the sexual and reproductive health and rights policy, and clearly defined protocols of care. The MHTF will also support countries to ensure that the full range of modern methods of contraception is available in maternity wards (prioritizing EmONC facilities) and delivered by skilled health providers as immediate post-partum family planning and post-abortion care contraception.
- **Intervention 9.2** Supporting cervical cancer programme management and the implementation of the screen and treat approach in functioning EmONC facilities. This will support countries to define a strategy to address cervical cancer, and develop a national cervical cancer programme with a costed plan and monitoring tools. The MHTF will also assist countries to implement secondary cervical cancer prevention (the “screen and treat” approach) in functioning EmONC facilities. This will entail training midwives and nurses on visual inspection, supplying required equipment and logistical capacities, analysing data, supervising staff and monitoring.

Table 2

MHTF Phase III (2018-2022) overview of strategic interventions for Outcome 2 – EmONC

Outputs (and related country level indicators)	Strategic interventions	Mostly contributing to
<p>MHTF OUTCOME 2 – EmONC Referral maternity facilities are staffed with skilled attendants at birth and monitored to deliver quality and accessible essential sexual and reproductive healthcare, including EmONC</p>		
<p>Output 6: Defined and monitored national network of EmONC facilities, and strengthened referral linkages within this network</p>		
<p>Output 6 indicator: The national EmONC facility network is defined and monitored</p>	<p>Intervention 6.1 Conduct a national EmONC needs assessment (or rapid assessment)</p>	<p>'accountability'</p>
	<p>Intervention 6.2 Design the national EmONC facility network using GIS technology to prioritize facilities and analyse referral links between basic and comprehensive facilities</p>	<p>'equity in access'</p>
	<p>Intervention 6.3 Monitor the national network of EmONC facilities</p>	<p>'accountability'</p>
	<p>Intervention 6.4 Provide technical assistance for addressing referral links between comprehensive and basic EmONC facilities, and with peripheral facilities</p>	<p>'equity in access'</p>
<p>Output 7: Strengthened capacities of skilled birth attendants in EmONC facilities to provide quality sexual and reproductive health services</p>		
<p>Output 7 indicator: The national mentorship programme for midwives is monitored</p>	<p>Intervention 7.1 Strengthen clinical and educational capacities in functioning EmONC facilities used by the ministry of health as pre-service training centres for midwifery students</p>	<p>'quality of care'</p>
	<p>Intervention 7.2 Strengthen on-site supportive supervision and mentorship programmes for the midwifery workforce in targeted EmONC facilities</p>	<p>'quality of care'</p>
	<p>Intervention 7.3 Support pre-service education of anaesthetists (including nurse anaesthetists) and monitoring their deployment in hospitals and comprehensive EmONC facilities</p>	<p>'quality of care'</p>
<p>Output 8: Strengthened functioning of the national network of EmONC facilities to provide quality sexual and reproductive health services</p>		
<p>Output 8 indicator: Direct Obstetric Case Fatality Rate in functioning EmONC facilities</p>	<p>Intervention 8.1 Encourage coordination mechanisms to upgrade designated basic EmONC facilities to fully functioning facilities</p>	<p>'quality of care'</p>
	<p>Intervention 8.2 Support the work of midwives (as a team) in providing sexual and reproductive health services in EmONC facilities</p>	<p>'equity in access'</p>
	<p>Intervention 8.3 Support coordinated bottom-up approaches using EmONC facility data to improve the quality of care in sexual and reproductive health</p>	<p>'quality of care'</p>
<p>Output 9: Improved integration of quality sexual and reproductive health services in the national network of EmONC facilities</p>		
<p>Output 9 indicator: Number of facilities of the national EmONC where at least two SRHR components are integrated</p>	<p>Intervention 9.1 Support the availability and utilization of family planning methods in maternity wards.</p>	<p>'quality of care'</p>
	<p>Intervention 9.2 Support cervical cancer programme management and the implementation of the screen and treat approach in functioning EmONC facilities</p>	<p>'quality of care'</p>

OUTCOME 3 – MPDSR: Causes of maternal and perinatal deaths are identified and addressed through MPDSR programmes.

MPDSR is a system that monitors maternal (and perinatal) deaths in real time, helps understand the underlying factors and determinants contributing to these deaths, and stimulates and guides actions to prevent future deaths. It is linked to the health information system and improves the quality of maternal health programmes by supporting multisectoral responses to address the proximate and distal determinants of maternal deaths.

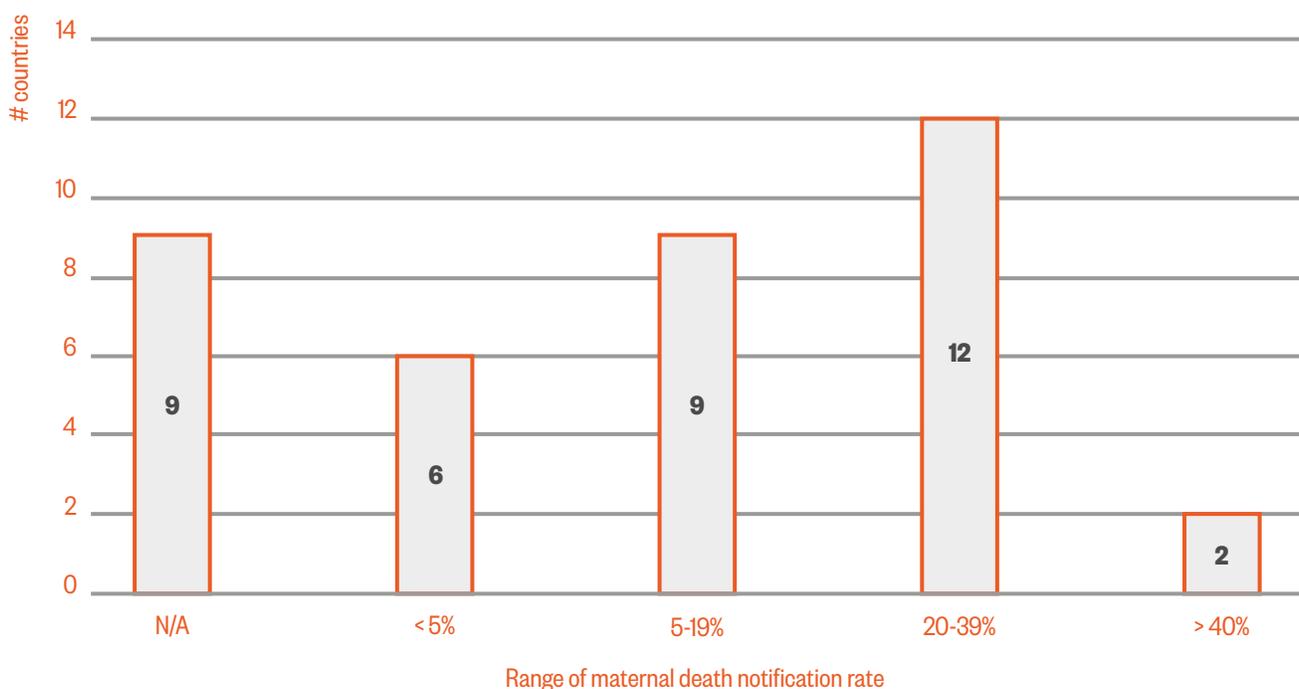
MPDSR has become more prominent in recent years. It integrates the elements of maternal (and perinatal) death monitoring, analysis and response to improve the quality of care for women and newborns, and pushes for responding to the findings of death reviews.

MHTF support to MPDSR is closely linked to the work of the MPDSR Technical Working Group, which brings together WHO, UNICEF, UNFPA, the Centers for Disease Control and Prevention, and others. This group analyses trends, strengths and weaknesses in MPDSR and suggests improvements. With its operational reach in countries, the MHTF is a consistent technical contributor to this group.

While the MDSR programme framework has been initiated in most high-burden countries, it remains incomplete in many. The coordination of stakeholders involved in MDSR is usually challenging for health ministries. Despite the fact that an intersectoral approach to MDSR has been adopted, how intersectoral coordination functions and how effectively it contributes to addressing the causes of maternal death require better monitoring and documentation.

Figure 9

Maternal death notification rate in MHTF-supported countries in 2016²⁹



29. UNFPA annual MHTF-supported country survey, 2017

Furthermore, most high-burden countries have limited focus on implementation of the MDSR programme. This is reflected by low maternal death notification rates in most countries (Figure 9) and by the absence in most countries of maternal death notification at the community level. Implementation is usually not supported by a relevant monitoring tool.

The maternal death review rate is also low in most high-burden countries.

Further, the quality of the maternal death reviews is often questioned. This negatively impacts the capacity of the system to use the reviews to address the causes of maternal deaths. In most countries, MDSR implementation is at an early stage without a fully developed “response” component.

Perinatal death surveillance and response should be integrated (when possible) in the MDSR programme, which should become an MPDSR programme. The MPDSR should be well integrated in the overall maternal and newborn health programme.

In MHTF Phase I (2008-2013), a number of countries used funds to build their MDSR programme framework and pilot its implementation. Phase II (2014-2017) consolidated the set-up of the program framework in most MHTF-supported countries and initiated implementation activities at national scale. Phase III (2018-2022) will further support national scale implementation by supporting countries to monitor performance, strengthen quality and implement the “response” component. As approved by governments, it will also support the integration of the perinatal component.

The MHTF has defined three outputs and six strategic interventions in support of the MPDSR outcome.

Output 10: Support countries to strengthen the MPDSR programme framework and coordination.

This output will support countries to set up: (a) the main programme components of MPDSR (guidelines and tools, mandatory notification, a costed national MPDSR plan included in the maternal health plan and a functioning MPDSR committee); and (b) a monitoring tool to track programme implementation (with key indicators) and the degree of intersectoral coordination by the committee. To achieve Output 10, the MHTF will support the following strategic interventions.

- **Intervention 10.1** Supporting the ministry of health’s validation of the key components of the MPDSR programme framework. The MHTF will facilitate a coordinated approach with the ministry and its stakeholders to support the elaboration of missing components. In collaboration with the main stakeholders, in particular WHO, it will support external and national technical assistance, coordination meetings, and regional and national workshops. It will also assist with the integration of the perinatal component in the MDSR plan and budget.
- **Intervention 10.2** Supporting stronger operational links at national, regional and local levels to ensure that MPDSR is jointly implemented by the ministries involved in the national maternal and newborn health plan. The MHTF will support ministries of health to design tools monitoring the implementation and performance of the MPDSR. The MHTF will also ensure that other relevant sectors like civil registration and vital statistics and subnational authorities participate in the programme.

Output 11: Support countries to strengthen national capacity for improving the quality of maternal death reviews and implementation of responses.

This output will support countries to strengthen the monitoring and analysis of the quality of maternal death reviews, a major weakness in many countries. It will also support health system actions based on the maternal death reviews in order to improve the maternal health programme, in coordination with other sectors. To achieve Output 11, the MHTF will support the following strategic interventions.

- **Intervention 11.1** Improving the quality of maternal death reviews in EmONC facilities through technical support to health-care professionals in conducting reviews. The MHTF will encourage countries to include maternal death technical guidance in a national maternal health mentorship programme. With support from the regional and national levels, mentors will be trained in maternal death review methodology to coach and support providers. As providers in most facilities fortunately do not often face maternal deaths, they do not necessarily have the training and required expertise and distance to investigate its causes. The MHTF will also encourage the reviews of the “near missed” to train providers in analysing, as a team, dysfunctions in the availability and quality of obstetric care and external causes. Where possible, the MHTF will also encourage the implementation of perinatal death reviews in EmONC facilities and possibly in peripheral facilities and at the community level. Building on its expertise in empowering staff in EmONC facilities, the MHTF will support the development of a “quality of care culture” and “no blame” approach under the leadership of the ministry of health, in collaboration with obstetricians and midwifery professional organizations and the mentorship programme. Finally, the MHTF will support the MDSR national committee to create an expert committee to analyse the quality of a randomized and anonymized sample of maternal death reviews. Special attention will be given to maternal deaths among vulnerable populations like adolescent girls, pregnant women with HIV and indigenous peoples. The approach could be extended to newborns as soon as perinatal deaths are covered by the programme.
- **Intervention 11.2** Providing financial and technical support for local, subnational and national meetings to analyse MPDSR data and to develop responses to address gaps across sectors. The MHTF will specifically support the efforts of health ministries and partners to ensure bottom-up data analysis in order to address dysfunctions in the health system. Once quality maternal death reviews are done, information should be used at the facility level, and transmitted to the district and subnational level, before being consolidated at the national level. Furthermore, maternal death anonymized data, combined with EmONC data and all other data available for maternal health, should be discussed on a regular basis – ideally, every six months – in a maternal health subnational workshop. At each level of the health system, lessons learned from data should be used to strengthen or review responses. All responses should be monitored, assessed at national and subnational levels, and recorded in annual reports. This approach should be extended to perinatal deaths as soon as they are included in the programme.

Output 12: Support countries to strengthen reporting and operational research in the MPDSR programme (processes and results on notification, review and response).

This output will support countries to develop a national MPDSR annual report. This report should include analysis of the implementation of the MPDSR national plan, progress towards defined milestones, follow-up on previous year’s recommendations and recommendations for the next year. To achieve output 12, the MHTF will support the following strategic interventions.

- **Intervention 12.1** Supporting the elaboration of an annual report to reflect on the MPDSR implementation process and results. In collaboration with the global MPDSR technical working group and UNFPA’s regional offices, the MHTF will make suggestions to harmonize the components of the annual report across countries. The report should be under the responsibility of the ministry of health, supported by key stakeholders. It should include evidence on intersectoral efforts to tackle maternal mortality. The report should describe and analyse the MPDSR implementation processes at the subnational level, measure results against milestones, follow previous recommendations and possibly provide new evidence-based recommendations. The national MPDSR committee should drive the process and ensure that available information is collected, analysed at subnational level and synthesized in the report. The MHTF will encourage the organization of a national meeting on maternal health, including on EmONC and MPDSR, drawing together stakeholders at the subnational level and other sectors to discuss findings and suggest interventions to include in workplans.

- **Intervention 12.2** Supporting advocacy and operational research to improve the maternal health programme based on maternal deaths findings. In collaboration with UNFPA's regional offices, the MHTF will support using maternal (perinatal) death reviews for operational research on targeted topics and documentation of best practices. An example would be operational research on whether the most vulnerable population, such as adolescent girls, indigenous women and stigmatized populations, face specific problems and higher mortality. Research could also be undertaken with a GIS tool to map maternal deaths and combine this information with the existing EmONC facility network and its catchment areas. Another possibility would be to better understand the intersectoral factors contributing to maternal deaths and the way these factors are addressed. The MHTF will in particular support operational research and best practices for improving the scale and quality of MPDSR at the community level.

Table 3

MHTF Phase III (2018-2022) overview of strategic interventions for Outcome 3 – MPDSR

Outputs (and related country level indicators)	Strategic interventions	Mostly contributing to
MHTF OUTCOME 3 – MPDSR		
Causes of maternal and perinatal deaths are identified and addressed through MPDSR programmes to improve quality of care		
Output 10: Strengthened MPDSR programme framework and coordination		
Output 10 indicator: Four main M(P)DSR program components are implemented	(Intervention 10.1) Support the ministry of health's validation of the key components of the MPDSR programme framework	'accountability'
	(Intervention 10.2) Support stronger operational links at national, regional and local levels to ensure that MPDSR is jointly implemented by the ministries involved in the national maternal and newborn health plan	'accountability'
Output 11: Strengthened national capacity for improving the quality of maternal death reviews and implementation of responses		
Output 11 indicator Maternal death review rate	(Intervention 11.1) Improve the quality of maternal death reviews in EmONC facilities through technical support to health-care professionals in conducting reviews	'quality of care'
	(Intervention 11.2) Provide financial and technical support for local, subnational and national meetings to analyse MPDSR data and to develop responses to address gaps across sectors	'quality of care'
Output 12: Strengthened reporting and operational research in the MPDSR programme (processes and results on notification, review and response)		
Output 12 indicator The annual M(P)DSR report is available	(Intervention 12.1) Support the elaboration of an annual report to reflect on the MPDSR implementation process and results	'accountability'
	(Intervention 12.2) Support advocacy and operational research to improve the maternal health programme based on maternal deaths findings	'quality of care'

OUTCOME 4 – Quality sexual and reproductive health information and services are accessible to prevent and treat obstetric fistula and other obstetric morbidities.

Since 2008, the MHTF has supported the most vulnerable groups of women and girls who develop obstetric fistula as a consequence of the lack of timely referral and access to quality skilled care at birth, coupled with the underlying factors of poverty, gender inequalities, socioeconomic barriers and early marriage.

Despite improvements in the prevention and treatment of obstetric fistula, millions of women and girls are still in need of treatment. Thousands of new fistula cases continue to develop each year, a violation of human rights that reflects the marginalization of those affected, and the failure of health systems to meet their needs. Further resources are critically needed to ensure that fistula is finally eliminated, and the health and well-being of women and girls who experience it are restored.

Ending obstetric fistula is critical to achieving the SDGs, as women and girls suffering from fistula are among those most left behind. Eliminating fistula is integrally linked to a number of the goals, including on poverty, health, education, gender equality, reducing inequalities and partnerships.

In 2016, United Nations Secretary-General Ban Ki-moon called upon the world “to end fistula within a generation.” This vision and goal were further strengthened by a resolution on ending fistula passed in the United Nations General Assembly in late 2016. As the leader of the Campaign to End Fistula³⁰, UNFPA is coordinating partners and stakeholders to develop a global action plan.

Contributing to the Campaign to End Fistula, the MHTF will particularly focus on strengthening the capacity of governments to develop, implement, and monitor an evidence-based national strategy for ending obstetric fistula, founded on three pillars: prevention of new fistula cases, treatment of existing fistula cases, and social reintegration and support for fistula survivors. The goal is universal access to this holistic spectrum of care for every woman who needs it. Fostering and supporting national leadership and ownership is key to ending fistula.

The main priorities that the MHTF will continue to support include the development of costed, time-bound national strategies and action plans for ending fistula; the creation or strengthening of government-led national task forces to convene all partners and stakeholders to coordinate implementation and monitoring of the national strategy; and advocacy for appropriate resources. The MHTF will also support national capacity-building to ensure that each country has a sufficient number and distribution of EmONC services to prevent fistula from occurring; expert, competent fistula surgeons and care teams to effectively treat fistula when it does occur; and comprehensive, women-centred social reintegration and rehabilitation services. The social reintegration programmes aim to break the cycle of poverty and vulnerability that render women and girls vulnerable to fistula in the first place. Further progress will be made to shift from campaigns to a more sustainable health-service delivery mode with permanent specialized fistula units offering quality care and scaled-up routine treatment capacities.

The MHTF has defined three outputs and eight strategic interventions in support of this outcome.

30. See: www.endfistula.org

Output 13: Support countries to strengthen health systems to expand access to quality treatment for obstetric fistula.

This output will support countries to develop and implement costed national fistula strategies in order to coordinate and galvanize prevention and treatment efforts. An appropriate number of facilities and health workers, according to estimates of prevalence and incidence, require equipment and training to treat the backlog of existing cases as well as new cases. Other efforts will help strengthen follow-up mechanisms, so that women receive a continuum of care, including for subsequent pregnancies. To achieve this output the MHTF will support the following strategic interventions.

- **Intervention 13.1** Supporting the ministry of health to develop a costed national strategy to end obstetric fistula and a costed operational plan. These should be aligned with the global vision of ending fistula within a generation.
- **Intervention 13.2** Supporting initiatives to prevent obstetric fistula, and enable more women and adolescent girls to access quality treatment. This intervention will support case identification and referral mechanisms through community sensitization and mobilization, surveillance/notification systems, outreach workers and use of mobile phones.
- **Intervention 13.3** Strengthening a competent health workforce trained in obstetric fistula prevention, management and repair. National capacity-building will support training of both fistula surgeons and surgical teams.
- **Intervention 13.4** Supporting the development and functioning of an appropriate number of health facilities with capacity to provide quality treatment for obstetric fistula, including follow-up.

Output 14: Foster and enhance national leadership, ownership and accountability for ending fistula and other obstetric morbidities.

This output will support countries to increase evidence-based sustainable resource mobilization, to intensify the collection and use of data in carrying out activities under the national strategy to end fistula, and to develop a national task force for fistula comprising key stakeholders to assist with and monitor implementation of the national strategy. The MHTF will support the following strategic interventions.

- **Intervention 14.1** Strengthening national capacity for evidence-based sustainable resource mobilization backing the national strategy for ending obstetric fistula.
- **Intervention 14.2** Supporting the creation/operation of a functional national task force for obstetric fistula.
- **Intervention 14.3** Supporting efforts to improve/strengthen data on obstetric fistula and other obstetric morbidities. This includes supporting data on incidence and prevalence as well as routine data on the key components and implementation of the national programme(s) for ending obstetric fistula and other obstetric morbidities (e.g., genital prolapse, severe anaemia and pelvic inflammatory disease).

Output 15: Strengthen the quality of social reintegration/rehabilitation programmes for obstetric fistula survivors.

This output will support countries to address the social and economic needs of fistula survivors, helping break the cycle of poverty and marginalization. The MHTF will help build evidence to scale up the most effective programmes. It will support the following strategic intervention.

- **Intervention 15.1** Supporting evidence-based social reintegration/rehabilitation programmes for fistula survivors. This includes support for such programmes in a national costed strategy/plan for ending fistula and related indicator framework. The MHTF will also support cost-efficient evaluations.

Table 4

MHTF Phase III (2018-2022) overview of strategic interventions for Outcome 4 – obstetric fistula and other obstetric morbidities

Outputs (and related country level indicators)	Strategic interventions	Mostly contributing to
Output 13: Strengthened health systems to expand access to quality treatment for obstetric fistula		
<p>Output 13 indicators:</p> <ul style="list-style-type: none"> – Success rate of obstetric fistula repairs at discharge – Success rate of obstetric fistula repairs at follow-up period according to the national standard 	<p>(Intervention 13.1) Support the ministry of health to develop a costed national strategy to end obstetric fistula and a costed operational plan</p>	'accountability'
	<p>(Intervention 13.2) Support initiatives to prevent obstetric fistula, and enable more women and adolescent girls to access quality treatment</p>	'equity in access'
	<p>(Intervention 13.3) Strengthen a competent health workforce trained in obstetric fistula prevention, management and repair</p>	'quality of care'
	<p>(Intervention 13.4) Support the development/functioning of an appropriate number of health facilities with capacity to treat obstetric fistula, and ensuring quality of care standards</p>	'quality of care'
Output 14: Enhanced national leadership, ownership and accountability for ending obstetric fistula and other obstetric morbidities		
<p>Output 14 indicators:</p> <ul style="list-style-type: none"> – An annual report on the implementation of the obstetric fistula program is available – Obstetric fistula incidence – Obstetric fistula prevalence 	<p>(Intervention 14.1) Strengthened national capacity for evidence-based sustainable resource mobilization backing the national strategy for ending obstetric fistula</p>	'accountability'
	<p>(Intervention 14.2) Support the creation/operation of a functional national task force for obstetric fistula.</p>	'accountability'
	<p>(Intervention 14.3) Support efforts to improve/strengthen data on obstetric fistula and other obstetric morbidities</p>	'accountability'
Output 15: Strengthened quality of social reintegration/rehabilitation programmes for obstetric fistula survivors		
<p>Output 15 indicator:</p> <p>The obstetric fistula social rehabilitation program is available and monitored</p>	<p>(Intervention 15.1) Support evidence-based social reintegration/rehabilitation programmes for fistula survivors</p>	'accountability'

6. Operating Model

6.1 Modes of Engagement

To achieve its vision, the MHTF will use various operational modalities and strategies. These comprise UNFPA's defined modes of engagement as follows:

- **Advocacy and policy dialogue** – referring to the interaction of the MHTF with national policy decision makers and other stakeholders towards the development, improvement, reform, and implementation and monitoring of policies, legislation, strategies, plans and programmes to improve maternal and newborn health, by:
 - Providing analysis, making recommendations on advocacy and policy issues, identifying opportunities, and offering options to address maternal and newborn health and broader sexual and reproductive rights and health issues. For example, the MHTF will continue to contribute to major advocacy platforms on maternal and newborn health, such as the UNFPA-led global Campaign to End Fistula. With more than 90 global partners operating in over 50 countries across Africa, Asia and the Pacific, the Arab States, and Latin America and the Caribbean, the campaign, led by UNFPA, aims to raise awareness and accelerate action to eliminate obstetric fistula. It focuses on three key interventions: prevention, treatment, and social reintegration and follow-up.
 - Convening and facilitating dialogue on policies across government ministries and agencies, and/or among government, financial and technical partners, and civil society;
 - Identifying major policy implementation issues, and developing strategies for government and partners to implement policies more effectively;
 - Advancing the IOPD agenda, including maternal and newborn health and the fulfilment of rights, and commitments by ministries, departments and agencies of government, other stakeholders and the international community to achieve zero preventable maternal and newborn deaths through appropriate frameworks of action and funding.
- **Capacity development** – referring to a set of interventions by which people skills, organizational and national systems, tools, resources and knowledge are strengthened, created, adapted, mobilized, deployed and maintained over time to achieve results. In Phase III, the MHTF will support capacity development:
 - At the individual level (for example, midwives, fistula surgeons, nurse anaesthetists) by providing training, mentoring, coaching and education incentives to strengthen skills, knowledge, experience, confidence and leadership;
 - At the institutional level (for example, midwifery associations, obstetric fistula national task forces, MPDSR national committees) by providing technical assistance and organizational development to strengthen capacities related to policies, strategies, plans, rules and regulations, procedures, collaborative structures, management and information systems, and abilities to develop and sustain partnerships; and
 - Across the overarching context in which organizations and individuals function (policies, laws, budgets, strategies, procedures, participation and social norms), making it more conducive to personal and organizational development, leadership and innovation through technical assistance, facilitation of sector-wide collaboration, and the exchange of knowledge and experiences.

- **Knowledge management** – referring to the dynamic process of generating, using and sharing quality knowledge products and evidence, including localized innovative solutions for advancing maternal health and the ICPD agenda in a timely manner. The MHTF will support national priorities and needs through creating, sharing and applying relevant knowledge and experience of what works with maximum impact and what does not, as well as supporting the adaptation of shared experiences in different contexts.
- **Partnership and coordination** – referring to building strategic connections, alliances and networks among stakeholders to exchange knowledge, solutions and innovations. As a catalytic and technical thematic fund, the MHTF will continue to strengthen its collaboration at all levels with technical working groups, partners, academics, professional associations and advocacy platforms active on sexual, reproductive, maternal, newborn, child and adolescent health.

In Phase III, the MHTF will further support countries to operationalize the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), particularly through the active involvement of MHTF focal points at country, regional and global levels in the H6 Partnership. The H6 brings together UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank, acting as the “technical arm” of the Global Strategy. It aims to coordinate SRMNCAH technical support to countries in operationalizing the Global Strategy. At country level, the involvement of MHTF focal points in the H6 partnership is critical to ensure the alignment of H6 partners (and others) on strategic interventions and to support their scale-up. For example, in Madagascar, the H6+ partnership (H6 plus the Agence Française de Développement and the United States Agency for International Development) has been instrumental in supporting the ministry of health to develop a national EmONC facility network and monitoring. Partners assist EmONC facilities in the different regions of the country. MHTF focal points at all levels will also continue to provide technical support for the development and implementation of SRMNCAH investment cases in countries benefiting from grants from the Global Financing Facility (GFF). Twenty of the 26 GFF-assisted countries were supported by the MHTF as of March 2018.

The MHTF will continue to be an active member of technical working groups such as EPMM, ENAP, the QoC Network, and the EmONC group. These advance the maternal and newborn health agenda in terms of new evidence, new/refined indicators, and operational guidance and tools to support programme implementation. The implementation expertise of the MHTF contributes to informing indicators and operational guidance.

The MHTF's collaboration with academics will continue driving innovative approaches and data that contribute to improved programme implementation. For example, MHTF collaboration with Columbia University (Averting Maternal Death and Disability, AMDD) and the University of Geneva have strengthened the approach to developing a national EmONC facility network through the use of GIS to measure geographic accessibility. Collaboration with Johns Hopkins University will provide the first global estimates of obstetric fistula prevalence and incidence. In Phase III, the MHTF will further strengthen these collaborations and pursue others with academics from supported countries.

Finally, the MHTF will continue closely working with the ICM and the International Federation of Gynecology and Obstetrics (FIGO) at the global level and with their member associations at the regional and country levels. The fund has contributed to guidance and tools developed by both organizations and to implementation at the country level. For example, since 2013, the MHTF has supported midwifery workforce assessments in five countries (Afghanistan, Bangladesh, Ethiopia, Mozambique and the United Republic of Tanzania) and gap analyses in 28 countries, with specific collaboration with the ICM in 21 francophone countries. Overall, about 33 countries (85 per cent) have done a midwifery workforce assessment or a gap analysis in the last five years.

Midwifery workforce assessments allow countries to review the implementation of midwifery programmes. They can model projections of midwifery service needs, and workforce demand and supply to inform costed scenarios and policy options for improving equitable access to quality services. Gap analyses are lighter assessments to identify key gaps in midwifery education, associations and regulations, according to ICM standards, and to systematically address these.

- **Service delivery** – referring to the provision of essential sexual and reproductive health information and services to bridge gaps. This predominantly applies to countries with the highest need and low ability to finance their programme (UNFPA’s red quadrant countries) as well as critical needs in fragile contexts. As a catalytic fund, the MHTF primarily focuses on strengthening national capacities; its service delivery support is therefore provided on an ad hoc and temporary basis. Examples of service delivery support include the procurement of kits for fistula repairs and the temporary hiring of international health workers, such as midwives serving as United Nations Volunteers during the Ebola crisis in West Africa.

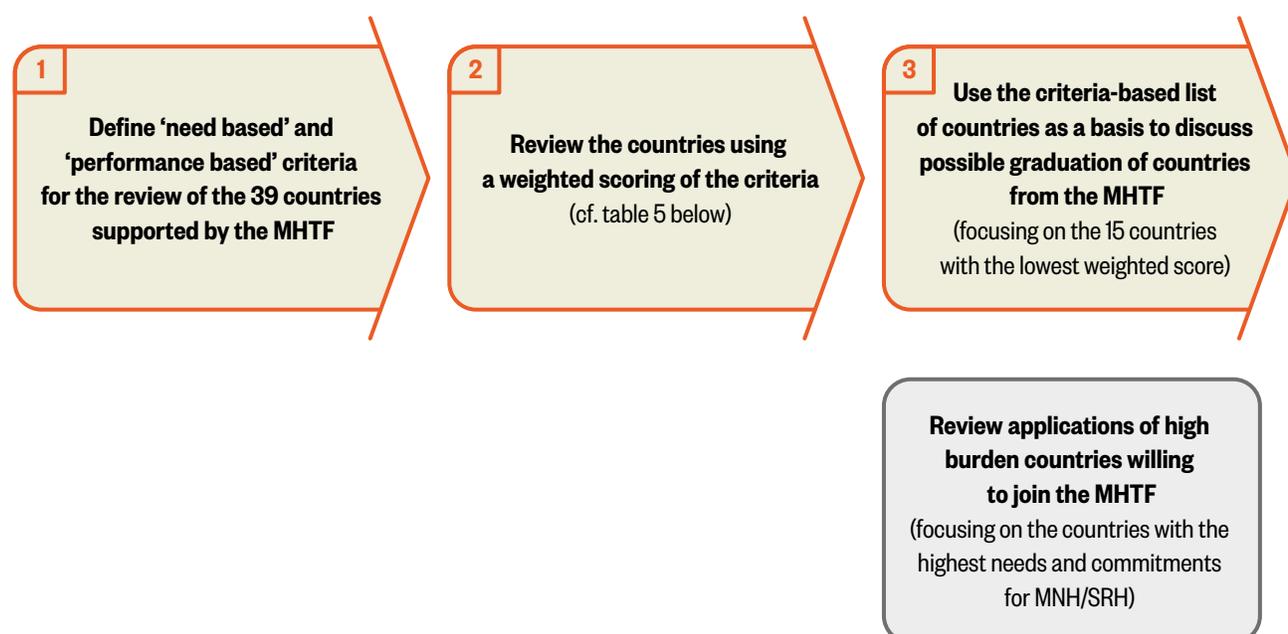
6.2 Countries designated for support

The MHTF is set up to support countries with the highest burden of maternal mortality and morbidity. In previous phases, these countries comprised 39 with a maternal mortality ratio above 300 maternal deaths per 100,000 live births.

In Phase III, the MHTF will continue focusing its catalytic support on countries with high burden of maternal mortality, defined as above 200 maternal deaths per 100,000 live births. In addition, the selection of countries in scope has taken into consideration the results and lessons learned from the implementation of the programme over the last 10 years.

Building on the transparent process set up during Phase II for the allocation of resources across countries, needs based and performance-based criteria defined in collaboration with UNFPA’s regional offices have been used to identify the countries for support in Phase III. This identification process consisted of three major steps described in Figure 10.

Figure 10
Process for identifying countries for MHTF support in Phase III



Selection criteria and related weights are described in Table 5. The MHTF will specifically focus on countries with the highest burden of maternal mortality but will also value results in countries since the launch of the MHTF in 2008. It will also emphasize UNFPA country offices with good operational performance.

Table 5

Needs-based and performance-based criteria to identify MHTF-supported countries in Phase III

Criteria Type	Criteria category and weight in formula	Criteria	Scores for criteria			
			1 (lowest score)	2	3	4 (highest score)
'Need based' criteria	Impact Indicators (40% weight)	Maternal Mortality Ratio	200-250	250-300	300-400	≥ 400
'Performance based' criteria	Result Indicators (40% weight)	EmONC availability	≤15%	16 – 34%	35 – 49 %	≥ 50%
		Maternal death notification rate	≤10%	11 – 19%	20 – 39%	≥ 40%
		Proportion of midwifery schools using the national curriculum based on ICM/WHO standards	≤29%	30 – 50%	50 – 70%	≥70%
		National costed strategy for ending obstetric fistula available	yes	–	–	–
	Performance Indicators (20% weight)	Expenditure rate (2017)	<80%	80 – 89%	90 – 94%	≥95%

Country Context

- Specific reflection for countries in humanitarian and fragile settings
- Specific reflection for countries with other funds for maternal health allocated to UNFPA Country Office for ≥ 500K USD

In light of efforts required to support countries to implement strategic interventions, the MHTF has reduced its focus from 39 to 32 high-burden countries. It will potentially include three new high-burden countries depending on available funding. Seven previously supported countries have progressively phased out from the MHTF from June 2018. These seven countries have the lowest combined needs-based and performance-based scoring after Phase II, and/or are facing chronic humanitarian contexts (with situations requiring a humanitarian approach, and where the health system has no short-term capacity for strengthening), and/or have significant other sources of funding for maternal and newborn health.

The seven countries progressively phasing out from the MHTF will use some of the funding received for 2018 to support an “exit strategy” with specific timelines and milestones, developed in collaboration with the ministry of health and partners. The strategy may, if deemed necessary, be further supported in 2019 to ensure a smooth completion of MHTF activities.

According to funding available for Phase III, three high-burden countries not yet supported by the MHTF will be invited (based on proposals from UNFPA's regional offices) to apply to join the fund. The selection of these additional countries will be based on:

- Their score on needs-based criteria (MMR).
- The commitment of the ministry of health and UNFPA's country office to the three core principles (equity in access, quality of care and accountability) and the four workstreams of the MHTF. This commitment will be assessed through analysis of national maternal and newborn health strategies and plans, recent progress in key related indicators, and remote and in-person technical discussions between UNFPA headquarters, regional offices and country offices.
- Funding for maternal and newborn health through the UNFPA country office.

6.3 Governance and Management

Governance

The MHTF will keep a light coordinating structure to strategically provide focused and catalytic technical and financial resources to selected countries. The MHTF complements UNFPA core and non-core resources. Existing UNFPA accountability lines will be used in which country office teams operate under the leadership of the UNFPA Country Representative, who reports to the Regional Director, who in turn reports to the Deputy Executive Director, Programme and the Executive Director.

As a global thematic fund for maternal and newborn health, the MHTF will continue to be coordinated by UNFPA headquarters in collaboration with UNFPA's regional offices. Oversight will be provided by an MHTF Advisory Committee, chaired by the Director of UNFPA's Technical Division and co-chaired by the Chief of the Sexual and Reproductive Health Branch, who reports to the Director of the Technical Division. The committee will be made up of representatives from donors contributing to the MHTF (one representative per donor), a representative from UNFPA's Non-Core Funds Management Unit and MHTF focal points from the five regional offices with MHTF-supported countries (West and Central Africa, East and Southern Africa, the Arab States, Latin America and the Caribbean, and Asia and the Pacific). The committee will also include representatives from the ministries of health of MHTF-supported countries (one country per region will be selected by the committee, and countries will rotate on an annual basis). Committee members may, in consultation with all members, invite other relevant parties to take part as required. The key tasks and responsibilities of the committee are described in Annex 1. It will meet once a year (mid-year) to discuss progress and results achieved, and to provide strategic directions and guidance. Meetings will take place in New York unless otherwise agreed.

A team of technical advisers and specialists based at headquarters will continue to coordinate the fund, and to provide integrated technical leadership on sexual and reproductive health and rights, midwifery, EmONC, MPDSR, and obstetric fistula and other obstetric morbidities. They will continue to work closely with regional offices, which will provide technical assistance to countries, and to MHTF planning and monitoring processes. The MHTF global team will serve as a secretariat for the Advisory Committee. The MHTF is supporting UNFPA staff members in a few countries to accelerate implementation and monitoring of strategic interventions. Many such positions are jointly supported with UNFPA Supplies to foster the integration of MHTF interventions with effective and efficient provision of essential medicines and family planning.

In terms of financial management, UNFPA created in 2015 a Non-Core Funds Management Unit that will continue to manage all UNFPA non-core funds, including the MHTF and UNFPA Supplies. The five specific goals of the unit are: 1) increased harmonization with other funds; 2) closer integration with existing strategies and programmes; 3) increased transparency in decision-making; 4) a higher level of accountability in the management of non-core funds; and 5) enhanced standardization of practices and processes. To meet these goals, the unit established four priorities: a new non-

core funds management policy, a frequent and standardized monitoring system, a needs-based resource allocation system as well as a new work-planning process with greater involvement of UNFPA's regional offices, and an earlier start to the planning process. The changes related to work planning and resource allocation took effect in 2016, with the aim of transferring funds to country offices earlier in the year, and allocating resources in accordance with pre-defined, transparent criteria based on country needs.

Management and planning

In phase III, MHTF-supported countries will develop a multi-year workplan (for 2019 to 2022) based on the MHTF strategic interventions and result indicators that best fit their context. This approach, which is different from the annual workplans developed in previous phases, aims to support country offices to develop a strategic vision on maternal and newborn health, in line with national strategies and plans, towards specific, realistic and measurable milestones. It will increase efficiency, and reduce planning and monitoring requirements. The multi-year country workplans will be developed in the second and third quarters of 2018, and implemented from January 2019. This process will be supported by the MHTF team at headquarters and MHTF focal points at the regional level.

Once the multi-year workplan is finalized and approved by the country Representative, the Regional Director, the Chief of the Sexual and Reproductive Health Branch, the Chief of the Non-Core Funds Management Unit and the Director of the Technical Division, it will be transmitted to the unit for managing the yearly disbursement of funds. Disbursement will depend on the yearly review of progress made.

Changes to the workplan's strategic interventions, activities and budget that exceed 10 per cent of the approved budget will require an official request from the UNFPA country Representative to the Chief of the Sexual and Reproductive Health Branch. After a review of the request by the MHTF team from headquarters and the regional office focal points, suggested changes will be submitted for approval by the Regional Director, the Chief of the Sexual and Reproductive Health Branch, the Chief of the Non-Core Funds Management Unit and the Technical Division Director. Changes below 10 per cent of the approved budget without changes in strategic interventions and activities will only require the approval of the UNFPA Representative and the Chief of the Sexual and Reproductive Health Branch.

At headquarters, each MHTF team member will continue to be a focal point for a set of countries (on average six to eight countries). The country focal point – in collaboration with the other members of the MHTF team, the regional office focal point and the regional desk officer of the Programme Division – will address the technical needs of countries on a continuous basis, share new evidence and guidelines in maternal and newborn health and sexual and reproductive health and rights, and coordinate MHTF planning and monitoring.

6.4 Monitoring and Evaluation

Monitoring

The MHTF Results and Indicators Framework for Phase III has been developed in alignment with UNFPA's Strategic Plan (2018-2021). As described above, the framework consists of 4 outcomes, 15 outputs and 35 strategic interventions that countries can select to best fit their context.

The indicators of the MHTF reflect progress towards improving maternal and newborn health through the three core principles of equity in access, quality of care and accountability.

The Results and Indicators Framework includes both result and process indicators that are relevant (for directly reducing preventable maternal and newborn mortality and morbidities), specific (target a specific area for improvement), measurable (quantify or at least suggest an indicator of

progress) and feasible (to be measured routinely through household surveys, health facility assessments and routine information systems), and that strengthen or complement existing monitoring frameworks (e.g., the SDGs; the Global Strategy for Women's, Children's, and Adolescent's Health; EPMM/ENAP; and the Quality of Care Network).

The MHTF outcome indicators correspond to the output indicators of the UNFPA Strategic Plan (2018-2021). Each output and strategic intervention will be measured by an indicator as detailed in Annex 2.

Indicator baselines and targets are defined based on those in the UNFPA Strategic Plan and the results from MHTF Phase II. A review of progress towards workplan milestones will take place twice a year, one at midterm implementation (June) and one at the end of the year (December).

In addition to the Results and Indicator Framework, the MHTF will collect a set of supplementary metrics (also described in Annex 2) that complement the framework, link to other strategic interventions and/or need further refinement that may be developed through the process of collection.

Evaluation

A midterm evaluation of the MHTF will be launched at the end of 2020 and is expected to provide an independent assessment of results achieved in Phase III, taking stock of the results of Phase II. The evaluation is expected to support learning among key stakeholders to inform the rest of Phase III as well as UNFPA's accountability for taking stock of progress and results achieved.

The evaluation will cover the programme's main intervention areas, its management output as well as cross-cutting themes such as gender equality, social inclusion and equity, and the catalytic role of the MHTF. It will identify lessons and good practices, and opportunities to strengthen planning, programme formulation and implementation. It will also generate knowledge on innovations supported by the MHTF.

The evaluation will be led by the Independent Evaluation Office at UNFPA,³⁰ with the support of a multidisciplinary team of externally recruited experts in themes relevant to the MHTF. The progress of the evaluation will be followed closely by an evaluation reference group consisting of technical UNFPA staff as well as other key stakeholders (such as donors and implementing partners) who are directly interested in the results. The evaluation report is expected at the end of 2021.

An endline evaluation of Phase III is planned in 2022.

6.5 Budget and Resource Mobilization

Budget

With a total budget of around \$78 million from 2014 to 2017 (of the requested \$128 million for Phase II), the MHTF has contributed to significant results in 39 countries with a high burden of maternal mortality and morbidity.

Financial resources received from donors are pooled in two thematic trust funds, one for maternal health overall and one for obstetric fistula.

In light of its vision and scope for Phase III, the estimated budget for the MHTF Phase III (from 2018 to 2022) is USD 150 million. Table 6 provides the detailed estimated budget.

30. Examples of recent evaluation reports related to sexual and reproductive health and rights are found at: www.unfpa.org/evaluation

Table 6**Detailed MHTF budget for Phase III (2018-2022)**

MHTF Phase III budget (USD)	2018*	2019	2020	2021	2022	Total for 2018-2022
1. Country level	10	16	23	27	26	103
Activities in line with MHTF strategic interventions	8	14	21	25	24	93
Human Resources	2	2	2	2	2	9.8
2. Headquarters and regional levels - technical support to countries	3.0	4.9	4.9	4.9	4.9	23
Technical assistance and global public goods	0.9	2	2	2	2	8.9
Human resources	1.7	2.5	2.5	2.5	2.5	11.7
Management & coordination (incl. audits and inter country workshops)	0.3	0.4	0.4	0.4	0.4	1.9
3. Implementing partners for direct technical assistance support to countries	0.5	2	2.5	3	3	11
Exploratory grants for innovation/operational research	0	0.5	0.5	0.5	0.5	2
Evaluation mid-term and end-line	0	0	0.6	0	0.6	1.2
Indirect Costs (7%)	1.0	1.8	2.4	2.7	2.7	10
Total requested	15	25	34	38	38	150

*Bridging year between Phase II and Phase III.

Resource mobilization strategy

In order to secure funding for the MHTF budget, UNFPA is committed to broadening the donor base among governments and non-governmental organizations, and to stimulating creative fundraising, including in collaboration with the private sector. Resource mobilization activities will include organizing panels and briefings, maintaining regular formal and informal dialogues with capital and mission-level contacts; and outreach and dialogue with parliamentarians, NGOs and other stakeholders.

A performance-based annual report on MHTF results linked with finance and resources will ensure the accountability and effectiveness of the resource mobilization strategy. A specific 'MHTF Resource Mobilization Strategy' will be developed during Q2-Q3 2018.

7. Annexes

Annex 1

Key Tasks and Responsibilities of the MHTF Advisory Committee

- To review and approve the Terms of Reference for the Advisory Committee and update and/or modify these, as necessary, over the life of the MHTF Phase III.
- To discuss and guide the MHTF priorities and strategic directions concerning, inter alia:
 - Programme management, including consistent and common approaches to costing and cost recovery, implementation modalities, results-based reporting and advocacy
 - Information and knowledge management.
- To review and approve the criteria for the allocation of MHTF resources, and to approve proposed allocations of available resources to countries, regions, and HQ.
- To review and approve Annual Progress Reports (programmatic/narrative and financial).
- To review findings of the evaluation reports and related management responses.
- To support and facilitate advocacy and resource mobilization initiatives.

Annex 2

Result Indicator Framework (with metadata, baseline and targets)

MHTF Phase III – Result Indicator Framework

Outcome 1 : Midwifery

Midwives deliver right based quality sexual and reproductive health information and services that are women centered, equitable, accountable, and accessible

Output 1: Strengthened education of midwives

Strategic Interventions for Output 1	1.1.	Improve the capacity of midwifery schools to provide quality pre-service midwifery education by harmonizing the curriculum to ICM/WHO standards (ensuring that it is gender sensitive and that adolescent health friendly services and issues of safe abortion and post abortion care are adequately covered); equipping the schools with necessary materials; training educators and ensuring compliance with accreditation mechanisms
	1.2.	Develop national education programmes for Bachelor of Science in Midwifery, Masters, and/or PhD levels to support career progression options for midwives
	1.3.	Develop and support a standardized competency based midwifery bridging education programme (12 to 18 months) and competency development trainings for midwives and tutors in BEmONC skills, safe abortion (where legal), post abortion care, cervical cancer screenings, family planning, essential newborn care, respectful maternity care (for tutors training should include teaching, clinical and mentorship skills).

Output 2: Strengthened regulation of midwives

Strategic Interventions for Output 2	2.1.	Strengthen midwifery regulatory body to support the development and implementation of midwifery act, midwifery scope of practice, (re)licensing, examination, school accreditation standards, grievance/complaint redressal mechanisms, and regular monitoring data on midwifery workforce availability, capacity, distribution /deployment and retention
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Output 3: Strengthened capacities of Midwifery Associations

Strategic Interventions for Output 3	3.1.	Strengthen the national midwifery association through supporting: (a) implementation of a costed Strategic Action Plan which is not more than 5 years old, (b) leadership capacity, including engagement of young midwifery leaders; (c) communication, advocacy, resource mobilization capacity; (d) organizational capacity of the association (e.g. membership, website, twinning); (e) capacity to provide continuous professional development of midwives.
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Output 4: Strengthened midwifery workforce strategies through increased use of gender sensitive policies, strategies, and plans to recruit, deploy and retain midwives

Strategic Interventions for Output 4	4.1.	Support an updated midwifery gap analysis/workforce needs assessment/Midwifery Services Framework that can feed into human resources for health policies
	4.2.	Support government to develop a midwifery workforce policy and strategy including, for example, defining equitable gender sensitive recruitment, placement and retention strategies, support for career pathways for midwives, bridging educational pathways, timely deployment and adequate remuneration packages
	4.3.	Generate and use midwifery-specific workforce data on a continuous basis

Output 5: Ensured enabling work environment for midwives

Strategic Interventions for Output 5	5.1.	Support governments to develop policies that regulate the work environment for midwives including supportive supervision mechanisms, mentorship programs and capacity building opportunities
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Indicators – Country level

Met need for midwifery

Number of midwifery schools (public and private) accredited by the government based on the recommended international standards

- 1.1.a. Number of midwifery schools that are accredited to a national standard aligned with WHO/ICM standards.
- 1.1.b. Number of midwifery schools that are linked to at least one accredited BEmONC and one CEmONC facility for pre-service education.
- 1.1.c. Number of midwives who graduated from pre-service education in the past year.

- 1.2. Number of midwives who graduated from BSc, Masters, and/or PhD level education.

- 1.3.a. A national validated and costed in-service bridging programme (12 - 18 months) to higher education levels for midwives is available.
- 1.3.b. A standardized in-service training programme for midwives for short- term competency based courses is available.

A regulatory body for midwifery that regulates midwifery practice for quality care and client safety and satisfaction is in place

- 2.1.a. A complete regulatory framework for midwifery is available (scope of practice, code of conduct, accreditation mechanisms for schools, register of midwives)
- 2.1.b. A professional electronic register of midwives which is updated annually is available.

Midwifery associations provide continuous professional development for midwives

- 3.1. Proportion of midwives registered as members of the midwifery professional association.
- 3.2. The national midwifery association has a costed strategic plan that is not more than five year old

A Human Resources for Health Policy that covers midwifery is available

- 4.1. Midwifery is mainstreamed in national human resources for health policies or a stand alone midwifery policy/strategy exists.

- 4.2. Proportion of newly graduated midwives who are deployed in the public and private sector within 1 year of graduation.

- 4.3. A set of midwifery indicators is available on a yearly basis in HMIS (cf. set of indicators in the metadata)

Measures (e.g. policies, incentives) to create an enabling environment for midwives

- 5.1 Midwifery work environment is included in workforce policy

MHTF Phase III – Result Indicator Framework

Outcome 2: Emergency Obstetric and Newborn Care (EmONC)

Referral maternity facilities are staffed with skilled attendants at birth and monitored to deliver quality and accessible essential sexual and reproductive healthcare, including EmONC

Output 6: Defined and monitored national network of EmONC facilities and strengthened referral linkages within this network

Strategic Interventions for Output 6	6.1.	Conduct a national EmONC Need assessment (or 'rapid EmONC NA')
	6.2.	Design the national network of EmONC facilities using a GIS technology to prioritize EmONC facilities and analyze referral links between B-EmONC and C-EmONC facilities
	6.3.	Support the ministry of health to monitor the national network of EmONC facilities (including monitoring of the deployment of skilled staff, MNH data, referral links)
	6.4.	Provide technical assistance for addressing referral linkages issues between EmONC facilities (C-EmONC and B-EmONC) and with peripheral facilities

Output 7: Strengthened capacities of skilled attendants at births working in EmONC facilities for the provision of quality sexual and reproductive health

Strategic Interventions for Output 7	7.1.	Strengthen clinical and educational capacities in the functioning EmONC facilities that are used by the ministry of health as pre-service education centers for midwifery students (and are linked to accredited midwifery schools)
	7.2.	Develop on-site supportive supervision and mentorship programmes for the midwifery workforce in targeted EmONC facilities
	7.3.	Support pre-service education of anesthetists (including nurse anesthetists) and monitor their deployment in hospitals - C-EmONC facilities

Output 8: Increased functioning of the national network of EmONC facilities to provide sexual and reproductive health services

Strategic Interventions for Output 8	8.1.	Encourage coordination mechanism to upgrade the designated B-EmONC facilities of the national network in functioning B-EmONC facilities (functioning coordination mechanism, national workshops, joint reporting, targeted support to facilities through "fostering")
	8.2.	Support the work of midwives (as a team) in providing sexual and reproductive health services in EmONC facilities
	8.3.	Support a coordinated bottom-up approach using EmONC facility data to improve quality of care in reproductive health (according to the MoH priorities) in the EmONC facilities of the national network

Output 9: Improved integration of quality sexual and reproductive health services in the national network of EmONC facilities

Strategic Interventions for Output 9	9.1.	Support the availability and utilization of family planning methods in maternity wards (prioritizing EmONC facilities) by: a) ensuring modern contraception in immediate post partum (advocacy, policy, availability and utilization of services); b) ensuring that modern contraception is delivered to all women receiving post abortion care (advocacy, policy, availability and utilization).
	9.2.	Support cervical cancer program management (monitoring and reporting) and the screen and treat approach implementation in the functioning EmONC facilities: train midwives and nurses on visual inspection, equipment, logistic, data analysis, and supervision

Indicators – Country level

Coverage of emergency obstetric and newborn care, as per the international recommended minimum standard

The national EmONC facility network is defined and monitored

- **6.1.** EmONC (rapid) Assessment report is available
- **6.2.** Proportion of population covered by functioning EmONC facilities (within 2h travel time - using GIS)
- **6.3.** EmONC set of indicators is available on yearly basis (cf. set of indicators in the metadata)
- **6.4.** Proportion of "functioning referral" links in the national EmONC network

The national mentorship programme for midwives is monitored

- **7.1.** Number of midwifery students trained in targeted pre-service education centers supported by UNFPA
- **7.2.** Annual report on national mentorship programme is available
- **7.3.** Proportion of graduated nurse anesthetists deployed every year in C-EmONC facilities

Direct Obstetric Case Fatality Rate in functioning EmONC facilities

- **8.1.** Proportion of functioning B-EmONC facility in the national network (B-EmONC)
- **8.2.** Proportion of EmONC facilities with no gaps in midwives according to the national standard
- **8.3.** Proportion of EmONC facilities with Quality Improvement (QI) process in place

Number of facilities of the national EmONC network where at least two SRHR components are integrated

- **9.1.a.** Proportion of women leaving the maternity ward of the EmONC facility with a modern contraception
- **9.1.b.** Proportion of women receiving post abortion care and leaving the EmONC facility with a modern contraception
- **9.2.** Proportion of women screened for cervical cancer who benefited from cryotherapy (if positive and eligible)

MHTF Phase III – Result Indicator Framework

Outcome 3: MPDSR

Causes of maternal and perinatal deaths are identified and addressed through MPDSR programmes to improve quality of care

Output 10: Strengthened MPDSR program framework and coordination

Strategic Interventions for Output 10

- 10.1. Support the validation by the ministry of health of the MPDSR programme framework (mandatory notification, national guidelines and tools, costed national plan & functioning MPDSR national committee)
- 10.2. Support strengthening operational links at national, regional and local levels to ensure that MPDSR is jointly implemented by the ministries involved in the national MNH plan

Output 11: Strengthened capacity for improving the quality of maternal deaths reviews and implementation of responses

Strategic Interventions for Output 11

- 11.1. Improve maternal death review quality in EmONC facilities through technical support to providers (mentorship programme, review committees, expert review of maternal deaths reviews ...)
- 11.2. Support (financial and technical) local, sub national and national meeting to analyze MDSR data and follow recommendations

Output 12: Strengthened reporting and operational research of the implementation of the MPDSR program (processes and results on notification, review and response)

Strategic Interventions for Output 12

- 12.1. Support the elaboration of the annual report to reflect on the MPDSR implementation process and results
- 12.2. Support advocacy and research to improve maternal health program that are based on maternal deaths analysis and findings

Indicators – Country level

Maternal death notification rate

Four main M(P)DSR program components are implemented

- **10.1.** Number of key components of the M(P)DSR programme framework that are implemented (out of 4)
- **10.2.** A national monitoring tool a) exists and b) is utilized to track processes implementation (including M(P)DSR framework components) and results at national and subnational level

Maternal death review rate

- **11.1.** Proportion of maternal deaths reviewed with quality standard to make relevant analysis on the causes of death. (this indicator can be extended to newborns)
- **11.2.** Number of maternal deaths (and perinatal deaths) a) reviewed and b) monitored at subnational level

An annual M(P)DSR report is available

- **12.1.** An M(P)DSR national report is available, including a) an analysis of the quality of the reviews and b) progress on the implementation by the health system of the recommendations from the previous report
- **12.2.** Number of MHTF supported peer-reviewed publications based on M(P)DSR analysis and findings

Outcome 4 : Obstetric Fistula and other morbidities

Quality sexual and reproductive health information and services are accessible to prevent and treat obstetric fistula and other obstetric morbidities

Output 13: Strengthened health systems to prevent obstetric fistula and to expand access to quality treatment for obstetric fistula

Strategic Interventions for Output 13	<p>13.1. Support the ministry of health to develop a costed national strategy to end obstetric fistula (aligned with UN/global vision of ending fistula within a generation) and an operational costed plan</p> <p>13.2. Support initiatives to prevent obstetric fistula and enable more women and adolescent girls to access quality fistula treatment (e.g., including case identification and referral mechanisms via community sensitization and mobilization; surveillance/notification systems; outreach workers, use of mobile phones)</p> <p>13.3. Strengthen a health workforce trained to competence in obstetric fistula prevention, management and repair (fistula surgeons and surgical teams)</p> <p>13.4. Support the development/functioning of an appropriate number of health facilities with capacity to offer quality treatment for obstetric fistula, including follow-up</p>
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Output 14: Fostered and enhanced national leadership, ownership, and accountability on ending fistula and other obstetric morbidities

Strategic Interventions for Output 14	<p>14.1. Strengthen national capacity for evidence-based sustainable resource mobilization in support of the national strategy for ending obstetric fistula</p> <p>14.2. Support the creation/operation of a functional national task force for obstetric fistula</p> <p>14.3. Support efforts to improve/strengthen data availability on obstetric fistula and other obstetric morbidities (including incidence, prevalence, situation analysis)</p>
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Output 15: Strengthened quality of social reintegration/ rehabilitation programmes for obstetric fistula survivors

Strategic Interventions for Output 15	<p>15.1. Support evidence-based social reintegration/rehabilitation programming for fistula survivors (costed plan, monitoring, reporting, cost efficiency evaluation)</p>
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Indicators – Country level

Number of women and adolescent girls living with obstetric fistula who receive surgical repair (disaggregated by source of funding: domestic, UNFPA, others)

- Success rate of obstetric fistula repairs at discharge
- Success rate of obstetric fistula repairs at follow-up period according to the national standard

- **13.1.a.** A costed national strategic plan for ending fistula (standalone or integrated in National Health Strategic plan) is available
- **13.1.b.** A costed operational plan for ending fistula is available
- **13.2.** Proportion of newly identified obstetric fistula cases (within the year) having surgical repair
- **13.3.** Number of fistula surgeons in the country meets the expected need for fistula treatment/repair (based on national fistula prevalence and incidence data/estimates)
- **13.4.** Proportion of obstetric fistula repairs with success at discharge and at a follow-up period according to the national standard (disaggregated by facility)

- An annual report on the implementation of the obstetric fistula program is available
- Obstetric fistula incidence
- Obstetric fistula prevalence

- **14.1.** Proportion of national fistula strategy that is funded (disaggregated by number and type of partners - e.g., public, private, domestic resources)
- **14.2.** A national task force for fistula is functioning
- **14.3.a.** A set of obstetric fistula indicators is available on yearly basis in HMIS (cf. set of indicators in the metadata)
- **14.3.b.** A set of indicators on other obstetric/reproductive morbidities is available on yearly basis in HMIS (cf. set of indicators in the metadata)

The obstetric fistula social rehabilitation program is available and monitored

- **15.1.** Number of fistula survivors who benefit from an evaluated social reintegration/rehabilitation programme

Annex 3 MHTF Supplementary Metrics

Outcomes	Supplementary metrics
Outcome 1: Midwifery - Every woman and adolescent girl can access right based quality sexual and reproductive health information and services delivered by midwives and that are women centered, equitable and accountable	Number of midwifery schools in the country (public and private)
	Number of midwifery schools supported by MHTF
	The prevention of stigma and discrimination is included in the pre-service curricula of health professionals (UNFPA SP indicator) supplement
	The Midwifery Association workplan based on their Strategic Plan is implemented.
	Number of midwives trained through in-service training for competency strengthening with UNFPA support
	Incentive mechanisms are in place to support the deployment of midwives to remote, rural areas
Outcome 2: Emergency Obstetric and Newborn Care (EmONC) - Every woman, adolescent girl and newborn in need of emergency obstetric and newborn care can access a referral maternity facility, staffed with skilled attendants at birth and monitored to deliver quality essential sexual and reproductive healthcare, including EmONC	Number of EmONC facilities supported by the MHTF
	Number of functioning EmONC facilities supported by MHTF
	Proportion of women satisfied by the quality of the sexual and reproductive health services received in EmONC facilities (done through patient satisfaction survey)
	Number of EmONC facilities providing quality-assured, adolescent-friendly integrated sexual and reproductive health services
Outcome 3: MPDSR - Causes of maternal and perinatal deaths are identified and addressed through MPDSR programmes	Number of perinatal death notified
Outcome 4: Obstetric Fistula and other morbidities - Every woman and adolescent girl can access quality sexual and reproductive health information and services to prevent and, if needed, to treat them from obstetric fistula and other obstetric morbidities	Number of fistula surgeons trained for fistula treatment/repair (disaggregated by UNFPA-supported and total number of surgeons)
	An evaluation of social reintegration/rehabilitation programme has been conducted or such evaluation is ongoing with technical and/or financial support from MHTF

List of countries supported by MHTF Phase III

West and Central African region (WCARO)

Haiti

Mauritania

Senegal

Guinea-Bissau

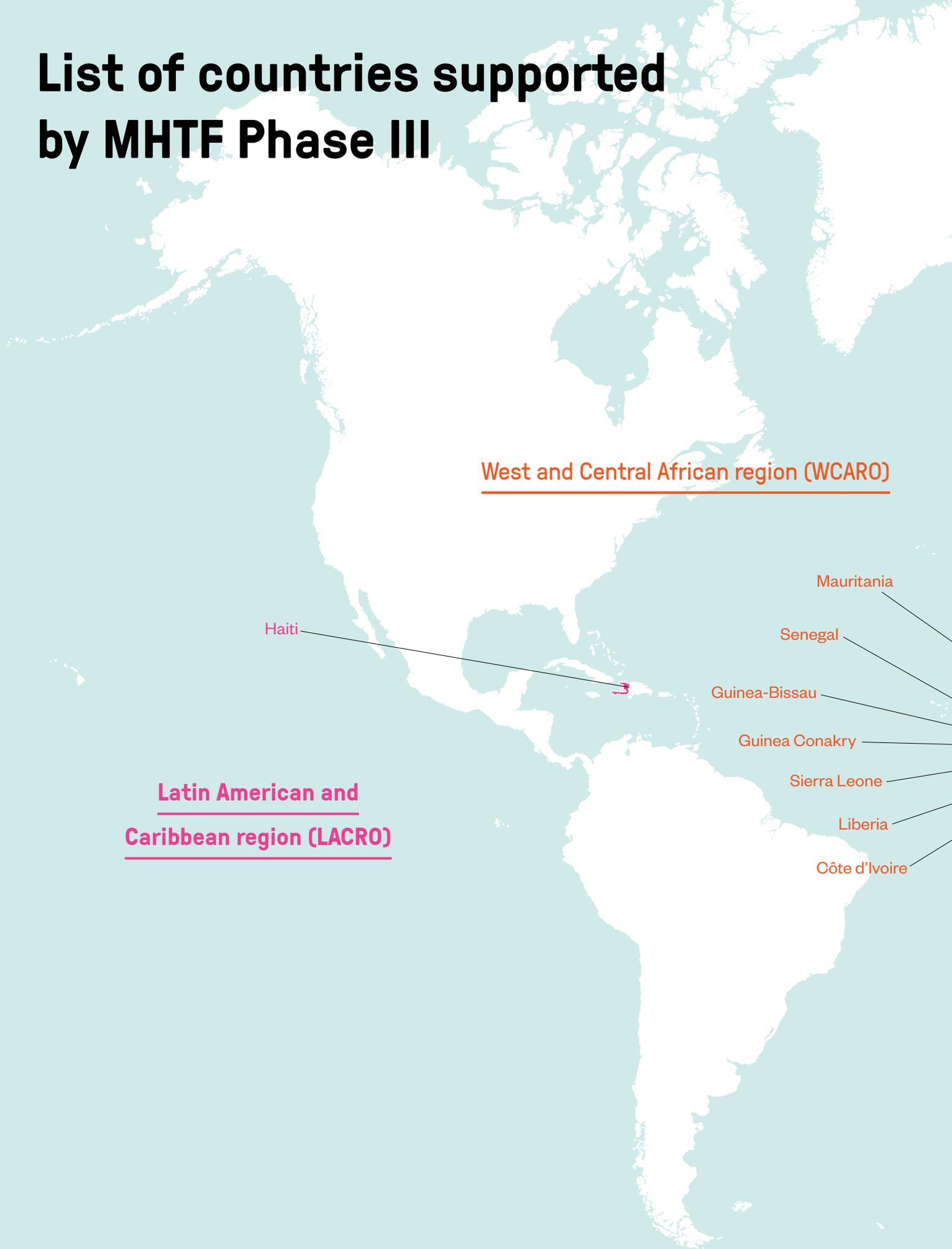
Guinea Conakry

Sierra Leone

Liberia

Côte d'Ivoire

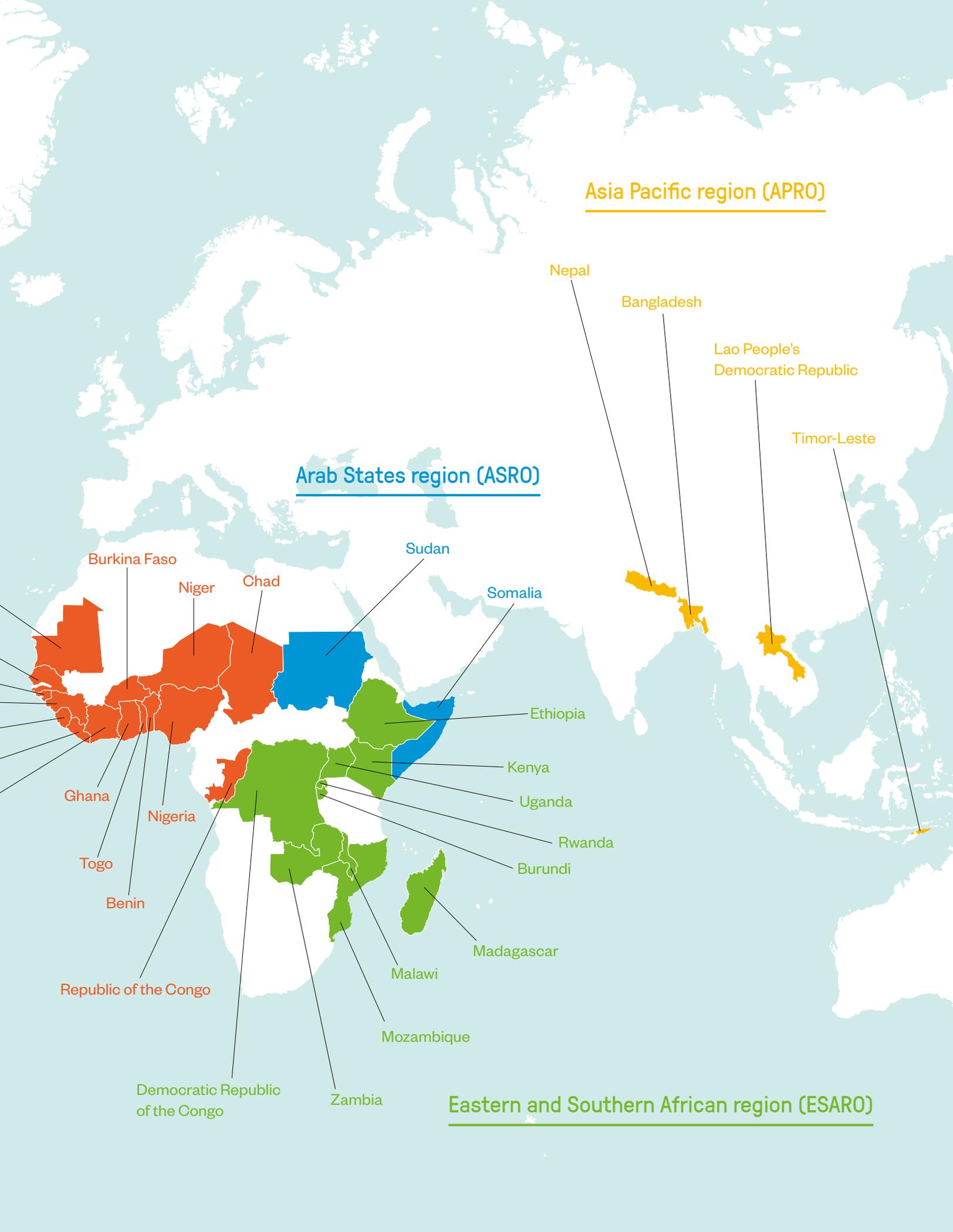
Latin American and Caribbean region (LACRO)



Asia Pacific region (APRO)

Arab States region (ASRO)

Eastern and Southern African region (ESARO)



Nepal

Bangladesh

Lao People's
Democratic Republic

Timor-Leste

Sudan

Somalia

Ethiopia

Kenya

Uganda

Rwanda

Burundi

Madagascar

Malawi

Mozambique

Zambia

Burkina Faso

Niger

Chad

Ghana

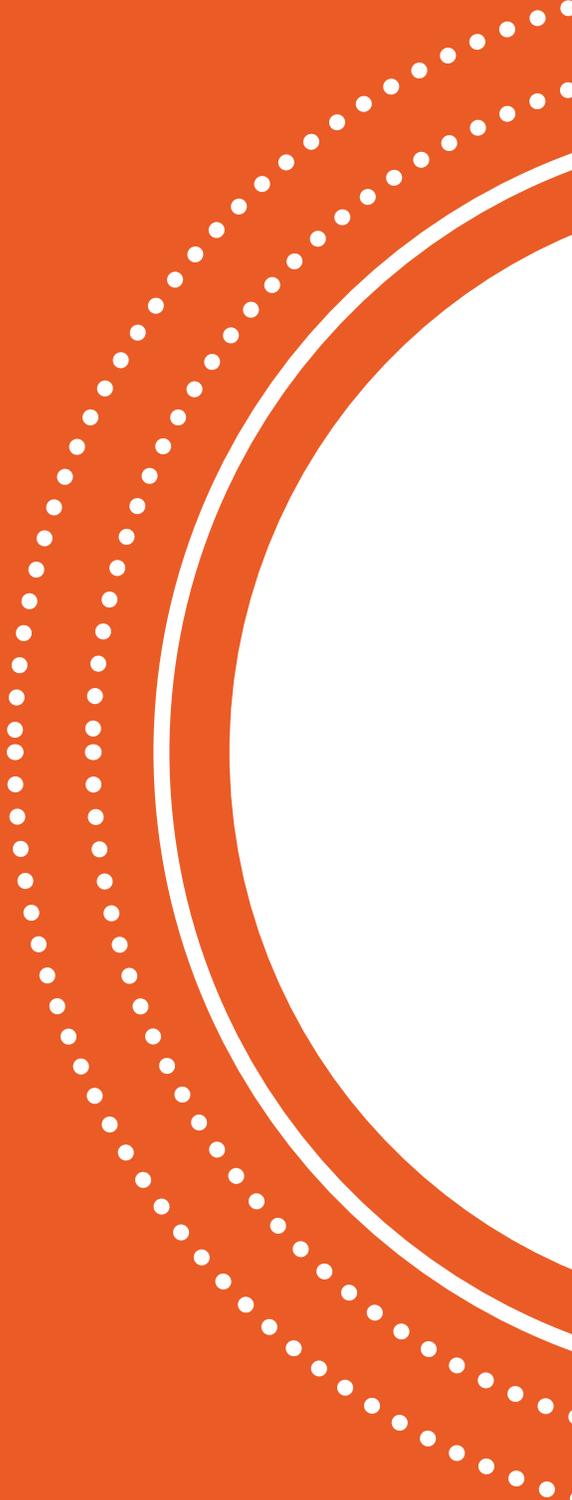
Nigeria

Togo

Benin

Republic of the Congo

Democratic Republic
of the Congo



United Nations Population Fund

605 Third Avenue New York, NY 10158
www.unfpa.org