
Mid-term evaluation of the Maternal and Newborn Health Thematic Fund

Phase III 2018-2022



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Foreword

Since 2008, the Maternal and Newborn Health Thematic Fund (MHTF) has served as the UNFPA flagship programme on maternal and newborn health. Now in Phase III, the MHTF has widened its scope to contribute to the broader sexual and reproductive health and rights agenda impelled by the International Conference on Population and Development's (ICPD) Programme of Action. Joining the momentum built up around the necessity of a greater focus on the newborn period along the continuum of care, and recognizing the indivisible interconnections between maternal and neonatal health (MNH), it changed its name to the Maternal and Newborn Health Thematic Fund in 2018. Its goal is to enable every woman, adolescent girl and newborn to have equitable and accountable access to quality sexual, reproductive, maternal and newborn health and rights by strengthening health systems in countries with a high burden of maternal morbidity and mortality, thus contributing to the global target of having fewer than 70 maternal deaths per 100,000 live births by 2030 (Sustainable Development Goal 3, Target 1).

The mid-term evaluation of the MHTF (Phase III) was conducted as an independent assessment of the performance of the MHTF in providing catalytic support through country-owned and -driven interventions in order to improve maternal and newborn health and rights in 32 high-mortality countries. The evaluation covers the period from 2018 to 2021 and provides learning to feed into the implementation of the MHTF in its current phase. It also informs the reflection on the strategic directions and operating model for the MHTF post 2022.

The evaluation highlights the significant and tangible contributions of the MHTF to country health systems and shows how the MHTF model (a combination of seed funding, links to established global partnerships, and technical support) enables programme countries to access guidance and support to upgrade relevant national approaches in order to meet global standards. In fact, the MHTF brings value across a significant range of technical areas and delivers considerable thrust with a limited package of resources, opening, in countries, specific entry points for health systems strengthening and for the integration of SRHR-MNH services. With the MHTF, UNFPA is a credible partner, taking the lead in midwifery, and is consistently valued for its responsiveness and strategic investments as well as for its knowledge products and technical guidance in maternal, newborn and adolescent health.

However, the MHTF faces a number of challenges that have started to constrain its impact, or will do so in the future. The evaluation points, in particular, at the need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. To fully exercise its catalytic effect, the evaluation also shows how important it is for the MHTF to further engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. This is key to support greater institutionalization of the MHTF systems strengthening investments.

I am confident that the lessons learned and the recommendations highlighted by this mid-term evaluation will help to further enhance the contribution of UNFPA and the MHTF to maternal and newborn health. The evaluation results are also particularly relevant as UNFPA channels its efforts to help health systems recover from the COVID-19 pandemic so that progress continues to be made in advancing sustainable development and promoting the health, rights and well-being of mothers and newborns to ensure that no one is left behind.

Marco Segone

Director, UNFPA Evaluation Office

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Abbreviations and acronyms

ANC	Antenatal care	MNH	Maternal and newborn health
AMDD	Averting maternal death and disability	MoH	Ministry of Health
BEmONC	Basic emergency obstetric and newborn care	MPDSR	Maternal and perinatal death surveillance and response
CEmONC	Comprehensive emergency obstetric and newborn care	NMR	Neonatal mortality ratio
COVID-19	2019 novel coronavirus/Coronavirus disease/SARS-CoV-2	PHC	Primary health care
DHIS	District health information system	PMNCH	Partnership for Maternal, Newborn and Child Health
DRC	Democratic Republic of the Congo	PPE	Personal protective equipment
EmONC	Emergency obstetric and newborn care	SDG	Sustainable Development Goal
EPMM	Ending Preventable Maternal Mortality	SGBV	Sexual and gender-based violence
FGM	Female genital mutilation	Sida	Swedish International Development Cooperation Agency
GIS	Geographic Information System	SoWMY	State of the World's Midwifery (report)
H6	A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank)	SRHR	Sexual and reproductive health and rights
HMIS	Health management information system	UHC	Universal Health Coverage
HIV	Human immunodeficiency virus	UN	United Nations
ICM	International Confederation of Midwives	UNFPA	United Nations Population Fund
ICPD	International Conference on Population and Development	UNICEF	United Nations Children's Fund
IPC	Infection prevention and control	USAID	United States Agency for International Development
Jhpiego	Johns Hopkins Program for International Education in Gynaecology and Obstetrics	WHO	World Health Organization
MHTF	Maternal and Newborn Health Thematic Fund		
MMR	Maternal mortality ratio		

Glossary of terms

Term	Definition	Source
Child marriage	<p>Child marriage is any formal marriage or informal union where one or both of the parties are under 18 years of age. Each year, 12 million girls across the world are married before the age of 18. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 globally.</p>	<p>https://www.girlsnotbrides.org/about-child-marriage/ https://www.girlsnotbrides.org/themes/health/</p>
EmONC: Emergency obstetric and neonatal care	<p>A standard of care to manage obstetric complications. EmONC designated facilities must have skilled attendants covering 24 hours a day, seven days a week, assisted by trained support staff.</p> <p>Basic EmONC (BEmONC) includes seven capacities or signal functions: (1) parenteral treatment of infection (antibiotics); (2) parenteral treatment of post-partum haemorrhage (uterotonic drugs like oxytocin); (3) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants like magnesium sulphate); (4) manual removal of the placenta; (5) removal of retained products following miscarriage or abortion; (6) assisted vaginal delivery, preferably with vacuum extractor; and (7) basic neonatal resuscitation care.</p> <p>Comprehensive EmONC (CEmONC) includes these seven capacities/ signal functions plus the provision to conduct a caesarean section/surgery and to administer safe blood transfusions.</p>	<p>https://www.unfpa.org/featured-publication/implementation-manual-developing-national-network-maternity-units</p>
Integrated MNH and SRHR	<p>This term refers to the integration of maternal and newborn health (MNH) and sexual and reproductive health and rights (SRHR) information and services. Note that the evaluation will not utilize the acronym for reproductive, maternal, newborn, child and adolescent health, as child health is not part of the scope of the evaluation. The MHTF encompasses focus areas related to MNH and SRHR interventions, including family planning, preventing mother-to-child transmission of the human immunodeficiency virus (HIV), prevention of HIV/sexually transmitted infections, and cervical cancer prevention and screening. A focus on adolescents cuts across all MHTF interventions related to MNH and SRHR.</p>	<p>https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-MHTF-WEB.pdf</p>

Term	Definition	Source
Maternal and newborn health (MNH)	Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (42 days following birth). Newborn health focuses on improving care around the time of birth, the first 24-48 hours following birth and in the first four weeks of life.	https://www.who.int/health-topics/newborn-health#tab=tab_1 https://www.who.int/health-topics/maternal-health#tab=tab_1
Maternal and perinatal death surveillance and response (MPDSR)	MPDSR is a continuous cycle of identification, notification and review of maternal deaths with recommendations made to improve care. The full cycle also includes follow-up of actions taken to improve quality of care and prevent future deaths.	https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_Death_Surveillance_and_Response_0.pdf
Maternal mortality ratio (MMR)	The number of maternal deaths during a given period per 100,000 live births during the same period. The global maternal mortality target (to reduce maternal deaths to at least as low as 70 per 100,000 live births) was agreed in 2015 in a consensus paper on Ending Preventable Maternal Mortality (EPMM) and adopted as the Sustainable Development Goal (SDG) target (SDG indicator 3.1.1). Maternal mortality is usually estimated or measured less frequently than other basic health indicators (every 3 to 5 years) and evidence would be strengthened where country civil registries and vital statistics systems were strengthened. There is a tendency in many countries to underreport maternal deaths.	https://apps.who.int/gho/data/view.main.1370?lang=en Health statistics and information systems: Maternal Mortality Ratio World Health Organization accessed 25 Feb 2021.
Newborns/ neonates	A newborn or neonate is a baby in its first 28 days of life. About 75 per cent of neonatal deaths occur in the first seven days of life and a third of these on the day of birth. Neonatal deaths are primarily caused by birth injuries and asphyxia, preterm birth, post-partum infections and birth defects.	https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020
Obstetric fistula	Obstetric fistula is a serious childbirth injury. It is a hole that has opened between the birth canal and bladder and/or rectum and is caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women leaking urine and/or faeces and can lead to chronic medical problems, social isolation and deepening poverty.	https://www.unfpa.org/obstetric-fistula
Perinatal death	A death that occurs between 28 weeks of completed gestation and the first seven days of life.	

Term	Definition	Source
Sexual and gender-based violence (SGBV)	<p>SGBV refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, patriarchal norms and harmful practices.</p> <p>SGBV is a violation of human rights and a life-threatening health and protection issue. It is estimated that one in three women will experience sexual or physical violence in her lifetime. During displacement and times of crisis, the threat of SGBV significantly increases for women and girls.</p>	<p>https://www.unhcr.org/uk/gender-based-violence.html</p>
SRHR	<p>A comprehensive range of services to enable every person to achieve sexual health and well-being. Services include contraceptive services; maternal and newborn care; prevention and control of sexually transmitted infections, including HIV; comprehensive sexuality education; safe abortion care, including post-abortion care; prevention, detection and counselling for SGBV; prevention and treatment of infertility and cervical cancer; and counselling and care for sexual health and well-being.</p>	<p>Guttmacher Lancet Commission on SRHR: https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary#</p> <p>This definition was endorsed by WHO and UNFPA: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30901-2/fulltext</p>
Stillbirth	<p>A baby born with no signs of life at or after 28 weeks of gestation. There are different types of stillbirths. More than half of all stillbirths, for example, occur during labour and birth. Some are most likely very early neonatal deaths. The majority are preventable.</p>	<p>Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020</p>
Young people, youth and adolescents	<p>Child: a person under 18 years of age, as defined by the United Nations.</p> <p>Adolescent: a person aged 10 to 19 years, as defined by the United Nations.</p> <p>Young person: a person between 10 and 24 years old, as defined by WHO.</p> <p>Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes but respects national and regional definitions of youth.</p>	<p>UNESCO (2018) International technical guidance on sexuality education: An evidence-informed approach</p>

Executive summary

PURPOSE AND SCOPE OF THE EVALUATION

Ending preventable maternal deaths is one of three transformative results of United Nations Population Fund (UNFPA) and includes an emphasis on the integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MHTF) was first established in 2008 and, now in its third phase, is closely associated with this transformative result. Unfortunately, global progress on maternal and newborn mortality reduction is not on track to meet the 2030 Sustainable Development Goal (SDG) targets and has been further affected by the health, social and economic effects of the global COVID-19 pandemic.

The MHTF delivers technical and financial support in 32 high burden countries to create catalytic and accelerated progress in one or more of four priority technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR) processes, and the prevention and treatment of fistula and other obstetric morbidities. The MHTF also contributes to the UNFPA presence and leadership of maternal health at the global level.

This evaluation assesses the MHTF progress against its 2018-2022 Business Plan and identifies key lessons and challenges to support its future evolution. In particular, the evaluation considers the extent to which the MHTF has contributed to strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders in partner countries. The evaluation also assesses the extent to which the MHTF supports the scaled up integration of SRHR-MNH services, reflecting the well-established and critical role of universal access to quality SRHR services as essential to achieving MNH.

METHODOLOGY

The evaluation identifies the contribution made by UNFPA and applies a theory-based approach in order to analyse the intended results of UNFPA support. It also takes into account the larger health system factors and economic and social determinants affecting MNH. The evaluation team adapted the MHTF theory of change to incorporate all aspects of UNFPA support and developed a series of nine detailed evaluation questions to set out and define the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around six country case studies (Benin, Sudan, Uganda, Zambia, Bangladesh and Togo) involving a range of methods and sources including document review, country-focused interviews and group discussions and, where feasible (given COVID-19 legal and public health restrictions), site visits and observation. Data were also collected through key informant interviews with global and regional stakeholders, through a comprehensive review of relevant documents and data sets at the global and regional levels and through an online survey completed by respondents from the MHTF partner countries. The evaluation followed a structured plan for analysis and triangulation of the data to respond to the nine questions.

MAIN FINDINGS

As one of the few United Nations funds and programmes supporting midwifery, with the MHTF, UNFPA has succeeded in raising the profile and standing of midwives at the global and country levels. The UNFPA partnership with the International Confederation of Midwives (ICM) is a key asset that amplifies its credibility with partner governments, supporting

the alignment of national policies with international standards. MHTF investments and expertise have led to global policy products and practical benefits supporting midwifery development in countries beyond the MHTF. Professional development is a long-term process, and the key challenge for the MHTF and its partners remains how to put midwifery policies into action at scale, particularly with limited resources. Furthermore, while UNFPA is ambitious in its aim to eradicate gender disparities, action taken in countries to ensure midwives have a seat at the table to effect policy change is inconsistent. Nonetheless, MNH partners recognize midwifery support as a central pillar of the MHTF and a critical driver of other technical priorities (namely EmONC, fistula and MPDSR) as well as a crucial strategy for effective integration of SRHR and MNH services despite a lack of holistic programming in some contexts.

The MHTF has championed the development and application of the EmONC network model in selected partner countries using an innovative health systems strengthening approach based on consensus building around standards of care, the rationalization of EmONC facility distribution, and routine facility monitoring. The phased approach of the EmONC network offers an objectively verifiable distribution model for elaborating service delivery standards that can be adapted to each country context. Viewed by key informants as rigorous and credible, this methodology – and the MHTF application of it – enables a concrete step forward in EmONC and MNH systems strengthening that creates leadership opportunities in partner countries and opens a pathway to improving quality of care. Two limitations affect the long-term sustainability of the MHTF investments in EmONC. The first is the limited consideration given so far to including the community level as a structured part of care networks. The second is the challenge of sustainability through the institutionalization of the monitoring process associated with quality improvement and without which the benefits of the model will be difficult to maintain. An additional challenge for the MHTF, given the range of countries it supports (including many that do not implement the EmONC network approach), is to balance a flexible and country responsive approach to EmONC support while also ensuring sufficient links to larger health system reform processes.

Sustained MHTF partnership has enabled MPDSR processes to be somewhat embedded across a range of health systems contexts and is valued by country governments and partners. MHTF technical and financial resources enable countries to develop MPDSR strategies, implement national and subnational committee structures and produce periodic reports. The MHTF has also participated in the development of new indicators for measuring the implementation of MPDSR in countries. While notifications of maternal deaths tend to be increasing, the sustained institutionalization of MPDSR has been difficult to achieve and progress varies depending on country leadership and commitment. Although exceptions can be identified, death audit/review findings are underutilized in most countries, which is indicative of a problem with the process itself rather than with MHTF technical support. The challenges faced in strengthening MPDSR systems stress the importance of demand creation and community engagement for better outcomes from SRHR-MNH integrated service investments as well as the need to maintain systematic action to encourage earlier attendance by women at the health facility and build trust between providers and beneficiaries of care.

UNFPA has made a clear contribution at both the global and national levels towards increasing the commitment of governments and partners to end fistula. As lead for the Global Campaign to End Fistula, UNFPA/MHTF effectively coordinates an advocacy and knowledge sharing agenda that has helped to maintain fistula as a global priority. At the national level, the strategic positioning of UNFPA is enhanced by its partnership with governments and its convening role, which has advanced national strategies to end obstetric fistula. Building capacity for fistula treatment and care is the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, with mobile teams, and with service delivery camps. However, in most countries, these services remain donor-dependent and have yet to be mainstreamed into the health system. Efforts to rehabilitate and reintegrate survivors into communities are at early stages overall. The rise in iatrogenic fistula (caused by medical treatment) is an emerging issue globally and requires renewed attention to safe surgical services and quality of care throughout all components of the MHTF.

The MHTF has been able to support integration of SRHR and MNH services to some extent and there is tangible evidence of progress in the integration of family planning into maternal health services across the care continuum. The MHTF supports each country to define the scope of integration between SRHR and MNH services according to its own opportunities and service priorities. However, integration of post-abortion care is inconsistently addressed. Moreover, the MHTF support to integrating both adolescent SRHR and sexual and gender-based violence (SGBV) is at an earlier stage of evolution and this task seems to be considerably harder as it requires midwives with an expanded skillset, more time

and space (privacy), and attitudes that are respectful and non-judgemental. At the centre of the integration process, the midwife is a critical lynchpin to expanding access to a full range of SRHR and MNH services for women and girls. Yet, efforts to support midwifery-led integration are obstructed by weak infrastructure and a lack of equipment, two structural health system failures that the MHTF can only partially tackle. An important emerging challenge is the need to balance the opportunity and vision to develop a comprehensive approach to women's health across the life-course without increasing the risk of overburdening midwives and associated health systems.

The MHTF is oriented towards equality, human rights and values associated with ensuring equitable access to services for all women and girls but with uneven results so far. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanding service delivery to underserved geographic areas and vulnerable populations, while also maintaining a spotlight on relevant social and economic determinants affecting MNH. However, the MHTF does not have a defined or explicit approach or process for identifying those most at risk or the most vulnerable. The MHTF lacks a framework for defining and operationalizing rights-based principles in programming, which leads to inconsistent application in country-based activities, including, for instance, varying attention to the need for respectful care. Because of limitations in the integration of SRHR and MNH, MHTF activities are less effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services, especially contraception, post-abortion care and, where legal, safe abortion services.

The MHTF method of combining technical knowledge, seed funding, and global partnerships in order to support country partners to tackle particular SRHR-MNH technical areas is a strength that positions it well to leverage catalytic results. The method allows the MHTF to provide high quality support in four critical technical areas and increases UNFPA credibility with country partners. The MHTF has produced an impressive range of global guidance, peer reviewed evidence papers and other policy documents. However, the potential behind many "catalytic" investments is still to be fully realized especially - but not only - given constraints to progress created by the ongoing COVID-19 pandemic (although these should be transient). Other stand-alone innovations and digital adaptations (such as mobile phone apps) have played a role in supporting results but are not, in themselves, necessarily catalytic or sustainable. The MHTF is currently addressing the twin challenge of firstly developing strengthened guidance that clearly defines what being catalytic means and secondly laying out the operational approach countries should take in order to build on and document catalytic effects more systematically.

The MHTF is benefitting from improved leadership and vision and the recently established Advisory Board supports more structured engagement with partners (including donors). These developments should help the MHTF address the several challenges it faces. These challenges include: positioning its strategic direction in relation to overarching UNFPA MNH; building SRHR-MNH integration across the life-course; overcoming bureaucratic constraints; and delivering clearer communication of results. Results data collected from countries tend to focus on outputs and build a cumulative picture of the MHTF activities, but they are less effective at helping identify the MHTF contribution to country-specific progress. The consequence is a difficulty in fully capturing the value of results achieved from the whole of the MHTF, including its strategic partnerships. The lack of community-facing links or investments into building demand for services is a visible gap, as are more systematic interlinkages between the MHTF support to MNH investments and larger health systems strengthening and reforms.

UNFPA effectively used the MHTF to respond quickly and flexibly to the COVID-19 pandemic through programmatic efforts and reallocation of available resources to ensure continuity of essential SRHR and MNH services while protecting the safety of clients and providers. UNFPA articulated a response in support of partner countries referencing key lessons learned from the West Africa Ebola outbreak, during which routine services were seriously disrupted causing high levels of preventable mortality, especially for women and children. The UNFPA/MHTF response included the development and dissemination of COVID-19-specific technical guidelines and protocols, the provision of personal protective equipment (PPE), other strategic support, such as transport vouchers for health personnel to get to work safely, and hospital triage support to ensure safe access to essential maternity services.

CONCLUSIONS

1. With the MHTF, UNFPA is a partner of choice providing visible and valued support to critical MNH priorities. The MHTF has evolved into a strong, focused and technically sophisticated tool for supporting MNH in the programme countries, especially in its four priority areas of midwifery, EmONC, MPDSR and fistula. The MHTF delivers support to programmes that are perceived to be of high quality, that address gaps in country health systems and that produce tangible results. At a global level, MHTF staff participate in and/or lead the development of a range of knowledge products whose impact extends beyond the 32 MHTF partner countries. It is a programme that delivers considerable thrust with a limited package of resources.

2. Midwifery is the anchor of the MHTF and the cornerstone of the UNFPA MNH response. Identified as the leading partner for midwifery, UNFPA has instigated major steps forward on the definition of midwifery practice (for example, standards of care, capacity and skills, and performance monitoring) that have been complemented by country-focused efforts to upgrade the education, training and deployment of midwives and initiatives to support their professionalization. The role of midwives is critical to promoting SRHR-MNH integration and to overcoming the three delays that lead to maternal mortality (delay in seeking care; in reaching the right level of care; in receiving the right care) particularly in promoting health-seeking behaviour among women and girls. However, the MHTF has not yet fully captured the pernicious effects of gender inequalities and power dynamics that affect health systems in programme countries.

3. The MHTF delivers value for money, both globally and for individual countries. Through leveraging global partnerships, deepening policy and technical coherence, and strengthening the quality of programme implementation, the MHTF has developed a programme model that delivers visible results and creates effective entry points for a range of interventions. To maximize these opportunities, the MHTF relies on a set of skills and a vision in the country office that are strong on systems strengthening, coordination, convening, advocacy and partnership building. Achieving optimal effects also relies on the country offices' ability to supplement the MHTF resources with core funds and to raise additional resources through engaging partners locally. At the global level, the MHTF has enabled UNFPA to influence the agenda on MNH and to deliver a wide range of policy and guidance products in all of the four technical areas that will influence MNH programming beyond the MHTF partner country context.

4. The MHTF is not clearly positioned within a holistic UNFPA MNH strategic framework. By focusing on four specific technical areas, the MHTF has carved out a defined expertise. However, at a global and organizational level, the MHTF is not aligned with or anchored in a UNFPA maternal health strategy. As the main (but not the only) UNFPA programming vehicle into maternal health, this leaves a policy and strategy gap between the MHTF (as a programme delivering specific inputs) and the UNFPA MNH strategy at the global and organizational level. In turn, this gap makes it difficult to clearly identify the locus of UNFPA policy, strategy, and programming effort in relation to the transformative result of ending preventable maternal deaths. Meanwhile, at the country level, the issue is the agility of the MHTF, and whether it can position its interventions within a holistic SRHR-MNH strategy that is context specific to the programme countries themselves. The challenge for the MHTF is to maintain its technical focus (and well-defined offer of expertise and support), while remaining flexible to assist countries in addressing their priority needs in MNH.

5. If not addressed, critical gaps will limit the relevance and the sustainability of the MHTF investments. Investing in the supply of high-quality maternal services is necessary but not sufficient to ensure sustainable results. There is a need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. Furthermore, while the MHTF has helped countries identify and set standards for the supply-side and delivery of quality EmONC and related MNH services and care, it should also actively incorporate the views of women and girls and what they value in relation to SRHR-MNH integrated services, especially in relation to respectful care. While each of the four technical areas of the MHTF aims to influence and strengthen quality of care improvements, the indicators that enable quality of care measurement and tracking (especially including the experience of women who have been through the care of the health services) are insufficient and underutilized.

6. The MHTF has not yet been fully designed to deliver its "catalytic effect" systematically. The MHTF leverages its limited financial resources through investments which have, by and large, a catalytic potential and are, at times, catalytic when taken to scale with necessary leadership, sustained national commitment and resources. However, the MHTF is not sufficiently systematic in identifying or creating opportunities to engage national leadership for MNH in order to target the

resource mobilization needed to take technical advances to scale. The realization of this catalytic potential depends on the ability of the MHTF to anticipate and prepare for the challenging shift from a relatively low-cost, intense technical process focused on developing a national policy or strategy to a much larger, longer-term, higher-spend, national scale-up of that policy. The absence of a strategy clearly positioned within the engineering of the programme itself and accompanied by a tried and tested toolbox to support the elevation of programme inputs in ways that generate the “catalytic effect” currently reduces the MHTF catalytic achievements.

7. The MHTF targets gender equality, human rights and equity, especially among adolescents, but does so unevenly.

The MHTF has identified three rights-based principles upon which its strategy is based (accountability, quality of care, and equity in access), but it lacks a framework for defining and operationalizing rights-based principles in MHTF programming, which has led to uneven application of these principles in country-based activities, such as for quality of care. Furthermore, while the MHTF aims to target vulnerable women and girls through the application of the “leave no one behind” principle, it has yet to define or articulate an approach or process for identifying those most at risk or the most vulnerable. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanded service delivery to underserved geographic areas and vulnerable populations. However, because of limitations in the integration of SRHR and MNH, MHTF activities are not as effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services.

8. Given its results and successes, the MHTF has considerable unrealized potential. The MHTF is a programme with a modest profile, whose strengths and accomplishments are not always well-known. Not enough has been done, at UNFPA, to highlight its achievements, drive resource mobilization, position it strategically within a coherent MNH strategy and use the knowledge gained through the MHTF to help better shape the global agenda. This is also the consequence of a monitoring system that does not emphasize the use of a small number of readily available results indicators, which can be interpreted and presented in a manner that increases visibility for the MHTF in both UNFPA and the global arena. The MHTF image deficit, compounded by monitoring that lacks sufficient qualitative and contextual analysis, may also constitute an impediment to the mobilization of more funding and the pursuit of long-term engagement from partners. Ultimately, this may prevent the MHTF from being valued in relation to its actual contribution to maternal and newborn health, which this evaluation demonstrates is significant and multifaceted.

RECOMMENDATIONS

1. As the key UNFPA vehicle for SRHR-MNH integration and support, continue the MHTF and expand it into a new phase

The MHTF makes a visible contribution to maternal health in the countries where it is working and to the overall UNFPA maternal health response. The MHTF should continue into Phase IV with design adjustments taking into account the strategic and operational recommendations identified in this evaluation. In particular, an expanded theory of change should identify the larger landscape in which the MHTF operates and its specific contribution. Phase IV of the MHTF should serve as an opportunity to clarify the MHTF role and positioning in relation to other UNFPA investments into maternal health as well as the larger, global MNH landscape.

2. Position the MHTF within a comprehensive UNFPA maternal health strategy and action plan

The 2022-2025 UNFPA strategic plan is shaped around three transformative results, including ending preventable maternal deaths. In this context, it is not clear whether the MHTF is intended to serve as a limited, catalytic fund, channelling a specific set of technical and financial resources to defined elements of MNH, or is expected to encompass the entire UNFPA MNH programme (with other UNFPA programmes supporting important MNH results). Drawing on the MHTF experience, UNFPA should develop an organizational-level comprehensive maternal health strategy and action plan that clearly situates the MHTF and other UNFPA MNH efforts within a coherent organizational mandate with roles and responsibilities in relation to its objectives in maternal health and its broader remit on integrated SRHR-MNH.

3. Champion quality of care at the point of delivery, including respectful care

The MHTF approach to strengthening user-centred quality of care, including respectful care, is still at an early stage. The MHTF should invest in building country experience and global leadership on scaling up quality SRHR-MNH services at the point of implementation (from the user’s perspective) and should champion respectful care especially, but not only, among

midwives. This includes developing and integrating actionable programming into all MHTF technical areas and strengthening progress monitoring to enable lesson learning and scale-up of good practices.

4. Be more systematic about integrating community engagement across all MHTF activities

Community decisions about whether, when and how to seek care affect MNH outcomes. Currently, the main thrust of the MHTF has been focused on the supply of services. While the MHTF does not necessarily need to invest extensively in demand creation and community engagement itself, it should integrate and promote a more structured approach to community engagement as part of a broader strategy to generate increased demand for timely and accessible MNH services. This adjusted orientation should focus on increasing the timeliness and efficacy of decisions to seek care, to access family planning and SRHR services, to elect to deliver in a health facility, to build the interface of the midwife with the community, and to participate in death audits/reviews. It will require developing and deepening partnerships with others and investing in country office staff capacity and advocacy skills.

5. Engage partners, especially donors, more actively in the MHTF progress

The recently created Advisory Board is in the early stages of carving out its role and has been welcomed by partners. Donor engagement in the work of the MHTF, including as part of the Advisory Board, will foster visibility and support, as well as create potential opportunities in specific countries or settings. Over time, the MHTF should invest in the role and functioning of the Advisory Board in order to strengthen its accountability to funding partners, to increase its participation in shaping strategic direction and to support improved communication of results and performance.

6. Improve the strategic coherence and responsiveness of the MHTF

A key strength of the MHTF is its programme model, which offers countries access to strategic global partnerships, technical expertise and financial resources to seed-fund investments. The four technical areas promoted by the MHTF are insufficiently coordinated with each other however, and are not all equally well supported at the country level. In addition, as priorities evolve, the MHTF will achieve more traction with more flexibility in its programme model to respond to country priorities. It should thus aim to clarify and streamline the linkages and coherence among the four current technical areas. It should also consider options to selectively include other technical areas without sacrificing its well-defined programme model. The development of the MHTF Phase IV and associated theory of change creates an ideal opportunity to include these critical aspects.

7. Embed the focus on midwifery and the health workforce environment across the MHTF

As a key entry point and “gateway” to women’s health across the life course, midwives and the larger health workforce environment in which they operate constitute tangible health systems strengthening investments. The experience of women and girls highlights the role that skilled health personnel play in their perception of what quality care is. The MHTF progress and leadership on midwifery and the health workforce environment continue to create a key entry point for MNH. This should be further developed in Phase IV by investing more in embedding midwifery into community and primary care, integrating more focus on respectful care, and investing in health systems reforms, including the EmONC network expansion.

8. Invest more in MHTF core added values: SRHR-MNH integration and promoting catalytic results

The MHTF has two core element features that add value. The first is the fact that it is uniquely focused on integrating SRHR and MNH services and has made good progress in this area. The second is that the emphasis on driving catalytic results is integral to its delivery model and a cornerstone of the MHTF approach. In both these areas, the MHTF has made visible but inconsistent and insufficiently documented progress. In Phase IV, the MHTF should develop detailed and actionable guidance for country offices to support design, partnership development, and implementation. This should include promoting, documenting and communicating on SRHR-MNH integration and the MHTF catalytic role.

9. Refine results monitoring to improve understanding and communication about the MHTF added value in different contexts

Although detailed, the current results-oriented monitoring system does not easily enable the MHTF to identify and communicate its results and contribution as a United Nations programme working in an often crowded field. The MHTF should adapt its current approach to track fewer, more immediately relevant results that can support a clear narrative about the MHTF contribution and value-added in varied settings. The results-oriented monitoring system should have a greater

focus on perceptions of change among stakeholders by supplementing a shorter indicator framework with reporting that makes use of qualitative information on the MHTF contribution to, and progress toward, outcomes. This would support increased understanding about what is working, where and why.

10. Invest in innovative funding approaches to attract an expanded donor base

The MHTF should develop a comprehensive funding model and financing plan to support Phase IV. The plan should be linked to its new programme of work and be well situated within a UNFPA maternal health strategy in order to enable the MHTF to address (and reverse) declining commitments, as well as the negative effects of onerous financial management processes. The plan should also foresee innovative funding options to generate country engagement and commitment to SRHR-MNH integration, for example through matching arrangements. Innovative funding modalities could extend the value of MHTF resources, leverage additional funds from core and other partner sources, and help open up additional programme priorities.



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Mother and her baby during an awareness session on the use of modern family planning methods in a village in Sô-Ava, Benin.



INTRODUCTION

1.1 EVALUATION PURPOSE

The purpose of the mid-term evaluation is to assess the performance of the United Nations Population Fund (UNFPA) Maternal and Newborn Health Thematic Fund (MHTF) in providing catalytic support through country-owned and -driven interventions to improve maternal and newborn health (MNH) and rights in 32 high-mortality countries.¹ It assesses the contribution of the MHTF to strengthen health systems through its focus on:

- Four components of health systems: workforce, service delivery, health information systems, and leadership and governance
- Outcomes in four integrated technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), and obstetric fistula and other maternal morbidities.

The evaluation assesses the MHTF contribution to:

- Increasing equity in access to sexual and reproductive health and rights (SRHR) information and services, including for those furthest behind
- Improving quality of care
- Increased accountability
- The promotion of gender equality and human rights in the context of maternal and newborn health.

1.2 EVALUATION OBJECTIVES

The evaluation has two principal objectives:

1. Analyse how and to what extent UNFPA support to MNH has been guided by the theory of change and results framework as set out in the MHTF Phase III Business Plan (2018-2022)² and assess the progress made thus far in the implementation of MHTF strategic interventions in the four overlapping and mutually reinforcing MHTF outcomes.
2. Facilitate learning and capture good practices from the MHTF across all its components to inform the implementation of ongoing programmes linked to MNH and to help shape and guide future UNFPA approaches and programmatic interventions in support of MNH and SRHR.

¹ The global midwifery programme works in over 100 countries and the global Campaign to End Fistula supports 55+ countries (including all 32 MHTF countries).

² <https://www.unfpa.org/publications/business-plan-maternal-and-newborn-health-thematic-fund>.

While the results of the mid-term evaluation are expected to feed into the implementation of the MHTF through to the end of its current phase, they will also inform reflections on strategic directions, programmatic scope and operating models for the MHTF post-2022.

1.3 TEMPORAL AND GEOGRAPHIC SCOPE

The evaluation covers the implementation period of the current MHTF Business Plan (2018-2022) from 2018 through to mid-2021. Its geographic scope includes operations at the headquarters level and all 32 countries in the five UNFPA regions of operation where MHTF interventions are currently being undertaken: Western and Central Africa, Eastern and Southern Africa, Asia and the Pacific, Arab States and Latin America and the Caribbean regions.

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A new mother caresses her baby after delivering safely at the maternity ward of Dhaka Medical College.





UNFPA, MATERNAL AND NEWBORN HEALTH AND THE MHTF

2.1 THE MHTF AND THE GLOBAL CONTEXT OF MNH

Ending preventable maternal deaths is one of three transformative UNFPA goals and the MHTF is most closely associated with that goal.³ The global and 32 country contexts in which the MHTF works are complex and changing rapidly. MNH has long been considered to reflect the strength and capacity of a health system to deliver quality services. Other wider societal issues are reflected in the supply of and demand for MNH services, including gender equality and the empowerment of women and girls, the factors that determine access and utilization, and trust. More directly, the role of midwives within the health system lies at the heart of quality maternal and newborn health and care. The realization of quality MNH has been affected by declining development assistance for health, often in favour of increased focus on universal health coverage (UHC). Meanwhile, the effects of the COVID-19 pandemic are yet to be fully understood, although there is emerging evidence that shows a decline in institutional deliveries and weakened access to family planning and other essential reproductive health services.

2.1.1 Trends in maternal and newborn health outcomes

By 2018, when the MHTF launched its third phase, maternal mortality globally had declined by 44 per cent since 1990. However, the rate of decline has been uneven and particularly slow in many of the countries and regions prioritized by the MHTF. Between 2000 and 2017, the average annual rate of reduction in global maternal mortality was 2.9 per cent,⁴ far short of what would be needed to achieve global goals (Section 2.2). In addition, this rate masks significant regional (and intra-regional) disparity ranging from 525 maternal deaths per 100,000 live births across Africa to 152 in Asia and 13 in Europe. Maternal disability and morbidity estimates are not well developed but currently suggest that for every maternal death there are between 20 and 30 injuries, infections, or disabilities.⁵ Many of these, including obstetric fistula, lead to long-term health complications, economic hardship and social isolation. Among all maternal deaths, 75 per cent are caused by severe bleeding, infections, hypertensive disorders, complications during delivery and unsafe abortion.⁶

Reflecting the inextricable link between the health of mother and newborn, the MHTF broadened its vision in Phase III to become the Maternal and Newborn Health Thematic Fund to ensure that the needs of women and newborns could be addressed together. Although the United Nations Children's Fund (UNICEF) (with the World Health Organization (WHO)) usually leads on programmes aimed at newborns and stillbirth, the health and well-being of newborns is deeply connected

3 UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) UNFPA, New York, 2018.

4 WHO. (2020). "Ending Preventable Maternal Mortality", <https://www.who.int/news/item/03-09-2020-ending-preventable-maternal-mortality-online-consultation-for-coverage-targets-for-ending-preventable-maternal-mortality>.

5 <https://doi.org/10.1186/s12884-015-0789-4>.

6 WHO. Maternal Mortality Factsheet, 19 September 2019, Geneva. <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

to maternal health (the mother-baby dyad or couple). Best practice has shifted to focusing on addressing the health of both together, especially as the health of newborns is so closely related to the health of their mothers. More than a third of all under-five child deaths annually occur in the first month of life (2.5 million out of an estimated 6 million child deaths),⁷ with a significant proportion occurring on the day of birth. More than 2 million stillbirths⁸ occur every year. Data on stillbirths have only recently started to improve thanks to a new focus on registering stillbirths more systematically.⁹ Stillbirths are largely preventable with quality antenatal and delivery care.

The MHTF also aims to address the specific needs of adolescent girls, especially to empower girls, avert unwanted pregnancies, to ensure healthy pregnancy by choice, and to promote safe childbirth and a healthy post-delivery period. It does this through improving access to comprehensive, quality SRHR-MNH services. Each year, 10 million unwanted pregnancies happen among 15–19-year-olds leading to 5.6 million abortions, of which about 4 million are unsafe and put girls' lives at risk, contributing to long-lasting health problems. For many adolescent girls, there is a link between unintended pregnancy and sexual violence, and up to a third of girls report that their first sexual experience was coerced.¹⁰ Adolescent girls are much more likely than women aged 20–24 to experience complications in pregnancy and delivery, including eclampsia, puerperal endometritis¹¹ and infections, which are among the leading causes of maternal death.

The MHTF identifies the integration of SRHR into all stages of maternal care – including the prevention of unwanted pregnancy – as its central purpose (see Box B). Access to quality SRHR is a critical dimension of saving the lives of women and girls in pregnancy. SRHR services are integral to maternal health as they promote knowledge about healthy sexuality, provide access to quality services, support women and girls to determine whether, when and how many children to have, and promote the right to live free of sexual and gender-based violence (SGBV) and coercion. Family planning services are the foundation of maternal health and the most cost-effective intervention to save both maternal and newborn lives.¹²

2.1.2 Social and economic determinants

The main drivers of preventable mortality and morbidity in both women and their newborns include a range of service delivery/supply side and demand side factors together with critical social and economic determinants that underpin the health and well-being of women and girls everywhere.¹³ The most vulnerable groups and populations are those women and girls who are exposed to risks (early and/or repeated pregnancies, SGBV) and/or those who are either unaware of, or unable to access, quality services. These tend to be the poorest women and girls in high-density urban areas or conversely in very remote geographies, indigenous, nomadic and marginalized groups, disabled women and girls, and those affected by conflict or humanitarian situations.

Structural inequalities and the prevalence of harmful practices, such as female genital mutilation, can affect a large majority of girls and women in any given society. Adolescent girls are particularly vulnerable and are disproportionately at risk of injury and death in pregnancy and childbirth. Addressing these needs requires sustained, long-term, multisectoral investments

7 UNICEF. (2020). Ending Preventable Newborn Deaths and Stillbirths 2020-2030: Moving faster towards high-quality universal health coverage in 2020-2025. UNICEF, New York, 2020.

8 A stillbirth is the death of a foetus in utero either before birth (macerated stillbirth) or during birth (fresh stillbirth). Babies are considered stillborn when they do not take one breath, move, or show any reaction or sign of life as they are born or thereafter. A neonatal death, on the other hand, is defined as the death of a baby who has taken at least one breath after birth and has died within seven days. About 15 per cent of neonatal deaths occur on the day of birth.

9 See for example, the current framework for global action on newborns: the Every Newborn Action Plan 2015-2030: <https://www.who.int/publications/i/item/9789241507448>.

10 Raj A, Boehmer U. (2013). "Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries". *Violence Against Women* 2013;19(4).

11 Eclampsia is a severe condition that causes seizures and stroke in and after pregnancy; Puerperal endometritis is a bacterial infection usually occurring post-partum.

12 See, for example, Guttmacher Institute (2019). "Adding it Up: Investing in SRHR" report, Guttmacher Institute. <https://www.guttmacher.org/adding-it-up>.

13 Examples of the leading factors and determinants that undermine maternal and newborn health are identified in the MHTF Mid-Term Evaluation Inception Report (Table 1, p.6) although even these are not exhaustive.

that support the healthy growth of children, the reduction of harmful practices such as female genital mutilation and child marriage, and the promotion of life opportunities for girls including education,¹⁴ skills training and safe employment.

2.2 THE MHTF IN THE GLOBAL HEALTH ARCHITECTURE

2.2.1 Formal commitments and targets

Framing the global health agenda, Sustainable Development Goals (SDGs) 3 (Health) and 5 (Women's Equality) between them identify clear targets together with suitable indicators and measurement approaches for maternal, newborn and adolescent health.¹⁵ These targets are captured and framed in the Global Strategy for Women's, Children's and Adolescents' Health, 2015-2030 (the Global Strategy). The Global Strategy anticipates a broad multisectoral, multi-stakeholder movement to continue the momentum on women's and children's health during the Millennium Development Goal era under the umbrella of the Every Woman Every Child movement, hosted by the H6¹⁶ partners including UNFPA until the end of 2021, which was expanded in 2015 to include adolescents.¹⁷

UNFPA supported the 2019 Nairobi meeting of the International Conference on Population and Development 25 (ICPD25)¹⁸ Programme of Action, which lies at the heart of the MHTF. "Sexual and reproductive health and rights spans the lives of both women and men, offering individuals and couples the right to have control over and decide freely and responsibly on matters related to their sexual and reproductive health, and to do so free from violence and coercion."¹⁹ As noted, there are indivisible links between SRHR and maternal health (Box B). Indeed, enabling women and girls to "delay, space, and limit" births and to control whether and when to become pregnant is essential as a basis for preventing maternal and newborn deaths and disabilities.

2.2.2 The global architecture to deliver these commitments

Global programmes and partnerships most central to MNH include a range of actors and technical implementation programmes. At the global level, a coalition of partners focuses on policy, technical and implementation challenges to build and maintain momentum for achieving global maternal death reduction goals. The Ending Preventable Maternal Mortality (EPMM) initiative, co-convened by UNFPA and WHO, seeks to "promote and track progress towards strategic priorities for maternal health and survival and to build the necessary momentum to end preventable maternal deaths within a generation".²⁰ The Every Newborn Action Plan plays a similar role in relation to newborns (and averting stillbirths).²¹ Together these two coalitions form the main global arenas monitoring MNH and supporting an agenda to end preventable deaths.

Align MNH²² has been initiated recently as a platform to support collaboration, spotlight country leadership, strengthen knowledge sharing and promote gap filling. Structured around a periodic high profile global conference, Align MNH is shepherded by the Averting Maternal Death and Disability programme²³ and funded jointly by the Bill and Melinda Gates

14 Education has been identified as a major driver of health especially for women and girls. There is extensive literature on this point. Most recently, see for example, Abigail Weitzman, (2017). "The effects of women's education on maternal health: Evidence from Peru", *Social Science & Medicine*, Volume 180, Pages 1-9, <https://doi.org/10.1016/j.socscimed.2017.03.004> and Tran DB, Pham TDN, Nguyen TT (2021) "The influence of education on women's well-being: Evidence from Australia". *PLOS ONE* 16(3): e0247765. <https://doi.org/10.1371/journal.pone.0247765>.

15 Summarized in the MHTF Mid-Term Review Inception Report, April 2021.

16 A group comprising six United Nations health agencies (UNAIDS, UNFPA, UNICEF, UN Women, WHO, World Bank).

17 Every Woman, Every Child, Every Adolescent (EWEC) <https://www.everywomaneverychild.org>.

18 <https://www.unfpa.org/icpd>.

19 UNFPA, Information Sheet, ICPD. (2019). <https://www.unfpa.org/icpd/5-pillars-population-and-development>.

20 As the central global vehicle for maternal health policy and practice, the Ending Preventable Maternal Mortality includes leading maternal health actors: FCI Program of Management Sciences for Health (MSH), Jhpiego, the Maternal and Child Survival Program (MCSP), United Nations Population Fund (UNFPA), UNICEF, United States Agency for International Development (USAID), White Ribbon Alliance (WRA) and the World Health Organization (WHO) in addition to the MHTF (UNFPA). <https://www.mhtf.org/projects/ending-preventable-maternal-mortality/>.

21 The Every Newborn Action Plan (2015-2030) was developed under the guidance of a thirteen-member steering group and a wide range of partners (p.56): <https://www.who.int/publications/i/item/9789241507448>.

22 https://alignmnh.org/wp-content/uploads/2021/04/AlignMNH-Factsheet_Final.pdf.

23 The Averting Maternal Death and Disability Program is part of the Department of Population and Family Health in the Mailman School of Public Health at Columbia University in New York City. <https://www.publichealth.columbia.edu/research/averting-maternal-death-and-disability-amdd/about>.

Foundation and the United States Agency for International Development (USAID).²⁴ UNFPA is one of many partners and participated in the first global event (April 2021). Other key elements of the architecture include the Global Financing Facility supported by the World Bank aimed at filling the MNH financing gap and the Partnership for Maternal, Newborn and Child Health (PMNCH), an advocacy and global accountability platform hosted by WHO.

The leading United Nations partners engaged in MNH are the members of the H6 Partnership, global health initiatives and academia, as well as technical and professional partners, and funders and implementing partners. Based on official development assistance trends (from the Organization of Economic Co-operation and Development (OECD)), donor funding to health is generally declining. In 2019, global development funding for health was about USD 22.4 billion. This is the lowest funding level since a peak at USD 25.1 billion in 2017 and it represents a 2 per cent decrease compared to USD 22.8 billion in 2018. Given that major global donors announced significant aid cuts in 2021 (for example, the United Kingdom cut aid by GBP 4 billion, much of it earmarked for health, including SRHR and MNH) and notwithstanding the increased funding made available as a response to COVID-19, the global health funding outlook is constrained. In this context, getting more value for money and ensuring that available funds are used to address root causes, basic systems and country-identified priorities are both essential to maximizing available resources.^{25,26}

2.2.3 Universal health coverage and primary health care

Most MHTF partner countries are making investments into long-term health systems and health financing reforms that aim to offer basic health care to all their citizens without incurring financial hardship. The COVID-19 pandemic has stalled progress in some settings but has also heightened the perceived value of universal health coverage based on primary health care (PHC). To maximize the health impact of universal health coverage processes, it is necessary to include SRHR and MNH services for all women and girls. In the wake of the 2018 Astana Declaration, 40 years after the Alma Ata Declaration set out the primary health care agenda, WHO and its member states re-committed to putting primary health care at the heart of the health system. Indeed, WHO, UNFPA, UNICEF and other leading global partners now identify primary health care as one of the main platforms through which countries will achieve universal health coverage, “the PHC approach is foundational to achieving [...] shared global goals in UHC and the health-related SDGs”.²⁷ Essential services for women and children – including SRHR and maternal and child health care (vaccinations, antenatal care (ANC), growth monitoring and nutrition) – constitute the core of primary health care and consume most of the time, capacity and resources in already constrained settings. The H6 partners, together with other global health organizations, have agreed to shift their high-level strategy towards advancing primary health care as the main strategy to deliver universal health coverage.

As the flagship thematic fund of UNFPA focusing on MNH, the MHTF supports countries (through UNFPA country offices) to advance universal health coverage, especially through primary health care. Without SRHR services, antenatal care, supportive community services for nutrition, infectious disease control and other basic care, women and their babies are much less likely to benefit from necessary referral. The MHTF works particularly on strengthening the health workforce, service delivery, demand generation and service utilization, and health information systems, and on reinforcing country leadership and governance in support of this broad health systems strengthening agenda (see also the MHTF theory of change in Section 3).²⁸

2.2.4 COVID-19

The 2020-2021 pandemic caused by the SARS-CoV-2 virus (COVID-19) has had multiple impacts on all aspects of life across the world. Not only have there been more than 300 million cases and 5 million deaths as of January 2022, but health services have been diverted towards addressing the implications of the virus on multiple levels, including around maintaining essential

24 USAID funding for maternal and newborn health is also through its Momentum Program: <https://usaidmomentum.org>.

25 See for example, <https://donortracker.org/sector/global-health>. In addition, the most effective interventions to support women and girls across the life course have been identified by the PMNCH.

26 For a summary of the most cost-effective MNCH interventions, see: The Partnership for Maternal, Newborn & Child Health. (2011). A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH). Geneva, Switzerland: PMNCH. https://pnmch.who.int/docs/librariesprovider9/governance/12th-board-meeting-2may2012-interventions-commodities-guidelines-for-rmnch-summary-en.pdf?Status=Master&sfvrsn=5255de6b_5

27 WHO webpage accessed 2 March 2021. <https://www.who.int/teams/primary-health-care/conference/declaration>.

28 <https://www.unfpa.org/publications/business-plan-maternal-and-newborn-health-thematic-fund> – page 17.

services for non-COVID-19 related diseases. The 2020 MHTF annual report indicates that the COVID-19 pandemic “has further strained already weak and fragile health systems, health workers and midwives in particular during the emergency response” and has served as a stress test for SRHR-MNH integrated services across all 32 MHTF-assisted countries.²⁹

Based on lessons learned from the 2014-2015 West African Ebola outbreak and other pandemics, interventions needed to control epidemic diseases can quickly shift health-seeking behaviours. The effect is that deaths from preventable or treatable conditions, no longer managed by a failing health system, quickly exceed epidemic-related deaths. It is therefore crucial to maintain essential life-saving health services, even while addressing the pandemic.³⁰ A study by UNFPA and Avenir Health, for example, showed that the pandemic disrupted contraceptive services for 12 million women, resulting in an estimated 1.4 million unintended pregnancies across 115 low- and middle-income countries.³¹

“The pandemic has already severely disrupted access to life-saving SRHR services. It is worsening existing inequalities for women and girls and deepening discrimination against other marginalized groups. SRHR is a significant public health issue that demands urgent and sustained attention and investment.”³²

2.3 THE MHTF AS AN INSTRUMENT TO SUPPORT MNH

2.3.1 The MHTF strategy and Business Plan

UNFPA initially launched the MHTF in 2008 to attract funding and commitment to maternal health as part of its core mandate. Its first phase (2008-2014) focused on supporting 40 low resource, high maternal mortality ratio (MMR) countries with three main technical areas (EmONC, midwifery and fistula). Its second phase (2014-2017) straddled the end of the Millennium Development Goal era and the shift to the Sustainable Development Goals when the global agenda pivoted significantly away from both women and children’s health toward health in general. Phase II focused more closely on midwifery, EmONC, fistula, MPDSR and first-time young mothers. UNFPA estimates that, together, between 2008 and 2017, Phases I and II have contributed to averting 119,127 maternal deaths.³³

The third phase of the MHTF (2018-2022) is aligned with the UNFPA Strategic Plan (2018-2021), centred on three major goals.³⁴ In this third phase, the MHTF partners with 32 countries and delivers support around four main outcome areas: midwifery, EmONC networks, MPDSR and support to ending obstetric fistula and other obstetric morbidities.³⁵ The MHTF focus on four technical outcomes is designed to enable it to build a comparative advantage in these areas, and to target its efforts in ways that maximize impact especially in large, high maternal mortality burden settings, by addressing priority health systems strengthening focus areas (Section 2.2.3). All four areas have technical specificities that require significant expertise but have the potential for impact on averting maternal deaths. The MHTF logic chain is laid out in Box A.

29 <https://www.unfpa.org/publications/maternal-and-newborn-health-thematic-fund-annual-report-2020>, page 43.

30 United Nations. (2020). United Nations framework for the immediate socioeconomic response to COVID-19. New York, April 2020. p.11.

31 UNFPA. (2021). “Impact of COVID-19 on Family Planning: What We Know One Year into the Pandemic” https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf.

32 https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Global_Response_Plan_Revised_June_2020_.pdf.

33 UNFPA. (2017). The Maternal Health Thematic Fund: Keeping the momentum. Annual Report 2017 and Review of Phase II (2014-2017), UNFPA, New York, 2017, P.vi. <https://www.unfpa.org/publications/maternal-health-thematic-fund-annual-report-2017>.

34 Working towards zero unmet need for contraception; zero preventable maternal deaths; and zero gender-based violence and harmful practices, such as child marriage and female genital mutilation.

35 The fistula outcome in the MHTF reflects the combined work of the MHTF and the Global Campaign to End Fistula. In practice the MHTF and the Campaign work together and harmonize resources but some donors provide funding through the Campaign window only.

Box A: The MHTF Phase III logic chain based on four technical outcomes**A focus on four technical areas working through five modes of engagement to strengthen health systems:**

The MHTF logic chain is centred on delivering results around four technical outcome areas through which the aim - as stated in the 2018-2022 MHTF Business Plan (p.21) - is to strengthen health systems to provide equitable and accountable access to quality sexual, reproductive, maternal and newborn health care. The MHTF aims to support “upstream strategic directions, technical assistance and capacity-building for the development, implementation and monitoring of MNH interventions aligned with country-owned and driven processes”.³⁶ It does this working through UNFPA five modes of engagement supporting implementation through three groups of partners (UNFPA country offices, partner governments, and non-governmental organizations /civil society organizations).

1. Midwifery

Midwives are increasingly the skilled health personnel most likely to come into contact with women and girls. UNFPA works on midwifery education (pre and in-service), midwifery regulation and professional development including roles in the health workforce, and professionalization of midwives as a cadre through associations. This three-prong strategy also aims to offer entry points for SRHR and MNH integration (See Box B) and gender-related interventions.

2. Emergency obstetric and newborn care

EmONC refers to emergency obstetric and newborn services aimed at saving the lives of mothers and their babies at birth. Basic EmONC care (BEmONC) and comprehensive care (CEmONC) are described in the Glossary. A critical element of EmONC is speedy referral from basic to comprehensive services. The EmONC network approach specifically refers to a methodology that identifies and maps out a rational chain of basic and comprehensive health facilities based on population distribution. The MHTF works on EmONC in all its countries but the EmONC network³⁷ methodology is delivered in a subset of countries depending on their interest and other factors. Its leading global technical partner is the University of Geneva, Geographic Information System (GIS) Unit in the Faculty of Medicine. Other partners include WHO, UNICEF and Columbia University (with its AMDD initiative).

3. Maternal and perinatal death surveillance and response

MPDSR is an accountability tool, and a form of audit and review. It aims to create a continuous action cycle for quality improvement based on a number of stages (notification, data collection, analysis, response, verification of response implementation). Maternal death reviews were originally focused on reporting maternal deaths and identifying cause of deaths at both the community and hospital levels. The four pillars of MPDSR include mandatory notification, a functioning national MPDSR committee, the development of national guidelines and tools, and a costed budget for implementation. The addition of perinatal deaths reflects the persistent rate of deaths among infants, especially at or just after birth, including stillbirths. The MHTF became involved in MPDSR in 2013. Main partners include UNICEF and WHO among the H6 and the Centres for Disease Control.

4. Fistula and other obstetric morbidities

A fistula is an opening between the vagina and either or both the bladder and rectum. The term fistula is also used to cover programmatic activities surrounding the Campaign to End Fistula. For example, ‘fistula efforts’ refer to efforts to end the suffering caused by fistulas. Each year, between 50,000 and 100,000 women worldwide are affected by obstetric fistula caused by obstructed/prolonged labour. Iatrogenic fistula is on the rise as well, reflecting the quality of care challenges associated with caesarean sections, the repair of a ruptured uterus and other surgeries related to women’s health. UNFPA fistula efforts began under the United Nations Campaign to End Fistula (led by UNFPA). UNFPA fistula efforts are largely hosted/funded under the MHTF and work on four areas: prevention, repair, rehabilitation and recovery and reintegration.

36 UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) New York, 2018, p.7.

37 The EmONC Network approach is described in this recent manual produced by the MHTF (and partners): https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Implementation_Manual_for_EmONC_facility_network_Sept_2020_web_0.pdf.

These four technical areas are parsed out through 15 specific outputs (described in detail in the MHTF Business Plan) that reflect the programme priorities around strengthening the health workforce, service delivery, demand generation and service utilization, health information systems, and reinforcing leadership and governance by leveraging the UNFPA five modes of engagement: service delivery, capacity development, partnerships and coordination (including South-South and triangular cooperation), knowledge management, and advocacy and policy dialogue and advice.³⁸

2.3.2 The global Campaign to End Fistula

In 2003, UNFPA and its partners launched a global Campaign to End Fistula (the Campaign),³⁹ in line with international targets to improve MNH and with the goal of ending fistula. The Campaign is active in more than 50 countries with support drawn from a wide pool of funders and continues to attract a wide range of partners drawn from among policymakers, health leaders and implementing partners. In 2017, the Campaign to End Fistula was the recipient of the Women's Empowerment Award from the United Nations Federal Credit Union Foundation, in appreciation for its "action for a new global agenda grounded in principles of rights, inclusiveness, and equality". Even though the funds raised by UNFPA for the Campaign are passed through and managed by the MHTF fistula team, the Campaign has a profile that extends well beyond the MHTF in its network of partners and countries of focus.

2.3.3 Linking SRHR and MNH

According to its Business Plan, the MHTF Phase III has "broadened its scope to further contribute to achieve universal access to sexual and reproductive health and rights and accelerate progress towards the ICPD Programme of Action".⁴⁰

Box B: Integrated SRHR and MNH services: A UNFPA global mandate

By supporting gender equality, access to work, and economic development for households and for whole nations, sexual and reproductive health underpins national development and contributes to all the Sustainable Development Goals.

According to the Guttmacher-Lancet Commission in 2018, each year in developing regions, more than 30 million women do not give birth in a health facility, more than 45 million have inadequate or no antenatal care, more than 200 million want to avoid pregnancy but are not using modern contraception, and nearly one in three will experience SGBV. Addressing these needs is critical to achieving the Sustainable Development Goals. To do so effectively, SRHR services need to be accessible and available to all and encompass a broad range of services that enable people to decide whether and when to have children, experience safe pregnancy and delivery, have healthy newborns, and have a safe and satisfying sex life.⁴¹

Integration is the strategy that brings all these components of service delivery together either on site or through referral and establishing strong linkages with other healthcare and related services. The rationale for doing so is to meet the needs for client-centred, comprehensive care in an acceptable, convenient manner that is effective and efficient. Universal access to integrated sexual and reproductive health services is thus a necessary corollary.⁴²

38 It is worth noting that the modes of engagement are not fully or strictly defined and in practice activities may be allocated differently depending on the perspective of the country office. There is likely to be blurred lines especially between capacity-building and advocacy for example.

39 UNFPA hosts the Campaign to End Fistula: <http://www.endfistula.org>.

40 UNFPA. (2018) UNFPA MHTF Business Plan (2018-2022) New York, 2018, p.5.

41 <https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary>.

42 Framing SRHR at the global level in ways that all countries agree can be difficult. An example of such framing is this resolution negotiated in the United Nations and agreed by a wide range of countries and states from across the spectrum:

https://www.un.org/en/development/desa/population/pdf/commission/2011/documents/CPD44_Res2011-1b.pdf.

A comprehensive approach is needed to advance integration and universal access. Most health and development initiatives typically focus on particular components of the full package: contraception, MNH, SGBV, or HIV and AIDS. While countries have made gains in these areas, they have been inequitable, and services fall short of full coverage and quality. “Acceleration of progress therefore requires adoption of **a more holistic view of SRHR** and tackling of neglected issues, such as adolescent sexuality, SGBV, abortion, and diversity in sexual orientations and gender identities.”⁴³

UNFPA leads on SRHR–MNH integration and has recently expanded its advocacy and guidance on **bodily autonomy**⁴⁴ and the rights of women and girls.⁴⁵

2.3.4 The catalytic role of the MHTF

The MHTF is conceptualized and presented as a catalytic instrument. Its Business Plan for 2018-2022 states that it 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”.⁴⁶ The catalytic role of the MHTF is described as: “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” accelerating “strategic interventions” and leveraging “coordination mechanisms”.⁴⁷

The MHTF Business Plan also indicates that by “systematically documenting results, best practices, lessons learned and emerging issues, the MHTF has a multiplier effect, including through mobilizing additional funding”.⁴⁸ At the global level, the MHTF aims to be “a catalyst for change and innovation, sustaining momentum around globally agreed goals [...], the realization of sexual and reproductive rights, and ending preventable maternal and newborn mortality”.

Acting as a catalyst or in ways that are catalytic is a potentially valid and valuable approach to technical support irrespective of resource availability. On the other hand, bearing in mind MHTF limited resources, its catalytic effect would amount to achieving a disproportionate influence on outcomes or achieve disproportionately more for the money than could normally be expected. Ultimately, catalytic actions (like an engine catalyst) aim to accelerate results.

2.3.5 The MHTF implementing partners

MHTF activities are delivered by three types of implementors. These are: (i) by the UNFPA country offices directly (47 per cent of all UNFPA resources are delivered this way); (ii) by partner governments (35 per cent of all resources are spent by governments at national and/or subnational levels); and (iii) by non-governmental organizations, which account for the remaining 18 per cent of MHTF resources.

2.3.6 The MHTF financial resources

UNFPA budgets are made up of core and non-core (programme) funding. Core funding can be channelled to any UNFPA expense while programme funds tend to be earmarked for particular expenditure. All MHTF funding is non-core (programme) funding. However, UNFPA country office expenditure on MNH and SRHR comes from more than just MHTF funding, with the ratio varying across countries. Core funds are then split between “institutional and corporate expenditure” (45 per cent of all core funds in 2020) and “core resources allocated to programmes” (55 per cent of all core funds in 2020).

43 Gutmacher Institute. (2018). “Accelerate progress—sexual and reproductive health and rights for all: report of the Gutmacher–Lancet Commission”, *Lancet* 2018; 391: 2642–92. Published Online May 9, 2018.

<https://sdgresources.relx.com/scientific-reports/accelerate-progress%E2%80%94sexual-and-reproductive-health-and-rights-all-report>.

44 UNFPA. (2021). Technical Brief, Bodily autonomy: a cornerstone for achieving gender equality and universal access to sexual and reproductive health and rights. April 2021 https://www.unfpa.org/sites/default/files/pub-pdf/Technical%20Brief_BODILY_AUTONOMY_English_%20May4.pdf.

45 UNFPA. (2021). The State of the World’s Population: My Body is My Own. https://www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_EN_web.3.21_0.pdf.

46 UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) New York, 2018. p.5.

47 UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) New York, 2018. p.13.

48 UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) New York, 2018. pp.13-14.

Resources available for all global programmes delivered through UNFPA in 2020 thus comprised 55 per cent of core resources in addition to the non-core programme envelope and, together, total USD 1.027 billion. The MHTF represents a very small share of this total envelope, amounting to USD 11.941 million in 2020 or just over 1 per cent of all available programme funds.

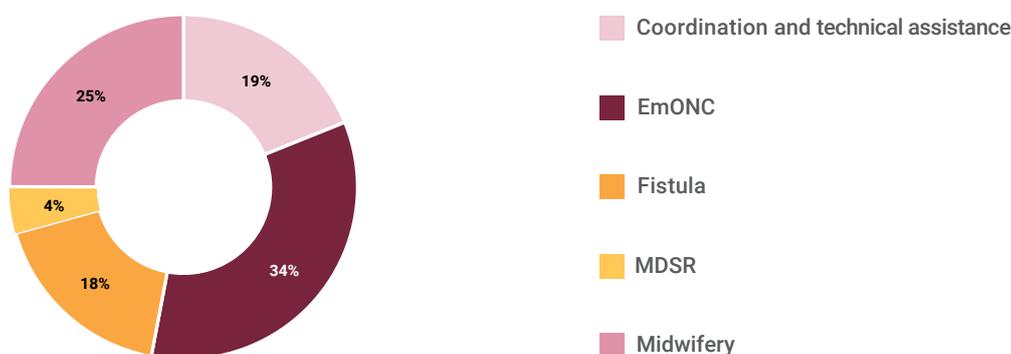
Considering the MHTF funding envelope, the total available funds over the three years covered by the present evaluation has been fairly stable. Most resources were raised directly by the MHTF, but a small proportion of funds were raised specifically for fistula and channelled through the MHTF. Table 1 shows the available funds raised directly by the MHTF and the additional fistula funds for the years 2017-2020. Funds raised for fistula peaked in 2018 and have been declining since, whereas funds raised for the wider maternal health pool continue to remain more or less constant.

TABLE 1: Total available funds spent through the MHTF, 2017–2020 (USD)

	2017	2018	2019	2020	Total	% of Total
Obstetric fistula	377,648	555,361	286,786	178,128	1,397,923	3%
Maternal health	12,176,270	10,910,225	10,222,354	11,763,099	45,071,948	97%
Grand total	12,553,918	11,465,586	10,509,140	11,941,227	46,469,871	

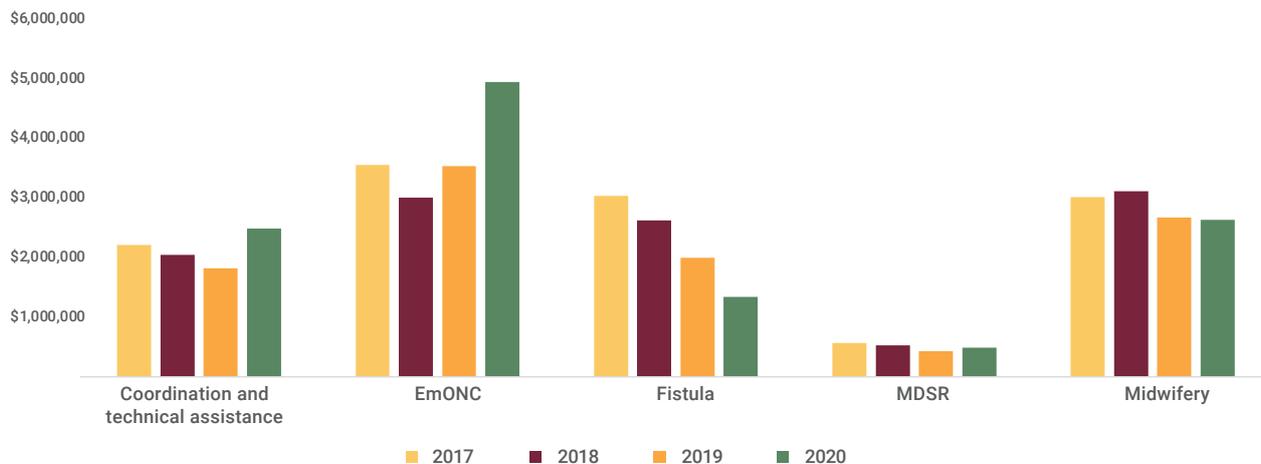
Within its envelope of funding (maternal health funds plus fistula funds), the MHTF expenditure across the four technical focus areas and headquarters-based coordination and technical assistance costs is shown in Figure 1. This reflects combined funds over the programme evaluation period (2018-2020). EmONC accounts for the largest volume of expenditure over the three-year period, followed by midwifery. The MPDSR is the lowest spending area.

FIGURE 1: Distribution of the MHTF expenditure, 2018-2020 (USD)



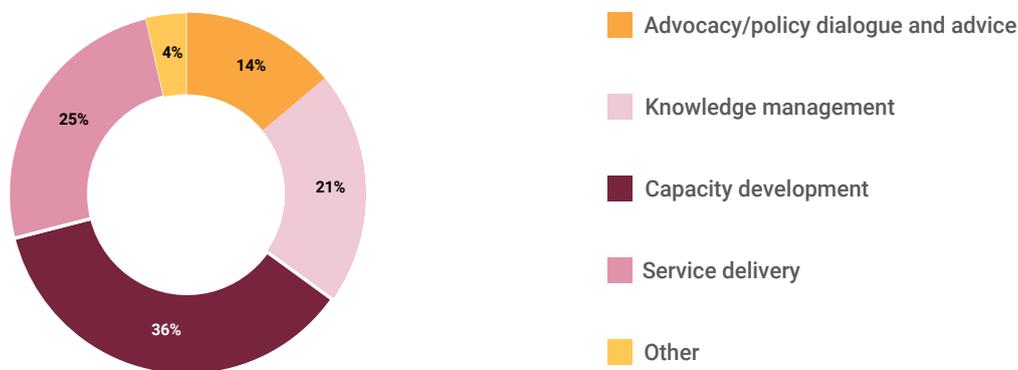
Looking at the year-on-year spending by technical focus area (Figure 2), spending on fistula appears to have been declining in recent years. This could be for a number of reasons, such as: other available partner funding, diminishing needs (which seems less likely), or choices about channelling funds to other priorities. The exceptional spending on EmONC in 2020 reflects additional funds channelled to the COVID-19 response to support services (including infection prevention control (IPC), community outreach and other areas - see Section 4.9), while the midwifery component was affected by suspended programmes in 2020. Meanwhile, coordination by and technical assistance from the MHTF team in headquarters has increased.

FIGURE 2: The MHTF spending by technical focus area, 2018-2020 (USD)



UNFPA country offices work through different modes of engagement and Figure 3 shows the distribution of all MHTF resources (2018-2020) across the five modes.⁴⁹

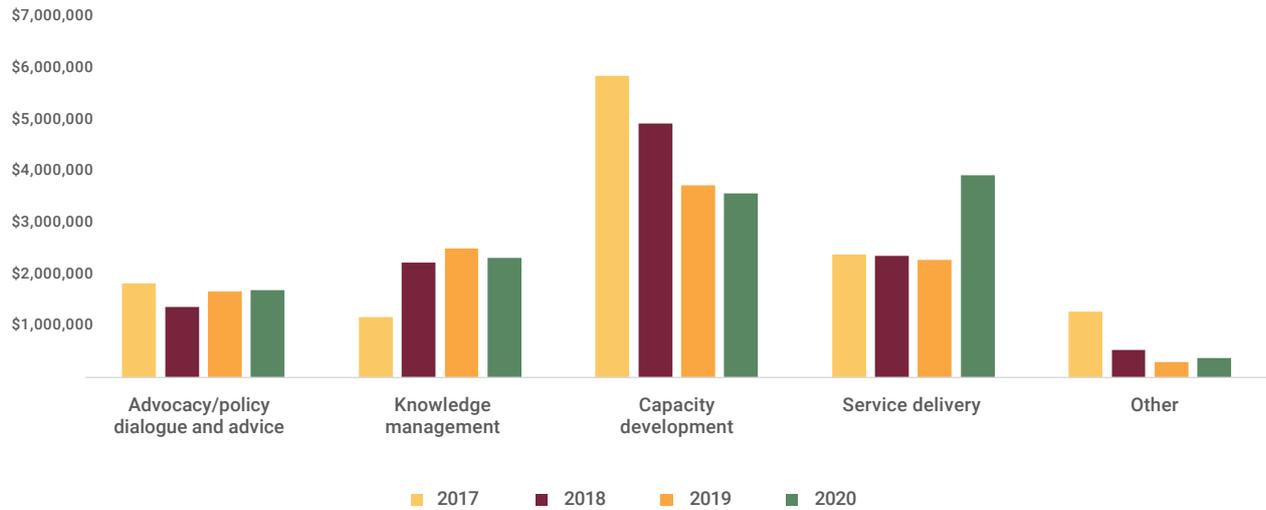
FIGURE 3: Distribution of the MHTF funds through the five modes of engagement, 2018-2020



Looking at spending by year across the five modes of engagement (Figure 4), there has been a steady decline in spending for capacity development. A notable increase in service delivery in 2020 reflects investments aimed at offsetting the impact of COVID-19 on women’s access to maternal health services (see Section 4.9) funded by the Takeda Foundation. The MHTF funds expended in 2017 are included in order to make spending patterns more visible.

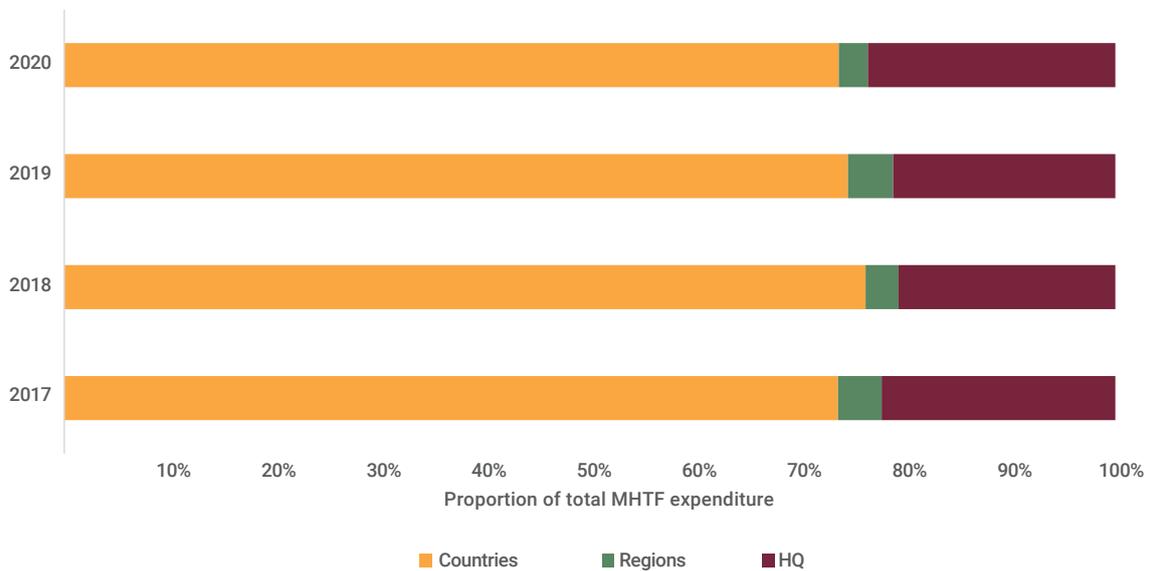
⁴⁹ Note that the fifth mode of engagement in the MHTF Business Plan was listed as “Partnership and Cooperation”. In practice, country offices badge the fifth mode of engagement as “Other”.

FIGURE 4: Distribution of the MHTF funds by mode of engagement, 2017-2020 (USD)



As noted, most MHTF funds are spent through country offices. Figure 5 shows the distribution among administrative units: UNFPA headquarters, regional and country offices for the years 2017-2020. The overall distribution does not significantly vary year on year.

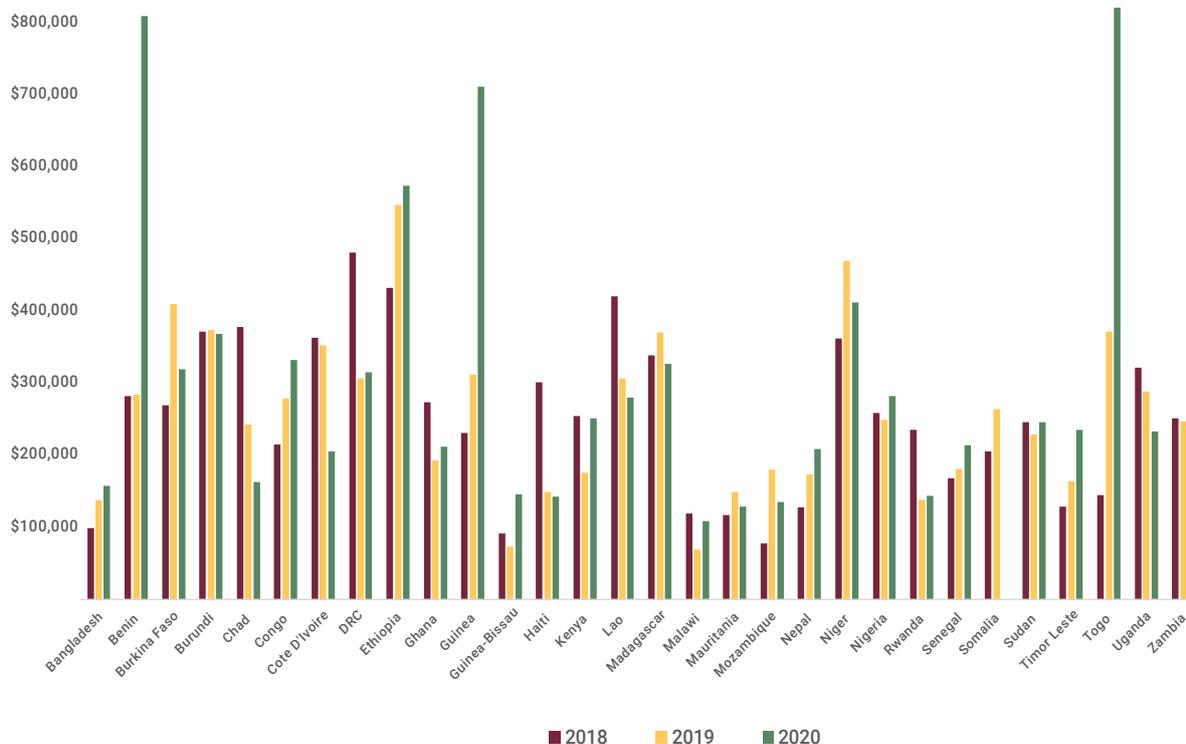
FIGURE 5: Distribution of the MHTF resources to headquarters, regional and country offices, 2017-2020 (USD)



Spending is not evenly distributed across the 32 MHTF programme countries. In 2018, spending occurred in nine countries (23 per cent) at a rate of less than USD 100,000 per year over the three-year period (2018-2020). In a few of these nine low spending countries, MHTF expenditure took place only in 2018 and was under USD 100,000 altogether. In 11 countries (28 per cent), spending ranged between USD 300,000 to USD 600,000 (medium spend) and in 19 countries (49 per cent) spending was over USD 600,000 up to over USD 1 million (high spend).

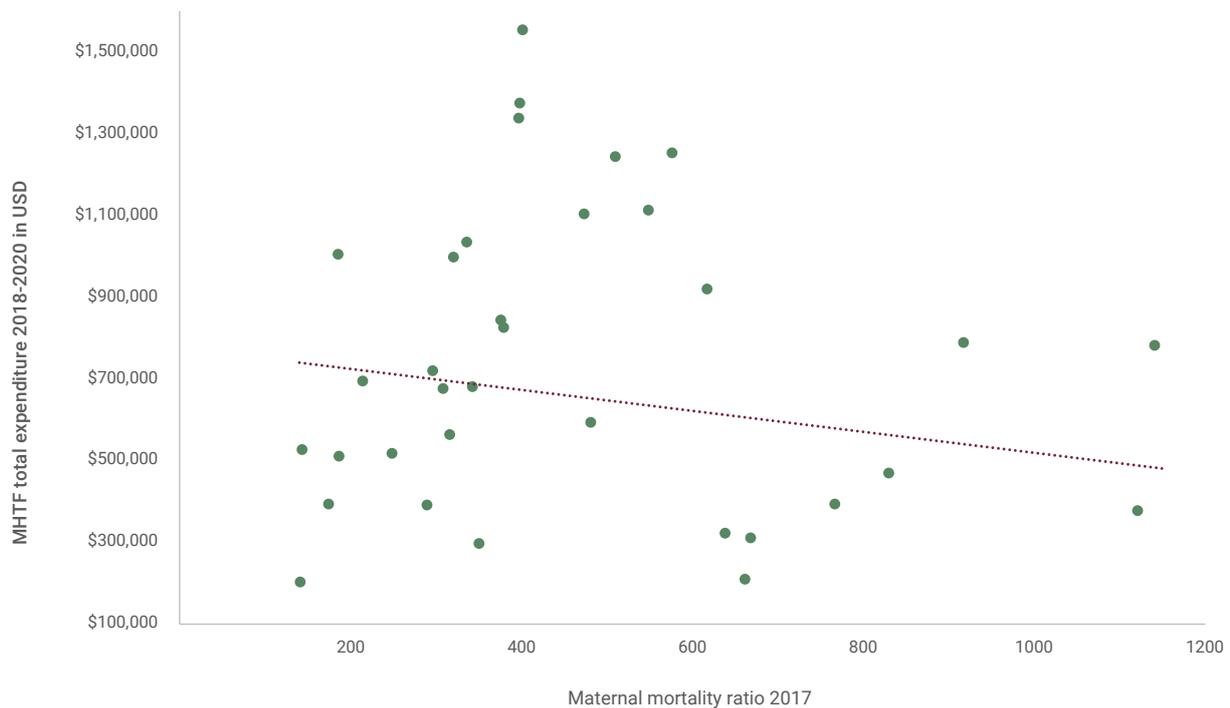
Figure 6 shows the MHTF expenditure in all medium and high spend countries. In three countries, Benin, Guinea, and Togo, spending in 2020 is notably high reflecting additional resources channelled through the MHTF by the Takeda Foundation to support the COVID-19 response.

FIGURE 6: The MHTF financial resources distributed by country*, 2018-2020 (USD)



*MHTF countries that spent under USD 100,000 over three years (low spend countries) were excluded from this analysis.

Lastly, the MHTF investments in each partner country were plotted along with maternal mortality ratios to assess whether any highly visible relationship between spending decisions and health burden (Figure 7) exists. The analysis is not conclusive. The regression line suggests there is an inverse association between expenditure and maternal deaths. In fact, several high burden countries are among those with the least MHTF spending. While it is important not to overstate this association, this suggests that absolute need is not the main driver of resource allocation or actual investment in MNH. This may be due to a range of contextual factors, such as weak systems and leadership or a poor reform environment, all of which can affect budget execution. In other words, better performing health systems are more able to absorb and spend additional resources, a finding that is unsurprising but highlights the potential value of MHTF modes of engagement especially partnerships and capacity-building.

FIGURE 7: The MHTF spending from 2018-2020 in relation to maternal mortality ratio (all MHTF countries)

Source: <https://data.worldbank.org/indicator/SH.STA.MMRT>

2.3.7 Funding maternal health at UNFPA

The MHTF is the leading, but not exclusive, source of funding for maternal health across UNFPA. As one of the three transformative results, UNFPA invests in maternal health in several ways and through various funding modalities. For example, through the Supplies Partnership,⁵⁰ countries access four life-saving maternal health commodities, including magnesium sulphate, oxytocin, misoprostol and mifepristone.⁵¹ While they represent a fraction of total commodities procured (7 per cent in 2020), the amount is significant in relation to the total funding received through the MHTF. For example, in 2020, 7 per cent spent by the UNFPA Supplies Programme on maternal health commodities is equivalent to more than 75 per cent of the whole MHTF expenditure that year (USD 11.9 million). The balance of the Supplies Partnership focuses on the distribution of other reproductive health commodities (primarily family planning commodities). About 18 per cent of the total budget is spent on supply systems strengthening and capacity-building interventions to strengthen family planning and reproductive health service delivery, which is also directly relevant for the MHTF ability to deliver results.

50 The Supplies Programme started into a third phase as of 2021 and was renamed the Supplies Partnership.

51 In 2018 and 2019, 28 countries received stocks of the four life-saving drugs: Afghanistan, Burkina Faso, Cameroon, Chad, Congo, Cote D'Ivoire, the Democratic Republic of the Congo (DRC), Djibouti, Eritrea, Gambia, Haiti, Liberia, Madagascar, Mauritania, Mozambique, Myanmar, Niger, Nigeria, Papua New Guinea, Rwanda, Sao Tome & Principe, Sierra Leone, South Sudan, Sudan, Tanzania, Togo, Uganda and Zimbabwe. In 2020, 35 countries received life-saving maternal health supplies: Benin, Bolivia, Burundi, Cameroon, Central African Republic, Chad, Congo, Cote D'Ivoire, DRC, Djibouti, Eritrea, Gambia, Guinea, Guinea-Bissau, Haiti, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Papua New Guinea, Rwanda, Sao Tome & Principe, Sierra Leone, South Sudan, Sudan, Tanzania, Togo, Uganda, Yemen, Zambia and Zimbabwe.

TABLE 2: Analysis of maternal health commodities expenditure through UNFPA Supplies, 2018-2020 (USD)

Year	Number of countries procuring maternal health medicines	Country expenditure on maternal health medicines procurement	As a per cent of all UNFPA supplies commodity procurement
2018	28	USD 6,957,647	5%
2019	28	USD 4,770,495	4%
2020	35	USD 9,165,502	7%

UNFPA operates other global thematic funds, in addition to the MHTF and the Supplies Partnership. These are the joint fund for the elimination of female genital mutilation (with the whole H6 Partnership), child marriage (with UNICEF), and the response to HIV.⁵² Expenditure through these funds is also quite modest and the bulk of programme funding is raised in-country, making it difficult to readily identify the total spending targeted at maternal health across all UNFPA programme funds. There are a number of regional funds (for example, the French-funded Muskoka trust fund in West Africa) that support a range of health programmes as well.

2.3.8 The MHTF results reporting

Monitoring and reporting on the MHTF results is challenging for several reasons. Firstly, the MHTF contributes to multiple policy, service delivery, and system strengthening components in health systems of widely differing structures. These vary by country and over time. Amalgamating these efforts into something that resembles a coherent set of results (rather than a statement of activities or a summary list of how funds were spent) requires a results-oriented performance monitoring system that is not completely in place. The MHTF has developed a comprehensive results framework based on 15 outcomes, 35 interventions and 44 indicators tracked across the 32 MHTF partner countries (although not all countries track all indicators). These indicators are reviewed and verified through an internal and peer-reviewed process. This evaluation did not include an assessment of the indicators themselves and it is presumed that they are robust, well formulated and verifiable. Countries elect to report on a subset of indicators based on what they consider relevant to their MHTF priorities, and these are collated at the regional and global levels. These indicators are used to measure activities undertaken by the MHTF as well as some outcome measures. To enable aggregation across MHTF countries, results are expressed as numbers – or counting – of outputs or are binary in nature; for example, a national MPDSR committee is operational (yes or no), with no indication of the reporting period, context or qualitative nuance. A supplementary MHTF annual survey sent to country offices collects information on the national policies and plans, political economy evolution and other matters.

The MHTF team points out that, while there are well understood limitations with counting results, in many countries this will be the first time that maternal health services, facilities, or supplies have been systematically quantified and measured. This can be a valuable contribution - country by country - especially where the baseline is clearly in place and the reasons for increased outputs/ outcomes (or limited progress) are followed up and understood. However, there are several dozen indicators to follow up and some countries attempt to measure them all. Identifying the contribution of the MHTF to the outputs and outcomes achieved – that is, assessing the results of the MHTF effort and its contribution to the larger whole – both in individual countries and across the range of 32 countries as well as globally – is likely to require significantly more qualitative and contextual analysis.

Furthermore, the monitoring approach only partially enables MHTF managers and stakeholders to understand the full contribution of the programme to progress made in countries towards MNH outcomes or towards the actual outcomes of the MHTF. This is partly because the MHTF works on complex health systems challenges, which require sustained effort

⁵² This is through the Unified Budget, Results and Accountability Framework (UBRAF).

from all partners – especially governments and health authorities – to address. In addition, given that the main contribution of the programme is catalytic in nature, this overall effect is less likely to be fully captured or understood through output monitoring. Another issue with the current results framework approach seems to be that the overall impact of the MHTF risks being underestimated since the programme is focused on helping countries make difficult policy shifts and strengthening systems that take time to deliver results.



© Sufian Abdulmouty/UNFPA Sudan.

UNFPA supported mobile team providing services to the affected population due to floods.

3

EVALUATION APPROACH AND METHODOLOGY

3.1 EVALUATION APPROACH

3.1.1 Contribution analysis: the analytical framework

This evaluation is designed to meet its objectives by using contribution analysis as its central, theory-based analytical approach. Applying contribution analysis requires the completion of the following steps⁵³:

1. Setting out the attribution problem to be addressed
2. Developing and adapting a theory of change for the programme and its related assumptions. The evaluation approach required further refinement of the MHTF theory of change (Section 3.2)
3. Gathering existing evidence on the theory of change and the changes that have taken place along identified causal pathways, in particular to identify the contribution of MHTF to those changes with regards to MNH and SRHR (the contribution story)
4. Gathering specific evidence related to the impact of COVID-19 on investments, activities and outputs of the programme
5. Seeking out additional evidence where needed
6. Revising the theory of change and identifying the contribution of MHTF support to positive results and trends in MNH and SRHR.

As a design tool for the evaluation, the theory of change made it possible to visualize how UNFPA is positioned within a complex landscape and where and how it expects to be active. Responding to needs in MNH is a complex and multifaceted challenge to health systems, therefore it is easy to underestimate the scale of need or conversely to overstate the impact of specific interventions. The theory of change helps to capture the expected level and locus of the chain of effects. It is also a crucial tool to:

- Identify causal linkages supporting the outcomes of the UNFPA Strategic Plan (2018-2021)
- Make explicit the causal assumptions that had to be realized for UNFPA support to contribute to identifiable results at the output, outcome and goal levels
- Formulate the evaluation questions and related assumptions for verification
- Develop the detailed evaluation design (as depicted in the draft evaluation matrix, including sources of information and data collection tools).

53 Mayne, John (2008). "Contribution Analysis. An approach to exploring cause and effect". Institutional Learning and Change (ILAC) Brief, 16. p2.

As shown in Section 2.3.1, the MHTF Business Plan laid out an intervention logic to make explicit its anticipated chain of effects. The evaluation team used this intervention logic to develop a refined theory of change (Section 3.2). The theory of change developed during the inception phase of the evaluation was used to design the evaluation matrix, which presents (in a structured manner) the data and information collected throughout the evaluation process (Annex 1).

3.1.2 Taking account of the COVID-19 pandemic

While this evaluation was being undertaken, the world was in the second year of the global pandemic caused by COVID-19. The COVID-19 pandemic has affected almost every aspect of MHTF-supported programmes and, indeed, this evaluation as well. The challenges were addressed in the following ways:

- **Evaluation design:** The myriad effects of the COVID-19 pandemic and UNFPA responses were integrated into the evaluation theory of change alongside the MHTF chain of effects. The purpose was to ensure that the role played by UNFPA was clearly identified as regards its support to maintaining access to SRHR and MNH services in partner countries as well as its role in mitigating the effects of the pandemic, specifically on MHTF activities (Section 3.4)
- **Data collection and analysis:** A specific evaluation question was developed with associated assumptions to facilitate an analysis of UNFPA actions to respond to, and mitigate the effects of, the pandemic on the MHTF interventions and their expected results
- **Methodological approach:** The approach to data collection had to be modified in some countries as a result of the pandemic. For example, international consultants were unable to travel in some cases (Sudan, Zambia). In-person interviews and observations were affected in most settings (Section 3.3).

TABLE 3: Evaluation questions by area of investigation

Evaluation questions and criteria	Evaluation criteria
Area of investigation 1: Midwifery	Relevance, coherence, effectiveness, efficiency, sustainability, integration
Evaluation Question 1: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated, and sustainable midwifery workforce?	
Area of investigation 2: Emergency obstetric and newborn care	Relevance, coherence, effectiveness, efficiency, sustainability, equity, and rights
Evaluation Question 2: To what extent has MHTF supported ministries of health to design, strengthen and scale up a national network of referral maternity facilities capable of providing quality SRHR services and MNH care, including EmONC?	
Area of investigation 3: Maternal and perinatal death surveillance and response	Relevance, coherence, effectiveness, sustainability
Evaluation Question 3: To what extent has the MHTF contributed to: firmly establishing the main components of the MPDSR programme; supporting its implementation at national scale; increasing the notifications of maternal deaths and strengthening the quality of maternal death reviews; and implementing the “response” component?	
Area of investigation 4: Obstetric fistula and other obstetric morbidities	Relevance, coherence, effectiveness, efficiency
Evaluation Question 4: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor national strategies for ending fistula cases that are founded on: prevention, access to quality treatment of fistula cases and other obstetric morbidities, and social reintegration of obstetric fistula survivors?	

Evaluation questions and criteria	Evaluation criteria
<p>Area of investigation 5: Integrated MNH and SRHR</p> <p>Evaluation Question 5: To what extent has the MHTF contributed to strengthened integration between maternal health and SRHR with a view to achieving quality service delivery, increasing client satisfaction, and stimulating greater public demand for SRHR services?</p>	<p>Relevance, coherence, effectiveness, efficiency, coordination, equity and rights</p>
<p>Area of investigation 6: Equitable and accountable access</p> <p>Evaluation Question 6: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information systems to meet the diverse and differentiated needs of women, newborns, and adolescent girls including those in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and living with disabilities?</p>	<p>Relevance, coherence, effectiveness, sustainability</p>
<p>Area of investigation 7: A catalytic role</p> <p>Evaluation Question 7: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to “punch above its weight” in support of MNH outcomes and integration with SRHR?</p>	<p>Relevance, coherence, efficiency, coordination, integration</p>
<p>Area of investigation 8: MHTF governance and management</p> <p>Evaluation Question 8: To what extent have MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme. Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) efficient and effective collaboration with other UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) effective oversight and guidance by the MHTF Advisory Board?</p>	<p>Effectiveness, coherence, efficiency, coordination</p>
<p>Area of investigation 9: COVID-19</p> <p>Evaluation Question 9: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at the national and subnational levels due to the COVID-19 pandemic?</p>	<p>Relevance, coherence, efficiency, coordination, sustainability</p>

3.2 Theory of change

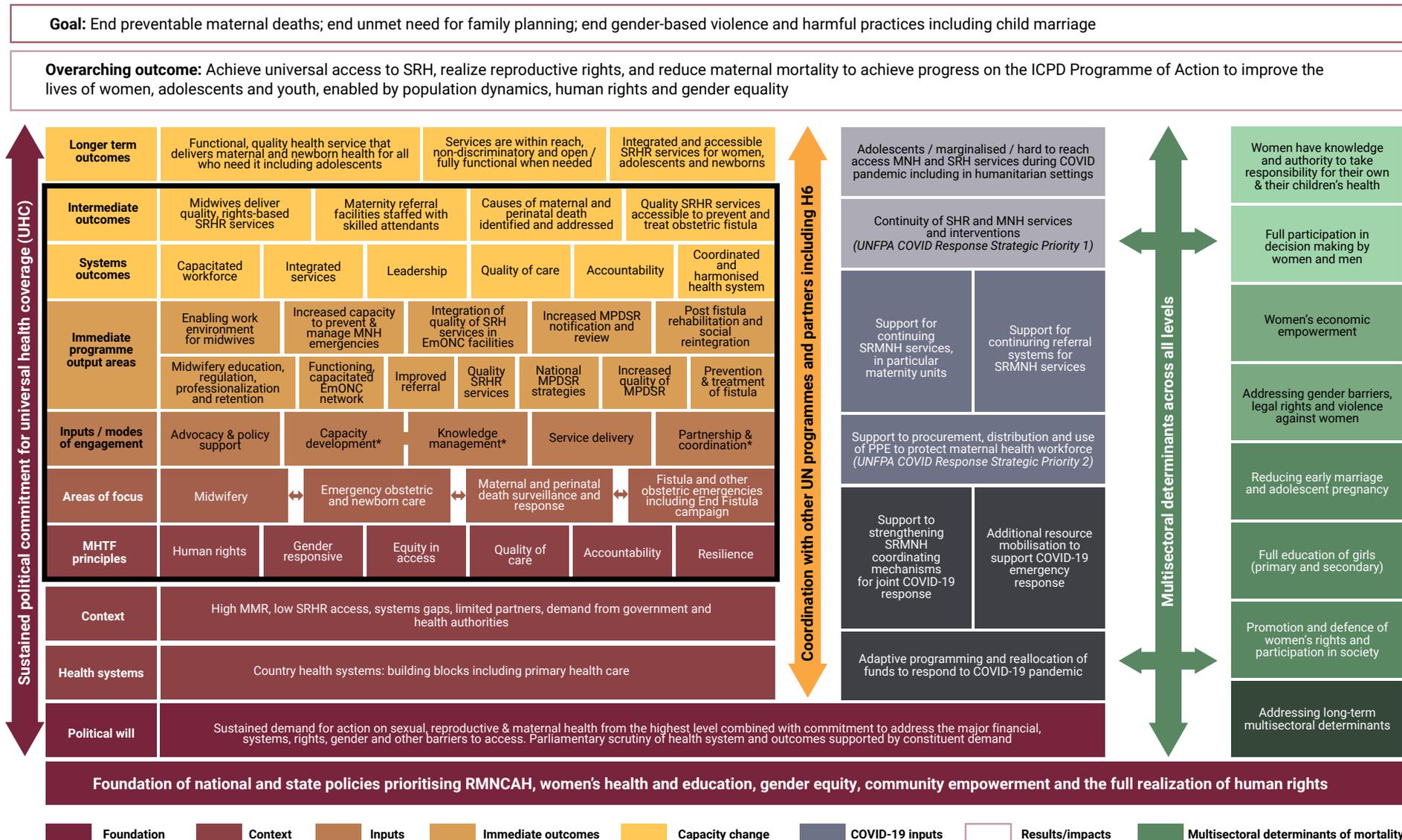
This section presents the overall theory of change for the MHTF as developed during the inception phase and refined during data analysis and reporting. The theory of change attempts to position the MHTF within the larger context in which women and girls experience SRHR, taking account of demand-side and supply-side factors, social and economic determinants, and broader influences. Within this context, the theory of change aims to pinpoint the different defined roles, modes of engagement, and activities of the MHTF and present them along a logical chain of results.

While the theory of change presents a comprehensive canvas, there is no expectation that all its elements are implemented in any given country. On the contrary, different sets of interventions and attendant results chains are activated in response to the needs and context in different programme countries. The MHTF theory of change is presented in two parts: (i) an overview of the MHTF at the global, regional, and country levels – including responses to COVID-19; and (ii) a closer view of the activities and related effects (along with the identification of the most significant causal assumptions), which are the focus of this evaluation.

TABLE 4: A key to help read the refined MHTF theory of change

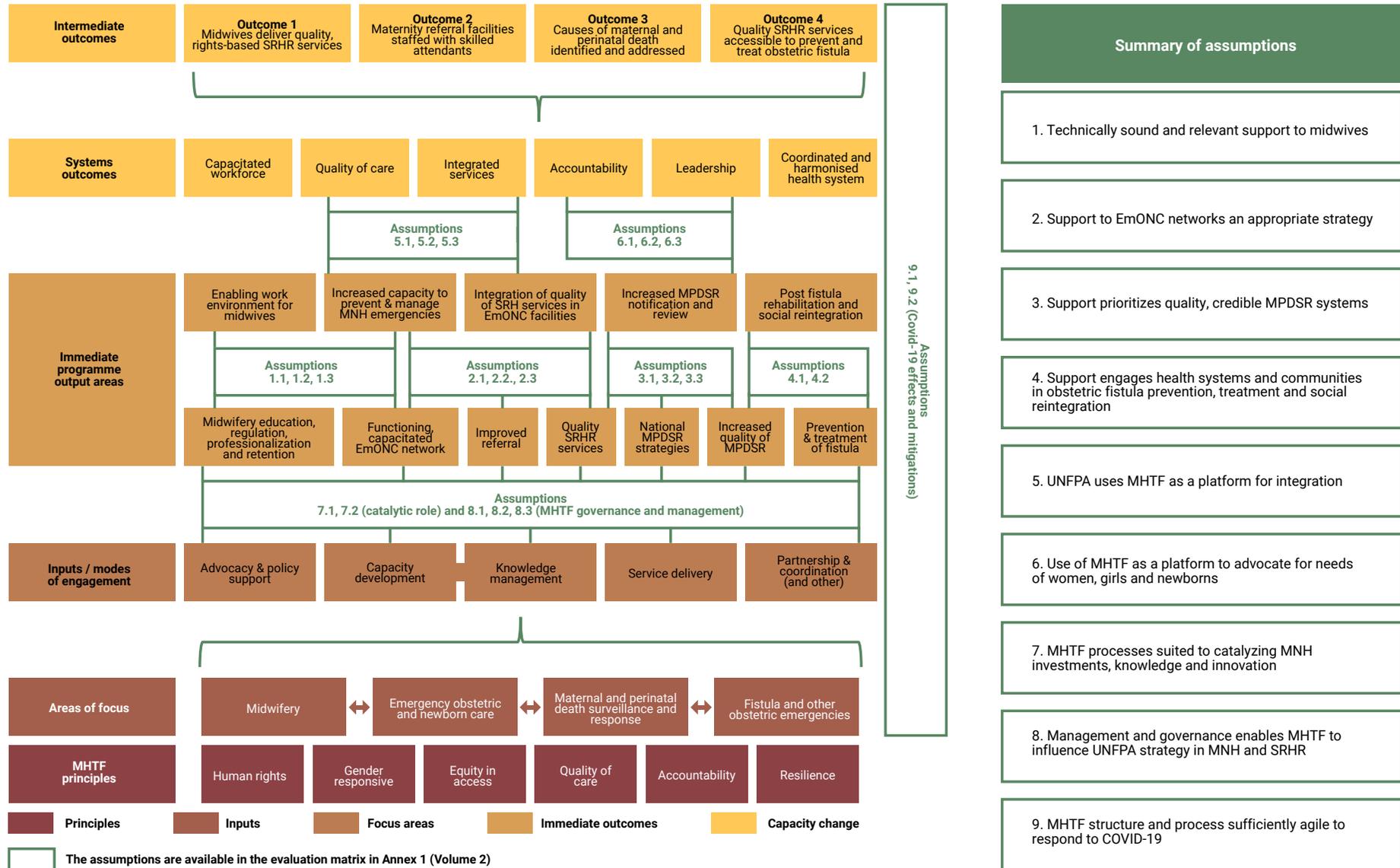
Line of the theory of change (from bottom to top)	Explanation
Foundation	The institutional setting, range of laws, and public policies that are the foundation of every country's approach to governance, public health and welfare.
Political will	The presumption that countries are invested in SRHR and maternal health and have the will to engage across political levels to improve outcomes.
Health systems	A recognition of the health system that will be in place in all countries at national and subnational levels. The MHTF will engage in some elements of some health systems' building blocks, but largely its efforts area is based on what is already in place.
Context	The specific context that MHTF partners operate in.
MHTF principles	The principles that shape the approach taken by the MHTF in developing and implementing its activities and support.
Areas of focus	The four major and interrelated areas of engagement of the MHTF.
Inputs/modes of engagement	The five modes of engagement that define the main vehicles for the types of support and specific inputs provided by the MHTF.
Immediate programme output areas	The expected direct outputs from MHTF inputs (a critical chain of effect to make visible and assess).
Systems outcomes	The broader outcomes expected to result from programme outputs and to which the MHTF will aim to shape and contribute.
Intermediate outcomes	The outcomes linked to the four areas of focus identified in the MHTF Business Plan.
Longer-term outcomes	The strategic outcomes to which the MHTF is contributing.
Overarching outcomes	The long-range outcomes identified in the MHTF Business Plan.
Goal	UNFPA organizational goals laid out in the UNFPA strategic plan (2018-2021).

FIGURE 8: Overall theory of change for UNFPA support to maternal and newborn health



* In practice, capacity building and knowledge management were often treated in financial and activity reports as interchangeable. They have been linked here to reflect that. No expenditure was badged as 'coordination'. The fifth MOE was usually just 'other' and was small.

FIGURE 9: Focused MHTF theory of change with evaluation assumptions mapped out



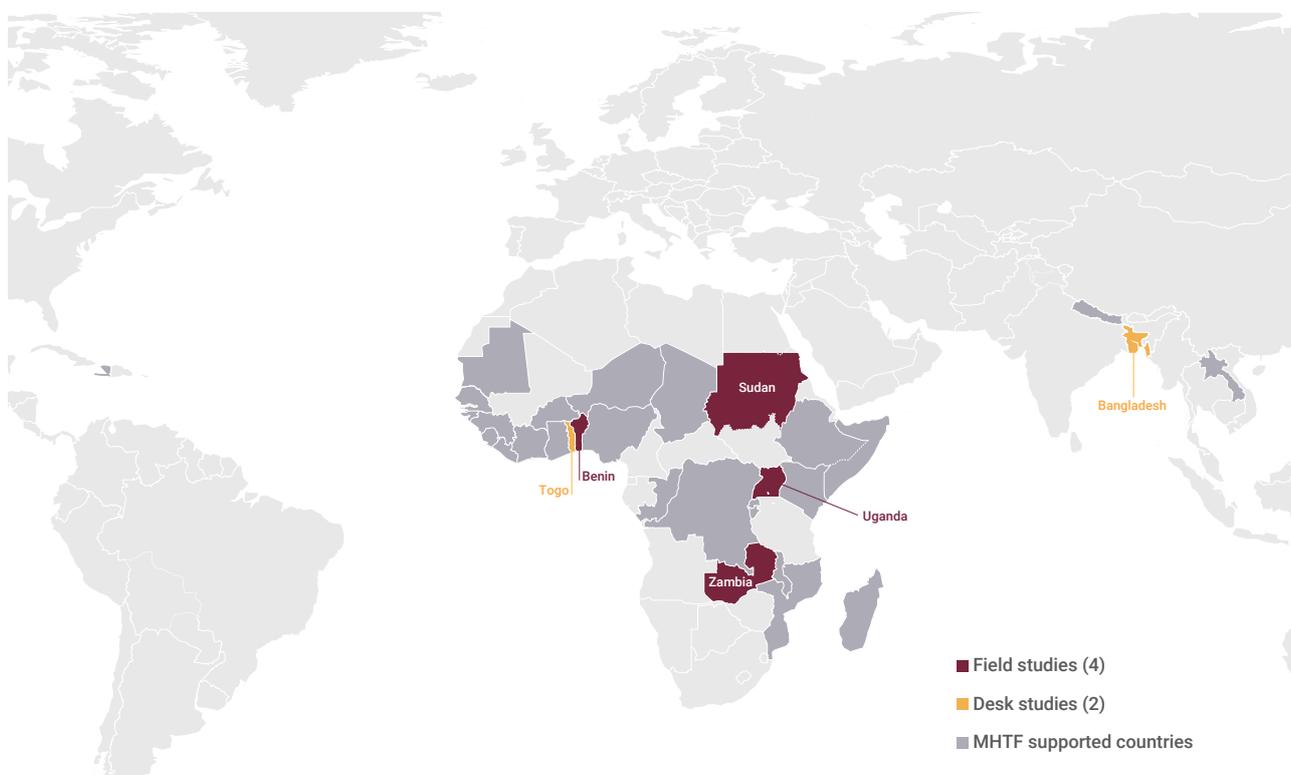
3.3 DATA COLLECTION AND ANALYSIS

3.3.1 Primary research method: A case study focus

The evaluation is structured around a series of country case studies, augmented by global and regional data collection. A case study-centred approach allows for the exploration of the MHTF in widely differing contexts and settings. The MHTF takes different shapes or paths depending on UNFPA interaction with other health actors and formulates responses to opportunities and barriers in different ways depending on a range of variables that are country specific.

The specific purpose of the case studies is to investigate the design and implementation of interventions under Phase III of the MHTF, and to assess the results achieved within the specific context of programme countries. The evaluation encompasses four field-based country case studies (Benin, Sudan, Uganda and Zambia) and two desk-based country case studies (Bangladesh and Togo) mapped in Figure 10. The case studies are not intended to present a statistically valid sample, nor are they representative of the entire population of programme countries.

FIGURE 10: Map of countries selected for the field and desk studies



The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Countries were selected for the field and desk studies to provide a set of variable examples of MHTF support in different regions and with varying MNH indicators. For example, some countries had high maternal mortality ratios and/or neonatal mortality ratios (NMR) despite declining fertility. Some countries also present a mix of conflict and humanitarian contexts, differing access to development assistance for health, or other factors that added nuance or complexity. Table 5 highlights some of these features.

TABLE 5: The selected case studies and features

Country	Region	Fertility rate ⁵⁴	MMR ⁵⁵ / NMR ⁵⁶	Focal areas and features
Field-based studies				
Benin	Western and Central Africa	4.8	397/31	<ul style="list-style-type: none"> • Focus is on midwifery, EmONC, MPDSR • Other partners and funds include the Takeda response to COVID-19 and the Muskoka Fund
Sudan	Arab States	4.3	295/27	<ul style="list-style-type: none"> • Fragile and conflict-affected with a large population of refugees • Few donors, a long period of sanctions and limited development assistance for health
Uganda	Eastern and Southern Africa	4.8	375/20	<ul style="list-style-type: none"> • Large numbers of refugee camps in Northern Uganda • Strong focus on integration of SRHR, HIV, SGBV • PHC-centred health system
Zambia	Eastern and Southern Africa	4.6	213/23	<ul style="list-style-type: none"> • Geospatial distance • Large number of donors • A large not-for-profit sector
Desk-based studies				
Bangladesh	Asia and the Pacific	2.0	173/19	<ul style="list-style-type: none"> • Complex humanitarian crisis • Other donor funding specifically for MHTF investments
Togo	Western and Central Africa	4.3	396/25	<ul style="list-style-type: none"> • Muskoka Fund • Persistent high MMR

The country case studies aim to provide insight into the evaluation questions and a comprehensive nuanced picture of the MHTF interventions at national and subnational levels and their results. Case studies used a theory-based evaluation approach rooted in the theory of change and causal assumptions developed for MHTF activities.

3.3.2 Data collection methods

Country case studies

Field-based case studies allowed exploration of the evaluation questions in greater depth than would be possible in a desk study. Because of travel and movement restrictions created by the COVID-19 pandemic, both the field and desk case study approaches were adapted to reflect conditions on the ground and the legal and public health constraints in each country. For example, a protracted national lockdown in Zambia ultimately prevented any site visits from being undertaken. Although this meant that some field studies were less “hands-on” than expected, the evaluation team took steps to strengthen the

54 Total births per woman, 2019. World average is 2.4 and among all low/middle-income countries is 2.5. See: <https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=BJ> accessed 30 September 2021.

55 Per 100,000 live births, 2017, accessed from WHO at [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-\(per-100-000-live-births\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births)).

56 Per 1000 live births, 2019, accessed from World Bank at <https://data.worldbank.org/indicator/SH.DYN.NMRT>.

desk study methodology in order to deepen the quality and breadth of each case study. This was done by establishing international and national consultant pairings (in both the desk- and field-based country case studies), increasing the number and expanding the scope of interviews, and conducting interviews in-person wherever possible. In all country studies, a thorough document review was also undertaken.

This resulted in a continuum of opportunity across the six countries and led to the adoption of a hybrid approach to the case studies (summarized in Figure 11).

FIGURE 11: A continuum of opportunity across the case study countries

Benin	Sudan	Uganda	Zambia	Bangladesh	Togo
<ul style="list-style-type: none"> • Field study format • International and national consultant in-country team • Multiple site visits and observations • Full range of interviews and focus group discussions with communities, health workers and clients 	<ul style="list-style-type: none"> • Field study format • National consultant in country and international consultant at a distance* • Three site visits • In-person and Zoom-based interviews • Some interviews with clients and health workers 	<ul style="list-style-type: none"> • Field study format • International consultant based in country and international consultant at a distance* • Multiple site visits and observations • Focus group discussions and exit interviews • In-person and Zoom-based interviews 	<ul style="list-style-type: none"> • Field study format • National consultant in country and international consultant at a distance* • No site visits possible due to national COVID-19 lockdown • Full range of in-person and Zoom-based interviews 	<ul style="list-style-type: none"> • Desk study format • National consultant in country and international consultant at a distance • No site visits as not part of the desk study format • Zoom and phone-based interviews 	<ul style="list-style-type: none"> • Desk study format • National consultant in country and an international consultant working at a distance • No site visits as not part of the desk study format • In-person and Zoom-based interviews

* Where international consultants could not travel, they were assigned to countries they knew well or had visited recently for a different evaluation. In Uganda, an international consultant living in the country conducted the data collection.

Data collection for the country case and desk studies involves a range of methods and sources; these are detailed in the respective country studies. Data collection instruments are contained in Annex 4. Broadly, they include:

- **Document review:** Identification and review of core documents at the country, regional and global levels, including programme documents and annual workplans, financial data and audits, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, meeting minutes and documents produced by other bilateral and multilateral agencies supporting MNH (Annex 2).
- **Country-focused interviews and group discussions:** Interviews were held with a wide range of key informants, notably: government decision-makers and technical staff, district managers, health workers, staff in non-governmental organizations (international and national), community, special-interest and faith-based groups, bilateral and multilateral partners, private sector partners, and civil society networks (Annex 3).
- **Site visits and observations:** In the context of field-based country studies, site visits to training institutions and to primary and referral service-delivery settings were conducted where permitted, to collect first-hand data on conditions and service delivery approaches and to conduct interviews with service providers and community members.

Supplementary data collection

The country studies are supplemented by data collected through key informant interviews with global and regional stakeholders, a comprehensive review of relevant documents and data sets at the global and regional levels as well as an online survey.

- **Global and regional key informant interviews:** Interviews were held with global and regional actors to supplement country studies and to explore the role of the MHTF in the global health architecture and its role in MNH more broadly (Annex 3). The interviews were conducted using a semi-structured interview protocol adapted to each key informant (Annex 4).

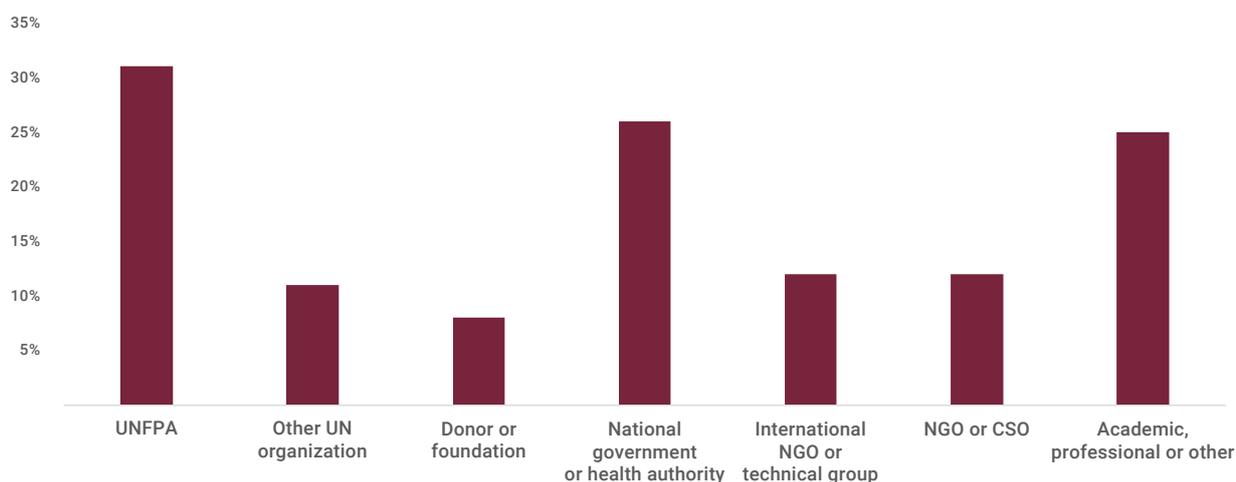
- **Online survey:** An online survey was sent to over 400 selected stakeholders across the 32 MHTF partner countries. The survey sample frame was developed in consultation with the MHTF focal points in the 32 programme countries and includes representatives of key stakeholders from the United Nations, national authorities and civil society (see Figure 12). The survey consists of both open and closed questions (Annex 5).

3.3.3 Data collection results

The evaluation team was able to access a wide range of sources of information provided by UNFPA staff in headquarters and decentralized units. Additional documents were collected and reviewed as part of the data collection process in all six country case studies. The UNFPA staff also helped the evaluation team identify key informants at the global, regional and country levels for one-to-one interviews or group discussions.

The response to the online survey was strong at 57 per cent. Altogether, 239 respondents in 29 (out of 32) countries completed the survey. About 31 per cent of respondents identified themselves as being from UNFPA and the rest were well distributed across different categories of key informants including more than 25 per cent from national governments or health authorities. The number of respondents per country ranged from 3 to 15 (average = 9, median = 7).

FIGURE 12: Self-identified affiliation of 238 online survey respondents



3.3.4 Data analysis

The evaluation followed a structured plan for analysis and triangulation of the data gathered using all the methods described above.

Country case studies: In the first step of the analysis process, the team responsible for each country case study compiled the relevant data in an evaluation matrix. The matrix presents all relevant data from multiple sources and enables the formulation of evidence-based findings corresponding to each assumption under the nine evaluation questions. For the field-based country case studies, preliminary evaluation findings were also presented to local stakeholders for discussion, comment and validation at the end of the field mission in each country. The evidence gathered was analysed and compiled into a formal country case study note for each of the field studies, which was submitted to the relevant country office for comments prior to finalization. In relation to each of the desk studies, an evaluation matrix was also prepared and a summary of the main findings produced.

Global and regional document review: The data identified through the global and regional document review were decanted and fed into the evaluation matrix, arranged by evaluation question and assumption.

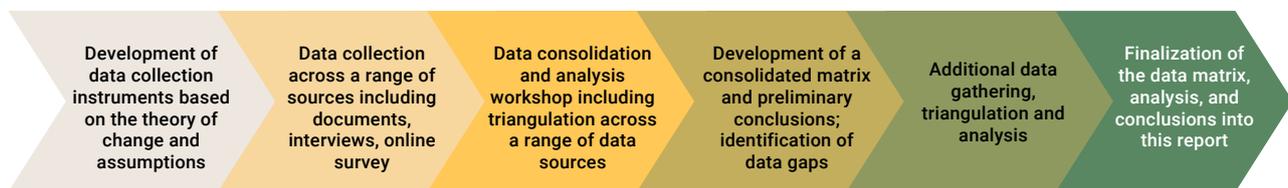
Key informant interviews: The data collected from global and regional stakeholders through key informant interviews were reviewed and slotted into the evaluation matrix under the relevant assumptions. Summary notes identified cross-cutting themes emerging from the interviews.

Online survey: Data from the online survey were compiled into a summary report with graphics and comments arranged by subject and question. The main results are included in the evaluation matrix.

At the end of the data collection phase, and with the first step of data analysis in hand, the evaluation team met for a three-day data consolidation and analysis workshop in New York City to present, discuss, critique and summarize all the evaluation information into a set of preliminary evaluation findings and tentative conclusions. The workshop was structured around a methodical review of each of the nine evaluation questions.

The data consolidation and analysis workshop enabled the development of preliminary findings and a consolidated evaluation matrix. Data gaps were identified at this stage prompting additional data gathering and analysis to firm up findings and complete the matrix. Data gathering, consolidation and analysis were followed by the development of the draft evaluation report for submission to the Evaluation Office of UNFPA (Figure 13).

FIGURE 13: Data collection, analysis, triangulation and consolidation process



At each step of the analysis process, the evaluation team has applied **triangulation** as the key method for validating findings. Triangulation involves bringing diverse sets of evaluation evidence to bear on the same evaluation assumptions and questions, including:

- Quantitative data drawn from different global, regional and national sources
- Opinions and experiences gathered from stakeholders representing a diverse set of organizations and operating in different contexts or on different aspects of the MHTF including from the online survey
- Observations made at sites in the field catering for a diversity of views and understanding of barriers to quality services, best approaches to strengthening health systems or improving access
- Documentary evidence representing a wide range of experience and views (of authors and organizations) on priorities for improving MNH
- Case study results from six countries with varied contexts and MNH indicators.

The evaluation team applied the principle of triangulation, both internally (within a given data set of information such as the results of global interviews) and externally (across different data sets, as when comparing the results of the online survey with those of the country case studies).

3.3.5 Gender equity and human rights

The evaluation addressed gender equity, under-represented groups and human rights in the following ways:

1. The evaluation team accounted for gender perspectives and under-represented groups within each of the evaluation questions related to technical content in order to determine how well UNFPA was adhering to its policies and principles regarding addressing the needs of vulnerable women and girls, taking a human rights-based approach and leaving no one behind. Where possible, the evaluation team identified evidence that highlighted different beliefs and practices related to gender roles, ethnicity, age and disability.

2. Evaluation question six concerned equitable access and served as a cross-cutting review of the extent to which the MHTF resources were used to address gender inequalities and the rights of vulnerable women and girls.

Unfortunately, due to the limitations imposed on the evaluation by the COVID-19 pandemic (Section 3.4), the evaluation team was unable to conduct sufficient interviews with actual and potential beneficiaries, including vulnerable women and girls in all the country case study countries. Group discussions were carried out in Benin and Uganda only. The team had to rely on situational analyses and other documentation, triangulated with key informant interviews to assess the gender and rights dimensions in this evaluation.

3.3.6 Assessing the MHTF aim to be catalytic

The MHTF is explicit in its logic chain (Box A) that universal access to SRHR is “critical and catalytic” to realizing the Sustainable Development Goals generally and MNH in particular. This is a fundamental basis for the MHTF programme and a strong driver of its positioning within UNFPA itself,⁵⁷ underpinning the link between SRHR and MNH and thus the absolute necessity of their integration.

A catalyst provokes or speeds up actions. In this evaluation, catalytic actions are those that are assessed to provoke or accelerate relevant change or progress. A catalytic role is therefore one that identifies, promotes and advances those actions. There is an implied counterfactual, which is that without the catalytic investment, significant change would not have occurred or would have occurred only very slowly. Given its wide scope, its relatively low resource envelope, its commitment to sustainability, equity, human rights, and gender equality, the MHTF proposition is that it gains more traction and achieves better results if it concentrates its effort on catalytic investments and actions. It aims at playing a brokering role within UNFPA and with external partners, and at sparking political, programmatic, and financial commitment beyond the limited MHTF investments. Catalytic support includes using the UNFPA mandate to good effect, focusing on its role to strengthen partnerships, coordination, strategy, policy advocacy and capacity-building. It also includes extending innovation through knowledge management strategies, including the identification of best practices to further support programming beyond the 32 focus countries.

To capture the extent to which the MHTF acts as a catalytic instrument in these significantly different ways, and the complexity of its nature, the evaluation identified three main types of catalytic action by the programme:

1. Brokering internal and external influence and partnerships: this includes seeking evidence on how the MHTF impacts other programmes and overall strategic thinking at UNFPA, programme countries and other partners at the global, regional, and national levels such as the H6 Partnership, EPMM, the EmONC revision global technical working group, and the MPDSR global technical working group
2. Leveraging and engendering political commitments and policy support, especially where this translates into financial commitment and investments
3. Fostering innovations, including identifying best practices, scaling up what works, replication of innovation in other MHTF (and non-MHTF) countries and broader knowledge management.

3.4 LIMITATIONS

The main limitations identified in this evaluation relate to the impact of the COVID-19 pandemic on country field studies (Section 3.3.2). Other limitations were notable and are described in Table 6 below. Despite efforts to vary the range of countries and contexts, it is not possible to capture every setting. Drawing generalized conclusions does therefore come with risks and has to be done carefully. While the evaluation team assessed the activities of the MHTF where these were visible, it was not able to undertake a comprehensive assessment of all MNH activities and strategies in MHTF countries. Thus, a further limitation is the recognition that MNH is a broad, multisectoral approach, which attracts many contributors, and encounters many mitigators and external effects. It is important therefore not to overstate the impact of the MHTF (or any single intervention) in relation to such a complex and multifaceted issue. In addition, the use of case studies to illustrate the general operation of the MHTF in a variety of contexts, while insightful, requires extrapolation to be carefully contextualized

⁵⁷ UNFPA. (2018). UNFPA MHTF Business Plan (2018-2022) New York, 2018. p.20.

by noting both similarities and differences across countries and triangulating findings from case studies with evidence from other data sources that are more comprehensive in breadth such as the online survey, global document review, and global and regional key informant interviews.

TABLE 6: *Challenges and limitations to the evaluation with associated responses*

Challenge/Limitation	Evaluation response
Global COVID-19 pandemic limited data collection opportunities, including site visits in some countries	The evaluation adopted a hybrid approach to the six case studies based on a continuum of opportunities. Mitigations included maximizing the use of digital communications and recording technology, using photographs and videos to share and validate findings within the evaluation team and strengthening the desk study methodology to collect more robust data
Diverse contexts could limit the generalizable nature of findings and results	This challenge was mitigated through careful selection of countries for the field and desk studies with the aim of being as widely diverse as possible while allowing the evaluators to capture the main settings where the MHTF works
It was not possible to comprehensively assess the full context of MNH in any given country	Through the use of a contribution analysis methodology, the evaluation shifted from the identification of MHTF-attributable results to, instead, documenting the contribution of the MHTF to the achievement of national programmes
MNH is a complex challenge that cannot be “solved” or delivered through a single programme; assessing the MHTF requires perspective	The theory of change specifically lays out a much larger canvas or landscape within which MNH outcomes are progressing. The relatively circumscribed area of MHTF operations clearly delimit areas of UNFPA expertise and focus
Results monitoring and reporting data relating to the MHTF do not differentiate among different socially isolated or marginalized groups of mothers and children, limiting analysis of their impacts on access and equity for these groups	In the absence of disaggregated data, the evaluation relied on other documentary evidence, such as assessments, demographic and health survey data or other research or reporting to identify issues regarding access and equity for vulnerable women and girls
COVID-19 travel restrictions limited direct observation of results among ultimate beneficiaries at health facility-level, including marginalized populations	Wherever possible, the evaluation relied on interviews of women (who are the ultimate beneficiaries of the MHTF) and site visits by nationally based team members for data collection and triangulation. Where this was not practical due to COVID-19, the evaluation relied on available written reports and triangulation of views and experiences across different categories of the intermediaries, including UNFPA staff, national health authorities, local health authorities, supporting development partners and civil society organization staff

While the challenges faced by the evaluation – and the resulting limitations - were all too real, specific features and adaptations in sample selection, study design, data collection methods and analysis approaches were designed and implemented to counter the challenges. As a result, the findings and conclusions presented in Sections 4 and 5 are supported by a strong body of evidence. The data and information supporting the evaluation findings are presented in the evaluation matrix in Annex 1.



© Robert Musoke/UNFPA Uganda.

A UNFPA supported ambulance referral system in Uganda made it possible for a mother experiencing obstetric complication to be transported to a hospital where she delivered safely.

4

EVALUATION FINDINGS

Findings draw on evidence compiled in the evaluation matrix (Annex 1). In this section, quotations are taken from key informants gathered through interviews and focus group discussions unless otherwise mentioned.

4.1 MIDWIFERY

UNFPA is one of the few United Nations funds and programmes supporting midwifery. MHTF contributions to midwifery are tangible at the global and country levels. The UNFPA partnership with the International Confederation of Midwives (ICM) is a key asset that contributes to the credibility and quality of evidence and technical guidance to align national policies with international standards. UNFPA has also leveraged its strong and long-standing partnerships with ministries of health to advance the midwifery agenda. As a result, UNFPA has visibly contributed to improving the scope of practice policies and regulatory frameworks. Midwifery development and professionalization processes are highly valued in and by countries. The combination of strengthening midwives' professional status alongside investments into regulatory management and capacity-building is welcomed. However, the review then approval of key policies is a lengthy process, as shown in the country case studies. Strengthening midwifery education remains a "work in progress" at different stages of development across the continuum of countries studied. The key challenge remains how to put midwifery policies into action at scale when the MHTF disposes of limited resources. UNFPA efforts to build the capacity of midwifery associations have evidently raised the professional standing of midwives across all country contexts, an important result. While UNFPA speaks eloquently of the need to do away with gendered disparities at the global level, insufficient action is taken in countries to ensure midwives have a seat at the table to effect policy change and implementation. Midwifery is recognized by all as a central pillar for MHTF and a critical driver of the three other technical areas (EmONC, fistula and MPDSR). Yet there is an absence of structured links between it and the other focus areas, which may result in missed opportunities to achieve a more holistic and synergistic programming approach in maternal health and more broadly for delivering an integrated SRHR package.

For details of the evidence supporting findings in Section 4.1, see Annex 1: Assumptions 1.1, 1.2 and 1.3

4.1.1 The MHTF global leadership helps to advance midwifery

At the global level, UNFPA has provided strong, focused, and visible attention to midwifery through its work to generate and disseminate evidence with a view to making the case for increased investments in midwifery programming. The MHTF championed the publication of the State of the World's Midwifery (SoWMy) report in 2021, resulting in a key vehicle for advocacy in midwifery. This report (with earlier versions published in 2011 and 2014) is the fruit of a collaboration between UNFPA and its partner, the ICM. Its purpose is to highlight evidence about the current challenges and areas of investments

needed in midwifery and to advocate for increased commitment to the midwifery workforce as a key requirement for reaching the Sustainable Development Goals related to sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH).

Global stakeholders credit UNFPA and the SoWMy 2021 report for improving the visibility of midwifery. As a United Nations agency, UNFPA brings weight to an issue that others are neglecting. The 2021 report also calls for a gender transformative work environment for midwives, in recognition of the gender disparities in pay, decision-making authority and career paths experienced by this workforce made up mostly of women. UNFPA (MHTF team members in particular) have also published a number of articles in the *Lancet* and in other peer-reviewed journals to provide evidence on how midwifery saves lives and to advocate for increased and sustained investment in supporting an enabling policy and programme environment for this critical cadre of health workers.

Regarding strategy, the MHTF Phase III Business Plan recognizes the central role that midwives play as caregivers for women and their newborns throughout the continuum of SRHR-MNH care. The overall MHTF strategy is aligned with and complemented by the UNFPA Global Midwifery Programme Strategy (2017-2030) to guide country offices, programme managers, ministries of health and other partner agencies to develop, scale up or strengthen midwifery programmes at the national level. This strategy builds on extensive work done by WHO and the Johns Hopkins Program for International Education in Gynaecology and Obstetrics (Jhpiego). The strategy does not prescribe a particular policy or programme approach, but offers ideas, lessons, and best practices that countries can adapt to suit their context. The midwifery strategy includes the three pillars of UNFPA programming in midwifery (education, regulation and association) but also expands on these to include three additional areas of focus (workforce, the enabling environment and the recognition of midwifery). The strategy also contributes to a well-defined focus on midwifery in countries receiving MHTF funds, as evidenced from a review of the activities supported in the countries studied for this evaluation.

ICM is a long-standing valued partner of UNFPA and receives MHTF support to implement a range of initiatives that contribute to the professionalization of midwifery both globally and through capacity-building of ICM national member associations. In particular, the identification of competencies for skilled midwives has guided national programmes. MHTF resources funded ICM to develop the Respect Toolkit that offers guidelines as well as an online courses on respectful care. In Zambia, these materials informed the Ministry of Health guidelines and training materials on eliminating disrespect and abuse in maternal care.

Other key partners engaged in the implementation of midwifery activities include the Maternity Foundation, the Woodrow Wilson Centre, and the Liverpool School of Tropical Medicine. The Maternity Foundation is a Danish international non-governmental organization working to ensure safer childbirth through innovative mobile health solutions to improve MNH. UNFPA is providing technical guidance and opening doors for the Maternity Foundation by encouraging country offices and their partners to use its Safe Delivery app, a mobile training tool for midwives. The main purpose of the tool is to allow midwives to have information readily at hand on evidence-based practices for EmONC while they are working, supervising or mentoring. UNFPA and the Maternity Foundation collaborate in ten countries: Afghanistan, Angola, Bangladesh, Ethiopia, Haiti, Ghana, Laos, Myanmar, Sierra Leone and Zambia. To support further use, MHTF has also translated the app into Arabic and a Spanish version is under development.

The collaboration between the Woodrow Wilson Centre's Maternal Health Initiative and UNFPA provides an opportunity for conducting meetings to disseminate best practices and smaller, expert forums to explore critical SRHR and MNH issues in more depth, conduct policy dialogues and foster global partnerships and synergistic programming in the field. Meanwhile, the partnership with the Liverpool School of Tropical Medicine focuses on the improvement of quality of care by developing state-of-the-art technical pre- and in-service training modules for midwives and partnering in their piloting and roll-out to strengthen the capacities of health workers, especially midwives. At the global level, activities include the development of a mentorship training workshop package and a comprehensive abortion care refresher training, as well as technical updates of other e-learning modules. UNFPA is highly valued by these partners for its openness to new ideas and innovation, technical expertise and deep understanding of country contexts nourished by its extensive field presence.

4.1.2 Improving the policy and regulatory environment for midwifery at the national level

As illustrated in the case studies, UNFPA is often the main partner called on by the Ministry of Health to help define policies and regulatory frameworks for midwifery. UNFPA is a trusted partner that provides technical support to ministries on matters

relating to SRHR. This position has helped UNFPA to make significant headway in establishing midwifery as a professional cadre through upstream policy work, using its technical platform with ministries of health to spearhead the adoption of new norms, protocols and guidelines.

In this context, the MHTF has been instrumental in the success of assessments and situational analyses that provide necessary evidence for policy development and reform. In Sudan, UNFPA with ICM, supported a situational and gap analysis to kick-start a methodical process to develop a four-year midwifery diploma, as well as the development of a regulatory framework for midwives and professional associations. The strategy (and diploma) was ready to launch in 2019, however, political upheaval, along with the high turnover of health and other government staff, has delayed decision-making and implementation. As the old approach to shorter training for community midwives was suspended in 2018, the delay in introducing the new course resulted in the disruption of midwifery training and has now created an even greater shortage of skilled birth attendants in the country. In retrospect, the positive transition to a more professional approach to training midwives lacked a durable implementation strategy in the difficult context of political upheaval.

Meanwhile, in Togo, Uganda and Zambia, UNFPA made major contributions to the regulatory framework for midwifery, including defining the scope of practice and establishing protocols for midwifery and aligning them to standards set by the ICM. In Uganda, the revision foresees task-shifting for midwives to perform assisted deliveries in lower-level health facilities, a change that stakeholders noted as critical for expanding EmONC services. In Togo, advocacy by UNFPA has not yet yielded progress in defining a new framework for midwifery practice and quality of delivery. Although the MHTF has constantly advocated for an Order of Midwives, it has not yet been fully successful, and Togo continues to have too few midwives as well as weak management of quality improvement or support to the enabling environment. Nonetheless, MHTF support has enabled the country to identify a national standard for the number of midwives per facility and to work towards meeting this standard more systematically. Thus, in 2015, the standard agreed was two midwives per facility, but there was a gap of 65 midwives across the country; by 2018, although the standard was raised to three midwives per facility, the gap was nonetheless just 13 midwives, the result of carefully targeting the appointment of newly qualified midwives to priority EmONC designated facilities.

UNFPA appears as the leader among partners in the development of midwifery programme strategies, policy formulation and technical support. Among the case study countries, midwifery programming has progressed the farthest in Bangladesh, where UNFPA assisted the Government to design the overall midwifery programme. Specifically, the MHTF provided technical support and advocacy to bring about the necessary changes in policies and practices. As a result, midwifery, a new profession in 2016 in Bangladesh, has become an essential cadre in a very short time and is now mainstreamed in the Government's national programme. The Directorate General of Nursing has been renamed Directorate General of Nursing and Midwifery, with staffing added to signal the Government of Bangladesh's ownership and leadership moving forward. In Uganda, MHTF funding supported the establishment of an online platform using GIS technology to provide access to data on the licensure, registration, and deployment of midwives. Piloted in three districts, the GIS system was subsequently rolled out to 28 districts through a combination of MHTF and other resources. Early results indicate that the system has been useful for needs-based planning and has led to the reduction of unsafe procedures performed by unlicensed practitioners. In Zambia, the MHTF supported the development of midwifery mentorship guidelines (yet to be disseminated) based on the ICM to develop the Respect Toolkit. These upstream activities are necessary components of a broader support of priorities of ministries of health in access and quality of SRHR-MNH services. However, limited finances remain a challenge for the partner governments to implement and scale up the policies UNFPA has helped develop.

4.1.3 The MHTF contributions to strengthen midwifery education

MHTF efforts to strengthen midwifery education are overwhelmingly seen by survey respondents as technically sound, based on international standards and responsive to national needs. UNFPA contributions have most often consisted of curriculum review and development activities (Bangladesh, Benin, Sudan, Togo, Uganda and Zambia). The 2019 training curriculum revision in Benin was based on an evaluation of its alignment with WHO and ICM norms and was updated to include safe delivery centred on respectful care, management of EmONC services and referrals. An unintended consequence of the reform of midwifery training has been a rift between the older midwives who have certificates, and the more recently educated midwives who have received degrees. This has led to workplace conflicts, which negatively affect motivation and the retention of both new recruits and tenured midwives, and, ultimately, quality of care. UNFPA has not yet used its position as a privileged interlocutor of government and midwifery associations to mediate and address these conflicts.

Many key informants see midwifery as critical to the MHTF with significant potential for linking it to the broader SRHR agenda. Others noted the importance of midwifery as an entry point for addressing gender inequality and the need to strengthen the gender and rights component as part of the midwifery agenda, including to ensure that midwives display gender-equitable attitudes. The countries studied show a mixed national response in terms of how gender equity is incorporated into midwifery curricula. In Sudan, a new curriculum, and associated materials (for example, teachers' guide, examination standards, student handbook) were developed in 2019. The new course (pending approval) is founded on a gender-sensitive approach to integrated a reproductive and maternal health services delivery that mainstreams key determinants such as female genital mutilation and the recently enacted law to raise the age of marriage. Similarly, UNFPA assisted the General Nursing Council in Zambia to review four separate midwifery curricula to consolidate into one comprehensive competency-based curriculum that incorporates emerging issues such as gender-based violence, adolescent health and people living with disabilities. In Benin, while efforts have been made to ensure alignment of the training curriculum with ICM and WHO standards, UNFPA did not push to ensure that it sufficiently addressed gender issues.

UNFPA also used MHTF resources to support midwifery schools in Benin, Togo, Uganda and Zambia. In Sudan, the community midwifery training schools were closed as a result of the aforementioned political upheaval. While in Benin, the focus was on improving the quality of teaching in two existing midwifery schools in the Cotonou and Parakou areas by using innovative teaching materials (such as virtual reality), strengthening the schools' management teams, and working towards regional accreditation by the West African Health Organization. In Uganda, UNFPA supported capacity development for midwifery tutors and preceptors, equipping midwifery-skills laboratories and libraries in 20 midwifery training institutions. Through the MHTF, UNFPA Zambia procured midwifery teaching models, set up clinical skills laboratories and conducted training of trainers for tutors. Similarly, in Bangladesh and Togo, UNFPA invested MHTF resources in faculty development and provided resources to facilitate teaching.

Other efforts to strengthen midwifery education include improving the quality of training (Uganda), supervision (Benin) and/or mentorship (Bangladesh, Uganda and Zambia). For example, UNFPA supported the Bangladesh Midwifery Mentorship Programme to bolster the competencies of midwives and enhance evidence-based MNH care. This programme demonstrated that well-structured mentorship results in improved competencies, including those related to respectful care.

MHTF resources were used in both Uganda and Zambia to provide tuition support for midwives and their deployment to underserved areas. These efforts were credited with improving access to skilled birth attendance. However, in both instances, the tuition payments are not sustainable as they have not been mainstreamed into government budgets.

4.1.4 Raising the profile of midwives

To advocate for and promote midwives as an essential cadre of the healthcare workforce, MHTF investments support the establishment and/or capacity-building of national associations in several countries. The global partnership with ICM adds technical credibility to this work. UNFPA has used MHTF resources to provide foundational support to the Association Des Sages-Femmes Du Bénin, Sudan Midwives Association, the National Midwives Association of Uganda, the Midwives Association of Zambia, the Bangladesh Midwifery Society and the Togolese Association of Midwives. For example, UNFPA supported the development of founding documents and strategic plans (Uganda and Zambia) as well continuing education for midwives through symposiums and convenings. These were often conducted in conjunction with the International Day of Midwives, an annual commemoration to raise awareness of the role of midwives, and are intended to increase recruitment and budgetary support for midwifery. Unfortunately, the focus on reporting is activity-based and outputs and outcomes from these interventions are not tracked, making it difficult to assess their effects.

National associations provide an important platform at the country level for midwives to advocate for better working conditions, participate in health policy matters, and grow their knowledge and skills. They allow them to network and collaborate and boost their professional image. However, challenges remain for midwives to "have a seat at the table" and be taken as seriously as their physician counterparts. UNFPA has developed a recognized strategic position to advocate and strengthen the voice and positions of midwives within ministries of health in countries where midwifery is not yet well represented in the administration structure. However, the evidence suggests that UNFPA efforts to address gender disparities faced by midwives have not yet been realized. These disparities include low pay and the perception that midwifery is "women's work" and lacks value. There exists a gap between rhetoric and action, creating a challenge to deploy a more focused and deliberate approach to addressing these issues in country programmes.

At the global and national levels, the UNFPA contribution to midwifery is unparalleled, being one of the only United Nations fund or programme addressing the role of midwives in universal health coverage and SRHR-MNH care. In the words of one key informant, prior to UNFPA engagement, “maternal health was a black hole”, as no other United Nations fund or programme was addressing it in any significant way. At least partly as a result of its engagement on midwifery, UNFPA is seen by global key informants as taking on an important role in the space of maternal health, both within the United Nations and beyond. UNFPA has worked with WHO to elevate the status of midwives through policy work with governments and, through its partnership with ICM, has filled an important gap with standards on education, regulation, deployment and association.

Yet, some stakeholders, especially at the field level, felt that UNFPA “does not understand the value of midwives to its maternal health strategy and dilutes it by having it on par with the other three technical areas”. They suggest that there could be stronger links among all the MHTF technical focus areas with midwifery clearly positioned as the driver for advancement more consistently across all MHTF efforts. Indeed, midwifery has an accepted central role within MHTF, without which the other components would falter. Competent midwives are recognized as essential to the delivery of quality EmONC services and the prevention of fistula. They are also critical to quality improvement and MPDSR processes, particularly at the facility level. Most importantly, they are the agreed focal point for clients and the gateway to, or direct provider of, integrated care. Their critical role also goes beyond the MHTF to family planning and other SRHR services. Given this consensus view, UNFPA is working to position the centrality of midwives within integrated SRHR and MNH packages; however, based on evidence in the countries studied, UNFPA has not yet fully utilized its strategic advantage in midwifery to accelerate the achievement of MHTF results overall.

4.2 EMERGENCY OBSTETRIC AND NEWBORN CARE SERVICES AND NETWORKS

The MHTF supports the identification and optimization of national EmONC networks in partner countries using an innovative and well-defined model based on GIS mapping, consensus building around standards of care and routine facility monitoring. The phased approach of the EmONC network offers an objectively verifiable model for elaborating service delivery standards that can be adapted to each country context. Viewed as rigorous and credible, this methodology – and the MHTF application of it – enables a concrete step forward in EmONC and MNH systems strengthening in partner countries. It helps create consensus around priority facilities, services and standards of care, and opens a pathway for improved quality and integration of SRHR services. It is widely valued and considered a useful and constructive contribution to health systems strengthening processes in different settings. The EmONC network model approach is clearly identified as a tangible health systems strengthening intervention that creates leadership opportunities and opens a pathway to improving quality of care. Two limitations affect the long-term sustainability of the MHTF investments in EmONC. Firstly, the MHTF has only just started to identify how it might systematically strengthen linkages between the EmONC network and the community level and so far only in one or two settings. This limited focus has created an imbalance between the supply of EmONC services and an insufficient inclusion of demand-side investments especially (although not only) in settings where most births take place at home. Secondly, the institutionalization of the monitoring and response (quality of care improvement) phases at national scale are critical components of the model that fall largely outside of UNFPA control or remit and unsurprisingly, given their scale, are not fully or systematically implemented yet in any setting. The EmONC network model has been started to date in 14 MHTF countries based on a limited roll-out pace that can be maintained. A number of additional countries have expressed interest in undergoing the process when resources become available. In countries that have not applied the network approach, MHTF EmONC inputs focus on improving quality of care in UNFPA geographic intervention areas and vary depending on country needs and priorities. An additional challenge for the MHTF, given the range of countries it supports, is thus to balance a flexible and country responsive approach with the necessity of ensuring the methodological rigour of all inputs and ensuring sufficient links to larger health systems reform processes.

For details of the evidence supporting findings in Section 4.2, see Annex 1: Assumptions 2.1, 2.2 and 2.3

4.2.1 The EmONC network model as a methodology to improve services

With the implementation of the EmONC network methodology, the MHTF seeks to promote at scale equitable and efficient EmONC service delivery through practical health systems adjustments and the rationalization of services. The model encompasses four phases: (a) design and consensus building among partners; (b) agreement on standards for EmONC delivery; (c) application of the geographic mapping tool and health facility characteristics to define national and subnational (regional/provincial/state levels) EmONC facility networks; and (d) the establishment of progress monitoring and quality of care improvement interventions through operational plans.

The different phases of the EmONC network approach create an objectively verifiable model for elaborating service delivery standards and for adapting them to each country context. The process enables partners to build consensus under the leadership of national authorities around what the network should offer at different levels of care and in individual facilities. It helps set priorities for the integration of MNH and SRHR services, define infrastructure standards, assess equipment and supply requirements, and, vitally, identify staffing needs and referral issues. In addition, it allows countries to monitor at scale their EmONC health facilities as part of their health management information system (HMIS).

The methodology is centred around the identification of facilities to include in the network at basic and comprehensive EmONC levels and respective minimum standards of infrastructure and capacity. It relies on globally agreed and nationally adjusted coverage standards.⁵⁸ Using objective criteria based on health facility and referral characteristics and coverage of the population measured with WHO software (called AccessMod) and mapped with the GIS tool, the methodology allows national and subnational stakeholders to identify which facilities are accessible and most used by women and where there are gaps (or duplication). Thus, the combination of health facility capacities and mapping of population catchment areas within two hours' travel time leads to tangible adjustments in the EmONC network that can help promote a more rational distribution of service coverage capacity and a more realistic targeting of resources. For example, the mapping resulted in adjustments of BEmONC facilities in the networks in Benin and Togo that reduced duplication and identified gaps. In Sudan, the MHTF supported the identification of the first formal EmONC network in the country, with 114 CEmONC facilities and 44 BEmONC facilities. The mapping tool (and the accompanying technical support) has been referenced as a good example of innovation (Section 4.7) by country offices and by national authorities. In addition, the EmONC network approach helps sharpen effectiveness in the use of available resources and strengthens priority setting, two key elements of improving value for money in the use of scarce resources.

Overall, the EmONC network model, in the 14 countries where it is being applied, has been well received and has contributed to reinforcing the credibility of UNFPA and the MHTF. Developing the criteria for the network, creating the maps and building agreement about the shape and size of the network at all levels of the health system are all areas that are widely valued by stakeholders and lead to a high level of participation. The workshops brought together a wide range of health partners including providers, professional associations, health authorities, local governments and funders, and together were perceived as creating a milestone moment for consensus building on EmONC service delivery, especially in terms of identifying the "offer" to women by the health services.

Across the three case study countries where the EmONC network approach is being implemented (Benin, Sudan and Togo), UNFPA has played a decisive role in progress to date. Partner countries value the participatory process for development of objectively verifiable standards. They also value the role and leadership of UNFPA in supporting this multi-stage process and recognize this as a decisive element of success. UNFPA country office staff and key actors in ministries of health (for example, in Benin and Sudan) particularly value the technical expertise provided by UNFPA headquarters as a source of encouragement, for the quality of inputs, and for the rigour in the application of the methodology. UNFPA country offices have shown leadership and were effective in convening stakeholders and supporting governments to build consensus among disparate partners to move forward the decision-making process (such as confirming proposed standards for the EmONC network in Sudan and Togo).

Once defined, the EmONC network has also led to improved targeting of other available resources for facility improvements or renovations. For example, in Sudan, emergency funding (from the United Nations Central Emergency Response Fund

⁵⁸ WHO. (2009). *Monitoring emergency obstetric care: a handbook*. Geneva.

to “build back better” following the 2020 floods) has been targeted to EmONC facilities in the relevant areas to support consolidation of the network.

4.2.2 Too soon to demonstrate lasting results

Institutionalizing monitoring and response

The EmONC network methodology requires sustained focus and attention over multiple stages. Institutionalization the monitoring component of the EmONC network model requires adequately trained standing teams able to conduct regular assessments of health facilities. The purpose of the monitoring missions is to identify the gaps between the standards (as agreed in Phase III) and the reality on the ground. The monitoring results must then lead to remedial action in the specific facilities to ensure they are brought up to the agreed standards. In this sense, monitoring the newly conceptualized network is the critical link to impact, as it allows facilities with weak service delivery in EmONC to become the focus of investment. For example, in Benin, the political decision to rebuild the national EmONC network was taken in October 2017. The consensus around the development of the national network of EmONC hospitals was agreed in May 2018. Prioritizing, mapping and validating the network was then undertaken in the following two years. The monitoring phase has now started, supported by the MHTF.

Togo was one of the earliest adopters of the methodology (introduced in 2012 and 2013) with the most recent adjustment to the mapping done in 2019. This was a result of monitoring that found only 35 per cent of BEmONC facilities (16 health care centres out of 46) and 71 per cent of CEmONC facilities (19 out of 27) were operational. As identified in Section 4.1, monitoring has enabled Togo to more methodically allocate midwives to priority EmONC facilities. A low level of functionality in existing EmONC facilities was also reported in Benin. In Sudan, the EmONC network process is an ongoing exercise involving a wide range of stakeholders that could potentially make material contributions to a national health systems strengthening process if it continues. However, the revolution and ongoing political situation in Sudan, compounded by COVID-19, have affected the rate of progress with the implementation of the EmONC network process.

Although this evaluation did not directly assess progress in all EmONC network countries, it appears that, while some countries have reached Phase III (the identification of the designated EmONC health facilities and related standards), none has yet been able to fully institutionalize a monitoring system, including the management response and remedial actions. Senegal and Togo have made the most progress and have performed several national EmONC monitoring processes in recent years. In Senegal, EmONC-related indicators have been added to the HMIS. Identifying the gaps in specific facilities is only half the need. The COVID-19 pandemic, among other factors, has been especially challenging to the advancement of this element of EmONC work given the need to deploy teams to health facilities, observe health services and interact with health workers. Other challenges affecting the monitoring and quality improvement phase include resource mobilization for MNH service improvements (at scale) and stakeholder coordination, including with other major MNH partners.

With monitoring comes the identification of needs to upgrade quality of care across the services delivered (especially linked to staffing, skills, facilities and equipment where standards of care are defined earlier in the network development process). Togo may be among the most advanced countries as it has undertaken some monitoring and started defining responses, which led to concrete improvements, including supply-side delivery (for example for improved allocation of magnesium sulphate), more systematic deployment of midwives in the network of EmONC facilities and an increase in the utilization of vacuum extraction. In Sudan, the identification of “almost there” facilities (those that were just short of reaching quality standards) is seen as a useful way to target resources towards improving quality as rapidly as possible. Benin also shows progress on the monitoring phase and many key informants referenced the processes they follow, completing forms or participating in reviews and supervisory visits. The fact that routine monitoring is undertaken suggests a certain level of functionality in health services management and indeed it is a necessary but not a sufficient element of EmONC network building. Yet, although there is monitoring, and some examples of improvements made in response to monitoring, the MHTF faces a significant challenge to engender a consistent management response and adequate action across all EmONC network processes. This is a challenge not just for the MHTF but rather for all health systems strengthening partners. However, it is the stage of the process that is critical to the institutionalization of the EmONC network model.

The challenge in scaling up and institutionalizing the monitoring phase – and its corollary, the absence of meaningful and systematic upgrading of services in response – can be traced in part to COVID-19. For example, in Sudan EmONC health facilities have been identified, standards have been agreed by stakeholders, and monitoring teams were selected in early

2020 to begin monitoring in many states. They were due to start training in April 2020 (with MHTF support) when the first COVID-19 lockdown happened. The impact of COVID-19 on slowing down the implementation of programmes is very clear in Sudan and across all the MHTF countries.

Institutionalizing monitoring and a quality improvement response also face the much larger issue of the scale of resources needed for this fourth phase of the EmONC network model. Phase IV poses the question of the role of partnerships with other major funders (like the World Bank) to drive sustained efforts to deliver results; these partnerships vary by country and the MHTF has capitalized on different opportunities depending on the country. Addressing the quality of care gaps identified in health facilities also requires broader health systems reforms and the inclusion of the EmONC network in these reforms. In Sudan, the EmONC network or the prioritization of BEmONC and CEmONC facilities for quality improvements was to be approved by the Federal Ministry of Health and individual states before the end of 2021, but has been delayed by the political situation in the country. One consequence of this delay is that the EmONC network with its priority facilities newly identified was not included in the new draft of the national health strategy (draft released in September 2021) to guide COVID-19 recovery.

In those countries that implement the EmONC network model, it is difficult to discern a systematic approach to developing a vision, partnership strategy and advocacy plan to engage national authorities (and other actors) that could influence and expand the fiscal envelope for EmONC. Those authorities could be, for example, high-level partners such as ministries of finance, those leading the broader universal health coverage development approach, or a holistic national health systems reform plan. In many countries, universal health coverage is still at a low level of implementation with weaknesses in important systems like referrals, which are still underdeveloped. The very slow reduction of maternal and newborn mortality in many countries is another sign that strategies, systems and funding (both domestic and international) are insufficient. The EmONC network model creates a platform from which UNFPA can support policy dialogue with ministries of health and maintain focus and attention on MNH and SRHR priorities.

In fact, while the advocacy and design phases of the EmONC network process (Phases II and III) engaged national authorities, technical and financial partners, professional associations and healthcare providers, the fourth phase (monitoring and remedy) has been mainly supported by UNFPA so far and, in some countries, other H6 partners. It is an important function to be institutionalized into national and subnational authority roles though and this deeper more sustainable, long-term shift has not happened yet in most countries. There is limited experience in this stage of monitoring, however, and together with the implementation challenges created by COVID-19 over the last two years, this makes it difficult to fully assess the MHTF approach on this element.

Critical importance of referral

The important role of referral in practical terms in the EmONC network emerges very strongly from the data. Referral is a critical link to saving lives at birth. In many countries, referral is considered insufficiently developed and is among the poorest quality of all maternal health services.

For example, in Uganda, there are preventable deaths due to a lack of equipment and supplies and surgical skills for caesarean sections. In Benin, the viability of the referral network is complicated by the changing state of the roads, seasonal effects on transport links and other aspects of non-health sector related elements of the EmONC network. In Sudan, although the police have been engaged in some settings to help overcome transport issues that prevent women reaching referral centres, the infrastructure in those higher-level hospitals is unpredictable and insufficient, and often inadequate compared to needs.

The need for robust referral networks that ensure the right skills, behaviours, commodities and other needs are available and put into action once a woman with an emergency arrives in a health facility constitute a serious and persistent failure in all the countries (MHTF efforts notwithstanding). At Phase IV of the EmONC network model, it is not the role of UNFPA to address these gaps identified in monitoring missions. They have to be institutionalized into the national health systems' response in order to constitute sustained systems strengthening. UNFPA nonetheless has a key advocacy role to play to ensure the referral links are forged and sustained, and that facilities are upgraded to the agreed standards. The EmONC network approach monitors and qualifies referral linkages, including the quantification of related financial barriers, and is a unique opportunity for UNFPA to further advocate for improvement and for the inclusion of referral into universal health coverage benefit packages.

4.2.3 Evolution of the EmONC network model

While the EmONC network model has many advantages (see Section 4.2.1), there are some notable limitations. The approach is very service delivery/supply-side focused and, in that sense, concentrates capacity and focus on the delivery of services at the facility level. It does not prioritize the strengthening of demand for all MNH care nor the building of a sense of entitlement in communities for quality care at birth. Although in Sudan, for example, more than seven out of ten births take place at home, the EmONC network process in that country does not link systematically to the community and household levels. Since the level of care in the EmONC network model is a health facility, the EmONC network approach will only address the needs of women once they have overcome the first and second delays⁵⁹ associated with health-seeking behaviour and reached the health facility.

Facility-based services are only helpful for those who actually use them. The theoretical argument that, as quality of care improves in health facilities, women and their families overcome their concerns and elect to deliver in their nearest health facility, could materialize too late to maximize the full impact of the EmONC investments. The integration of the EmONC approach into the wider health system, in absence of the critical link to demand for care, poses a question about sustainability. This is especially the case as, even where quality of care improves, a range of social determinants (from poor feeder roads to gender norms) still inhibit access.

The EmONC network approach model does not yet include community engagement and interaction (other than in Congo where there have been focused investments on linking EmONC services and indigenous communities)⁶⁰. There have been attempts to create synergies between the MHTF-supported EmONC facilities and other programmes aimed at generating demand for family planning among youth or among the general population (for example, in Benin and as discussed further in Section 4.5) but efforts tend to be isolated and unsystematic. In Sudan, for example, the network methodology does not include the community level at all, except to specify that the population should be within a two-hour drive of a BEmONC facility. The network model does not directly address the causes of the first delay – seeking treatment. Some Sudanese women have said they prefer midwives working in the community and considered that they provide better quality care than those working in facilities for a range of reasons, including accessibility, accountability and empathy. Community-based midwives are not trained to degree level and are being phased out in the health system. This presents a challenge for the evolution of the EmONC network methodology unless it continues to broaden its relevance and inclusion through more systematic community links.

At a global level, the EmONC network approach has already contributed to the development of a new indicator measuring the proportion of the population covered by: a) all maternity units; b) planned EmONC facilities; and c) functioning facilities. The indicator has been adopted by the EPMM initiative as a target to accelerate progress towards SDG 3.1 on reducing maternal mortality.

Under the leadership of WHO working in consultation with the H6 and other global partners (including UNFPA/MHTF), the definition of EmONC networks is being expanded to include families and the community in the more holistic concept of “network of care”. The MHTF is engaging in this expanded approach although as yet, its translation at an operational level in MHTF partner countries is not visible. The MHTF has adopted an approach based on supporting countries to optimize their EmONC network as a first step and then to expand to lower-level health facilities and communities. This is a legitimate approach but also raises important methodological questions about whether any kind of complex health systems reform delivered at scale can be undertaken in such a clearly defined sequential way. There are global health voices suggesting that as a long-term and messy (complex) process, engaging lower systems levels needs to start sooner.

While technically sound and invigorating from a process perspective, the EmONC network approach as currently implemented does not necessarily lead to the delivery of either the facilities or the service standards needed to address quality of care before, during and after delivery, where it is most needed (that is, in the community). This perception also emerges from the survey results that indicate more respondents doubt the soundness of the MHTF strategy in its approach to EmONC

59 There are three delays that typically slow or inhibit women’s access to care: the first delay is around taking the decision to seek care; the second delay is around reaching the right level of care (either the BEmONC or, once there, the decision by the midwife to refer); and the third delay is around receiving the right care at the referral facility.

60 Benoit C et al (2018). *Biomédecine, savoirs et pratiques autochtones autour de la grossesse et de l’accouchement dans le département de la Sangha en République du Congo*, UNFPA August 2018.

facility support and distribution (network building) at 65 per cent (30 per cent neutral or unfavourable), in contrast with its role in advocacy (a more robust 80 per cent favourable) or its approach to strengthening skilled birth personnel (86 per cent favourable). Survey comments highlight community links, focus or engagement as an area for future development. However, the MHTF is engaging with long-term and complex issues through its EmONC support and development work, creating valuable and relevant opportunities to improve health outcomes for women and newborns.

4.2.4 The effectiveness of EmONC networks relies on midwives

The role of midwives is the keystone in assuring the effectiveness of EmONC services, including timely referral and follow-up. Particularly when there is a pivot to the community level (as with the networks of care model), midwives are really at the heart of the EmONC approach, building trusting relationships with communities, encouraging attendance at the facility for antenatal care and for delivery, and ensuring women get the right level of intervention for their needs. Midwifery skills, behaviours, incentives and motivation, as well as the professional standards they abide by, are determinants in the process of raising standards of care and driving up quality. Midwives cannot thrive in the absence of a strong health system including the “network” (facilities, equipment, commodities) and the policies, investments, links and structure provided by that network. Midwives are vital also to ensuring the network achieves its potential.

In all countries assessed, it was evident that better distributed and equipped facilities will not improve access and quality of care without trained and competent midwives; it is the midwives who make the system work for the patients. The EmONC network process supports this clear finding by identifying objectively how many midwives are needed and thus where midwives are missing. The later phases of the process help measure progress gap-filling and progress towards the achievement of standards.

Similarly, the quality of services provided by midwives is directly linked to the quality of the facilities themselves, the availability of equipment and medicines and the presence of supportive supervision and leadership. To have an impact on care, adequately trained midwives must work in a good work environment. Yet, good work conditions are not yet fully in place or still need improvement and, while the EmONC network process should help establish and maintain those conditions, the link between the process and larger health system reforms or systematic quality improvements is not always clear. However, in many cases it is still too early to determine if this is the case.

In Benin, for example, sulphate is not available at peripheral centres but, as one respondent noted: “The absence of magnesium sulphate leads to deaths from eclampsia; most centres lack it, but sulphate is available centrally.” Thus, the midwives working in the periphery are still unable to maximize their training in this setting as they are not yet fully equipped to do so. The EmONC network process helps identify the gap, but others need to act to fill that gap as the solution lies beyond the network monitoring process (and UNFPA/ MHTF). The important question then is what role does the MHTF (and UNFPA) play in building or strengthening the links between health management solutions and these gaps that the network monitoring process identifies.

4.2.5 EmONC in countries that do not implement the EmONC network model

The EmONC network model is not being implemented in all MHTF programme countries. This is partly due to financial constraints that limit the number of countries that can be supported at one time, as well as limitations created by the COVID-19 pandemic. MHTF country partners must choose to adopt the EmONC network approach and several MHTF countries have opted to pursue EmONC improvements in other ways.

Programme countries that do not implement the EmONC network model have taken alternative steps to support EmONC. These steps sometimes include elements of the EmONC network approach, including baseline assessments, policy and advocacy for EmONC and MNH, and response to addressing gaps. They have not embarked on the optimization of the EmONC service delivery structure and do not support national monitoring of EmONC data but have usually focused on upstream policy, advocacy and regulatory processes, for example baseline assessments and gap analyses. This includes operational support, as is well illustrated by the Bangladesh case study. While the focus is on the quality of care offered by midwives (with inputs on skills-building, training and mentoring), UNFPA also supports the national leadership and governance by the Ministry of Health-led EmONC Core Committee. The Committee has overseen the development of a National Post-Partum

Haemorrhage and Eclampsia Action Plan. On the operational side, UNFPA also organized training for 53 warehouse managers to support stock management followed up with regular communication to remedy low stock situations.

In Zambia, UNFPA held preliminary discussions with the Ministry of Health in 2018 on the concept of the EmONC network approach but the Ministry of Health ultimately followed a different path. UNFPA uses MHTF to work at the decentralized level with provincial health authorities to support staff knowledge and capacity-building and targeted facility upgrades. This support is aligned with the findings of a baseline assessment supported by the MHTF and includes a series of assessments to identify key gaps in the provision of EmONC services, including in skilled staff shortages, and in incomplete emergency management kits for eclampsia and post-partum haemorrhage. The assessments also identified inadequate knowledge and skills among health facility staff to perform selected EmONC procedures (such as manual vacuum aspiration, cervical tear repair and use of anti-shock garments).

To address these gaps, UNFPA has supported capacity enhancement training of 37 health workers to provide better quality EmONC and other SRHR services, 28 new mentors in EmONC, and 64 nurses to qualify as midwives. UNFPA also procured assorted reproductive health equipment for targeted facilities and supported the Ministry of Health for Zambia to implement a substantial mentoring programme focused on midwives and strengthening midwifery confidence and skills. The EmONC-related quality improvements, including training and the monitoring of quality in the health system, is dependent on donor funding. Budget resources for quality monitoring are not guaranteed. By first engaging in gap analysis work at the district level and subsequently supporting tailored capacity-development work, UNFPA has been effective in adapting its MHTF strategy to the Zambian context. However, the desired quality improvements are fragile given uncertain funding and wider systems challenges.

In Uganda, in contrast to the district-level approach in Zambia, UNFPA concentrated on supporting the development and implementation of a national SRHR policy. As a result, the Ministry of Health drew on UNFPA support to develop a national SRHR policy that includes MNH improvements. UNFPA is now supporting the sequence of steps needed to elaborate, have approved, and then fully operationalize that policy. These include the issuing of a Certificate of Financial Implications by the Ministry of Finance, Planning and Economic Development, followed by the completion of a Regulatory Impact Assessment and submission to the Uganda Cabinet for final approval.

UNFPA also supported the Reproductive Maternal Newborn Child and Adolescent Health Assembly, the third National Family Planning Conference, and, in Uganda, the Network of African Parliamentary Committees on Health Conference with resolutions and commitments made on how to advance the reproductive maternal newborn child and adolescent health agenda. For example, the Network of African Parliamentary Committees on Health committed to increasing advocacy for domestic financing for SRHR/family planning and fast-tracking the National Health Insurance Scheme Bill, which paves the way for expanded SRHR and MNH services.

In summary, while UNFPA has mostly used the MHTF to support EmONC through the network development model, it has supported alternative strategies and approaches where either this model is not available (due to the limited resources) or a different strategic choice was made by the national government.

4.2.6 Linking EmONC with broader maternal health quality of care efforts

Quality of care (including respectful care) is both at the heart of health care and remains the main problem with EmONC services offered in most case study countries. In many environments, including Benin and Sudan for example, the concept of respectful maternity care is “completely absent”, even though Benin has reached the fourth phase of the EmONC network model implementation process. In Benin, a survey among midwives revealed that 67 per cent did not understand the definition of obstetric violence. Across the case study countries, the lack of respectful care and indeed, the documentation of abuse of women (especially the most vulnerable) makes for painful reading. In Sudan, where the EmONC network approach is being implemented to improve quality of care, the lack of respectful maternity care was beyond its remit. In fact, as identified in Section 2, quality of care and respectful care are elements that have been long overlooked in relation to measuring practical service delivery improvements.

Investments in quality appear to be country specific. In Zambia, for example, UNFPA (with support from the governments of the Netherlands and Austria) is going to scale up “continuous quality improvement” approaches to enhance the delivery of quality services in order to address gaps impeding delivery of quality antenatal care, labour, delivery and newborn care

services in target districts. In 2019, UNFPA, collaborating with the Ministry of Health, supported the Midwives Association of Zambia to organize and conduct a five-day workshop to develop Respectful Maternity Care Guidelines. “Zambia is the first country to develop Respectful Maternity Care guidelines as most countries have developed advocacy toolkits and training guides.” The process was participatory and drew in the health services, the Ministry of Defence, the General Nursing Council of Zambia, and leading maternal health partners (Jhpiego, USAID/ John Snow Inc (JSI) Deliver) as well as educators from midwifery colleges and senior midwives from across the country. Respectful care support has been initiated in one region of Congo as well.⁶¹

In fact, EmONC improvements relating to quality of care are increasingly gaining traction in health systems strengthening circles, well beyond the MHTF and other MHTF-supported systems processes. The EmONC network model, the Quality of Care network, convened under WHO leadership in partnership with UNFPA and UNICEF,⁶² aims to engage governments in specific actions to improve and sustain quality of maternal, newborn and child health. The network currently has 11 members and more have expressed interest.⁶³ There is potentially substantial overlap with MHTF programme countries depending on whether and how the processes work together. For example, in Cote d’Ivoire, UNFPA/MHTF works specifically to create close linkages between its interventions and the Quality of Care network and is advocating for neighbouring francophone countries to join the Quality of Care network also to create a larger community of practice.

4.3 MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

UNFPA has been a long-standing partner in MPDSR in many countries, (working closely with WHO and UNICEF) and is recognized and valued by country partners for its sustained support. At the global level, the MHTF is an acknowledged leader in MPDSR. The MHTF supports countries to develop MPDSR strategies, implement national and subnational committee structures, produce periodic reports and maintain an active stance in relation to different components of the MPDSR methodology. The MHTF has also been instrumental in developing new indicators for measuring the implementation of MPDSR in countries. Overall, sustained institutionalization of MPDSR has been difficult to achieve and progress varies depending on country leadership and commitment. There are challenges related to reconstructing reasons behind maternal deaths accurately and identifying both the cause and actions for prevention in the future. Generally, although there are excellent examples as exceptions to this, death audit findings are underutilized, although this is a common problem with the process itself. There are also some significant obstacles to triggering systemic improvements through MPDSR processes, in large part because the problems identified in reviews and audits are often beyond the abilities of a health facility or even a district authority to resolve. In particular, the MPDSR component of the MHTF shines a light on limitations in demand creation and community engagement as well as the lack of systematic action to encourage earlier attendance by women at the health facility and more trust between providers and beneficiaries of care.

For details of the evidence supporting findings in Section 4.3, see Annex 1: Assumptions 3.1, 3.2 and 3.3

4.3.1 MPDSR is complex and difficult but fundamental to MNH improvements

The MPDSR aims to increase maternal and perinatal death notifications and to institutionalize processes that allow reflection on the causes of individual deaths, sound decision-making around remedial actions and tracking the implementation of those actions. It is thus an articulated process in that it has multiple components and stages. The MHTF focuses on notification and review or audit as foundational elements of the process (discussed further in Section 4.3.5 below). Notifications require indicators and information systems, autopsies demand skills in cause of death analysis, remedial actions call on consensus-based analysis of system failures and solutions, while accountability and follow-up rest on governance and leadership. It

61 Ministry of Health of Congo, UNFPA and Philips. (2018). Programme for Connected Healthcare: Innovative and inclusive solutions for an accelerated reduction of maternal and newborn mortality in the Republic of Congo, September 2018. UNFPA.

62 Quality of Care Network: <https://www.qualityofcarenetwork.org/about>.

63 Members: Bangladesh, Côte d’Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, Tanzania, and Uganda. Have expressed interest in joining: Botswana, Bhutan, Cameroon, Chad, DRC, Indonesia, Liberia, Maldives, Mozambique, Myanmar, Namibia, Niger, Senegal, South Sudan, Sudan, Sri Lanka and Timor-Leste.

is not surprising that case study countries found elements of the MPDSR difficult to institutionalize, and progress was not observed in any setting that could approximate systematic quality MPDSR processes across the whole country. For example, in its 2019 report, the MHTF estimated that 17 per cent of maternal deaths were reviewed across programme countries, up from 7 per cent in 2015 but well below the 40 per cent threshold required by a functional MPDSR process. By their nature, MPDSR processes are very difficult to do well in a sustained way. It is difficult, too, to identify good examples in weak health systems settings.

4.3.2 Leadership and partnership for MPDSR

National leadership around maternal mortality varies depending on individual leadership, other priorities and impediments to progress. However, in most countries observed, there is a high-level Ministry of Health leadership in relation to, at least, the annual review meetings. UNFPA and other partners play an important role in advocating for high-level commitment and Uganda recently stepped up its leadership. In 2020, with maternal deaths spiking, the Government renewed its efforts to implement MPDSR as an important continuous quality-improvement tool in the provision of MNH services.

“Using the revised National MPDSR guidelines, the focus for 2020 has been on increasing mandatory notification and reporting for all maternal and perinatal deaths, functioning of facility, district and national MPDSR committees, review of all deaths and response by implementing recommendations at the different levels.”

UNFPA support (drawn from a range of sources including MHTF, Swedish International Development Cooperation Agency (Sida), and UNFPA core funding) was brought to bear on these processes.

UNFPA works successfully in case study countries to position the MPDSR as a visible process with high-level government commitment. National meetings are often chaired at a high level by the minister directly or other senior leadership figure and thus attended by a wide range of partners including professional associations, teaching institutions, service providers and technical bodies. National meetings are also the driver of annual report development where the summary of activities is brought together across different MPDSR processes within a country (as noted in Benin, Togo and Uganda and mentioned by several respondents to the online survey).

UNFPA has a long-standing relationship with WHO around MPDSR. WHO issued comprehensive normative guidelines for MPDSR processes in 2013 and UNFPA has been an active agency supporting implementation in partner countries. Both organizations have been working with different countries over a protracted period to support the establishment and functioning of maternal death reviews in various forms. In Benin, the MHTF began its support in 2015 following the lead by WHO in that country, while in Sudan, WHO joined (in 2014) the programme that had been supported by UNFPA since 2009. UNICEF joined as the other major United Nations partner as maternal death audit processes evolved to include perinatal deaths. Beyond the United Nations Funds and Programmes, a wide range of partners are involved in the MPDSR processes. For example, in Uganda, the MPDSR programme is rolled out in coordination with the World Bank, Uganda Reproductive, Maternal and Child Health Services Improvement Project, USAID, and Clinton HIV and AIDS Initiative, among others. In Sudan, professional associations, especially doctors, are in the lead.

The involvement of other partners associated with support to civil registration and vital statistics (the Global Financing Facility, for example) is less apparent in the countries studied for this evaluation. This may be due to a separation between the government departments leading the MPDSR processes (ministries of health as opposed to district authorities) and those dealing with civil registration (birth and death notifications tend to be overseen by a central statistics office in most countries). In contrast, health actors directly engaged in MNH are more visible (especially those from the H6 Partnership).

4.3.3 The MHTF supports most aspects of the MPDSR process

MHTF support includes technical expertise and financial support for most elements of the MPDSR, starting with the development of a national strategy, policy and operational process. This can be a lengthy process that requires high-level commitment and participation from a wide range of health service providers, managers, and decision-makers. Once in place, most countries maintain regular national meetings (as in the case in Benin, Sudan and Uganda for example) funded by UNFPA with MHTF financial support.

Many countries also institute regular meetings at the subnational or district levels. Meetings are periodic (three- or six-monthly in most cases) and serve to maintain focus on MNH and its key indicators (deaths, morbidity, stillbirths and others). The aim is also to ensure that participants remain focused on MNH outcomes and support specific goals around integration and quality of care. In Uganda, monthly meetings take place in hospitals, for example, and in specific districts (as UNFPA does not have resources to support MPDSR in all 135 districts). MHTF funds supported the compilation of the national MPDSR report in 2019 after which UNFPA drew on Sida funds to support MPDSR district capacity-building in 14 districts.

There is a notable gap around the systematic inclusion of the community level into the MPDSR process. This gap – for example in Sudan – creates the impression that the MPDSR serves the purpose of service delivery needs only. The MPDSR is sometimes perceived as too exclusively linked to EmONC network investments and therefore insufficiently linked to the community: “We can help to shape the MPDSR component... it should not be linked to EmONC because there needs to be a linkage with the community.” The lack of community engagement in the MPDSR processes is notable given the rate of home births (and the number of deaths in the community). The MHTF works through the MPDSR global working group to promote the idea that orienting the MPDSR around EmONC services does not necessarily have to exclude the community, especially since decisions to seek care earlier can significantly reduce the need for emergency services during delivery.

In 2020 and 2021, WHO and UNICEF co-led a global revision of MPDSR tools and guidance to countries. UNFPA was part of the working group to develop and update tools and materials to support implementation of MPDSR processes in order to ensure it reflected UNFPA experience and expertise and was present at the launch of the guidance in late 2021. However, the revised guidance to countries was published by WHO and UNICEF and it is not clear why UNFPA was not a co-author given its leadership in MPDSR.⁶⁴

4.3.4 Continued training is needed to institutionalize MPDSR

Along with high-level leadership, continual training is needed even during the COVID-19 pandemic. Because of high staff turnover, sensitizing health staff to the MPDSR process is a constant task, which is also necessary to keep information “fresh” and in the front of mind. For example, in 2020, the East and Southern Africa Regional Joint United Nations Team organized a series of virtual trainings to support the strengthening of MPDSR systems. This initiative was supported by the Sida-funded UNFPA “2Gether4SRH” emergency grant for continuing essential SRHR services during COVID-19. It consists of a six-month project that entails two-monthly virtual trainings to strengthen health workers’ capacity to: (a) identify and report all maternal and perinatal deaths; (b) correctly assign and code maternal and perinatal deaths; and (c) analyse maternal and perinatal death data. The inception meeting, held on 30 November 2020, included MPDSR focal persons from WHO, UNICEF, UNFPA (MHTF midwifery advisor) and ministries of health.

4.3.5 The challenges to MPDSR institutionalization

There are examples of progress in strengthening MPDSR in some of the case study countries. In particular, UNFPA supported root cause identification at regional referral hospitals in Uganda (Sida-funded) to enable specialist teams to visit lower-level referral hospitals in order to discuss and identify the root causes of maternal emergencies and support remedial action. UNFPA then provided equipment and materials for the new neonatal unit (Kawempe hospital) and funded a neonatologist to develop protocols of care, and to train and mentor the teams through the different emergency conditions of neonates. As a result of these actions, “unnecessary” referrals to Kawempe have dropped to almost zero and blood transfusions are now handled at the lower level rather than being referred to Kawempe. Newly agreed procedures also enable referral to a wider range of hospitals if needed.

Interventions to support a root cause analysis as undertaken in Uganda were also requested in Benin in order to identify remedial action and prevent future deaths. In Bangladesh, Togo and Zambia, better perinatal outcomes have been reported although there is limited evidence that these improvements are underpinned by the MPDSR.

However, despite evident progress in many settings, the sustained engagement of UNFPA in the MPDSR process underscores the long-term nature of the MPDSR process and the challenges with its institutionalization. Each stage or element of

64 WHO. (2021) Maternal and Perinatal Death Surveillance and Response: Materials to Support Implementation. Geneva: World Health Organization; 2021 <https://apps.who.int/iris/bitstream/handle/10665/348487/9789240036666-eng.pdf?sequence=1>.

the MPDSR process has its specificities but also requires the guidelines, supervision, commitment, and verification that strong, accountable institutions can provide. For example, death notifications (and birth/stillbirth notifications) require the establishment and management of a vital statistics/civil registry function, which is often not a health department function. Once a death has occurred, the audit process needs to be convened and all relevant individuals and authorities present their cases in order to fully disclose their evidence, which is then formed into findings, recommendations and actions.

These steps are complex. For example, the full disclosure of evidence requires an institutional culture that seeks to learn not to blame. In most settings, it requires a legal framework that protects health providers from legal action by families or the health system. Additionally, audits need to deliver a finding with recommendations that are formulated in ways that are clear, actionable, and verifiable. Recommendations in turn need to be implemented and verified as having been implemented. Institutionalization ensures a more systematic level of accountability by health authorities for the care that communities receive. MPDSR institutionalization thus requires governance and leadership that is difficult to build and sustain in all countries.

UNFPA, with the MHTF resources, supports the MPDSR process in many settings, funding meetings at the subnational and national level, helping to convene audits, providing guidelines and advice and compiling summary reports. In addition, the MHTF is working on developing review indicators, engaging in advocacy around including midwives and developing supportive supervision and mentoring processes. These are all important and necessary elements of strengthening MPDSR and contribute to improving the role and standing of MPDSR in country health systems. While investments at this level are valuable, they are probably not sufficient to spark the critical evolution of sustained institutionalization. For example, it is unclear what role the MHTF (and UNFPA) play in identifying quality standards of individual death audits or reviews in specific countries, or ensuring they are reaching the right balance of technical rigour and remedial action in addition to formulating or supporting the implementation of actionable recommendations. These would all be signs of supporting the necessary steps to build sustainable institutionalization of MPDSR in programme countries. These are time-intensive processes however and the MHTF approach based on long-term support is thus the right one.

“Furthermore, institutionalization in the Sudan context would require a legislative and policy framework, agreed norms and standards for the process and resources allocated from the public budget, as well as its adoption, along with associated protocols, into the health system and clinic management systems. To date, the MPDSR sits outside of a national legislative framework despite ongoing development of a national MPDSR strategy. Therefore, in a country like Sudan, where the MPDSR in some form or other has been supported by UNFPA since 2009, institutionalization is still a work in progress.

In Bangladesh, capacity was developed at the national level and the MHTF supports elements of the process necessary for institutionalization through funding routine meetings, convening audits, and supporting summary reporting. The challenge there, as elsewhere, is how to roll it out, who supports this roll-out and what are the sustainability prospects (who will “keep the flame burning...” over the long term). Likewise, in Benin, the MPDSR process has been institutionalized after eight years of sustained UNFPA support to the extent that it is mandatory to conduct death audits according to an *arrêté ministériel* (ministerial decree). Yet, the notification rate is still 50 per cent despite persistent efforts. This is related to a complex array of factors including management capacity, constraints on time and resources along with other pressures and leadership gaps. In Benin, as elsewhere, the MPDSR format is complex to deliver and sustain because of social and economic sensitivities, political factors and other environmental issues that serve to underscore the extent to which the MPDSR is much more than a technical process.

4.3.6 MPDSR processes highlight critical health worker issues

Beyond institutionalization, a core challenge of MPDSR processes is to empower health workers to act and respond to the findings of associated audits. Effective remedial action is constrained by three main issues: exclusion of some health workers from audit processes, the legal framework surrounding the MPDSR, and the skills required to conduct and follow-up on the MPDSR process.

Exclusion of some health workers from MPDSR processes stems partly from power relations among health staff and “who is willing to talk to whom” about what has happened and why. This challenge is deeply entrenched in power and gender dynamics within health systems more widely. These particularly impact women health workers, including midwives (Section 4.1). For example, in Sudan, MPDSR is largely conducted by medical personnel under the auspices of the National Medical Professional Associations and although hospital-based nurses may be involved, there is a tendency to limit their participation.

The MPDSR is thus not fully integrated into the health system or the national HMIS. Shifting the MPDSR to be embedded in the health system itself rather than in the professional medical body could help broaden the role and participation of health workers. By contrast, in Benin, Zambia and Uganda, nurses participate more systematically in the process, which, as one nurse said, “made her feel involved and proved useful in terms of learning”.

In many settings, as discussed above (Section 4.3.5), the MPDSR process is not confidential, and the legal protections are not in place to ensure that individuals are not prosecuted or the subject of civil action. If health workers are going to work together to deconstruct how or why a woman died, they will come into close contact with behaviours, decisions and actions of individual people, and this immediately introduces a range of sensitive issues. The root causes that are identified through this process are often not well articulated and/or suggested reforms and service adjustments identified by the review process are too weak or vague to result in concrete action. When suggested reforms and adjustments are vague, issues are much less likely to be acted upon. Staff turnover also affects the implementation of findings.

Finally, for MPDSR processes to be effective, staff need the skills to know “how to conduct the verbal autopsy, the death audit, what happens to the notes, and what happens with follow-up”. It is also important that managers capable of making decisions are fully engaged in the processes. System-level problems were in many ways easier to describe and rectify when higher-level managers were present. For example, in Uganda the MPDSR pinpointed the blood bank failures and attracted commitment to ensure solutions from Ministry of Health managers although even here “gaps remain in the quality of follow-up and delivery of results at all levels”.

Across most countries, there is a lack of incentives and skills, including the interpersonal and managerial skills of individuals tasked with conducting death audits. In Zambia, at the facility level, “whenever a death is being reviewed there is fear, and we do not get the depth and detail” needed to take action. In response to this problem, Zambia is investigating a shift to include confidential inquiries into maternal deaths using anonymous teams. Across all settings, the successful use of the MPDSR process requires the creation of a management culture that supports identifying service weaknesses to prevent maternal deaths as a rewarding exercise in self-improvement for all staff, and not a threatening process for allocating blame. It also requires a focus on continuous quality improvement rather than liability.

4.3.7 Two critical gaps in MPDSR roll-out

MHTF needs to grapple with two difficult operational gaps as it develops and extends its leadership in this area. One of the most critical gaps in MPDSR roll-out in many countries results from weak or non-existent systems to report community deaths, with the result that only deaths in facilities are reported. The direct effect of this gap is that death reviews and audits may not assign the right weight to either the first delay (the decision to seek care) or even the second delay (the delay reaching care). If not fully factored into the review and/or audit process, the role of delays in seeking care could be underestimated, or equally, overestimated. In Sudan, where there is still an overwhelming preference for homebirths, the community is where most deaths occur. This weakness is compounded by the lack of a vital statistics system to consistently report community deaths (also evident in Benin). An MPDSR process that does not incorporate the community thus risks excluding the appropriate consideration of evidence that would help fully understand how preventable deaths have occurred. Crucially, it will also exclude the opportunity to audit many preventable maternal deaths and to develop remedial actions.

Excluding communities also closes off the opportunity to build community knowledge and willingness to attend the health facility for delivery. Furthermore, it creates an incentive to “blame” families and women themselves for deaths as women often arrive late and in a state of crisis. Even in countries like Bangladesh, Benin, and Uganda where most maternal deaths occur in hospitals, it prevents the holistic review of how a death could have been avoided or how health systems could be strengthened (including for demand creation). Further, the lack of, or weak, community engagement creates a problem for accountability:

“If you only focus on supply/facility level, and if you do not work on the community level, you will not succeed... the MHTF should add a stronger community component, including an accountability mechanism which provides feedback...to the quality of services so what happened, does not happen again. If the feedback mechanism is not working, MPDSR is not useful.”

A second important gap occurs when the MPDSR does not systematically address stillbirths. Although the Every Newborn Action Plan includes a welcome focus on stillbirths, they are still not fully counted or addressed during MPDSR processes. While MHTF has been playing a role in highlighting the issue of stillbirths as part of quality initiatives and through support for launching the Helping Babies Breathe programming in over 25 countries (in coordination with Jhpiego and Laerdal⁶⁵), there is a notable absence of focus on stillbirth overall within MPDSR. Most stillbirths are preventable and occur during delivery and are thus related to the quality of care received at delivery, the timeliness of care, and the strength of the referral system. While there is an increasing effort to count stillbirths globally, there is not much evidence of its systematic inclusion in the MPDSR processes.

4.3.8 MPDSR faces the same challenges in all countries but to varying degrees

MPDSR, even where it works well, suffers from an “underutilization of findings”. More reviews may be conducted (Togo) but these do not necessarily result in improvements in health services as there is a disconnect between the review and the integration of the response into future health practices. In Benin, one informant pointed out that, although maternal death surveillance and response activities “bring a lot, the ‘R’ [response] is tiny. Yet it is the ‘R’ which fixes the problem.” In Sudan, supervision tours identified many gaps between national recommendations of the MPDSR and implementation at the state levels. Although management protocols for emergency obstetric problems (haemorrhage, hypertensive disorders and its complications, and sepsis) “have been designed and endorsed, implementation and adherence to these is deficient in almost all health facilities”. In Benin, although enthusiasm and participation in the audits and accountability seem to have been affected by the per diem payments that were made for attending audits, it did not extend to the implementation of required improvements in care practices.

Furthermore, the problems identified with the MPDSR are often “too huge” for participants to resolve. For example, the root causes of medicine shortages (in Uganda and Sudan) or midwifery failures (in Bangladesh, Benin and Togo) are not always possible for a small group of health workers in a single health facility to diagnose in a meaningful way, let alone to resolve. Some elements related to larger systems issues go beyond the level of problems or bottlenecks that small districts or hospitals can address, which can make people feel like they have less, rather than more, control over solutions. Some health workers have said that being asked to diagnose issues that they have no ability to solve is demotivating. However, this is a problem that health systems solve by creating the right kind of feedback loops and through valuing staff participation in prioritizing quality improvements. MHTF guidance and support to the MPDSR process is very well positioned in relation to tackling this challenge and to enabling countries to institutionalize death reviews in this context as evidenced by a long track record of national review, report writing and increasingly, more creative dissemination of report findings in ways that influence priority setting and the identification of training needs and quality of care support.

4.4 FISTULA AND OTHER OBSTETRIC MORBIDITIES

UNFPA has made a clear contribution at both the global and national levels towards increasing the commitment of governments and partners to end fistula. As lead for the Global Campaign to End Fistula, UNFPA effectively coordinates an advocacy and knowledge-sharing agenda that has helped to maintain fistula as a global priority. At a national level, the strategic positioning of UNFPA is enhanced by its partnership with government and its convening role, which has enabled it to develop and/or revise national strategies to end obstetric fistula. With MHTF resources, UNFPA has also strengthened coordination of fistula at the national level to ensure coverage and allocation of resources. Building capacity for fistula treatment and care is the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, with mobile teams, and with service delivery camps. However, in most countries, these services remain donor dependent and have yet to be mainstreamed into the health system. Efforts to rehabilitate and reintegrate survivors into communities are at early stages overall, though the topic has been included in new/revised strategies. Prevention is linked to

65 Laerdal Global Health, established in 2010 as the not-for-profit sister company to Laerdal Medical, in Stavanger, Norway.

midwifery capacity and the EmONC response and is not explicitly implemented as a programme component. Few country programmes pursue a comprehensive approach with all components of fistula care. This is likely due to resource constraints, but also points to the lack of an overarching framework to guide programming. The rise in iatrogenic (caused by medical treatment) fistula is an emerging issue globally and requires renewed attention on safe surgical services and quality of care throughout all components of MHTF.

For details of the evidence supporting findings in section 4.4, see Annex 1: Assumptions 4.1, 4.2 and 4.3

4.4.1 UNFPA assumes a strong leadership position globally through the Campaign to End Fistula complemented by MHTF resources

Through the Global Campaign to End Obstetric Fistula (the Campaign) and the MHTF, UNFPA is a recognized leader in fistula programming. Established in 2003, the Campaign, led by UNFPA, now counts 92 partners and is active in over 55 countries. The Campaign has served as a vehicle for resource mobilization from 16 governments and 12 private or corporate donors/foundations. UNFPA and the Campaign infuse a human rights perspective throughout their work on fistula, recognizing that this condition is more likely to affect vulnerable women and girls, while also rendering those who experience it even more vulnerable. The Campaign and UNFPA ensure their messages support the dignity of women and girls with fistula, working to empower, not further victimize, them. This sensibility flows through the activities and messages delivered by UNFPA in country programmes.

Interviews with key informants speak to the important role and platform that UNFPA has played through both the Campaign and the MHTF. No other partner brings the reach that UNFPA has through its extensive network of country programmes. Stakeholders noted that UNFPA made a key contribution, in 2018, by advocating and supporting the United Nations resolution to intensify efforts to end obstetric fistula. This has put fistula on a par with other global initiatives, for example, those to end preventable maternal and newborn deaths, HIV and female genital mutilation. The Campaign has also played an important convening role, notably to bring together technical partners to review the state-of-the-art in fistula programming. This, in turn, informed the 2020 publication of guiding principles for clinical management and programme development. UNFPA is considered an excellent partner to lead the Campaign, promoting the whole partnership and not just its own organizational ends.

Since 2013, the Campaign has supported annual commemorations of the International Day to End Obstetric Fistula. In 2020, the International Day to End Obstetric Fistula was the opportunity to launch the countdown towards the goal of ending obstetric fistula by 2030 (as called for by United Nations member states). These days of commemoration are also conducted at the national level, using key advocacy messages and materials provided by the MHTF team to UNFPA country offices and others implementing fistula programmes.

The Campaign brings important visibility to UNFPA and attracts donors that might be specifically interested in fistula and not in the organization's broader SRHR mandate (such as for family planning, although an important aspect of fistula prevention). Once managed separately, the Campaign is now housed within the MHTF team and overseen by the SRHR Branch within the Technical Division. The MHTF provides technical support to countries to implement their fistula agendas, offering synergy between global and national efforts. However, resource constraints negatively affect the capacity of the MHTF team to accommodate growing expectations by Campaign partners to address new issues (that is, additional maternal morbidities and the ramp-up of communications and resource mobilization) while attending to technical exigencies of MHTF.

4.4.2 UNFPA is a key partner for national leadership and strategy development

In all the countries studied for this evaluation, UNFPA is recognized as a major actor with ministries of health in setting the agenda for addressing obstetric fistula. Linked to the global awareness-raising campaigns, including the actions of the Global Campaign to End Fistula, UNFPA uses its strategic position as a trusted and reliable partner to implement a systematic approach to advocate for increased attention and resources for fistula. With MHTF resources, UNFPA supports the development of national strategies in all the countries studied. These national strategies are complemented by work at the regional level, such as the effort to develop a regional road map for making pregnancy safer in Eastern and Southern Africa. By 2019, 12 countries in the region had developed individual road maps that included fistula.

Generally, the approach to strategy development encompasses conducting situation analyses, engaging with stakeholders (to deliberate programmatic options appropriate for their context), and identifying strategic priorities for prevention, treatment and reintegration. In Sudan, recent MHTF investment combined with other resources supported the Federal Ministry of Health to develop a national fistula strategy shifting focus from surgical repair camps to an approach of systems strengthening. The strategy also forms a basis for raising and pooling resources to support a network of identified treatment sites in six states where the risk is the highest. Similarly, in Uganda, MHTF resources supported the process to revise, review and approve the costed Obstetric Fistula Strategy 2021/22-2024/25, aimed at strengthening the integration of fistula repair as a routine service and practice at the national and regional levels as well as in selected general hospitals. In Zambia, UNFPA is credited with putting fistula on the national agenda, generating commitment from the Government and other partners, and contributing to finalizing the Fistula Operational Plan. UNFPA also supported fistula technical working groups at the national level (in Bangladesh, Sudan, Uganda and Zambia). These technical working groups, chaired by the Ministry of Health, are important coordination forums to ensure the strategic allocation and leveraging of resources along with the alignment of partners with the national strategy and overall ownership by the government.

Among the countries studied, UNFPA engagement in fistula appears to have progressed the furthest in Benin. Following years of investment in a holistic strategy encompassing prevention, repair, and reintegration, UNFPA shifted its strategy in 2018 to support knowledge-management activities. This shift is the culmination of a successful catalytic strategy whereby the MHTF created awareness about the subject and provided quality technical support to deliver improved programmes and to strengthen the health system through information management. This in turn, has enabled UNFPA to phase out its support as other technical and financial partners are involved and are taking the programme forward, allowing the MHTF to concentrate its limited resources on other activities and goals.

4.4.3 Fistula prevention implemented through other MHTF and UNFPA programme components

Fistula prevention includes an array of different interventions categorized as primary (health promotion and family planning), secondary (basic obstetric care) and tertiary (comprehensive obstetric care). UNFPA invested MHTF resources in activities to improve community awareness about the importance of antenatal care, birth preparedness, the role of early marriage and teenage pregnancy in fistula (Sudan, Uganda and Zambia) and family planning (Benin). On the other hand, when asked about prevention, UNFPA staff referred to the MHTF investments in EmONC and midwifery as key elements of the prevention strategy for fistula and obstetric morbidities. The role of midwives is critical in obstetric fistula prevention and detection given their broad service delivery role both in health facilities and at the community level. However, efforts to systematically address the capacity of midwives in fistula care have achieved mixed results (Section 4.1.3) in part due to the low status of midwives in the context of a highly specialized and technical service area.

Iatrogenic fistula is an important new challenge in fistula care (Bangladesh, Uganda and Zambia). This type of fistula is caused by complications that occur from gynaecology surgery, such as caesarean sections and hysterectomies. As efforts to improve maternal health progress, more women deliver in facilities and have access to emergency surgeries. Safe surgery is an emerging issue in health systems strengthening, as the recognition grows that unsafe surgical care can cause substantial harm, a significant proportion of which is preventable.⁶⁶ In Uganda and Zambia, UNFPA has not yet undertaken an assessment of the reasons for the rise in iatrogenic fistula and their relation to poor quality of EmONC interventions.

4.4.4 Building capacity for fistula repair

Oriented around reducing fistula incidence, national strategies (Section 4.4.2) focus on building a sustained in-country capacity for fistula repair and other components that will take time. Training fistula surgeons is challenging given the specialized skills and the number of repairs required to achieve - and maintain - competency. In the early years of fistula programming, the common conviction was that more surgeons were needed to staff more centres in order to ensure equitable access. More recently, there has been recognition that highly trained surgical specialists are unlikely to go where fistula clients reside (in poor, rural settings). Therefore, strategies must include ways to practically engage fistula surgeons from tertiary facilities in urban areas to bring services to those who need them.

⁶⁶ World Health Organization. "Why safe surgery is important". Accessed from: <https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery>.

In Togo, UNFPA is credited with establishing a referral site (in Sokodé) for fistula repairs and for conducting two repair camps per year to address the backlog of cases, estimated at 1,000 women. UNFPA has also supported advanced training by establishing a centre of excellence in Dhaka Medical College working with the Bangladesh Obstetrics/Gynaecology Society to set up a fistula training institute. Furthermore, UNFPA is advocating with the Government of Bangladesh for earmarking costs for fistula treatment within the national budget.

In Sudan in 2018, UNFPA supported the Federal Ministry of Health to create a mobile or flexible surgical team to provide repair services where needed in the states where surgeons were living and working. The mobile team is an innovation that has led to increased use and deployment of fistula repair skills in difficult-to-access places. For example, in 2020, when the fistula surgeon was no longer available to do fistula repairs in Blue Nile State, UNFPA arranged for the fistula surgeon based in Al Fashir (North Darfur) to visit Blue Nile State to undertake fistula repairs. Since 2018, UNFPA also helped establish a fistula fellowship programme between the Sudan Obstetrics and Gynaecology Association and the International Federation of Gynaecology and Obstetrics to establish fistula repair capacity in a limited number of hospitals.

In Uganda, fistula repairs are conducted through camps by experienced surgical teams from national and regional referral hospitals. Over the years, capacity has been built at the national level to perform fistula repairs and to train and mentor other surgeons. There are, however, serious challenges with the provision of routine fistula repair services due to the lack of dedicated operating rooms and staff in overburdened regional referral and general hospitals. Fistula treatment is not yet considered in the Uganda health system as part of the routine package of services, nor is it adequately funded by the Government.

As a result, camps remain the dominant mode of service delivery for fistula repairs in Uganda (as well as Zambia) and are highly donor dependent. Nonetheless, providing services via camps offers opportunities to train surgeons while also increasing awareness of providers from the host facility about fistula prevention and safe surgical practices. It also offers an opportunity to address growing anecdotal evidence of iatrogenic fistula from unsafe caesarean sections.

4.4.5 Mixed progress for case identification, registration and tracking

The establishment of well-functioning identification, coordination and referral mechanisms are critical for enabling women and girls to access quality treatment. To this end, different strategies are employed across the different country contexts. For example, in Bangladesh and Uganda, a pocket handbook was developed for use by government health workers to identify and refer fistula clients for treatment. The handbook guides community volunteers and fistula survivors to serve as advocates to identify fistula clients while simultaneously addressing community bias and discrimination among these vulnerable women (Bangladesh and Uganda). Annual commemorations of the International Day to End Obstetric Fistula utilize mass and social media and community mobilization to identify clients (Uganda and Zambia). In Zambia, the strategy is to engage with community-based “safe motherhood action groups” to increase awareness, identify potential fistula clients, and follow-up clients who had repair to track post-surgical outcomes.

Systems for case registration, categorizing/typing cases and tracking outcomes, as well as indicators to measure outcomes of care are at various stages of implementation in the countries studied. Fistula data has been integrated into the District Health Information System 2 (DHIS 2) in Bangladesh and Togo. Meanwhile, in Benin, UNFPA supported knowledge management and the collection of evidence via the production of annual post-operation monitoring reports on women. These provide lessons on the profile of women and the effectiveness of their reintegration and have resulted in the integration of fistula data into the national system.

In Uganda, UNFPA supported the fistula technical working group to develop and approve HMIS documentation and reporting tools, including theatre, treatment and follow-up registers. MHTF resources helped conduct exercises in two provinces in Zambia to track outcomes following fistula services; however, these efforts were discrete and one-off. In Sudan, there is no system for case registration and tracking, neither at the state nor at the national level. Work is beginning to establish indicators to measure the quality of the services and outcomes of care and strengthen the reporting system.

4.4.6 UNFPA efforts to expand fistula care beyond prevention and repair to reintegration are nascent

As already shown, most direct efforts have been levelled at the development of national strategies and building capacity for fistula repair. Once fistulas are repaired, recovery takes time and requires rehabilitation. Most women suffering from fistulas are excluded from their families and communities due to the antisocial side-effects associated with fistulas. Therefore, every survivor needs practical support to re-join their community. Women need to acquire new skills and/or psychosocial support to re-establish their lives. So far, social services of this kind are not routinely available; and there is generally limited engagement between the health services and the community or between health services and other social services. While reintegration requires a multisectoral approach, fistula strategies tend to be the purview of ministries of health only. As a result, the reintegration component fails to gain traction. UNFPA staff in Zambia are starting to explore work with the ministry responsible for social cash transfers as an entry point for reintegration programming.

UNFPA has begun to address reintegration as part of the process to develop and/or revise national strategies to end fistula (Bangladesh, Sudan, Togo, Uganda and Zambia). To date, there has been little progress in supporting reintegration beyond strategy development in Sudan and Zambia. However, in Bangladesh, UNFPA established a referral model to ensure that all identified fistula cases are referred to available rehabilitation and reintegration programmes. Approximately 95 fistula patients a year will undergo rehabilitation in the Rangpur Division. The holistic model includes identification, referral and management of fistula cases and psychosocial and mental support for all fistula clients, as well as need-based rehabilitation and reintegration support through linking clients with other ministries/departments (such as the Department of Social Welfare, or the Department of Women Affairs).

The efforts of Uganda are further along. Uganda assessed its existing social reintegration programme in 2019 and found that efforts were mainly deployed in private facilities. In response to this, the MHTF funded technical support to develop a Minimum Fistula Reintegration Package/Standards (guided by WHO principles for reintegration), at both the facility and community levels, with an emphasis on linkages between the two. In this endeavour, an important partner for UNFPA and the Uganda Ministry of Health is the Association for the Rehabilitation and Re-orientation of Women for Development (Terrewode), headquartered in Soroti, eastern Uganda. Terrewode uses a holistic approach to address the issues of obstetric fistula, with a strong focus on community engagement to empower and educate young women in rural communities. MHTF funding has contributed to Terrewode, providing a leading voice in Uganda around the vulnerability of women with fistulas and the need to ensure their rights and restore their dignity by providing access to holistic services, including reintegration.

4.5 SRHR AND MNH INTEGRATION

Integration underpins the UNFPA transformational goals and is well defined at a strategic level. There has been tangible progress in some areas, including the integration of family planning into maternal health services across the care continuum. Integration is less evident at the MHTF operational level, where each country defines the scope of integration between SRHR and MNH services according to its own opportunities and context. Integration of service priorities (family planning, post-abortion care or cervical cancer screening) is “natural” in most contexts at the point of service. However, integration of post-abortion care is not consistently addressed. Moreover, integrating adolescent SRHR and eliminating SGBV is at an earlier stage of evolution and seems to be considerably harder because it requires midwives with an expanded skillset, more time and space (privacy), and attitudes that are respectful and non-judgemental. The midwife, again, is at the centre of the integration process and a critical lynchpin to expanding access to a full range of SRHR and MNH services for women and girls. While SRHR-MNH integration is one of the elements binding the four MHTF technical areas, the expected synergy does not materialize as fully as could be expected because of the deficit of skilled health personnel. This effect is further compounded by weak infrastructure and a lack of equipment, two structural health system failures that the MHTF can only partially tackle directly. The challenge, in this regard, is to link effectively with other partners, leveraging resources, policy commitment and capacity-building to achieve further results.

For details of the evidence supporting findings in Section 4.5, see Annex 1: Assumptions 5.1, 5.2 and 5.3.

4.5.1 Integration underpins the UNFPA transformational goals and is well defined at a strategic level

The ICPD agenda is integrated and based on a comprehensive life course approach to SRHR, which requires programmatic integrated approaches. Integration is also a core component of health systems strengthening and key to the three transformational results laid out in the current 2022-2025 UNFPA strategic plan. There is also increasing advocacy to include integrated SRHR under universal health coverage, for example, as shown in the new UNFPA strategic plan.

Integration binds the four MHTF technical areas together, which might otherwise operate independently (siloes) from one another. The effectiveness of the MHTF is thus substantively based on internal interconnections and synergies that support the MPDSR to identify causes of maternal and perinatal deaths and then provide recommendations that would not only inform the design of the activities to strengthen EmONC services and facilities, but also inform the training of midwives and skilled health personnel to prevent maternal mortality and morbidity. In parallel, effective integration at the service delivery level would maximize the benefits of the EmONC network.

While the strategic definition and justification of integration among the technical areas is clear, there is no operational definition or guidance and few indicators measure it within the MHTF, which leaves scope for each country to set their own ambitions. This shortcoming is well acknowledged among MHTF staff at the headquarters level and was also raised in recent UNFPA evaluations on HIV and the Supplies Programme.

4.5.2 Integration is visible in country offices but less so at the headquarters level

UNFPA country offices all put an emphasis on integration, seeing it as their “comparative advantage” (Uganda), or the “how of the MHTF programme” (Benin). It promotes client-centred perspectives in service delivery and is justified by SRHR indicators, especially in countries where young girls account for the majority of maternal deaths, are more vulnerable to HIV, and are at higher risk of early and child marriage, SGBV and fistula. Some country offices have engaged with integration through their operational structure by uniting MHTF programmes, adolescent SRHR and their Supplies Programme into the same operational unit (Benin, Sudan and Uganda). Key informants report that this reorganization makes it easier to coordinate, improves efficiencies, and ensures that opportunities to build synergies are less likely to be overlooked. For example, in Sudan, when emergency funds to support reproductive health were made available to the SRHR team, they were targeted to EmONC facilities in the relevant areas (see Section 4.2).

At the headquarters level, however, even though individual programme leads do cooperate, programmes are still siloes and rather vertical. This is the case in relation to the larger programme funds (the Supplies Programme, the MHTF and the Female Genital Mutilation Elimination Programme), which are all situated in different branches of the Technical Division. This is also quite visible within the MHTF team itself where the four technical areas are treated as four independent domains with different technical advisors. The four technical areas largely work alongside each other and tend to provide vertical technical assistance to MHTF countries. There are some exceptions to this tendency, with support to the EmONC network and to the MPDSR process delivered by the same staff members. Also, the MHTF assigns one team member as the overall country focal point to keep an overview on all MHTF efforts in that country. There have also been individual efforts, within the headquarters team, to collaborate and work in a coordinated way across technical areas, a trend towards better team working that has significantly increased in the last year. Headquarters management and leadership is explored further in Section 4.8.

4.5.3 Although integration is one solution to scarcity of resources, context matters

In a context where national resources are scarce, integration makes financial sense and appears as a logical option to provide MNH and SRHR services in an efficient manner. National stakeholders pointed to existing recommendations “to take advantage of one service to render another”. Most countries are working towards integrated services, or have declared an intention to do so, and many have made significant progress in this direction. By and large, countries advocate for the integration of comprehensive MNH and SRHR, including family planning into universal health coverage plans and arrangements, as exemplified by Benin, Sudan, Togo and Uganda.

However, country contexts vary and not all countries have the same experience of integration. For example, countries particularly affected by the HIV and AIDS epidemic have long-term experience building institutions that design and implement

integrated programmes and they can draw on and further develop this knowledge. This is the case of the Sida-funded, UNFPA “2gether4SRHR” programme in the East and Southern Africa region, which integrates HIV, family planning and SGBV. Uganda and Zambia participate in this regional programme and are in the process of developing an integration model at the service-delivery level, linking MNH, SRHR, HIV and SGBV services. UNFPA has conducted successful advocacy around integration, resulting in the development of service integration policies (pending approval in Uganda) as well as the development of operational guidelines and manuals. In fact, UNFPA is recognized by its partners as an important convener with technical expertise providing visible (and valued) support to the Ministry of Health in matters of integration.

Other countries have adopted a primary health care approach and some a “One Health” approach. Both these models promote integration (Benin, Sudan and Zambia) and offer an enabling environment for integration of all basic services, irrespective of MHTF efforts. The primary health care approach, in particular, focuses on addressing a continuum of basic service needs from SRHR to MNH and encompassing child health and infectious disease prevention and treatment. But integration is clearly not just a service provision challenge, and the scope of integration is still limited in many countries by gender-based inequities where the limitations on rights of girls and women, adolescents, or key populations leads to the curtailment of access to a fully integrated set of essential services across the life course. The shifts required to foster integrated care will take longer to achieve in this setting and the role played by UNFPA at the country level is also shaped by its sensitivity to an acceptable pace of evolution in social and cultural practices.

4.5.4 Integration on the ground: family planning leads the way

According to the MHTF Business Plan, integration of MNH and SRHR services focuses on post-abortion care, preventing mother-to-child transmission, family planning, immunization and cervical cancer prevention. This is a far narrower scope than what most countries define as integration and seek to operationalize. Their approach is more comprehensive and ambitious and extends to SRHR for adolescents and SGBV services, as in the case of the Benin country office.

There are however clear commonalities in the MHTF investment in integration at service delivery level. For example, the topic of integration is typically tackled in the midwifery training curricula (Bangladesh, Benin and Sudan), with some having a particularly wide scope. In addition, Zambia offers training on eliminating SGBV and SRHR including for adolescents, as well as disability inclusion in both pre-and in-service training of health care providers. There has been widespread training on adolescent SRHR, and growing training on SGBV, usually on SGBV guidelines on post-rape care (Benin), as well as integration of HIV into MNH (Togo). Vaccination and nutrition training are also routinely included, notably for outreach services conducted by midwives.

Integration between family planning services and maternal health services is at the heart of the UNFPA political mandate as the prevention of maternal deaths is largely based on delaying, spacing and limiting pregnancies and thus requires access to comprehensive family planning services. Integration of MNH and SRHR, including comprehensive family planning services, is considered as “natural” by country stakeholders and a routine practice already in facilities, especially through post-partum family planning and during antenatal care visits, irrespective of MHTF interventions. The MHTF does not fund but “promotes” family planning through partnerships with other programmes such as the UNFPA Supplies Programme. This is exemplified by those country offices drawing on the Supplies Programme funding to conduct family planning training for midwives trained with MHTF resources for MNH-related interventions. This is consistent with the Supplies Programme supporting supply systems strengthening efforts as well as commodities (not just contraception but other life-saving maternal health commodities – see Section 2.3.7). Collaborations with community-based family planning demand generation programmes directed at youth and linked with EmONC facilities were also noted (Benin and Zambia).

4.5.5 Midwives are at the centre of integration

The analysis of the MHTF in all the country case studies underlines the pivotal role of midwives in the practical integration of services. There is an expectation that midwives will be the primary caregiver to women and girls at multiple stages of the life course. In particular, quality of care, including respectful care of the client (woman) is seen as a critical dimension in midwifery training and for the credibility of midwives to offer integrated services (see Section 4.2).

However, one area for improvement regarding the integration of family planning, SRHR and MNH pertains to the gender attitudinal barriers that persist among midwives. Not only is there evidence of lack of respectful care towards women in delivery settings (Section 4.2), but there is also evidence that midwives often voluntarily self-limit their promotion of contraception and sexuality education services to adolescent or unmarried girls and women. This suggests that current training may not tackle gender norms directly or sufficiently, nor do they adopt approaches that are sufficiently gender transformative. Placing midwives at the heart of integration can be a positive force for change but, in fact, it can also act as a powerful barrier.

Midwives have limited capacity themselves and, as a department of health senior policy staff pointed out, “the problem is all the topics we put under the term of integration: maternity services (and midwives) cannot resolve them all”. The scope of integration carries a range of consequences for midwives. While integrating topics such as family planning, post-abortion care or cervical cancer screening is “natural”, integrating SGBV and adolescent SRHR is considerably harder because it requires an expanded skillset, more time and space, and midwife attitudes that are respectful and non-judgemental.

SGBV and SRHR require services that are open-ended and ongoing. EmONC facilities, on the other hand, are geared towards an emergency response, referral and literally delivering a specific outcome although they form an important platform for a wider SRHR response. Despite some similarities (an effective quality response to SGBV also requires a referral system), addressing SGBV spreads beyond the health system and calls on social, justice or law-enforcement services. It also requires a survivor-centred approach rooted in women’s rights and gender equitable attitudes of all staff, which is often absent. In addition, while midwives are the key to integrated SRHR-MNH services, there is a limit to how much each midwife can do in a day and the more comprehensive their service delivery role becomes, the more midwives are needed.

Although SRHR-MNH integration is one of the elements binding the four MHTF technical domains, the expected synergy may not be realized because of health system limitations, including the deficit of skilled health personnel, a finding that emerged in all countries, and the weak infrastructure, commodity stock-outs and poor-quality equipment often hampering quality of care. These health systems weaknesses are only partially tackled by the MHTF or by UNFPA, and challenges persist, including in those countries most advanced on the integration journey, such as Uganda and Zambia. “The problem with integration is if you only look at service delivery level, you bump into issues of salary, motivation and incentives. We need a system strengthening approach for integration to work, and it is not that strong in the MHTF.”

4.5.6 Leading on adolescent SRHR and the reduction of harmful practices

Averting adolescent unwanted pregnancy is a foundation of maternal health and survival and is rooted in access to quality contraception services, often seen as the most cost-effective intervention to save maternal lives. UNFPA has a reputation as a strong supporter of adolescent SRHR embedded in an integrated approach to basic service delivery in most countries. Yet, the link between the MHTF (focused as it is on four technical areas) and adolescent SRHR is not made sufficiently clear in some countries and suggests that the MHTF has not put its weight behind the all-important investment in averting unwanted pregnancies, despite the potential impact of family planning services for adolescents. In Benin and Sudan, adolescent SRHR is mainly funded by other bilateral programmes and is not guided by specific adolescent-targeted programmes despite there being large national family planning programmes in the two countries. By contrast, in Uganda, the adolescent SRHR programme, “Live your Dream” campaign is directly funded by the MHTF (and others), and tackles harmful practices, SGBV and family planning.

Despite some progress made in ensuring that young people can access SRHR services, there is a perception that more could and should be done to reduce maternal mortality among adolescents, given adolescent SRHR trends and the demographic youth bulge in many countries. In addition, the integration of adolescent SRHR within EmONC facilities is often limited due to health worker capacity (and attitudes) and lack of skills, equipment, and commodities. All of these factors hamper the quality of care for adolescents (Section 4.5.5).

Eliminating gender-based violence and harmful practices is one of the three transformational goals of the 2022-2025 UNFPA strategic plan and should not be separated from efforts around the other two transformational goals (eliminating unmet need for family planning and eliminating preventable maternal death). The integration of SGBV services is part of the

“2gether4SRHR”⁶⁷ programme as implemented in Uganda and Zambia and has seen progress in training midwives to better deliver these services. UNFPA is also taking the lead on SGBV in Sudan. However, the scope of the response to SGBV that the MHTF can and should promote is not clear and not integrated into the current Business Plan. Yet, the complex picture of the evidence emerging from countries is that the sexual experience of many girls and women appears to be intermingled with violence, and adolescent girls are especially vulnerable to high rates of maternal mortality and morbidity as well as other compounding conditions such as HIV.

There is an intrinsic and inseparable link among these three dimensions (SRHR especially for adolescents, averting preventable maternal deaths, and eliminating SGBV) that calls for their active integration at all levels. While midwives have a role in identifying and referring SGBV survivors, as well as providing first-line support, this is only feasible under certain conditions. While these conditions are described in normative guidance,⁶⁸ access to comprehensive, quality SRHR services continues to be affected by gender norms in countries and as noted above, the attitudes of midwives themselves (Section 4.5.5). In this regard, MHTF investments in midwifery training curriculum development make an important long-term contribution although tackling gender norms across the health system is a very real challenge for all partners.

4.5.7 Integration is used as a strategy to leverage resources

With its very modest budget, the MHTF cannot fund all the pieces of the integration puzzle. Instead, it has shown creativity and flexibility in ensuring integration of funding in a number of ways. UNFPA country offices, regional offices and headquarters have sought and added co-funders to support the implementation of activities in some MHTF technical areas (such as the Takeda Foundation and Johnson and Johnson). Examples of this include the Muskoka Funds or the Takeda Fund in Benin and Togo, or Sida-funded contributions to midwifery training in Sudan, Uganda and Zambia. UNFPA also explored the possibility of extending its reach through creating links and synergies with other programmes, such as the World Bank programme to fund the SGBV training component of the EmONC nurses and midwives (Benin). Furthermore, UNFPA core funds are also typically used to augment and extend the MHTF funds for integrated services (see Section 4.8). However, there seems to be limited interconnection with the Supplies Programme (around the provision of maternal health and family planning commodities and related systems strengthening) and, at the headquarters level in particular, technical staff in the MHTF are unsighted on the ways in which MHTF partner countries accessed funding from the Supplies Programme.

This creativity translates into a “patchwork of resources”, which could be difficult to coordinate but which also builds flexibility and responsiveness. “We will use the MHTF to train a midwife who is going to work in the comprehensive abortion care room, and another project will procure the manual vacuum aspiration kits. You have trained the midwife, but you get the kits from a different programme... [managing the] resource envelope is a challenge to coordinate all the inputs.” The main challenges around managing different funding sources relates to delays in disbursement. The management of myriad funding sources also leads some partners to perceive UNFPA as having “output-based management” that is not integrated enough, as reflected in the need to report to different donors on different projects in parallel. This has high transaction costs, can work against integration, and requires constant juggling and siphoning off results in a piecemeal manner to meet donor accountability requirements (see Section 4.8).

4.6 STRENGTHENING ACCESS AND EQUITY

The UNFPA SRHR-MNH agenda is underpinned by a focus on equality and meeting the needs of all women and girls. The MHTF is geared to improving equity in a series of ways including through improving the supply of essential SRHR-MNH services for women and girls, strengthening access to quality services, increasing accountability in MNH, and improving the role, capacity and position of midwives. Despite this, there is a notable absence of interventions addressing the demand-side barriers to access although these are often picked up beyond the MHTF (which has limited resources). The four MHTF technical areas focus on strengthening equity in their individual ways,

67 The “2gether 4 SRHR” is a comprehensive regional programme with applied learning in ten countries, funded by the Regional SRHR Team of Sweden. The programme aims to improve the SRHR of all people in East and Southern Africa, particularly adolescent girls, young people and key populations, by promoting an integrated approach to SRHR, HIV and gender-based violence. Accessed at: <https://esaro.unfpa.org/en/2gether-4-srhr>.

68 WHO. (2020). Strengthening the health system response to violence against women in Uganda: lessons learned from adapting and implementing WHO guidelines and tools. Geneva: World Health Organization, and: WHO, UNFPA, UN Women, Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook, Geneva.

including by working through the principle of “leaving no one behind” and prioritizing underserved geographic areas and vulnerable populations (in particular adolescent girls and young women, notably in addressing fistula). The MHTF also seeks to improve the supply of EmONC services in ways that ensure that all women and girls are within reach of care. However, prioritizing vulnerable women and girls requires a multisectoral approach that goes beyond the health system and should address demand creation, not just supply. Access and equity require normative and structural interventions that the MHTF, with its strong focus on the supply of services and limited resource base, cannot currently fully address. Furthermore, the challenges with integration, notably in some settings, the lack of SGBV services and provision of impartial, non-judgemental access to family planning and post-abortion care, undercut the MHTF aim to lead on gender equity and to reach the most vulnerable (especially adolescent girls).

For details of the evidence supporting findings in Section 4.6, see Annex 1: Assumptions 6.1, 6.2 and 6.3

4.6.1 An elaborate approach to gender equality, empowerment and access

As evident in the global literature (Section 2), gender equality and empowerment underpin health outcomes for women and girls in a myriad of ways. Not only is their health at risk from harmful practices (female genital mutilation, early marriage), but girls may also lose life opportunities including access to education because of early pregnancy inhibiting their sense of autonomy and ability to assert their rights to care. Adolescent girls and young women are disproportionately at risk from early pregnancy and both they and their newborns are at risk from a lack of quality care before, during and after delivery.

The MHTF adopts an approach to access and equity that is rooted in this understanding. While a range of wider societal issues are also reflected in the supply of, and demand for, health services including gender equality and norms and factors such as education (as laid out in the theory of change in Section 3). MHTF investments aim to tackle the specific health systems dimensions of equity and empowerment from a number of angles. These include: the overarching focus on leaving no one behind; building the supply of quality health services to provide quality care; improving the capacity, working conditions and attitudes of health workers (especially midwives); strengthening access to quality MNH services (especially by adolescents and young women); and integrating SRHR and MNH services in ways that reduce the need for emergency care in pregnancy (Figure 14).

FIGURE 14: A wide array of strategies enable the MHTF to influence access and equity



Although several MHTF interventions are tagged to “equity in access”, it is difficult to assess progress against this partly because “access” is a higher-level outcome in the framework for the MHTF theory of change. Meanwhile, MHTF reporting is largely focused on the output level, which makes it difficult to track actual improvements in access over time. Similarly, there is an absence of a systematic approach to track the drivers of progress, which are critical inputs to preventing maternal death and disability, for example uptake of family planning services by adolescents and young women.

4.6.2 A strong focus on “leaving no one behind” runs through the MHTF strategies and programming

The MHTF activities are guided by the human rights principles of equity in access, quality of care and accountability.⁶⁹ The MHTF Business Plan (Phase III) lays the foundation for the principle of equity in access to SRHR information and services and takes a human-centred, rights-based approach to MNH.

“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 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.” – MHTF Business Plan Phase III, p.12

MHTF investments are targeted at underserved geographic areas and/or vulnerable populations and groups across the different country contexts. MHTF assists high-burden countries, which account for 78 per cent of maternal deaths and which are also affected by humanitarian crises. Within countries, UNFPA has targeted MHTF resources to complement core or other funding in underserved areas, such as in 25 hard-to-reach districts in Uganda and two remote provinces in Zambia. In Uganda, UNFPA and the Ministry of Health commissioned a study in 2018 to differentiate vulnerable groups and define subgroups within the broad category of the “hard-to-reach”. Beyond the case study countries, there are other examples, including MHTF support to health service delivery for indigenous women in two districts of Congo Brazzaville. Among the hardest to reach are those with multiple disabilities, victims of female genital mutilation, and women with fistula. UNFPA is advocating for universal health coverage in Benin to support the fees for deliveries, which are currently not covered (with the exception of caesarean sections). In Bangladesh, UNFPA supported interventions that prioritized women living in tea garden communities or rural, hilly, or climatically vulnerable areas, in the lowest wealth quintile, belonging to an ethnic minority or being disabled. UNFPA collaborated with the Zambia Library for Persons with Visual Impairment to mainstream disability in the country programme through the development of selected information, education, and communication materials in Braille and training modules for service providers.

4.6.3 Building the supply of quality MNH services for all adolescent girls and women

The MHTF midwifery, EmONC and fistula components are all geared towards improving equitable access.

The EmONC network development process in Sudan (Section 4.2) has revealed huge inequities in access to emergency care across the states. In response, the EmONC model applies a rigorous and verifiable methodology to map services based on needs and identify service delivery standards. The model is based on an equity to services approach aiming to provide all women and girls (or at least most) access to life-saving services within two hours. However, as shown in Section 4.2, the lack of community engagement, or investment in building community demand, is a considerable gap affecting the network investment model. While interventions implemented under the MHTF stimulate the supply of services to those most in need, there is little evidence that these address the demand-side barriers. This, in turn, suggests limited direct investment in promoting the empowerment of girls and women. The evaluation of the EmONC component also reveals insufficient attention to the integration of respectful care for the patient and quality of care in practical service delivery, even though UNFPA takes these elements very seriously at the institutional level.

⁶⁹ UNFPA addresses the other two highlighted human rights principles, accountability and quality of care, mainly through the MPDSR component (Section 4.3). The focus of this section is on equitable access.

The fistula component is explicitly grounded in a human rights-based approach that recognizes how women at risk lack agency for making and implementing decisions. This component also lines up with programmes to address women's empowerment as fistula is preventable where women are able to attend the right level of health care at the right time. UNFPA also increasingly addresses the vulnerabilities of women with fistula through recent efforts to support reintegration of fistula survivors and women with persistent fistula into their communities (Section 4.4). MHTF support has enabled UNFPA to build national capacity to repair fistula and strengthen rehabilitation and reintegration efforts (Bangladesh, Togo, Sudan and Zambia), all critical dimensions of improving outcomes for the most vulnerable women and girls and gradually shifting community attitudes to fistula as a preventable and treatable condition. But progress has been slow as access to fistula treatment remains dependent on donor resources in most countries. However, the ongoing shift from a vertical approach and treatment interventions for quick results (desired by donors) to a more horizontal approach that offers systematic attention to structural transformations, reinforces the link of fistula with broader programmes on gender, human rights, disabilities, quality of care and SRHR.

4.6.4 Increasing accountability to increase equity and access

The MPDSR methodology is centred on accountability and as such, has the potential to increase the visibility of preventable deaths of women and girls in many concrete ways. UNFPA investments in MPDSR processes in MHTF countries and related progress (Section 4.3) show that the MPDSR has an important role to play in supporting access and equity. Where implemented as intended, the MPDSR increases death notifications, hence ensuring that women and girls who die from pregnancy-related causes are counted. The MPDSR model also creates an opportunity for health workers to objectively review how a death occurred and what could have been done to prevent it. While many of these actions might be health facility-specific, over time, a state or national committee would be in a strong position to make recommendations to increase access to vital services for particularly vulnerable groups of women and girls (such as adolescent access to family planning or improved investments in post-abortion care). Lastly, the MPDSR approach is also designed for accountability purposes in that in principle it aims to hold health services (and health authorities) accountable to the communities they serve for the quality of care provided and this is a powerful function that can increase trust and raise demand for services.

4.6.5 Investing in midwifery as a means to strengthening gender equality and empowerment

The MHTF invests in midwifery across all its components (including pre-service education, standards of service and delivery, regulatory roles and professionalization). As identified in Section 4.1, UNFPA investments in midwifery also serve as an entry point for addressing gender inequalities and the need to strengthen gender-based rights and empowerment. For example, in supporting midwifery associations, UNFPA is aiming to aid midwives to constructively demand and negotiate an enabling work environment that empowers them as professionals in their own right.

Midwives are – or could be – the first primary health care provider for most women and girls across the life course. As a result, their attitudes towards gender issues, including who is entitled to what services and when, influences access to quality care and trust in health services. Ultimately, women's and girls' perceptions of the health services are shaped by their experiences, especially the first time, and the midwife can contribute to a lasting impression. However, midwives demonstrate gendered behaviours and attitudes from within the health service in ways that can express judgement and exclude people from fully accessing equitable care.

There are many examples of specific efforts to prioritize vulnerable women and girls in relation to midwifery investments. Bonded midwife and scholarship programmes (Uganda and Zambia) are meant to provide opportunities to marginalized girls, while supporting service delivery in underserved areas. At a global level, MHTF leadership on the development and publication of the State of the World's Midwifery (2021)⁷⁰ has contributed towards establishing midwifery leadership in challenging gender norms and the role of midwives to promote access by all women and girls to essential SRHR and MNH services without judgement. In this way, the MHTF has begun to address gendered disparities faced by midwives (as well as the gendered behaviour that midwives demonstrate) although key informants expressed some frustration that there has not been more active engagement in identifying and addressing these disparities.

70 UNFPA. (2021). State of the World's Midwifery, 2021: <https://www.unfpa.org/sowmy>.

4.6.6 Focused emphasis on gender and youth

Effective access to comprehensive quality SRHR and MNH services is closely linked to gender-based rights and entitlements, especially for adolescent girls and young women. Further, maternal mortality is the second highest cause of death for adolescent girls aged 15-19. Equally, the greatest risk of maternal and newborn death is among adolescents and young women.

In high burden countries, the rights of girls and unmarried women are constrained by social and gender norms that encourage early marriage and large families. They experience discrimination, judgmental treatment, and lack of confidentiality when attempting to access SRHR and MNH services. This is especially concerning given that the most effective way to avoid maternal death and disability for adolescent girls is to avoid unwanted pregnancy. The link between SRHR and MNH, including through both contraception and, where legal, safe abortion care is therefore critically important.

Existing research and models of good practice in SRHR reinforce the need to strengthen demand for these services among vulnerable populations, including adolescent girls and unmarried women, without neglecting the efforts to improve supply.⁷¹ To date, the MHTF has concentrated on improving the equitable supply of SRHR and MNH services, including for adolescent girls. For example, in Sudan, although UNFPA demonstrates sensitivity towards the needs of adolescents, the national policy and cultural context prevents targeting unmarried girls with specific SRHR services. Sudanese girls often marry young and have little access to confidential SRHR and other health services unless married. Prohibitions and social mores combined with early marriage and gender-based inequalities make access to the full range of SRHR services severely limited for both girls and boys. In Sudan, the rights of women and girls are “not fully granted” yet, and UNFPA must be sensitive to the context, ensuring it walks on the right side of the line between pushing rights-based services too openly and respecting national and local social norms. The MHTF in Sudan, especially through EmONC network investments, is focused on supporting an equitable supply of services, for example by ensuring every woman and girl can access an EmONC facility within two hours travel time and through expanding the role and quality of midwifery in the health system.

It is not just in the more sensitive context found in Sudan that MHTF interventions are based mainly on enabling UNFPA to improve the supply of quality SRHR and MNH services for girls and women, rather than demand creation and access. For example, UNFPA in Benin has supported interventions aimed at strengthening the quality of health services and systems, particularly those related to improving SRHR services for adolescent girls. These efforts include selected innovations (for example, the use of drone technology) that promote “last mile” supply of care. In other case study countries, adolescent SRHR and eliminating SGBV are important priorities for UNFPA, but are generally supported with non-MHTF funding (Uganda and Zambia).

UNFPA has also integrated some service delivery elements of preventing early marriage and teenage pregnancy into MHTF activities, such as capacity-building for midwives (Bangladesh, Benin and Uganda), guidelines for mentorship and supervision (Uganda and Zambia) and strengthening the adolescent service lens (Benin and Togo). More explicitly, the MHTF invests in bringing the pre-service, basic midwifery curricula into line with global standards to shape attitudes towards all clients with a better understanding of human rights and gender approaches, as well as providing non-judgemental care for all.

In summary, while the MHTF is primarily geared toward addressing supply-side rather than demand-side barriers to access (especially through the work on EmONC and fistula), its work on strengthening midwifery (especially in terms of sensitivity and confidentiality of care for adolescents) offers, over the longer-term, the possibility of extending services to more women and girls and generating more demand through improving quality and trust. Currently, the link between more adolescent-friendly midwifery services and increased demand and access to quality SRHR and MNH services is not fully visible in the MHTF programming and is not being measured.

71 See: “Engender Health: Supply–Enabling Environment–Demand (SEED) Programming Model”; accessible at: <https://staging.engenderhealth.org/files/pubs/family-planning/seed-model/SEED-8pg-English.pdf>.

4.7 CATALYTIC SUPPORT

The MHTF method of combining technical knowledge, seed funding and global partnerships to support country partners to tackle particular SRHR-MNH technical areas is a real strength. The approach allows it to provide high quality support in four critical technical areas and increases UNFPA credibility with country partners. A partner of choice, especially on midwifery, fistula and some aspects of EmONC and MPDSR, UNFPA plays a valuable coordinating and convening role, brokering commitments and accountability processes that maintain focus on SRHR-MNH integration. The MHTF invests in ways that are catalytic and have the potential to deliver significant shifts in MNH access (for example, the use of GIS/Access maps, support to midwifery professions). However, the potential behind many “catalytic” investments is still to be fully realized especially given constraints to progress created by the ongoing COVID-19 pandemic, although these should be transient. Other stand-alone innovations and digital adaptations (such as mobile phone apps) have played a role in supporting results but are not, in themselves, necessarily catalytic or sustainable. Across the MHTF, despite the aspiration of being a catalytic programme, there is currently a lack of guidance that firstly, defines what being catalytic means, then secondly, lays out the operational approach countries should take to build on catalytic effects more systematically.

For details of the evidence supporting findings in Section 4.7, see Annex 1: Assumptions 7.1, 7.2 and 7.3.

4.7.1 UNFPA as a broker to build alliances and partnerships for SRHR-MNH

With a clear mandate to lead on SRHR, UNFPA has tried to shape the MHTF in ways that link MNH to this broader agenda. Each of the MHTF four technical areas has the potential to advance and expand both MNH outcomes and SRHR. A key strength of the MHTF resides in the way it forges technical partnerships with global leaders in priority technical areas and then connects these directly to country offices and partner countries. A good example of this approach is the partnership with the ICM, which globally sets standards for midwifery education, regulation, skills and performance. By brokering the global partnership with the ICM in support of a core package of interventions (gap analysis, needs assessment, curriculum development, professional association development), the MHTF enabled its midwifery programme to facilitate a link directly between ministries of health and the world leading midwifery partner around core institution-building activities.

Similarly, although to a lesser degree, the partnership with the GIS unit at the University of Geneva enabled countries to access a standard of input and technical support that was brokered at the global level and foresees accountability for performance and results. Thus, when MHTF partner countries access these global technical partners, they are doing so in a context of a brokered arrangement that includes pre-negotiated levels of input, standards of performance and accountability. These partnerships are widely appreciated and considered “astute”, “well-chosen”, “brilliant”, “objective, technically sound, focused on quality”. Taken together, they enable the MHTF to considerably extend the value achieved from its resources and to deepen its influence and reach.

At a global level, the role that UNFPA plays around harnessing commitment to the SRHR-MNH agenda is seen as vitally important, “their primary mission in the United Nations system”, but many key informants thought the voice should be louder, more coherent, more visionary, and more compelling especially at the senior organizational level. A global partner said that they missed the voice of the MHTF in the global sphere: “It would be good to hear more reference to the MHTF and to maternal health generally – in UNFPA presentations and speeches in the global arena especially at the senior level. It seems almost marginalised and is certainly under-represented in UNFPA dialogue and communications.” Country informants are concerned that insufficient engagement of the MHTF in building commitment to the global agenda will render the work of country offices more difficult and, potentially, less effective: the MHTF has a role “in facilitating and advocating around the issue of SRHR and MNH issues and to lobby government to give priority to and allocate more resources in the area of MNH”. As for the role of the regional office in the translation of the MHTF vision and objectives to the country level, it is unclear. While most key informants value regional offices as a source of technical support, they point to the “lack of political echo [around the MNH-SRHR agenda] at the regional level”.

The convening role of the MHTF is variable at the global level and its visibility and leadership for MNH is sometimes not visible. On the positive side, MHTF is recognized as the co-convenor of the global Ending Preventable Maternal Mortality

initiative, the leading advocacy platform for assembling and coordinating global action on maternal health. UNFPA/MHTF is also co-leading, along with WHO, the operationalization of the EPMM Target 4 on coverage of the population by EmONC health facilities within two hours travel time. This was the target agreed by consensus among the global maternal health community, given its value for countries and contribution to EmONC systems strengthening. Some global partners suggest evolving the EmONC model to link more consistently with communities and take account of the first and second delay. Similarly, while UNFPA is clearly a leader on MPDSR in many countries (and a partner of choice for governments), it faces a constant challenge to advance institutionalization of the process and embed maternal death reviews and audits at all health service levels.

As discussed, the MHTF is valued for its own technical expertise and many countries pointed to this as a strength and contributor to success. The MHTF also creates a “spill over” effect beyond the 32 programme countries in many elements of its work. For example, the midwifery team in the global MHTF unit led the generation of the State of the World’s Midwifery, a landmark document that shifted the global dialogue around midwives and their role in the health system. The midwifery programme now extends to over 120 UNFPA-supported countries and the MHTF and regional teams support the strengthening in all these. By the same token, the global Campaign to End Fistula addresses fistula both at a global level and specifically in over 50 countries. In this case, the MHTF is hosting a platform that reaches well beyond its own map, fostering commitment and building knowledge around fistula beyond the MHTF. In both cases, the MHTF is supporting the extension of core technical knowledge beyond the 32 countries to a wider platform (of countries or, indeed, with global reach).

Interestingly (and not surprising given the direction of global health debates), attitudes towards the way technical expertise is delivered is evolving. Increasingly, the model based exclusively on the supply of expertise to partner countries as adjudicated by headquarters is being challenged in favour of much greater country engagement and leadership to “find ways to involve country experts in the global dialogue...and support the growth of expertise in countries”. This point emanates from the delivery of supply-side focused technical support but goes beyond it to include the methods used by UNFPA to provide inputs to countries. In this regard, UNFPA could “look around at the current global trends and start shifting away from directing knowledge and input to countries and towards a more interactive, partnership-based model of working”. There is another aspect of this evolution as well around the value of “more emphasis on co-creation” and “practical cooperation”.

4.7.2 Coordination and convening as a foundation for catalytic working

UNFPA plays a role supporting coordination in most countries. Coordination support to partner governments includes supporting meetings, preparing materials and helping to move complex agendas forward. Where the coordination role extends to convening, it includes an element of agenda shaping, attracting and aligning partners around common objectives, and building a coherent platform for support to partner governments. While there are many positive examples around UNFPA coordination activities, these appear to fall short of UNFPA deploying its full potential to strengthen rather than fragment the SRHR and MNH agendas and continuum of care and to respond to the need to “enhance” convening. UNFPA is not always seen to be maximizing the SRHR-MNH linkages and the continuum of care (notably through the way it arranges its thematic funds and programmes), although this is a valued role for UNFPA. This makes UNFPA less likely to be a credible actor in attracting long-term partnerships in support of catalytic working. The Zambia team seems alive to this challenge and, in supporting government planning, aims to build the SRHR-MNH commitment, “to more strategically support national planning processes... we need to know the unit cost for high-impact interventions. Once that appears in the strategic plan, then we can see significant progress in EmONC.”

4.7.3 MHTF boosts UNFPA production of global knowledge and goods

UNFPA has effectively utilized MHTF as a platform for leadership in MNH especially related to midwifery but across all the technical areas. This leadership role is reinforced through the development of global goods ranging from technical guidance and consultations to the publication of peer-reviewed evidence that, to varying degrees, supports countries to aim for best practice and work through common obstacles to achieve better results.

The production of relevant strategic and programmatic guidance in each of the four technical focus areas (Section 2), and more recently, for COVID-19, that the MHTF has led or participated in delivering makes for a long list, a sample of which is listed in Table 7.

TABLE 7: A selection of MHTF global knowledge products and guidance

Technical area	Product
Midwifery	<ul style="list-style-type: none"> State of the World Midwifery report, 2021 UNFPA global midwifery strategy (2018-2030) Potential impact of midwives in preventing and reducing maternal and neonatal mortality and stillbirths: a Lives Saved Tool modelling study (peer reviewed article in Lancet, 2020)
EmONC	<ul style="list-style-type: none"> Implementation manual for developing national network of maternity units – Improving emergency obstetric and newborn care (EmONC), 2020 Monitoring maternal death surveillance efforts at global and national levels: proposed notification and review coverage rates, peer reviewed paper in collaboration with the Centres for Disease Control and WHO, submitted to the British Medical Journal, 2021
MPDSR	<ul style="list-style-type: none"> Monitoring maternal death surveillance efforts at global and national levels: proposed notification and review coverage rates (article submitted for peer review, 2021)
Fistula	<ul style="list-style-type: none"> Obstetric fistula and other forms of female genital fistula – guiding principles for clinical management and programme development, 2020
COVID-19	<ul style="list-style-type: none"> COVID-19 Technical brief for maternity services, July 2020 (also see Box D)

Much of this guidance is produced in partnership with other global institutions and partners with UNFPA providing its convening power and, more importantly, ensuring the engagement of country offices and national stakeholders to provide a field perspective during consultations to frame and deliberate on the content. As such, UNFPA has contributed to the development of knowledge products and guidance that takes account of and reflects field realities, rather than a theoretical and sometimes unrealistic vision of programming that is less likely to be implemented.

4.7.4 The MHTF enables the expansion of investment into integrated SRHR-MNH

The MHTF operates with a low resource envelope and is not in a position to fund extensive investments. Few countries spent more than USD 1 million over the three years considered in this evaluation (see Section 2). Yet, in working on EmONC, skilled health personnel and other large-scale areas, the potential cost implications are enormous. While some elements are relatively cost-light (the policy-heavy, consensus building processes identified in Sections 4.1 to 4.4), their roll-out requires (and where most successful, leverages) resources from others, primarily governments. There is significant evidence that this is indeed what the MHTF is achieving. For example, in Bangladesh, UNFPA advocacy “sowed the seeds” with the Government leading to the development of midwifery as a professional cadre and the roll-out of MPDSR across the country. UNFPA provided initial resources – technical and financial – to demonstrate value. Then, the Government shifted to full-scale implementation drawing on support from additional partners as needed. In Bangladesh, midwifery expansion is an example of support that started with the MHTF and “took off like fire”. Elsewhere, a similar approach is at work:

- In Togo, UNFPA undertakes advocacy and technical support for certain interventions (EmONC, midwifery, MPDSR) drawing on funding from beyond the MHTF, including from the French Muskoka Fund and Takeda
- In Benin, UNFPA “helped find additional resources,” including from the Muskoka and the Takeda Foundation. Meanwhile Canada is preparing to finance the SGBV component of EmONC, and other funds were leveraged such that the UNFPA country office estimates that the MHTF had an impact of “ten times its initial investment”

- In Sudan, support to midwifery has led to the development of a new health cadre and diploma course which is now with the Government waiting for approval and the next stage of roll-out
- In Uganda, UNFPA mobilized resources from Sida, under the United Nations Joint Programme on Gender-Based Violence, and the European Union-Spotlight Initiative to support 18 fistula repair camps undertaken by 14 hospitals strengthening in-country expertise for surgeries and increased social reintegration support for survivors
- In Zambia, MHTF funding has gradually declined as the national midwifery strategic plans and curriculum have been put in place. Activities have “reached a sustainable level so that they do not solely depend on UNFPA support” and resources have been mobilized from other programmes (Clinton HIV and AIDS Initiative, Jhpiego) with increased funding for midwifery such that “instead of just doing in silos, we pooled resources together....”.

4.7.5 The MHTF accelerates practical, sustainable results

Catalytic actions (Section 3.3.6) are those that catalyse or stimulate multiplier effects or actions disproportionate to their funding and technical support. In other words, when catalytic, investments by the MHTF deliver a far greater return than the actual value of the investments. This return can result for a range of reasons, including the engagement of new partners, or the leveraging of additional funding that might not otherwise have been available. It can also take the form of UNFPA using its mandate, knowledge, convening power or resources to unblock a barrier that is in some way preventing progress. The ability to act in a catalytic manner is instrumental to the sustainability of the MHTF interventions while a catalytic action leads to a process or outcome that can be sustained independently of the initial investment.

Drawing on the definition above, there are many examples where the MHTF invested technical expertise and financial resources that could be considered as, or have the potential to be, catalytic (see Box C). While many of the examples seem to fit well with the criteria set out above, for some it is too early to confirm whether they have been catalytic. A good example is the EmONC network in Togo, which led to increased resources allocated by the Government to deploy additional midwives in response to the EmONC monitoring. In some settings, other partners have also financially contributed to EmONC network processes and/or national monitoring, such as in Benin and Togo. For a range of reasons (including programme slow-downs due to the COVID-19 pandemic), few countries – possibly only Togo so far – have moved fully to monitoring their EmONC network. This is the stage that requires leveraging from partners and funders, and a sustained effort to realize the effects of UNFPA initial investments in technical expertise and financial resources.

Similarly, in relation to midwifery, an excellent example around the catalytic approach emerges from Bangladesh, where UNFPA handed over to others and the midwifery programme has thrived. In Sudan, the very impressive start towards the same potential scale of results has been stalled due to the lack of government approval for the midwifery diploma (an area in which UNFPA should be comfortably engaged in pushing forward), complicated by the 2019 revolution, leadership turnover, and the COVID-19 pandemic. Therefore, at this stage the catalytic effect can be assessed as probable, but yet to materialize.

Across the programme countries, the MHTF invests in important and innovative systems strengthening efforts that are potentially catalytic. In some cases, MHTF achieves a level of catalytic effect that represents what the programme aims to stimulate everywhere. However, in many cases, the catalytic effects have not yet happened or possibly have not been documented or monitored. Two critical findings emerge on this central programmatic issue. The first is that the MHTF aims to be catalytic but has not laid out a pathway in its operating model to plan, monitor and track catalytic achievements. The Business Plan uses the language of catalysis and yet does not include guidance to countries on how to generate, sustain and track catalytic achievements in practice. In addition, the programme logic chain (as provided in the Business Plan) does not identify a clear pathway for catalytic action by the MHTF. Without a more systematic approach to monitor, track and report catalytic working and embed it into business practices, the MHTF actions and investments suffer from a lack of guidance or a purposeful design that plots the investment of MHTF resources in a particular context to spark a catalytic effect.

Box C: Examples of potentially catalytic investments by the MHTF**Bangladesh**

- Launch and expansion of midwives in Bangladesh: “UNFPA is the acknowledged leader for technical development of midwifery in Bangladesh. It has played this role most effectively, as a result of which within a short time, midwifery which was an absolutely new profession in 2016 is now established in the country and expanding fast.”
- The fistula programme started with MHTF funds but is a bigger programme now and is being implemented following a National Strategy for Fistula, which consists of fistula case identification, referral for repair, rehabilitation of patients and reintegration. This involves, beyond the Ministry of Health, the Ministry of Women and Children’s Affairs, the Local Government Ministry and the Social Welfare Ministry etc. This is an excellent example of the “catalytic” effect of MHTF.

Benin

- In Benin, the MHTF invested in fistula repair, paving the way for others to intervene. Ultimately, the MHTF handed off fistula repair to other partners willing to support this more expensive component, freeing UNFPA to use MHTF resources for other investments.

Sudan

- Programmes supported only by UNFPA which, having demonstrated value, attracted support from other United Nations partners: “It is obviously catalytic, for example, the EmONC and MPDSR are both programmes started firstly with full support from UNFPA only. With the huge progress in those programmes and increased needs for the support, other partners, including UNICEF, WHO and others, have contributed and are strongly involved.”
- UNFPA brokered the partnership with the ICM, which supported the gap analysis and needs assessment. With the Ministry of Health leadership and MHTF resources (technical and financial), Sudan has agreed to the creation of a formal cadre of midwives. This shift implies that the funding commitments from the Ministry of Finance needed to pay salaries and the organizational health service delivery changes needed to fully introduce midwives into a new and expanded role across the health system have been secured.
- UNFPA developed a series of trainings that shifted the capacity to respond to fistula needs onto resident surgeons, rather than flying surgeons in periodically. The aim was to build flexible fistula surgical capacity – a specialized skill set – and thereby put into practice a system that enables surgical teams to move to different hospitals when needed. This adaptation increases efficiency and removes the necessity for each district to have its own (scarce) surgery team. The approach has delivered value for money and created the momentum to start implementing reintegration programmes more systematically.

Togo

- Actions carried out after the UNFPA-supported EmONC mapping process resulted in targeted investments in facility strengthening and rehabilitation and skills-building of service providers, equipping facilities, and rehabilitation or even the construction of maternity hospitals to meet standards. New funding commitments are directed towards strengthening the EmONC network in the Kara region in accordance with agreed standards.

Uganda

- UNFPA supported the GIS to monitor and track midwives and their distribution in country. “We are still in the roll-out stages and have reached 30 districts. Sida has come on board to facilitate and further scale-up. MHTF is catalytic: the platform was created, and then we used it to mobilize funds from other donors.” MHTF used to fund a dedicated UNFPA staff to support the midwifery department of the Ministry of Health in the past; now, UNFPA supports capacity development of the Ministry of Health staff working in the department.

- MHTF funding and advocacy for the compilation of the annual MPDSR report has been catalytic in that it attracted the interest and support of the Ministry of Health and other donors and partners, including Sida, which then funded UNFPA to operationalize the MPDSR at the district level.

Zambia

- UNFPA is perceived to be a champion of MPDSR playing a catalytic function tackling the issue of strengthening subnational coordination committees in lieu of strong coordination mechanisms at the national level as, “these are not so strong at the subnational level. MHTF has been supporting MPDSR to ensure that the committees should be as strong as the national level.” In Zambia, it is well appreciated that to understand problems and inform interventions, “there is a need to strengthen coordination mechanisms at lower levels too”.

4.7.6 The MHTF encourages innovation

Equity in access, quality of care and accountability are closely intertwined. The MHTF aims to stimulate innovative measures and catalytic interventions so that high-burden countries accelerate action to improve MNH quality. UNFPA has shown “an openness to new ways of working, i.e., digital solutions and interventions”. The use of GIS mapping both for the EmONC network and for other purposes (tracking the professional careers of midwives in Zambia) constitutes a good example of the practical integration of digital technology. In this case, the technology enables mapping to be more efficiently, objectively and systematically achieved, with better results (as opposed to simply transferring a manual task to a digital format).

The replication of GIS mapping processes and national capacity-building across multiple MHTF partner countries is underway (where welcomed by the relevant ministries of health). Another promising innovative way of working consists of using drones to support improved emergency blood supplies to remote areas in Uganda; this is currently interrupted by the COVID-19 pandemic but could be replicated in other similar settings. In Zambia, the Safe Delivery app was developed by the Maternity Foundation as a free communication and technical resource application for use by midwives and other skilled health personnel. It provides direct access to evidence-based and up-to-date clinical guidelines for BEmONC services. E-learning modules (where technology allowed their deployment) to support skills-building in obstetric emergencies are much valued in Bangladesh. The modules were developed with UNFPA support and are being rolled out to midwifery colleges more widely.

However, in defining whether and how these innovations are actually catalytic, it is necessary to assess the extent to which they are genuinely enabling widespread engagement and scale-up across a range of settings and partnerships, as opposed to just getting additional results (even if these are solid and valuable in themselves). Innovation in and of itself, is not necessarily catalytic. Nor is the sequential delivery of that (best practice) innovation where it is the same partner moving methodically from one district to the next to roll out the intervention in support of scaling up. For example, there is a range of digital apps in development or use that have had limited catalytic impact so far or for which the evidence of being “catalytic” is not yet visible. In addition to being sustainable and prompting a multiplier effect, innovations and best practices need to be assessed for their potential and actual impact, and their costs including for maintenance, repair and replacement in due course (for example, drones to support improved or emergency blood supplies to remote areas). Assessing best practices is a critical component of promoting innovations as catalytic in order to ensure that they are sustained, valued and supported by a wide range of stakeholders.

4.8 GOVERNANCE AND MANAGEMENT

MHTF leadership is perceived to be improving and the recently established Advisory Board is well received among the MHTF funding partners who see it as a forum for constructive dialogue around strategic direction, building SRHR-MNH integration across the life course, and in support of communication of MHTF results. Partners report a lack of clarity on the part of UNFPA as to the intended role and position of the MHTF in advancing the overall agenda on maternal health, for example, beyond the four technical areas, and its link to the transformational goal on ending preventable maternal mortality. Allocation of MHTF resources to countries is affected by late decision-making and, until recently, delayed disbursements, as well as by a bureaucratic, overly onerous reporting system. Resource allocation to countries is based on an algorithm, but the total number of countries targeted by MHTF (32)

is considered too high by some. Results data collected from countries focus on outputs and build a cumulative picture of MHTF activities, but are less effective at helping identify MHTF contribution to country-specific progress. The consequence is a diminishing nuance in communications about the MHTF and a difficulty in fully capturing the value of results achieved from strategic partnerships. The lack of community-facing links or investments into building demand for services is a visible gap, as are more systematic interlinkages between the MHTF support to MNH investments and larger health systems strengthening and reforms.

For details of the evidence supporting findings in Section 4.8, see Annex 1: Assumptions 8.1 and 8.2.

4.8.1 The MHTF governance and setting strategic direction

MHTF leadership has been visibly strengthened in the last year: “It was evident when new leadership arrived in UNFPA both at the MHTF and the branch level.” The timing of this positive trend is almost certainly related to the appointment of a global coordinator. This revitalized leadership role has reinforced the strategic direction of the programme, creating a stronger sense of renewed collaboration within the MHTF team. In addition, donors and other technical partners report improved engagement and improved constructive links with other organizational units of UNFPA.

The initiation of the high-level MHTF Advisory Board in 2020 has been welcomed by funding partners. Although the Board has not yet met frequently, several partners expressed appreciation at its involvement in consultations and high-level decision-making around the MHTF. Partners see the value of the Board in supporting alignment, communication and coordination.

However, the role of the MHTF in supporting MNH at the level of the UNFPA transformational goal on ending preventable maternal deaths has not been effectively communicated and perceptions of the link remain unclear. Within UNFPA, the MHTF has not been assigned a sufficiently high level of visibility and its role in supporting the achievement of the transformational goal is not explicit. Thus, while the MHTF constitutes a conduit for funds in four clearly delineated technical areas, its role in relation to the larger UNFPA maternal health agenda or to the UNFPA organizational strategic plan is opaque.

A leading element of the UNFPA mandate and role is to build the narrative and evidence around SRHR-MNH across the whole life course. Not all donors are willing to support the full SRHR and MNH integrated agenda and therefore tag their support to specific technical areas only (for example, to fistula). For others, it is precisely the full range and integration of SRHR and MNH that attracts them to the MHTF, noting that it “is really the only partnership that does that”. This poses a challenge for the MHTF (as with UNFPA more widely): The MHTF raises funds from donors who might otherwise not contribute funds, but there are other contributors who would like to see much more proactive integration. For the latter, UNFPA is not doing enough to build links and coherence between the SRHR and MNH agendas, especially at the global level. For bilateral partners wishing to invest in a fully integrated approach to SRHR and MNH, there is indeed a perception that UNFPA does not speak out clearly and strongly enough at the global level. For these partners and the other stakeholder, the MHTF, the programme countries and technical partners have a key role to play in developing a more comprehensive approach that “weaves the maternal health story from family planning, midwifery, EmONC, fistula, MPDSR, and from increasing access to quality services using a logical thread of progression”.

4.8.2 Delivering, monitoring and presenting results

The MHTF offers more than just financial resources to countries, with technical resources comprising a significant part of the programme. The work supported by the MHTF varies from country to country yet, in an effort to compile an estimate of cumulative impact across 32 countries, the MHTF workplan requires country offices to oversimplify results (count outputs or use binary reporting) and thus take a “lowest denominator” approach to measurement. MHTF results tracked through global performance monitoring include process and outputs. There is a presumption that completed activities will deliver anticipated results (for example, midwives participating in a training programme on respectful care will return to the workplace and deliver more respectful care), however this is not monitored or reported. In addition, the very real benefits the MHTF brings to countries through the work delivered in partnership with technical bodies like the University of Geneva, the ICM, and others, which help boost UNFPA credibility and quality, go almost uncaptured in the current results focus.

As is clear from the country case studies, the delivery of results requires more than the production of outputs.⁷² There are choices to be made about investments and timing, partnerships, implementation strategies and policy and political skills to build country-level commitments. Reporting on activities does not inform the extent of progress towards outcomes. What does it mean to have “trained” 28,800 midwives? What is the effect of this cohort of trained midwives on the quality of services and increase of access and demand for services? Finally, monitoring (and reporting on) activities rather than actual results prevents the MHTF from fully deploying its catalytic effect, which heavily rests on the MHTF ability to show “what works” and why (Section 4.7).

4.8.3 Gaps in the MHTF approach

MHTF strategic and operational management has resulted in a programming approach that focuses on some but not all the necessary components to effectively address its mandate. For example, as already identified (for example, in Section 4.2 and 4.3), the MHTF lacks “a community component” that extends to supporting demand creation for essential SRHR-MNH services, overcoming barriers to the first delay, expanding uptake of SRHR services (including family planning services), or the introduction of a community-level notification and surveillance system for maternal and perinatal deaths. The absence of a community-facing approach and the systematic engagement or consideration of the community, not to mention the role of demand-creation in the catalytic programme model, is a notable gap in all MHTF countries.

Furthermore, the context in which the MHTF inputs are being delivered is insufficiently considered at the overall programme level. In particular, the necessary link, at the country level, to the larger health system constraints or reforms (like universal health coverage) is not well established. For example, in Sudan, a weak health system and supply chain, limited human resources, rapid turnover, and poor retention all contribute to and result from weak community demand for services and the absence of a patient-centred culture. In Uganda, on the other hand, the need for strengthening the accountability and feedback systems for SRHR-MNH at the community and national levels was clear. In Benin, it is evident that trained midwives were operating in under-resourced health facilities, yet there is a lack of clarity on how the MHTF investments connect to a larger, health systems strengthening agenda.

In addition, the MHTF investments are not fully interrelated with UNFPA practical support to advance universal health coverage in partner countries. In fact, there are examples of disconnects at the country office level on this point. In Sudan, the new COVID-19 recovery investment plan makes no reference to the EmONC network or the MHTF-supported/Ministry of Health-approved proposal to target infrastructure renewal investments to selected EmONC facilities. This is certainly largely due to stalled validation of the EmONC proposals, which has been further delayed by the various effects of COVID-19, revolution and a high Ministry of Health leadership turnover. However, it is also relevant that in this regard, the orientation that country offices receive from the MHTF regarding these systems issues (if any) is not evidenced.

Another common theme that emerges is a general lack of economic analysis and public expenditure management skills to enable the UNFPA country offices to develop return-on-investment calculations in support of advocacy for budget allocation decisions in a universal health coverage context. Similarly, the links with post-abortion care, female genital mutilation, SGBV and other challenging areas are not sufficiently explicit and clearly laid out up-front to ensure coherence between the MHTF with other funds delivered by UNFPA and indeed, in building coherence with other partners. These links are necessary to ensure equity and access, and to meaningfully take forward the principle of leaving no one behind.

⁷² This is an example of what was reported by the MHTF in 2019:

- 80 per cent of the 32 MHTF-supported countries have integrated respectful maternity care, safe abortion care (to the full extent of the law), cervical cancer, fistula and HIV prevention as part of the pre-service curriculum and in-service training
- 28,800 midwives were educated and trained
- 400 midwifery schools received training equipment, simulation models and books, and 2,700 midwifery tutors benefited from upgrades in teaching and clinical skills
- 12 out of 32 countries featured EmONC facilities with 100 per cent met need for midwifery staffing
- In several MHTF-supported countries, 50 per cent of the population are now able to reach EmONC facilities within two hours of travel time.

4.8.4 The MHTF resource allocation and use

As a small programme fund, the MHTF makes critical choices about what to invest in and where to work. With limited funds and 32 target countries, there are arguments to support the view that the MHTF is thinly spread with small financial allocations to countries while headquarters and regional-based expertise has to stretch to all countries. The presumption is that more money would enable a country office to do substantially more.

However, no country office relies only on the MHTF funding to support all its efforts in the four technical areas. Most country offices co-mingle MHTF resources with core funding and many raise additional funds in-country from bilateral donors and foundation partners. In fact, despite a small resource envelope, the MHTF provides great access to partnerships with leading global experts in certain technical areas (midwifery and ICM, EmONC and the University of Geneva GIS/Access unit), which introduces the possibility of creating entry points for country offices. Furthermore, and perhaps most critically, as a catalytic fund, the financing component of the MHTF is not its main offer. What is more relevant is the combination of resources and support it offers to open up priority areas of engagement, service delivery and quality, which it then hands off to others to scale up at a certain critical time, supporting this process by leveraging funds from other partners. The MHTF is thus more than the resources it offers to countries and resources should not be the determinant of its added value.

Of course, the number of countries introduces other pressures, including the support needed from headquarters and global partnerships, both of which are core elements of the MHTF “offer”. Some of this pressure may be alleviated by UNFPA regional expertise. However, while there is evidence of regional support in some settings, overall, what emerges is a lack of clarity about the role of the regional office in the MHTF and in fact, its limited function. Partly this seems to be due to a lack of clarity around the specific roles of the regional office in the MHTF programme model.

Another source of confusion and a potential contribution to weaker value for money in the use of the MHTF funds is insufficient guidance to countries around whether they are required to take forward actions in all four technical areas. This requirement – which may not in fact be a requirement but was understood as such by many country offices – led some countries to engage in technical areas they might not have otherwise elected to pursue. Combined with restrictions on how funds can be used (for example, some country offices were sure that MHTF funds cannot be channelled towards country office staffing needs), a country office could receive support from the MHTF, but not necessarily have the skills in the country office to take maximum advantage of the support.

Generally, there is a prevailing sense of the interrelatedness among the four technical areas and their potential to reinforce each other. To some extent, the four areas are integrated on the ground (although this varies by country). Yet, there is considerable evidence of siloed working, especially between EmONC and midwifery in several settings, or advocacy that is sometimes conducted separately around the four technical areas. Siloed working is largely due to the separation among headquarters expert teams addressing different technical areas, each of which has its “offer” and its own focus (Sections 4.1 to 4.4). To some extent, the role of individuals in countries and their ability to make the linkages and see the relationships mitigates this effect, but there is little concrete guidance to countries on blending the four technical areas into a harmonized maternal health programme.

Finally, taken together, the four areas are “relevant” “important” and “compelling”. However, while they are likely to be of value for every country, it has to be asked whether they necessarily respond to the main barriers to MNH outcomes in each and every MHTF country. Although country offices identified MHTF technical issues of greatest relevance to them, there was no evidence that countries were required to start with a structured, guided MNH analysis to identify needs and priorities and then assess how the MHTF could help to address these.

4.8.5 Administration and management of MHTF resource flows to countries

Country offices received disbursements quite late, creating pressure to spend later in the year and sometimes in a rush. While this has recently changed through the introduction of a multi-year work plan and the automatic disbursement of funds at the beginning of the year, previously, funds were sometimes not received until the second month and even the following quarter. Furthermore, the reallocation of funds mid-year sometimes led to a reduction of agreed budgets during the implementation period. This occurs periodically and unexpectedly and subsequently leads to reprogramming late in the year. In addition, the approval of the following year’s budget envelop can come late in the year, creating challenges with planning and commitment for implementing partners.

These challenges are often due to the late disbursement of funds by donors. Taken together, these problems can add up to inefficiencies that are detrimental to the programme effectiveness. The situation reflects a lack of steady funding flows based on multi-year funding agreements (starting with donors to UNFPA but with knock-on effects for implementing partners and country offices). At the headquarters level, some exploration of alternative options has started, for example, bridging mechanisms to enable smooth budget management.

Finally, the frequency and detailed level of reporting required of implementing partners by UNFPA seems out of balance and disproportionate, given the small funding grants to technical partners (especially where there is a special arrangement in place regarding a lower indirect charge levied by the partner). From a donor's perspective, on the other hand, some "struggle to justify" their continued financial support to the MHTF in a context where they provide core funds to UNFPA, reflecting a lack of understanding of the catalytic role of the MHTF within the broader support provided by UNFPA and its partners. Continued donor support references the valuable role MHTF plays with its specific focus on SRHR and MNH integration especially linking family planning, maternal health, SGBV and other women's health issues across the SRHR-MNH continuum (including cancer of the cervix prevention and post-rape care).

4.9 THE RESPONSE TO THE COVID-19 PANDEMIC

UNFPA responded quickly and flexibly to the COVID-19 pandemic through programmatic efforts and reallocation of available resources. The objective was to ensure continuity of essential services while protecting the safety of clients and providers. UNFPA articulated a response in support of partner countries referencing key lessons learned from the West Africa Ebola outbreak, during which routine services were seriously disrupted causing high levels of preventable mortality especially for women and children. The UNFPA/MHTF response included the development and dissemination of technical guidelines and protocols to ensure the safety of providers. The response also included provision of personal protective equipment (PPE) and other support such as transport vouchers for health personnel to get to work safely, as well as hospital triage support to ensure safe access to essential services including delivery and post-natal care. The UNFPA/MHTF partnership with the Takeda Pharmaceutical Company boosted these efforts in West Africa and resulted in the maintenance of MNH service provision at 2019 levels. Other MHTF activities were affected, which contributed to the observed increase in teenage pregnancy, SGBV and poor maternal outcomes. UNFPA flexibility and support during the crisis enhanced the reputation of the organization as a valued partner.

For details of the evidence supporting findings in section 4.9, see Annex 1: Assumptions 9.1 and 9.2

4.9.1 UNFPA increased awareness of the impact of COVID-19 on integrated SRHR and MNH outcomes

The pandemic has affected weak health systems in the MHTF programme countries, especially those that were already struggling to provide equitable access to SRHR and MNH services. The lockdowns and fear of infection have affected health-seeking behaviours and access to health facilities and created bottlenecks for essential supplies, including from blood banks. This has exacerbated the delays in seeking and receiving quality care and impacted women's health, both directly and indirectly. Disruptions were observed in EmONC services, fistula repairs and social reintegration interventions, MPDSR processes and training, supervision, and mentorship of midwives. They also led to an increase in teenage pregnancy and SGBV and to a reduced access to services, especially for vulnerable populations. To increase awareness of the challenges posed by COVID-19, UNFPA has produced several publications, conducted a series of webinars, and launched a new joint global research study with ICM on the impact of COVID-19 on midwives.

4.9.2 UNFPA contributed to rapid development of technical guidance and preparedness response plans

In anticipation of and in response to the pandemic, at the global level, UNFPA moved rapidly in collaboration with other United Nations agencies to address the need for technical guidance by programme countries regarding the emerging COVID-19 pandemic in early 2020 (Box D).

Box D: UNFPA technical guidance notes on COVID-19

- COVID-19 technical brief for maternity services
- Technical brief on the implications of COVID-19 on census operations
- Sexual and reproductive health and rights, maternal and newborn health and COVID-19
- Gender equality and addressing GBV and coronavirus disease (COVID-19) prevention, protection and response
- Sexual and reproductive health and rights: Modern contraceptives and other medical supply needs, including for COVID-19 prevention, protection and response
- Adolescents and young people and coronavirus disease (COVID-19)
- COVID-19: A gender lens

UNFPA also ramped up its support to health ministries to develop guidance on managing health services during the pandemic and, more specifically, guidance on how to manage SRHR and MNH services while protecting the safety and lives of both providers and clients. The guidance included policies, service protocols and updated training materials incorporating guidance on case management, isolation, infection prevention control and how to triage and safely treat COVID-19 patients, including women in labour (Sudan, Togo, Uganda and Zambia). In Bangladesh, UNFPA supported the development of COVID-19 preparedness plans in accordance with WHO global COVID-19 guidelines for establishing mechanisms for early detection, quarantine and treatment of infected persons, along with strengthened surveillance capacity nationwide.

With MHTF resources, UNFPA stepped up the development of remote training opportunities, through its partnerships with the Liverpool School of Tropical Medicine (updated midwifery e-modules) and the Maternity Foundation (translated modules of the Safe Delivery app) (Section 4.1).

4.9.3 Rapid and flexible response to support essential services

UNFPA was quick off the mark in terms of its COVID-19 response. Stakeholders credit the UNFPA response to lessons learned from the West Africa Ebola epidemic for its focus on channelling and reallocating investments towards protecting access to SRHR and MNH services. MHTF investments were mainly reallocated away from activities that require in-person participation and domestic or international travel, such as information dissemination management events, symposiums, etc.

These investments took many different forms depending on the country and its context. For example, the MHTF headquarters and regional team in West Africa partnered with the Takeda Pharmaceutical Company to provide support, via the MHTF, to respond to COVID-19 in three countries – Benin, Guinea and Togo – in collaboration with health ministries. Through this partnership, PPE was widely distributed to EmONC facilities and funding was provided to deploy midwives, strengthen transportation for referrals and conduct training on infection prevention and control. In Benin, the innovative use of drones helped to distribute life-saving commodities and blood supplies. Preliminary results of a tracking study in these countries indicated that MNH services were maintained, and even increased compared to the same period in 2019.

UNFPA support has been varied and activities to support essential services included: integration of COVID-19 education into an ongoing MHTF behaviour change communication programme for youth (Sudan); the provision of infection prevention training and PPE materials (Benin, Sudan, Togo and Uganda); support for transport, such as fuel cards (Zambia) and ambulances (Sudan); online platforms to disseminate COVID-19 standard operating procedures (Uganda); and the redirection of midwifery mentors to serve as frontline workers (Bangladesh).

4.9.4 UNFPA partnership reputation enhanced through the rapid and flexible response

The speedy and flexible UNFPA response to assist its partners to cope with the pandemic is highly appreciated by stakeholders. The provision of material as well as the “psychological” support during a time of high anxiety and uncertainty was lauded by key informants in all the countries studied, as was the clear commitment by UNFPA to maintain its focus on the health of women and girls during the pandemic.

Some opportunities have also arisen out of the pandemic. In Sudan, targeting resources for infection prevention and control, triage and PPE to facilities created opportunities to reinforce the role of EmONC facilities as referral services and for supporting community engagement and networking. The focus on provision of infection prevention and control training and PPE gave traction to provider interest in and commitment to infection prevention and control protocols, something that had not taken hold through past trainings (Benin, Uganda and Zambia). The pandemic also accelerated the use of online platforms for networking and training, which may have future implications for cost-efficient and inclusive convening and education, although this was more effective for urban than rural residents because of internet connectivity.



© UNFPA Zambia.

A young mother in urban Lusaka, Zambia benefiting from ongoing maternal and newborn health services supported by UNFPA and partners.

5

CONCLUSIONS

The MHTF aims to influence and strengthen health systems in order to stimulate equitable access to integrated, quality SRHR-MNH services across a wide spectrum of countries, each with different priorities and at different stages of health system development. The MHTF has made tangible contributions through its four technical areas (midwifery, EmONC, MPDSR and fistula) to country health systems and has been instrumental in enabling UNFPA to become a leading partner in midwifery, carving out a critical niche that is largely unsupported by other partners, certainly at the level of the H6 Partnership. The MHTF delivers value for money to its funders and for programme countries, creating a host of entry points for all four technical areas and across the UNFPA modes of engagement, particularly advocacy, partnership and capacity-building, and opens specific opportunities for health systems strengthening and the integration of services. It is a programme that delivers considerable heft with a limited package of resources. However, the MHTF faces a number of challenges that have started to constrain its impact or will do so in the future. It thus needs to adapt to a changing environment in order to maintain and increase its relevance and impact.

The objectives of this evaluation included an assessment of the MHTF investment in four aspects of health systems strengthening (workforce, service delivery, health information systems, and leadership and governance) and the MHTF contribution to improving quality of care, expanding access, improving gender equity and delivering higher accountability. In its Business Plan and logic chain (Section 2), the MHTF shows how it proposes to contribute to the UNFPA transformative results by investing in the four technical areas in ways that strengthen country health systems to promote the delivery of comprehensive, quality MNH and SRHR services. The MHTF interaction with individual health systems components is captured as an assessment of MHTF strengths and challenges (Table 8) and highlights a common thread that runs through a set of eight specific conclusions (Section 5.1-5.8): the MHTF is not always fully rooted in larger country health systems reforms or in a broader UNFPA organizational approach to maternal health. As a critical thematic fund that addresses one of three leading UNFPA priorities, the MHTF is doing valued and valuable work that often hits the mark and has visibly improved the prospects for MNH in many of its partner countries. However, it sometimes lacks holistic organizational framing and would benefit from a more comprehensive approach to broader health systems reforms.

TABLE 8: The MHTF strengths and challenges across the health system

Issues	Strengths and challenges
Health systems strengthening overall	<p>Strengths: The MHTF tackles aspects of health systems supply-side constraints including rational distribution of adequate facilities and the promotion of the midwife as the skilled health worker of choice. MHTF modalities enable country offices to link investments to larger processes (for example, universal health coverage) and address complex issues often under-supported by other partners.</p> <p>Challenges: It is left to UNFPA country offices to make links between MHTF inputs and larger health systems reforms like those associated with universal health coverage or primary health care. They are not supported with sufficient formal guidance on pursuing these linkages. Health systems investments are often not comprehensive or holistic and often, even where progress on one aspect is visible (midwifery capacity, for example), gaps in other elements diminish the value of achievements (for example, support to midwifery without attention to commodities, equipment and supplies in the same setting leaves staff feeling frustrated and unable to work as effectively as their capacity might allow).</p> <p>There seems to be limited joint work across UNFPA investments through other funds. Life-saving maternal health commodities provided to countries by the UNFPA Supplies Programme, for example, are untracked, unaccounted for and unconnected to the MHTF efforts (particularly EmONC and midwifery).</p>
Workforce	<p>Strengths: MHTF investments in the health workforce at the systems level have been largely based on global standards and best practices. In particular, pre-service training, support to professionalization and the regulatory environment enable midwives to carve out a defined role in MNH and SRHR with significant, visible contributions to midwifery.</p> <p>Challenges: Discussion around the larger public expenditure environment seems absent from UNFPA engagements with partner governments, yet salary scales and the total public budget envelope for public sector salaries have a direct bearing on MHTF investments. UNFPA appears to support a great deal of training, especially in-service training, but without any systematic measurement of the results of training at the outcome level or in terms of value for money.</p>
Service delivery	<p>Strength: The MHTF is well oriented towards service delivery planning and has excelled at supporting consensus building processes aimed at defining standards of care at different service delivery levels. The EmONC network identification process also maps the distribution of basic and comprehensive service delivery centres in ways that aim to strengthen access within a limited travel time, thus supporting this aspect of equity. The process creates a pathway to defining and potentially improving quality of care.</p> <p>Challenges: The emphasis on supply over demand for services and the absence of community-facing efforts especially through the EmONC and to a lesser extent, the MPDSR (fully discussed in Section 5.5), constrains effectiveness and sustainability. In addition, the combination of inputs needed to deliver services are not equally considered. The emphasis on workforce can create a wider gap in relation to the availability of equipment, facilities, commodities and supplies. As noted above, medicines are unrelated to the larger MHTF investments in service delivery, which creates an artificial and unhelpful division.</p>
Health information systems	<p>Strengths: Data and information system strengthening and use is targeted through the national EmONC monitoring process and, to some extent, through the MPDSR with specific strengthening of HMIS/DHIS 2 in some countries. Some promising results on strengthening HMISs in countries is evident and needs further scale-up.</p> <p>Challenges: Overall, the MHTF has not yet found traction on HMISs in a systematic way at scale. The gap created by insufficient investments in data collection, management and use, despite significant needs, suggests that MHTF influence on HMISs has not been its main priority or focus. Given its resource constraints as well as the engagement of many other partners in HMIS strengthening, this is not surprising.</p>

Issues	Strengths and challenges
Leadership and governance	<p>Strengths: The EmONC network methodology and the midwifery reform processes create high profile leadership opportunities. The MHTF enabled national health authorities to assert their leadership, to take important and sometimes far-reaching decisions, and to articulate and approve actions that move difficult reforms forward. The MPDSR processes are potentially deeply enriching for health system governance where they translate into meaningful reforms and sustained change.</p> <hr/> <p>Challenges: The MHTF does not define tracking indicators to methodically assess leadership and governance inputs or to measure the MHTF influence over time. Information is largely anecdotal and based on individual examples making it difficult to systematically identify lessons and best practices to strengthen leadership and governance of health systems and services.</p>
Higher accountability	<p>Strengths: Accountability is a critical cross-cutting dimension of the MHTF. It is most evident through the MPDSR process, which is founded on the explicit presumption that death audits shine a light on preventable deaths of marginalized women and girls and allow health authorities to take steps – and be seen to be taking steps – to ensure that the same failures do not happen again. The MHTF promotes accountability as a core component of governance. At a programme level, accountability is linked to increased visibility of improved services that deliver better health outcomes to the most disadvantaged women and girls.</p> <hr/> <p>Challenges: Institutionalization of the MPDSR has been minimal in most countries and, throughout Phase III, it has continued to be necessary for the MHTF to fund national and subnational committees to ensure their functioning. The lack of government funding and, in some countries, the insufficient legislative framework and protections needed to safeguard individuals act to inhibit progress as well. MPDSR processes reach their full potential as accountability mechanisms only if they include affected communities.</p>

5.1 With the MHTF, UNFPA is a partner of choice providing visible and valued support to critical MNH priorities

UNFPA is a credible partner, valued for its responsiveness and strategic investments and for its knowledge products and technical guidance. The MHTF delivers support to programmes that are perceived to be of high quality and that address gaps in country health systems. UNFPA demonstrates leadership and coordination support to country governments that is visible, valued and appreciated, making the organization a partner of choice. This is particularly so in relation to midwifery and fistula and, sometimes, MPDSR. The MHTF-supported EmONC network approach methodology leads to significant coordination processes and high-level system strengthening plans among a wide group of stakeholders, sometimes for the first time, making it a powerful strategic planning process. UNFPA sustains its investments over a prolonged period (for example, ten or more years in MPDSR in Sudan and Zambia) and this is valued as a sign of long-term institution-building and organizational partnership and commitment. UNFPA is clearly identified with adolescent SRHR services, especially where this is a neglected or contested area. Among the continuum of women's health services, UNFPA is increasingly seen as the partner of choice for "orphan issues", such as cervical cancer screening and post-abortion care, which are also increasing in priority in many countries. At a global level, MHTF staff participate in, and/or lead, the development of a range of knowledge products whose impact extends beyond the 32 MHTF partner countries. The MHTF demonstrates high value for money in relation to knowledge-building and technical material production with its impact extending beyond the programme itself.

5.2 Midwifery is the anchor of MNH and the cornerstone of the UNFPA MNH response

Midwifery is the anchor of MNH, and indeed, SRHR more broadly and women's health across the life course. UNFPA is now identified as the leading partner for midwifery, which appears to be a result of the sound work supported by the MHTF in this area across many countries (bearing in mind that the midwifery work is broader than the MHTF). Major steps forward on the definition of midwifery practice (for example, standards of care, capacity and skills, and performance monitoring) have been complemented by country-focused efforts to upgrade the education, training and deployment of midwives as well as initiatives to support their professionalization. The midwife is a key service delivery link to overcoming each of the three delays and for saving lives at birth, both through the application of core skills and through timely referral. The role of the midwives in delivering the full range of SRHR and MNH services across the whole of the life course is now well established,

crystallized further through the publication (under UNFPA leadership) of the global SoWMy report. Thus, through its focus on midwifery, UNFPA has achieved a strong and unique position to accelerate gains in access to a continuum of SRHR–MNH services and in quality of care. In addition, by positioning the midwife at the centre of SRHR, the health system has also found a critical pathway to integration.

However, the MHTF has not fully captured, nor does it systematically measure and track, the pernicious effects of gender inequalities and power dynamics in country health systems that create pressures on midwives personally and that affect their motivation and behaviour. Disconnected from their formal training, the position of midwives as women within hierarchical health systems affects their experience in the workplace and their ability to control the quality of their performance. A knock-on effect of this gender dynamic is the role of the midwife in creating an environment that prioritizes respect for the patient, given that this also requires respect for the midwife and nurse – particularly midwives and nurses who are women – across the health system. The MHTF inputs lay foundations for professional development of the midwife in strategic ways, yet management support, professional retention interventions and improved working conditions (including fair policies and supportive supervision) are not well understood nor sufficiently addressed by the programme.

5.3 The MHTF delivers value for money, both globally and for individual countries

The MHTF model delivers value across a significant range of technical areas and by using a defined approach that centres on quality technical expertise with relatively small funding grants. The model is based on the combination of seed funding and links to established global partnerships plus periodic support from headquarter-based technical expertise in each of the four technical priority areas. The approach enables countries to access guidance and support to upgrade relevant national approaches to meet global standards without having to negotiate the partnerships individually. This model also enables the MHTF package of support to target a relatively narrow range of interventions linked to normative standards and global guidance around programming best practices. Brokerage by MHTF headquarters staff helps prioritize country demand and mediate between countries and global partners as well as provide direct implementation guidance to countries.

UNFPA country offices take forward the relationships and the programmes, in turn brokering these with partner governments and building coherence in relation to broader health system investments. Hence, through extending partnerships, deepening this coherence, and strengthening the quality of programme implementation, the MHTF “offer” creates entry points for a range of diverse interventions. This rests on a set of skills and a vision that is strong on systems strengthening, coordination, convening, advocacy and partnership-building. It also relies on the country offices’ ability to supplement MHTF resources with core funds and to raise additional resources through engaging partners locally.

5.4 The MHTF is not clearly positioned within a holistic UNFPA MNH strategic framework

By offering four specific technical areas, the MHTF has carved out defined areas of expertise, and is generally delivering these well. However, at a global and organizational level, the MHTF is not aligned with or anchored in a UNFPA maternal health strategy, as there currently is no such formalized strategy. As it is the main programming vehicle associated with UNFPA investments into maternal health, this leaves a policy and strategy gap between the MHTF as a programme delivering specific inputs and the UNFPA MNH strategy at the global and organizational level. This, in turn, poses the question of the MHTF role in relation to the UNFPA transformative result of ending preventable maternal deaths. The MHTF is not the only UNFPA investment into MNH (another important programme is the Supplies Partnership), which makes it difficult to clearly identify the locus of UNFPA policy, strategy, and programming effort in relation to the transformative result.

At the country level, the four MHTF technical areas, while all pressing issues for MNH at the aggregate level, are the only technical areas on offer from the MHTF. Although they may respond to genuine needs, they are not necessarily responding to countries’ own priorities. In this case, the question is about whether the MHTF is agile and, if so, how agile, and whether it can position its interventions within a holistic SRHR–MNH strategy that is context specific to the programme countries themselves. While the MHTF is designed within a more general UNFPA mandate in relation to the broader landscape, there is, at times, a lack of alignment between its offer and country priorities. The challenge for the MHTF is to maintain its technical focus and well-defined offer of expertise and support, while remaining flexible to assist countries in addressing their priority needs in MNH.

5.5 If not addressed, critical gaps will limit the relevance and the sustainability of the MHTF investments

The MHTF interventions are heavily based on service delivery investments while the voice of communities and community engagement in developing solutions to local service delivery issues tends to be absent. There are some exceptions, as with the relatively recent expansion of fistula efforts to include rehabilitation and reintegration. But even here, the focus is on supply of (community-based) services: fistula will be prevented where women attend health facilities in good time. The absence of community engagement is visible in the EmONC network model, which is facility-based in nature. While this element is important, many births happen at home and arrivals to the health facility are often already at an emergency stage. Therefore, investing only in the supply of high-quality maternity services is necessary but not sufficient to ensure sustainable results. Similarly, where midwives expect to address the full continuum of SRHR-MNH care, community engagement and demand creation is central to their credibility and ability to reach women and girls with the right services.

MHTF interventions follow diverse pathways to influence quality and respectful care of the patient. However, these are mainly implied rather than laid out in a monitoring that is largely focused on outputs and process. The investments in quality of care focus on identifying standards and performance measures (for example, for midwifery skills or EmONC facilities). Yet, if the midwife is the pivotal determinant of a woman's birth experience, it is the quality of that birth experience that needs to be measured and tracked, and this includes more than the availability of supplies and commodities. While it is relevant that the EmONC process establishes a standard list of equipment that health facilities need in order to deliver an adequate standard of care, it is also important to measure whether and how the equipment is used in practice. The MHTF process anticipates this level of monitoring although for the reasons clearly identified (Section 4.2.2) they have not achieved widespread results at this level yet. Likewise, the midwife needs skills and to have functioning equipment at hand, but she/he also needs kindness and empathy in her/his delivery of care. While each of the four technical areas of the MHTF aims to influence and strengthen quality of care improvements, the indicators and associated metrics that enable quality of care measurement and tracking (especially including the experience of women who have been through the care of the health services - demand-side quality) are insufficient and underutilized.

5.6 The MHTF has not yet been fully designed to deliver its "catalytic effect" systemically

The MHTF is a programme with genuine potential to prompt a transformation or multiplier effect. In many cases it already has, although some of these are not sufficiently documented. The realization of this catalytic potential depends on the ability of the MHTF to anticipate and prepare for the challenging shift from a relatively low-cost, intense technical process focused on developing a national policy or strategy (on one of the four MHTF technical areas, for example the establishment and roll-out of a new midwifery cadre or the identification of a network of EmONC facilities) to a much larger, longer-term, higher-spend, national scale-up of that policy.

It is only when the MHTF investments lead to a formalized, sustainably scaled up or rolled out policy that the catalytic effect of the MHTF has materialized. However, the shift from strategic policy making to the adoption and scale-up of public policies requires an astute analysis of the evolving landscape, anticipation of potential influencers and prospective funders, and a comprehensive risk assessment. At the programmatic level, UNFPA has not systematically documented and tracked catalytic investments. This is partly because there is neither a programme definition around what constitutes catalytic working and how to do it, nor an acknowledged strategy regarding the necessary requirements of the catalytic role of the MHTF at the early stages of programming. The guidance and monitoring framework for measuring the results of the MHTF interventions using a catalytic lens is not apparent in the MHTF Business Plan and logic chain.

As a result, there are a considerable number of examples where the MHTF has moved programmes to a position where they have or could spark a catalytic effect if the engineering were in place, but which have not been systematically pushed forward or have stalled due to a variety of impediments, some of which may have been foreseeable (although not, for example, COVID-19). In that sense, the catalytic results realized are a result of context and circumstances, the fortuitous convergence of multiple factors upon which UNFPA has been able to capitalize. The absence of a strategy clearly positioned within the engineering of the programme itself and accompanied by a tried and tested toolbox to support the elevation of programme inputs in ways that generate the "catalytic effect" currently reduces the MHTF catalytic achievements.

5.7 The MHTF targets gender equality, human rights and equity especially among adolescents, but does so unevenly

The MHTF has identified three rights-based principles upon which its strategy is based: accountability, quality of care and equity in access. It does not explicitly refer to other human rights principles or standards that would apply to MNH, such as acceptability, availability or non-discrimination. Furthermore, the MHTF lacks a framework for defining and operationalizing rights-based principles in MHTF programming, which leads to their uneven application in country-based activities, such as for quality of care. Although the MHTF aims to target vulnerable women and girls through the application of the “leave no one behind” principle, it does not have a defined or explicit approach or process for identifying those most at risk or the most vulnerable. While the MHTF delivers high quality technical inputs to service delivery systems, realizing the rights of women and girls requires going beyond the health system and engaging at the community level around social, cultural and economic determinants of health. UNFPA has contributed to meeting the needs of vulnerable women and girls through its work at the policy level by bringing evidence and perspectives about the social determinants of poor maternal outcomes (such as early marriage and adolescent pregnancy) to strategic deliberations. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have also resulted in expanding service delivery to underserved geographic areas and vulnerable populations. However, because of limitations in the integration of SRHR and MNH, MHTF activities are not as effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services, especially contraception, post-abortion care, and where legal, safe abortion services.

5.8 Given its results and successes, the MHTF has considerable unrealized potential

The MHTF is a programme with a modest profile, whose priorities and objectives are not always well known or understood outside of UNFPA (and at times even within it). Furthermore, its results are difficult to communicate, as investments take time to crystallize, systems strengthening is complex, and progress may seem slow. This is further compounded by the reliance on a monitoring system that tracks the implementation of interventions and aggregates these up to the programme level across countries. A process-focused and overly detailed results framework seems to work against the capacity of the MHTF to gain visibility, in both UNFPA and in the global arena, partly because it is difficult to draw conclusions from the reporting of the overall impact of the MHTF on MNH in the countries where it is working. Indeed, the results that are tracked need to be carefully contextualized and nuanced in relation to events and progress in individual countries. Without this it is difficult to use the results gathered and, ultimately, this may prevent the MHTF from being valued in relation to its contribution to maternal and newborn health, which this evaluation demonstrates is significant and multifaceted.

This is especially so recently, as the MHTF has helped to ensure the continuity of SRHR and MNH services and the protection of health workers and clients throughout the COVID-19 pandemic. The MHTF image deficit, compounded by monitoring that lacks sufficient qualitative and contextual analysis, may also impede the mobilization of more funding and the pursuit of long-term engagement from partners. It so happens that the current level of donor commitments and access to resources by the MHTF leads to late disbursements that, in turn, affect the pace of implementation and the ability of the MHTF to develop medium-term plans and strategic partnerships with governments and other global health actors.

6

RECOMMENDATIONS

RECOMMENDATION 1: As the key UNFPA vehicle for SRHR-MNH integration and support, continue the MHTF and expand it into a new phase

Take all necessary steps to design and obtain approval and funding for the next phase of the MHTF (Phase IV) taking into account the strategic and operational recommendations identified in this evaluation. Phase IV of the MHTF should be based on an expanded theory of change that identifies the role and positioning of the MHTF in relation to other UNFPA investments in MNH and the larger, global landscape of maternal mortality reduction.

Type: Strategic recommendation

Priority: High

Rationale: This evaluation has highlighted the significant contribution that the MHTF is making, both in absolute terms and as the leading UNFPA programme responding to MNH. The evaluation identifies several ways the MHTF can be strengthened and/or reoriented to tackle emerging global and country priorities. The programme format enables UNFPA to focus on specific priorities, hone its expertise, efficiently complement the work of partners, and deepen its catalytic approach, filling key gaps in MNH. The focused MHTF programme model, based on specific key technical areas and aimed at achieving catalytic effects, is likely to achieve greater value for money and sustainable results for MNH than distributing these resources as marginal income to country offices. This is due to the deployment of strategic, targeted approaches and partnerships, the focus on limited, high-impact interventions, and the sustained long-term investment on institutional commitment and leadership under the MHTF approach.

Based on conclusions: All conclusions contribute to shaping this recommendation.

Directed to: Technical Division (Sexual and Reproductive Health Branch and Commodity Security Branch), Policy and Strategy Division, regional offices, the MHTF Advisory Board

Operational implications:

- Set the ambition of Phase IV and the expected gap it will fill. Identify why the UNFPA contribution to filling this gap is best wrapped into a global programme approach rather than through routine country budgets
- Develop Phase IV goals, objectives, strategies, targeted partnerships and investments, and expected outcomes (elaborate the new programme) working in collaboration with the Advisory Board and regional and country offices to strengthen buy-in, fundraising and stakeholder engagement
- Develop a revised theory of change to guide Phase IV and ensure it identifies the role and positioning of the MHTF in relation to other UNFPA investments in MNH and the larger landscape of maternal mortality reduction.

RECOMMENDATION 2: Position the MHTF within a comprehensive UNFPA maternal health strategy and action plan

Drawing on the MHTF experience, in anticipation of Phase IV, and in light of the 2022-2025 UNFPA strategic plan, develop a UNFPA organizational-level maternal health strategy and action plan that clearly positions the MHTF and other UNFPA MNH efforts including roles and responsibilities.

Type: Strategic recommendation

Priority: High

Rationale: Ending preventable maternal deaths is one of the three UNFPA transformative results that, together, form the scaffolding of the 2022-2025 UNFPA strategic plan. Both within and beyond UNFPA, the MHTF has come to be seen as the main expression of UNFPA work in the field of MNH. However, its tight focus on four specific technical areas (a positive feature from a programming point of view) risks marginalizing actions not funded by the MHTF yet aimed at supporting MNH both in countries and at a global level. It is unclear whether UNFPA fully engages the MHTF team in efforts to influence the global dialogue on maternal health. There is some ambiguity as to whether the MHTF is intended to serve as a limited, catalytic fund, channelling a specific set of technical and financial resources to defined elements of MNH, or is expected to encompass the entire UNFPA MNH programme. This lack of clarity risks undercutting the achievement of the transformative result since, in the absence of an overall organizational maternal health strategy, the MHTF is not situated within a coherent set of interventions and associated rationale, including but not limited to, the MHTF.

Based on conclusions: 5.4

Directed to: Technical Division (Sexual and Reproductive Health Branch and Commodity Security Branch), Policy and Strategy Division, regional offices

Operational implications:

- Develop a comprehensive cross-organizational maternal health strategy and action plan that is clearly situated in relation to the 2022-2025 UNFPA organizational strategic plan and its transformative result of ending preventable maternal deaths
- Identify the MHTF contribution at the organizational level to this maternal health strategy (including roles and responsibilities) as well as contributions from the Supplies Partnership (maternal health commodities) and other thematic funds (ending child marriage, female genital mutilation, and the HIV response), humanitarian resource funds and core funds
- Clarify the role of the MHTF within UNFPA in relation to the maternal health strategy and action plan and in support of the UNFPA transformative result
- Refine and update the MHTF logic chain in the next phase of the programme to reflect its contribution to the organizational maternal health strategy and action plan and its role as co-convenor of the global Ending Preventable Maternal Mortality initiative.

RECOMMENDATION 3: Champion quality of care at the point of delivery, including respectful care

Invest through the MHTF to build global leadership on scaling up quality care for SRHR-MNH services at the point of implementation and to champion respectful care.

Type: Strategic recommendation

Priority: High

Rationale: The MHTF engagement in actively promoting, tracking and measuring quality of care as experienced by women and girls themselves (rather than through the supply of services, where it has considerable experience) needs to be strengthened. Currently the MHTF approach to strengthening respect for the patient and for respectful care (a growing conceptual priority in MNH) is still at an early stage and could be more formally described and approached. In many partner countries, concern about poor quality of care and the lack of respectful care contributes to deterring or delaying the decision to seek care during pregnancy and delivery, often with negative health consequences. UNFPA is mandated and well positioned to build expertise on delivering quality of care systematically across SRHR-MNH integrated services (including expanding quality and safety of surgical care, given its importance in preventing iatrogenic fistula). Through the MHTF, UNFPA has an opportunity to contribute to global best practices on the experience of care and respectful care as the critical link between the supply of quality health services and the demand for quality care, including through communities of practice.

Based on conclusions: 5.3, 5.4, 5.5 (also: Table 8 on the MHTF strengths and challenges across the health system)

Directed to: Technical Division (Sexual and Reproductive Health Branch), regional offices, country offices

Operational implications:

- In the UNFPA maternal health strategy and action plan (Recommendation 2), identify how UNFPA and the MHTF will contribute to developing and scaling up knowledge and practice related to systematically delivering high quality, respectful SRHR-MNH care
- Articulate programmatic investments to promote quality of care across the MHTF and to position respectful care at the centre of all MHTF technical areas at the strategic level
- Develop and integrate an actionable programme model into the MHTF to promote respectful care in practice, especially through EmONC and midwifery (for example, through the implementation of a midwife-led model of care)
- In the MHTF results-oriented monitoring system (Recommendation 9), include key performance indicators on community engagement, demand-side quality of care and measures that track the experience of respectful care (embedding these in EmONC, midwifery, fistula and MPDSR components more systematically).

RECOMMENDATION 4: Be more systematic about integrating community engagement across all MHTF activities

Shape the MHTF to promote a more structured approach to community engagement as part of a broader strategy to generate increased demand for timely and accessible MNH services. This reorientation should focus on increasing the timeliness and efficacy of decisions to seek care, to elect to deliver in a health facility, and to participate in death audits/reviews; all linked to improved quality of care.

Type: Strategic recommendation

Priority: High/Medium

Rationale: The “three delays” is a long-standing framing that identifies the typical periods of risk for maternal health outcomes: (i) delay in taking the decision to seek care; (ii) delay in getting to the right level of care, including decision by the midwife to refer; and (iii) delay in getting the right care at the referral level. The MHTF should increase its focus on the first delay. Community norms, financial barriers, and family decision-making play a vital role regarding whether, when and where to seek maternal care during both pregnancy and delivery. The contribution of the MHTF is circumscribed as a result of its supply-side focus, limiting the critical role of community engagement and demand-generation around, for example, decisions to seek care, to deliver in a health facility or to participate in respectfully managed death audits and reviews. Each of the MHTF technical areas has community-facing dimensions that should be systematically incorporated in ways that strengthen demand and response (in other words, accelerate the role of community demand on raising supply-side quality, delivery and accountability). While perceived poor quality of care is one factor in community delay, there are many others, including individual and community knowledge, beliefs, financial barriers, experience, decision-making processes and expectations.

Based on conclusion: 5.5

Directed to: Technical Division (Sexual and Reproductive Health Branch), regional offices, country offices

Operational implications:

- Through the UNFPA maternal health strategy and action plan (Recommendation 1) anticipate how to integrate community-facing work across all MHTF dimensions and technical areas to include both supply- and demand-side considerations
- Ensure that the orientation of the MHTF technical interventions takes better account of the first delay and systematically incorporates community demand and engagement to the greatest extent possible. In particular:
 1. Broaden the EmONC network approach to include community health and household engagement in decisions to seek care and an increase the interface with community-based health workers where relevant
 2. Orient midwifery to include community engagement and demand-creation for all SRHR–MNH services especially in support of antenatal care, family planning and fistula prevention
 3. Where possible, include communities into MPDSR processes
 4. Invest in knowledge-building around strengthening community demand for care and health service responsiveness.

RECOMMENDATION 5: Engage partners, especially donors, more actively in the MHTF progress

Invest in the role and functioning of the Advisory Board to strengthen accountability to funding partners, to increase participation in shaping strategic direction and to support improved communication of results and performance.

Type: Governance recommendation

Priority: Medium

Rationale: The Advisory Board is welcomed by funding partners as a means to better understand the work of the MHTF. The Board is an ideal forum to engage funders, technical partners and potential country representation in a more structured approach to shaping the strategic direction of the MHTF and building a greater sense of shared oversight. The Board is well positioned to help communicate MHTF programmes and results to both current (and potential) funding partners. This more proactive engagement of partners through the Advisory Board can strengthen accountability to global stakeholders through improved communication around the purpose, functioning and results of the MHTF. In addition, it could also help ensure the MHTF is continually challenged to respond to evolving global priorities and counteract the current trend in declining funding.

Based on conclusion: 5.8

Directed to: Technical Division (Sexual and Reproductive Health Branch), Resource Mobilization Branch

Operational implications:

- Develop a revised terms of reference for the Advisory Board, which includes its contribution to shaping the MHTF strategic direction, accountability to its members, and results monitoring roles
- Establish an annual calendar of meetings (including the ad hoc participation of specific strategic, technical, or implementing partners)
- Develop a comprehensive communications strategy (building on existing strategies) around the role of the MHTF in relation to the UNFPA transformative result on ending preventable maternal deaths, its approach and results achieved in programme countries. As part of the strategy, tools or products should be designed so that messaging can be tailored to reach a wide and diverse audience, including key stakeholders (funding partners, other strategic and technical partners, country governments, implementing partners and beneficiaries).

RECOMMENDATION 6: Improve the strategic coherence and responsiveness of the MHTF

Clarify and streamline the linkages among the four technical areas and strengthen their coherence while also enabling more responsiveness to evolving MNH priorities and specific country needs.

Type: Operational recommendation

Priority: High

Rationale: A key strength of the MHTF is its programme model, which offers countries access to strategic global partnerships, expertise from headquarters and financial resources to seed-fund investments. However, the four technical areas are insufficiently integrated with each other and are not all equally well supported at the country level. Although relevant, in many countries, the four technical areas do not reflect country priorities. Furthermore, the current model is restrictive and the perceived pressure to work on all four areas is increasingly onerous for some countries, while excluding key dimensions of maternal health. Countries should have more latitude to draw on support they most value in relation to country priorities and other partner commitments whether that is in one or all four technical areas. Adopting a more flexible approach by opening a door to addressing additional technical challenges that the MHTF is uniquely positioned to support through its funding model would increase MHTF responsiveness to countries (for example, building post-rape care in the context of SRHR-MNH integration, where the MHTF might match a country office allocation of core funds, up to a ceiling amount, over two or three years and broker key partnerships with global technical leaders to support country implementation). Concentrating on a limited number of additional technical areas will open space for the MHTF to evolve over time (for example, around building expertise and partnerships on quality care at the point of delivery and respectful care, including safe surgery care) while preserving the added value of its current model.

Based on conclusions: 5.2, 5.5, 5.8

Directed to: Technical Division (Sexual and Reproductive Health Branch), regional offices, country offices

Operational implications:

- Clarify the MHTF working arrangements so that linkages and inter-relationships among the four technical areas are clearer, and their tendency to operate as siloed areas of support is reduced
- Consider developing an option to enable the MHTF to be more responsive to country priorities. This approach should enable countries to select their technical priority areas among the four MHTF technical areas and to access the MHTF support for further technical areas where relevant
- Develop an application-based approach to allocate a portion of the MHTF funds with a country office matching arrangement, together with the MHTF brokered partnerships and technical expertise
- Consider implementing this approach in the following ways: (a) setting aside a portion of funds to be allocated to a limited number of countries each year through an application process; the process could be based on multi-year grants matched by core funds and/or other country-leveraged funding, or (b) selecting (based on consultation with country offices) a limited number of additional technical areas to focus on for a three to five-year period and accepting applications from countries wishing to work in these areas.

RECOMMENDATION 7: Embed the focus on midwifery and the health workforce environment across the MHTF

Further develop MHTF engagement in and leadership on midwifery and the health workforce environment as a key entry point for MNH. To this end focus on embedding midwifery into community and primary care and into investments in health systems reforms, including the EmONC network expansion.

Type: Operational recommendation

Priority: High

Rationale: Midwifery is a key entry point and the “gateway” to women’s health across their life course especially around SRHR-MNH integrated care. While midwives are enthusiastic when engaged in gaining new skills, this is tempered by disappointment as they are often unable to effectively use them. Midwives are often stymied by hierarchies (frequently gendered in nature), an unsupportive or even disabling work environment, or a weak health system, with insufficient equipment or infrastructure, and a lack of support from other midwives. This shows how training, in and of itself, is insufficient to strengthen the role of midwives in the health system. The complex task of ensuring midwives can meaningfully shape quality of care and respectful care (Recommendation 3, Section 6.3) requires a comprehensive and continuous strategy embedded in health systems strengthening and reform, including primary health care/universal health coverage and close collaboration among all partners, notably the H6 and other technical partners. This includes empowering midwives to deliver better quality care to women and girls in impartial and non-judgmental ways.

Based on conclusions: 5.2, 5.5, 5.7

Directed to: Technical Division (Sexual and Reproductive Health Branch and Commodity Security Branch), country offices

Operational implications:

- “Mainstream” midwifery across all other technical elements of the MHTF, identifying especially how midwifery support contributes to quality of care, respectful care and community engagement and demand
- Reposition midwifery through analysing and planning more far-reaching interventions to support midwifery in action. For example, consider whether and how to integrate the opportunity triangle analysis model to deepen midwifery inputs and programming more systematically at the global and country levels. The opportunity triangle helps to separate out capacity (the skills element) from the incentives affecting decision-making and the motivation needed to apply knowledge consistently, taking account of critical environmental enabling factors, gender dynamics and systems context. Together, these elements reflect the need/requirement for health workers to do the right thing, at the right time, in the right way against a backdrop of a specific health system and gender and rights environment. The MHTF could usefully apply this approach to ensure it is investing in ways that sharpen the impact of midwives in practice, taking the MHTF foundation work on midwifery regulation, education and professionalization to the next level.

RECOMMENDATION 8: Invest more in MHTF core added values: SRHR-MNH integration and promoting catalytic results

Develop and promote detailed and actionable guidance for country offices around the core strategies underpinning the MHTF: (i) integration of SRHR-MNH services; and (ii) guidance on planning, achieving and documenting catalytic effects.

Type: Operational recommendation

Priority: High

Rationale: While the MHTF theory of change emphasizes SRHR-MNH integration and includes wording on the programme's catalytic effects, better articulation of these two core elements could amplify results and strengthen momentum in countries. The focus on SRHR-MNH integration does not include adequate guidance on processes and measures to ensure effective integration. It also lacks specificity and guidance on how the MHTF is intended to advance gender equality, for example, by addressing gendered barriers to professionalizing midwifery. Linked to that, midwives need ongoing and sustained support to offer the full package of care to every woman and girl they encounter, rather than making individual decisions around access to care. This is particularly important in relation to girls, to unmarried women and to disabled girls and women, but it affects everyone. The current MHTF theory of change is silent on operational guidance to thoroughly and more methodically ensure the programme can achieve its ambition to systematically spark catalytic action. The Business Plan does not identify the steps necessary to work in a catalytic way, including the long-term vision, the required partnerships, evolving governance, tools and guidance, documenting and reporting processes and results or investing in the institutional and budgetary reforms needed for sustained results.

Based on conclusion: 5.6

Directed to: Technical Division (Sexual and Reproductive Health Branch and Commodity Security Branch)

Operational implications:

- Develop, regularly update, and share widely with country and regional offices, comprehensive guidance and tools on designing, implementing, measuring, documenting and communicating catalytic interventions under the MHTF programme
- Develop, regularly update, and share widely with country and regional offices, guidance on strengthening integration, including approaches to removing gender barriers to integration
- In the MHTF results-oriented monitoring system (Recommendation 9), include indicators to track progress on integration and the catalytic effect of interventions across all technical areas
- Establish communities of practice to more methodically share lessons learned among country offices to strengthen their investment at an early stage, and to identify potential processes as well as partners.

RECOMMENDATION 9: Refine results monitoring to improve understanding and communication about the MHTF added value in different contexts

Adapt the results-oriented monitoring system to track fewer, more immediately relevant results that can support a clear narrative about the MHTF contribution and added value in varied settings as well as its progress and achievements in relation to integrated SRHR-MNH services. The results-oriented monitoring should have a greater focus on perceptions of change among stakeholders. It should supplement the formal indicator framework with reporting through more use of qualitative information on the contribution to, and progress toward, outcomes. This would support increased understanding about what is working, where and where.

Type: Operational recommendation

Priority: High-Medium

Rationale: The current information collected by the MHTF does not easily support the identification of a nuanced picture of the MHTF results and outcomes in different settings or the added value the MHTF is bringing to different contexts and situations. This risks undervaluing the strengths of the programme and its importance as a United Nations hosted programme. Overall, the MHTF achieves more complex and potentially far-reaching results than its current performance-monitoring framework suggests. It is difficult to use the current framework to identify what can be strengthened and improved or what may be worth replicating. Results are based on a multiplicity of activities and outputs – especially those that can be counted or for which there is a binary result (yes/no). Anecdotal narratives – which can be very helpful – do not usually reference the wider country maternal health landscape, health systems reforms, the work of other partners and partnerships, or government leadership. In the absence of information on results, and progress towards the desired outcomes, it is impossible for the MHTF to fully deploy its catalytic effect.

Based on conclusions: 5.8, 5.4, 5.7

Directed to: Technical Division (Sexual and Reproductive Health Branch), regional offices, country offices

Operational implications:

- Refresh the MHTF theory of change and logic chain in line with previous recommendations
- Adapt the results framework and performance management approach to focus on fewer, more relevant results at output level but more meaningful results at immediate and intermediate outcome levels; develop key performance indicators tracked by all MHTF partner countries that help capture the added value of the MHTF and UNFPA more broadly to MNH and integrated SRHR-MNH
- Present the MHTF results-oriented monitoring system to partner countries (country offices) to enable them to see how and whether they contribute toward the achievement of MHTF outcomes and to capture information on the degree of success achieved through interventions adopted
- Regularly transmit and discuss results with the Advisory Board as well as through the current “MHTF Wins!” rubric to strengthen buy-in and accountability for results.

RECOMMENDATION 10: Invest in innovative funding approaches to attract an expanded donor base

Develop a comprehensive funding model and financing plan to support the next phase of the MHTF that addresses declining commitments, counteracts the negative effects of onerous financial management processes, and enables the MHTF to strategically expand its scope and depth in its next phase.

Type: Operational recommendation

Priority: High

Rationale: The MHTF adds value as a focused instrument for strengthening elements of MNH systems at the country level. The programme has an important comparative advantage as a channel for member states to engage in challenging work to end preventable maternal deaths. This is constrained by the lack of clarity around the role of the MHTF in UNFPA organizational strategy: it is not clear how to achieve this transformative result and the situation is further compounded by insufficient results monitoring and reporting. These limitations negatively impact the ability of the MHTF to demonstrate accountability and mobilize resources. Estimated country-funding needs for MNH are elaborated with assistance from key partners, such as the Global Financing Facility. In addition, there is considerable ongoing work across the United Nations system to develop and support an integrated financing facility at the country level with a strong emphasis on the combination of national budgets and external funding as critical to re-energizing progress toward the Sustainable Development Goals in the recovery from COVID-19. These efforts place considerable emphasis on stable funding for health services and social protection. Opportunities to engage with this process to ensure that MNH investments (including national budgets and the MHTF) are not overlooked represent an avenue for addressing funding issues.

Based on conclusion: 5.8

Directed to: Technical Division (Sexual and Reproductive Health Branch and Commodity Security Branch), regional offices, country offices and Resource Mobilization Branch

Operational implications:

- Elaborate a funding strategy to attract multi-year commitments from existing donors and broaden the donor base to attract new partners
- Build continuity in funding flows by creating a bridging mechanism that will enable funding to be disbursed continuously in support of multi-year contracts, limiting fallow periods and supporting sustained action
- Undertake a fundraising campaign linked to quality of care and women's health across the life course in the context of an organizational maternal health strategy and action plan
- Establish mechanisms that enable the MHTF to strategically and carefully widen its programme model, including through the use of an application-based match funding model for a portion of available funds aimed at leveraging additional resources from country offices and country-based partners, including bilateral donors (also see Recommendation 6).



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