MATERNAL AND NEWBORN HEALTH THEMATIC FUND (MHTF)

BUSINESS PLAN Phase IV (2024-2028)

13 March 2024

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Acronyms

ANC	Ante Natal Care
CAC	Comprehensive abortion care
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CHS	Community Health System
CHW	Community Health Workers
EmONC	Emergency Obstetric and Newborn Care
ENAP-EMPP	Every Newborn Action Plan & Ending Preventable Maternal Mortality initiative
ENC	Essential Newborn Care
GBV	Gender Based Violence
GF	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GIS	Geographic Information System
HMIS	Health Management Information System
HRP	Human Reproduction Programme (of UNDP, UNFPA, UNICEF, WHO, World Bank)
HSC	Heat Stable Carbetocin
HSS	Health Systems Strengthening
ICM	International Confederation of Midwives
LMICs	Low and Middle Income Countries
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Package for SRH in Crises
MNH	Maternal and Newborn Health
MNHW	Maternal, Newborn Health and Wellbeing
MMR	Maternal Mortality Ratio
MPDSR	Maternal and Perinatal Death Surveillance and Response
PAC	Post abortion care
PHC	Primary Health Care

PMNCH	Partnership for Maternal, Newborn & Child Health
PNC	Postnatal Care
PPH	Postpartum Haemorrhage
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TXA	Tranexamic Acid
UHC	Universal Health Coverage

1. Introduction

UNFPA's vision for maternal and newborn health and wellbeing is **a world where no woman or girl or baby dies of a preventable cause during pregnancy or childbirth** and where the woman and her newborn's physical, mental, emotional, and social well-being is promoted and protected. Bolstered by a new sense of urgency from the stagnation in reduction of maternal and newborn mortality and stillbirths and from the major disruptions and regressions caused by the COVID-19 pandemic, UNFPA is determined to reinvigorate its support to countries in achieving the SDG global targets on maternal and newborn health and stillbirths, while contributing to the result of ending unmet need for family planning and ending gender-based violence and all harmful practices.

The Maternal and Newborn Health Thematic Fund (MHTF) is **UNFPA's flagship programme** for improving maternal and newborn health and wellbeing in close collaboration with partner countries and technical partners. It is now entering its fourth phase, from 2024 to 2028, after having completed phase I (2008-2013), phase II (2014-2017) and phase III (2018-2022), with 2023 acting as a bridging year. It is set up to provide catalytic support in countries burdened with a high maternal mortality ratio and/or high number of maternal deaths. It provides strategic direction and guidance, technical assistance and capacity-building for the development, implementation and monitoring of MNH interventions aligned with country-owned and driven processes.

Since its launch in 2008, the MHTF has proven its catalytic impact. A mid-term evaluation of its phase III conducted as an independent assessment in 2022[1] concluded that UNFPA is a **unique partner of choice providing** visible and **valued support to critical MNH priorities**. The evaluation showed that the MHTF provides evidence based support and tools for supporting MNH in programme countries, especially in its priority areas of midwifery, emergency obstetric and newborn care (EmONC), Maternal and Perinatal Death Surveillance and Response (MPDSR), obstetric fistula prevention and response as part of an integrated package of SRHR services. Midwifery is the anchor of the MHTF and is the cornerstone of the UNFPA's MNH response. The MHTF delivers tangible results, high-quality programmes and addresses gaps in health systems, and value for money, both globally and for individual countries. As the key UNFPA vehicle for SRHR-MNH integration and support, the evaluation's first recommendation was that UNFPA should continue the MHTF and expand it into a new phase.

The MHTF phase IV serves as the main vehicle for delivering UNFPA's new Maternal and Newborn Health and Wellbeing (MNHW) Strategy 2024-2030, developed following a recommendation from the MHTF Evaluation. The MNHW Strategy addresses the core drivers of mortality and morbidity. The Strategy is structured around 8 interconnected areas of intervention which aim to enable the legal, financial and policy environment for maternal and

[1] https://www.unfpa.org/mid-term-evaluation-maternal-and-newborn-health-thematic-fund-phase-iii-2018-2022

newborn health, improve access to quality MNH services in the context of strengthened, more resilient and integrated health systems, increase the bodily autonomy of women and adolescent girls, and promote equitable gender norms. It is also a key building block towards the achievement of the transformative result of ending preventable maternal deaths by 2030 in UNFPA's Strategic Plan 2022-2025.

MNHW Strategy Pillars	Specific MHTF focus
I. Enabled legal, financial and policy environment for maternal and newborn health as part of a comprehensive package of SRHR services throughout the life course	Result1: Support on policy, norms, and financing for universal access to MNH services as part of a comprehensive package of SRHR services
II. Improved access to quality maternal and newborn health services in the context of strengthened, more resilient and integrated health systems	Result 2: Improve the availability and quality of MNH care in the context of comprehensive SRHR
III. Empowered women and girls in inclusive, healthy and active communities	Result 3: Empower women and girls, their partners/ families and **communities** to take charge of their own health and hold governments accountable for quality healthcare.

The MHTF Phase IV aims to contribute to more aligned global health initiatives under the **SDG 3 Global Action Plan (SDG3 GAP)**[2], which UNFPA is a signatory of. It further ensure alignment of UN support to countries under the **Ending Preventable Maternal Mortality (EPMM) and the Every Newborn Action Plan (ENAP)** country acceleration roadmaps 25 countries are both MHTF focused countries and have developed an ENAP-EPMM country acceleration plan. It also intends to align and contribute to the new global **Roadmap to combat postpartum haemorrhage** between 2023 and 2030.

It will host/implement two global initiatives co-led by UNFPA:

[2] The Global Action Plan for Healthy Lives and Well-being for All, launched in 2019, brings together 13 multilateral health, development and humanitarian agencies and aims to help countries accelerate progress on the health-related SDGs targets. UNFPA co-leads with WHO the SDG3 GAP Working Group on data and digital health, a technical collaboration on strengthening CRVS# and GIS# systems, and contributes to the Working Group on PHC.

- ★ The **Global Midwifery Acceleration Roadmap**[3]

- ★ The **Global Campaign to end Fistula**[4]

The MHTF Phase IV primarily focuses on Africa, the continent currently bearing the highest burden of maternal mortality and morbidity and aligns with the New Public Health Order in Africa called by the African Union and aims to help African countries to achieve the strong maternal health commitments included in the Agenda 2063 ("the Africa we want"), the Maputo Protocol and Plan of Action 2016-2030[5], the Africa Health Strategy 2016-2030, and CARMMA[6]. The MHTF will also seek to align and contribute to other critical regional commitments as outlined in the MNHW strategy.

The present business plan takes into account the recommendations from the 2022 evaluation, which notably advised to champion quality of care at the point of delivery including respectful care, be more systematic about integrating community engagement across all MHTF activities, engage partners, especially donors and supported countries, more actively in the MHTF progress, embed the focus on midwifery and the health workforce environment across the MHTF, and invest more in MHTF core added values -SRHR-MNH integration and promoting catalytic results. In response, phase IV adopts **a more holistic approach, expanding its community and policy work, while keeping the health systems elements that have been core** to supporting catalytic MNH during the previous phases.

The non-core resources of the MHTF will continue to complement UNFPA's core[7], other non-core[8] and humanitarian resources. The burden of maternal mortality, stillbirths, and newborn deaths (ratios and number of deaths), but also countries' size, political commitment and progress in setting and sustaining quality MNH/SRHR services, will guide UNFPA's prioritisation of countries, differentiation of support (type and thematic), and determination of allocation size (see section 5.3).

[3] The Global Midwifery Acceleration Roadmap ais to catalyze collective commitment among global, regional and national partners to improve maternal and newborn health and wellbeing through a shared vision of universal continuity of midwife care; Align key stakeholders at the country, regional and global levels in support of shared goals, objectives and commitments to advance midwifery models of care and midwife-led continuity of care; and Increase domestic and international funding and more efficient use of funds and financing for midwifery. It is co-led by UNFPA, WHO, ICM and Jhpiego.
[4] https://endfistula.org/
[5] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and Maputo Plan of Action to implement the AU Continental Policy Framework on SRHR
[6] CARMMA: Campaign on Accelerated Reduction of Maternal Mortality in Africa
[7] Maternal mortality ratio is one of the criteria guiding UNFPA's prioritisation of core resources.
[8] Notably the resources of the Supplies Partnership

2. Tackling maternal and newborn mortality and morbidity

2.1 The world is off track to achieve the SDG targets on maternal and newborn mortality

Despite progress over the last two decades, women and newborns continue to die at unacceptable rates from causes related to pregnancy and childbirth. New estimates[9] show that the maternal mortality reduction has stagnated since 2016, and in some regions the trend is on the increase. In 2020, an estimated 287,000 women globally died from a maternal cause, equivalent to almost 800 women dying every day and approximately one every 2 minutes. These global trends obscure large inequalities between regions of the world and countries within those regions. In Sub-Saharan Africa, previous successes in reducing maternal mortality have stagnated in the first five years of the SDG era (2016-2020): in 2020 it was the only region with a very high maternal mortality ratio (MMR), estimated at 545 per 100 000 live births and accounting for approximately 70% of maternal deaths globally. The direct causes of the deaths of pregnant women are well known, and nearly all preventable: Postpartum haemorrhage (PPH), obstructed labour, infections/sepsis, hypertensive disorders of pregnancy, unsafe abortion are preventable and complications are treatable if there is access to quality of care. Adolescent girls are particularly vulnerable. Complications related to pregnancy and childbirth are a leading cause of death globally among adolescent girls 15-19 years old. Women also pay a heavy toll of maternal morbidities. For every woman who dies during pregnancy and childbirth, an expected 20-30 experience acute or chronic morbidities. The latest estimates regarding stillbirths and newborn mortality are similarly worrying: there are an estimated 1.9 million stillbirths and 2.3 million newborn deaths each year.

Late presentation at health facilities, financial barriers, long distances, and weak referral mechanisms are factors constraining the timely access to essential services. While access remains a major barrier, the provision of these basic services at appropriate quality remains deficient: weak health systems fail to respond to women's needs. The global health workforce crisis affects the insufficient human resources for maternal and newborn health. There is a scarcity of skilled health personnel. Estimates for midwives alone show there are at least 900,000 less than needed. The insufficient access to quality assured life-saving commodities is also a major challenge. Supply chains are insufficiently supported and life saving drugs are unavailable. Overall, African countries are currently underutilizing quality-assured medicines for the prevention and treatment of PPH at primary and community levels. These gaps in quality of care, commodities, workforce, are reflected in the deficient access to and availability of basic health services. While political commitment to UHC is strong, concrete progress has been limited, and half of the world's population still lacks access to essential health services.

[9] https://www.unfpa.org/sites/default/files/pub-pdf/Trends%20in%20Maternal%20Mortality%202000-2020.pdf

Maternal and newborn health remains largely underfunded. The structural underfinancing of health systems in low income countries remains a major challenge.

Structural and indirect factors also contribute to poor maternal and newborn health outcomes. Nearly half of all pregnancies are unintended, more than 60% of unintended pregnancies end in abortion, and an estimated 45% of all abortions are unsafe, making them a leading cause of maternal death. An estimated 218 million women who want to avoid pregnancy are not using modern contraception methods. Inequality is growing within many countries and impacting MNH within and between countries. Specific groups of people, such as ethnic, racial or religious minorities, often face additional barriers to good MNH, leading to preventable deaths. Gender-related risk factors contribute to pregnant women's and girls' vulnerability, poor nutrition, delays in seeking care, reaching facilities, and receiving adequate care, all of which also influence newborn health outcomes. Pregnancy itself might be a result of sexual violence or reproductive coercion. The gravest consequences of Intimate Partner Violence during pregnancy include suicide, but it also triples the odds of postpartum depression and increases the risks of miscarriage, preeclampsia, low birth weight, and stillbirth. Mal, over– and undernutrition continue to have adverse effects on maternal health by increasing the risks of complications during pregnancy, delivery as well as poor newborn outcomes.

Global trends in a turbulent world are also impacting MNH outcomes. Climate change, by increasing frequency and intensity of heat waves, droughts, floods, rising sea-levels and air pollution, is having direct and indirect effects on maternal and newborn health. The global food crisis is affecting millions of people around the world, including pregnant women, mothers and newborns. Maternal and newborn health is always in great danger in protracted and emergent humanitarian crises and in fragile settings, which are multiplying and placing women and newborns at increased risk of adverse health outcomes. As health systems are disrupted and overwhelmed, SRH needs are usually overlooked. The demographic trends pose old and new challenges for maternal and newborn health. In sub-Saharan Africa, the population is expected to nearly double between 2022 and 2050. Two thirds of projected population growth is based on the large number of young people who are yet to have children, meaning that demands for maternal and newborn services will increase substantially even if fertility rate declines more than is expected. As experienced during the COVID-19 crisis, pandemics affect maternal and newborn health. The risk of perpetuating 'panic-and-neglect' cycles remains, and the delivery of essential services will likely be disrupted during the epidemics and pandemics to come.

Lastly, in an increasingly polarised world, divergence on certain parts of SRHR and of gender equality continues, and concerted attacks in some countries are further limiting women's ability to decide when, if to have a child, and with whom, to have safe access to essential, life-saving

care including safe abortion care[10], and the freedom to raise children in a safe environment. Strong policy advocacy will continue to play an immense role to ensure compliance and delivery SRHR as basic human rights.

A more detailed context analysis, which further informs the MHTF Phase IV is available in UNFPAs Maternal and Newborn Health and Wellbeing Strategy 2024-2030.

2.2 The MHTF support to high burden countries yields results

In close collaboration with concerned partner governments, since 2008 the MHTF has delivered technical and financial support in countries with high burdens of maternal and newborn deaths to catalyse progress in midwifery care, emergency obstetric and neonatal care (EmONC), maternal and perinatal death surveillance and response (MPDSR) processes, and the prevention and treatment of fistula. A total of 350 000 midwives have been trained with the support of the program, and based on monitoring data from the EmoNC facilities, it is estimated that supporting the management of obstetric complications contributed to at least 28 million safer births since inception. 148,000 fistula surgeries have been conducted with MHTF support, changing women's lives and restoring their dignity and quality of life. As part of comprehensive SRHR, over the course of the three years (2020-2022) and in partnership with governments, UNFPA has supported the training of 1,300 healthcare providers on quality, comprehensive SRHR services, including safe abortion care to the full extent of the law and post-abortion care. The MHTF also contributes to the UNFPA presence and leadership in maternal and newborn health in global health initiatives and partnerships.

Results in high burden countries

Between 2018 and 2023, the MHTF has supported 32 high burden countries. ***According to the 2022 evaluation of phase III***,

- ★ **The MHTF method of combining technical knowledge, seed funding and global partnerships** in order to support partner countries to tackle particular MNH-SRHR areas **is a strength that positions it well to leverage catalytic results.** The method allows to provide high quality support in critical technical areas;

- ★ **The MHTF has been able to support integration of MNH and SRHR services and there is tangible evidence of progress in the integration of family planning into maternal health**

[10] The technical definition of comprehensive abortion care as per WHO is the following: comprehensive abortion care includes the provision of information, abortion management (including induced abortion and care related to pregnancy loss/spontaneous abortion) and post-abortion care (WHO, 2022a). UNFPA works with governments and partners to ensure comprehensive SRH and RR services. At the request of governments, this may include comprehensive abortion care, covering safe abortion care to the full extent of the law, and post-abortion care in all settings in line with the ICPD PoA.

services across the care continuum. The MHTF supports each country to define the scope of integration according to their own opportunities and service priorities.

★ **As one of the few UN programmes supporting midwifery, the MHTF has succeeded in raising the profile and standing of midwives at the global and country levels.** The partnership with ICM is a key asset that amplifies the credibility with partner governments, supporting the alignment of national policies with international standards. MHTF investments and expertise have led to global policy products supporting midwifery development in countries beyond the MHTF.

★ **The MHTF has championed the development and application of the EmONC network** model in partner countries **using an innovative health systems strengthening approach based on consensus building around standards of care, the optimization of EmONC facility distribution, and routine facility monitoring.** The phased approach offers an objectively verifiable model for elaborating service delivery standards that can be adapted to every country's context. This methodology enables a concrete step forward in EmONC and MNH systems strengthening that creates leadership opportunities in partner countries and opens a pathway for improving quality of care. The MHTF has also enabled **MPDSR processes to be embedded across a range of health systems contexts** and is valued by country governments and partners.

★ **The MHTF has made a clear contribution at both the global and national level towards increasing the commitment of governments and partners to end fistula.** Building the capacity for fistula treatment remains the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, mobile teams and with service delivery camps.

Results at global level

The MHTF continued to actively contribute to the creation of global public goods/technical guidance that benefit all countries beyond the countries directly supported by the MHTF. This includes engaging in the Every Newborn Action Plan and Ending Preventable Maternal Mortality (ENAP-EPMM) initiative and various other technical partnerships[11], which are instrumental in developing and refining best practices, sharing knowledge, and implementing evidence-based interventions for integrated SRHR and MNH, but also in global stewardship and mobilising support for an integrated approach delivered through a primary health care approach. As co-chair of the ENAP-EPMM, the MHTF team contributed notably to the development of the new

[11] Quality of Care Network, Prevention of Unsafe Abortion Partners Group, International Obstetric Fistula Working group, global MPDSR technical working group, Alliance to Improve Midwifery Education (AIME), partnership under the HRP, H6 partnership focusing on SRH notably.

coverage targets to end maternal mortality. As a co-sponsor of the HRP, it supported a research agenda across SRHR that is inclusive of maternal and newborn health.

According to the 2022 evaluation of phase III,

- ★ **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 realised notably -but not only- due to constraints to progress created by the COVID pandemic. The evaluation noted that the catalytic impact of the MHTF is demonstrated when it focuses on brokering internal and external influence and partnerships; leveraging political commitments and policy support, and fostering innovations, including identifying best practices, scaling up what works, replication of innovation in other countries and broader knowledge management.

Challenges and limitations. The positive results and progress of the MHTF at country and global level were constrained by the structural weaknesses of underfunded health systems that the modest MHTF can only tackle very partially: poor infrastructure, lack of equipment, understaffing, commodities stock outs, etc. As in most development efforts, ensuring the **sustainability** of the improvements achieved and services strengthened remained the main challenge. Regarding the **integration of SRH and MNH** services, a key strength of the MHTF, ***the 2022 evaluation*** commented that integration of post-abortion care is inconsistently addressed. Moreover, the MHTF support for integrating both adolescent SRHR and GBV 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 non judgmental. An important emerging challenge constraining further integration is the need to balance the opportunity 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 evaluation also considered that the MHTF focus on ensuring equitable access to services for all women and girls had uneven results so far. Finally, the 2022 evaluation noted that the MHTF was not clearly positioned within a holistic UNFPA MNH strategic framework and that the MHTF had **not yet been fully designed to deliver its 'catalytic effect' systematically.** Key gaps limiting the relevance and the sustainability of the MHTF investments needed to be addressed: **need to engage with communities** to address barriers to access, overcome delays, improve accountability, and better ground MHTF investments with affected populations, and **need to actively incorporate the views of women and girls** in relation to SRHR-MNH services, especially in relation to respectful care.

The key areas of focus recommended by the 2022 evaluation were the following:

- ➢ Champion **quality of care at the point of delivery** including respectful care.
- ➢ Be more systematic about **integrating community engagement** across all activities.
- ➢ **Engage partners,** especially donors, **more actively** in the MHTF progress.
- ➢ **Embed the focus on midwifery and the health workforce environment across the MHTF.**

- ➢ **Invest more in MHTF core added value**: SRHR-MNH integration, promoting catalytic results.
- ➢ Invest in **innovative financing approaches** to attract an expanded donor base.

The 2022 evaluation also advised UNFPA to develop a comprehensive corporate maternal health strategy that is clearly situated in relation to the 2022-2025 UNFPA's Strategic Plan and its transformative result of ending preventable maternal deaths. The UNFPA responded to this important recommendation and developed a cross-organizational Maternal and Newborn Health and Wellbeing Strategy, which will be launched in 2024. The present business plan proposes a strategic direction and framework that responds to the recommendations of the evaluation to "unfold the considerable unrealized potential" of the MHTF, and articulates the role of the MHTF within the new corporate MNWH Strategy

3. UNFPA approaches for phase IV

The MHTF is a thematic fund that pools resources within UNFPA and drives efforts at global, regional and country levels to provide targeted support to critical proven interventions in improving maternal and newborn health outcomes.

The MHTF phase IV will drive the implementation of the new UNFPA MNHW Strategy, alongside core-resources, UNFPA's Supplies Partnership, Humanitarian Action Fund, Equaliser Accelerator Fund, Population Data Thematic Fund and support Country Programmes to further prioritise maternal health and support governments to scale up high impact practices. The conceptual framework of phase IV has been revised and expanded to align with the strategic framework of UNFPA's new MNHW Strategy.

The MHTF will continue in phase IV the long-term work of strengthening the capacity of public health systems of high burden countries - often weak, underfunded, understaffed, underequipped, - to provide quality MNH care and other SRHR services within PHC and UHC. In doing so, the MHTF aspires to renew its catalytic role by

- Leveraging and engendering political commitments and policy support, especially where this translates into financial commitment and investments in MNH and SRHR at national level

- Fostering innovations, including identifying best practices, scaling up what works/high impact practices, replication of innovation in other MHTF (and non-MHTF) countries and brokering knowledge management including through renewed attention to south-south partnerships.

- Brokering internal and external influence and partnerships: this includes the impact the MHTF has on other programmes and overall strategic direction on MNH/SRHR at UNFPA, programme countries and other partners at the global, regional, and national levels. This includes contributing to global public goods (global standards, norms, measurement, stewardship and accountability) and their application at country level

3.1 Concepts and approaches

The MHTF rests on a set of core public health concepts, this includes clearly conceptualising MNH as a part of comprehensive SRHR, and SRHR as central to Universal Health Coverage. It further advances the idea that primary health care is the most inclusive, equitable and cost-effective way to achieve UHC. Finally, noting that women have SRHR needs throughout the course of their lives, it adopts a life-course approach underpinned by the aim to address maternal and newborn morality, morbidity and importantly maternal and newborn wellbeing.

MNH as an integrative component of comprehensive SRHR

UNFPA understands maternal and newborn health within the comprehensive framework and package of essential SRHR interventions proposed by the Guttmacher-Lancet Commission[12]. The MHTF focuses specifically on the components of the SRHR package that are essential to MNH including routine antenatal care, childbirth and postnatal care, emergency obstetric and newborn care, care for small and sick newborns, comprehensive abortion care (including safe abortion care to the full extent of the law and post-abortion care in all settings), prevention and holistic treatment of fistula and other obstetric morbidities. It also puts a strong emphasis on integration with other essential SRHR services, especially postpartum family counselling, cervical cancer screening and adolescent SRHR counselling (the prevention and treatment of HIV/STIs, treatment of subfertility and infertility, sexual health counselling, clinical care of GBV are SRHR services prioritised in other UNFPA programmes). In line with UNFPA's new MNHW Strategy, the MHTF is also determined to advance the universal coverage of SRHR, hence to join the collective efforts, policy and health financing reform dialogues to advance UHC.

MNH/SRHR as a core component of UHC

Encapsulated in SDG target 3.8[13] and inherently political, Universal Health Coverage (UHC) is the aspiration that all people have access to the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. UHC is closely linked to equity, financial protection and public financial management. While contributing with others to advance UHC reforms in partner countries, UNFPA will promote and support the incremental integration of comprehensive MNH/SRHR into UHC, acknowledging that each country can only chart a progressive path towards UHC.

PHC as the most inclusive, equitable and cost-effective way to achieve UHC

Primary health care (PHC) is a whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities. It has 3 components: (1) integrated health services to meet people's health needs throughout their lives; (2) addressing the broader determinants of health through multisectoral policy and action, (3) empowering individuals, families and communities to take charge of their own health. Since the Alma-Ata Declaration of 1978, it is widely regarded as the most inclusive, equitable and cost-effective way to achieve UHC. UNFPA promotes an Essential Package of Healthcare Services at PHC level that includes comprehensive MNH care, including EmONC.

Life course approach

UNFPA recognizes that women have SRHR needs throughout the course of their lives. Sexual and reproductive health needs of adolescents, and women prior to and during pregnancy differ. Demographic shifts in many countries toward older populations and women that delay

[12] https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

[13] SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

childbirth until later in life mean that health systems must be prepared to meet the needs of older mothers who have unique needs and risks. Ensuring women's health during their reproductive years and post-childbirth is paramount for individual well-being and societal health. The MHTF will support the integration of MNH as part of a comprehensive approach to SRHR throughout the life course.

Wellbeing

The concept of 'wellbeing' is an emerging concept, whose definition, domains and measurement tools are currently being debated in the global community. In the context of maternal and newborn health, UNFPA refers primarily to women and newborn's physical, mental, and social well-being, acknowledging the intersectionality of many of these factors. Wellbeing however impacts women throughout their life course, is impacted by structural and social determinants, and needs to be contextually relevant. The MHTF will promote wellbeing comprehensively, through bolstering PHC, strengthening midwifery care which promotes physiological process of pregnancy and delivery, ensuring the respectful care at all levels of facilities, and through promoting and supporting perinatal mental health as a priority from community to national level .

3.2 Focus populations

Women and adolescents girls and newborns in high burden countries

The MHTF prioritises:

- ★ women and adolescent girls with particular focus during pre-pregnancy, pregnancy, childbirth and 6 weeks after delivery, hence primarily pregnant and postpartum women and adolescent girls, and
- ★ the first 28 days for newborns.
- ★ Women and girls living with fistula and other obstetric morbidities

Acknowledging the inextricable link between the health of mothers and their newborns, the MHTF will promote mother-baby dyad, focusing on addressing the health of both together, and complemented by UNFPA's effort to prevent unintended pregnancies, in particular among adolescents. The MHTF will continue gathering and analysing data on inequality to inform programming and advocacy to ensure that those left behind are reached. Lastly, the MHTF will also work with enlisting men and boys as partners and allies for MNH outcomes.

3.3 Innovation and scaling and sustaining high impact practices

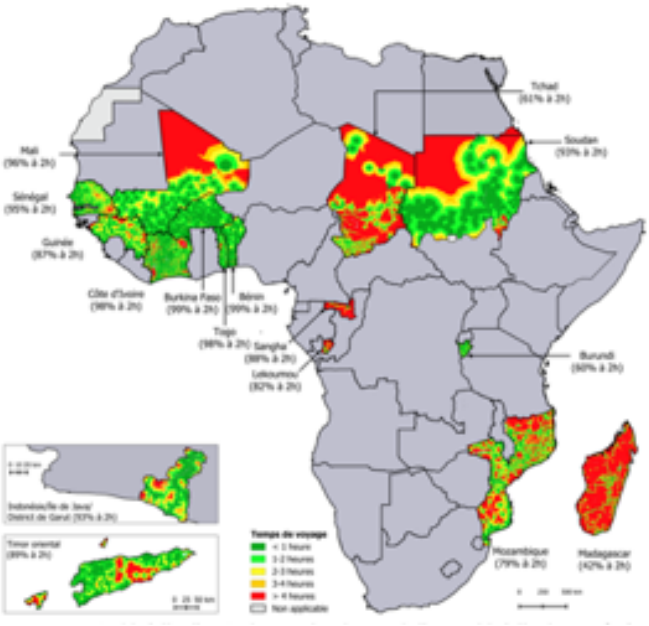
The MHTF is a **catalyst for change** in maternal and newborn health, where needed, test innovative approaches but more importantly facilitate strategic investments to scale up essential, high impact practices for sustainable results. By leveraging UNFPA and technical

partners' expertise and focusing on evidence-based approaches and by fostering knowledge management and south-south learning, the MHTF supports interventions with a high return on investment, and intended to be sustained by governments and local partners beyond the initial investment. The proven models/high impact practices that the MHTF supports nationally endorsement and scaler are:

Midwifery

The MHTF works towards professionalisation and strengthening of the midwifery workforce within its activities, including continuing professional development and pre-service programmes. It does so through a gender-transformative approach.

The MHTF will deepen integration of midwifery across all levels of health facilities, this will include strengthening the role of midwives in delivering comprehensive MNH/SRHR services, strengthening their EmONC skills in managing and referring complications during pregnancy and childbirth to save women and newborn lives. Midwives are key providers who promote well-being of women, girls and newborns through ensuring positive experience of pregnancy and giving birth, respectful care to women, newborn and family and providing maternal mental health support. Strengthening an overall enabling environment is crucial for midwives to perform their functions effectively and remain motivated for which policy support will be provided with national counterparts for integrated service provision. Through these interventions, the transition to **midwifery models of care (MMoCs)**[14] will be supported at global, regional and country levels in phase IV.



National EmONC networks

The MHTF will continue supporting the establishment or strengthening of national networks of health facilities able to provide basic and comprehensive **Emergency Obstetric and Newborn Care (EmONC)**. The main objective of the EmONC model is to optimise access to comprehensive MNH services and improve quality of care. Universal access to health centres providing the full suite of EmONC services is critical to ending preventable maternal deaths and

[14] MMoCs are models of care for women and babies which cover the continuum from pre-pregnancy to the postnatal period and beyond, in which the PHC providers are educated, licensed, regulated midwives, enabled to legally practise autonomously across the full scope of midwifery practice, and integrated into a well functioning health system in the context of effective, functional, equal and respectful interdisciplinary teams, supported by referral processes and sufficient resources. In MMoCs, midwives provide and coordinate respectful quality care for women and their babies in collaboration with other health-care workers

promotion of UHC. The MHTF's methodology to identify and optimise national EmONC facility networks through GIS mapping, consensus building on quality of care metrics, and routine monitoring.

By 2024, 16 countries in sub-Saharan Africa and Asia have implemented this innovative approach to ensure a balance between maximising the population able to access to MNH services, including EmONC, in a timely manner (e.g. within 2 hours of travel time) and selecting a limited number of needed health facilities providing the full package of MNH and SRHR services.

Maternal and Perinatal Death Surveillance and Review (MPDSR)

MPDSR is an essential accountability mechanism and a quality of care intervention. It is a system that monitors maternal and perinatal deaths in real time, helps health managers and facilities' staff to understand the underlying factors and determinants contributing to these deaths, and stimulates and guides intersectoral coordination and actions to prevent future deaths. MPDSR also plays an important role in improving community engagement and strengthening accountability of health systems to communities through community death reviews and verbal autopsies. It is linked to the health information system and improves the quality of MH programmes by supporting multi-sectoral responses to address the proximate and distal determinants of maternal deaths. The MHTF support to MPDSR is closely linked to the work of the MPDSR Technical Working Group[15].

The multi-sectoral coordination of stakeholders involved in MPDSR is usually challenging for health authorities, and most countries are not fully implementing a MPDSR programme yet. This is reflected by low maternal death notification rates, the absence of death notification at the community level, and low maternal death review rates in most high-burden countries. In phase IV, the MHTF will further support national scale implementation, with a focus on strengthening the monitoring, the 'response' component to improve quality and enable learning, and the linkages at community level.

Beyond maternal death data, **maternal health evidence and data** will remain a central area of work supported by the MHTF. Using existing as well as generating new evidence to identify, promote, and invest in and take to scale promising and proven interventions, as well as investing in systems that empower Ministries of Health to ensure their policies are working for their people and adapt to emerging and changing situations

Obstetric Fistula Prevention and response - Strengthening Country Ownership and Sustainability

Via its significant funding to the UNFPA – led Campaign to End Fistula, the MHTF will continue its support to the development and implementation of national strategies to end Fistula. By the

[15] It brings together WHO, UNICEF, UNFPA, Centres for Disease Control and Prevention and other partners

end of 2023, more than 50% of MHTF supported countries had developed cost national strategies to end fistula either as a standalone or integrated in broader national maternal and reproductive health plans. The MHTF through these strategies is maximising its support to strengthen national capacities to tackle preventable maternal morbidities using obstetric fistula response as an entry point. Through the implementation of fistula strategies a comprehensive approach to tackling the root causes of fistula incidence and prevalence is employed including healthcare infrastructure strengthening (capacity building of service providers, equipment and medical supplies enhancing quality of care in prevention and routine treatment) community engagement and education (enhancing access to and utilization of available maternal health services, SRH information and services, fistula treatment services, and a heightened focus on the engagement of fistula survivors), and monitoring of progress (including through national fistula task teams and robust data collection).

3.4 What is new in phase IV

From EmONC to comprehensive MNH and integrated MNH-SRH services

In addition to providing good quality services to manage obstetric and neonatal complications 24 hours a day, 7 days a week, EmONC facilities are key contributors to the integration of SRH information and services. They provide immediate family planning (including long-term methods), postnatal care (PNC), essential newborn care (ENC) and post-abortion care (PAC), safe abortion to the full extent of the law. They also perform maternal and perinatal death reviews (in the framework of MPDSR programs). They treat obstetric fistula and other maternal morbidities. Through the support to EmoNC facilities, the MHTF intends to improve the rights based and quality (including respectful care) of a comprehensive package of MNH information and services, including nutrition services[16]. Furthermore, the MHTF supports the expansion to other key SRH services, notably the elimination of mother-to-child transmission of HIV (eMTCT), the immunisation of newborns, the prevention of reproductive morbidities particularly cervical cancer (screen & treat approach), and the treatment of infertility. The 2022 evaluation noted that post abortion care was inconsistently adopted: in phase IV, both PAC and comprehensive abortion care (CAC) will be supported as a key component of MNH services.

Stronger focus on respectful care

Respectful care is an essential component of experience of care and wellbeing. UNFPA supports offering women a breadth of choices around their labour and child birthing experiences and prevents, and addresses any kind of mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services. The phase IV will support respectful care across all its HSS work as one of the components to improve the quality of care, but also as a way to ensure emotional support, empower the bodily autonomy of women, and promote wellbeing. This will include strengthening providers' capacity and

[16] Micronutrients supplements to all pregnant women; Calcium supplementation to mothers at risk; Vitamin A supplementation for pregnant/lactating women; Universal salt iodisation; Identification and treatment of acute malnutrition (moderate & severe)

transforming the belief, attitudes and behaviours to deliver respectful and dignified care, underscoring the importance of values clarification and attitude transformation (VCAT)[17] approaches to ensure providers are not only able to deliver respectful, quality care. It will also entail ensuring that services are provided in a culturally appropriate way to meet the needs of ethnic minorities, addressing service providers' biases which may result in poor treatment of adolescent mothers, and challenging stigma against certain marginalised communities resulting in mistreatment or discrimination in health facilities.

Stronger involvement in the health financing agenda

To advance the catalytic impact, the MHTF also intends to **engage further in the advocacy and policy dialogue processes** that aim to leverage and engender further political commitments for MNH and SRHR, in the broader context of advancing UHC, and to leverage and engender the translation of these commitments into further financial commitments and investments. One vehicle for this coordinated policy dialogue is the Global Midwifery Acceleration Roadmap.

While contributing to the efforts to raise steady external health financing for MNH and SRHR, mindful of the importance of additionality, the MHTF team will engage in the concerted efforts and dialogues at global, regional and country level with government and like-minded partners to advocate for and monitor sustainable health financing. The MHTF support will focus on the value of investing in MNH/SRHR in the context of UHC and PHC, including analyses on funding gaps, estimates of costs and impacts, and returns on investment. It will also direct its efforts towards increasing the efficiency in the spending of MNH funds.

It will work with civil society and communities to broker their engagement in policy reform and accountability for sustained investment in MNH. Expand foundational knowledge within UNFPA in health financing and UHC, including public finance management and social insurance schemes to support the organisational shift from funding to financing.

Enhanced community engagement

Community engagement is prioritised as a stream for holistic functioning of the MHTF. To enhance community engagement in MNH programs, it is imperative to foster collaboration with local governments, NGOs, community-based and women-led organisations, and various stakeholders, establishing robust partnerships with community-based constituents. Capacity building is key, involving support for community midwives, community health workers, women's networks and support groups and leaders through MNH training and resource provision. Participation and empowerment enables communities to actively promote MNH, raise awareness, and facilitate preventive measures. Community education and awareness campaigns play a vital role in disseminating MNH information, promoting healthy behaviours and creating an enabling social and cultural environment in which women and girls are able to

[17] Values clarification and attitude transformation (or VCAT) is an evidence-based approach to address stigma and discrimination related to abortion and other SRH interventions to promote empathetic, non-judgemental, respectful care. VCAT approaches allow participants to explore perceptions, attitudes, values and beliefs and better understand the ways in which these affect their ability to deliver on professional commitments and ultimately, affect women's and girls' access to services.

exercise their sexual and reproductive rights in accessing quality care. The MHTF will encourage community engagement in MNH programs, notably through strengthening community referral mechanisms, monitoring community feedback and accountability mechanisms and strengthening reproductive literacy, women's agency and equitable social and gender norms to facilitate access to care. It will support advocacy for accessible and quality SRH at the community level, especially in remote or underserved areas, and advocacy efforts at local and national to influence policies supportive of MNH.

New focus on readiness of partner countries to uptake the full range of recommended life-saving maternal health commodities

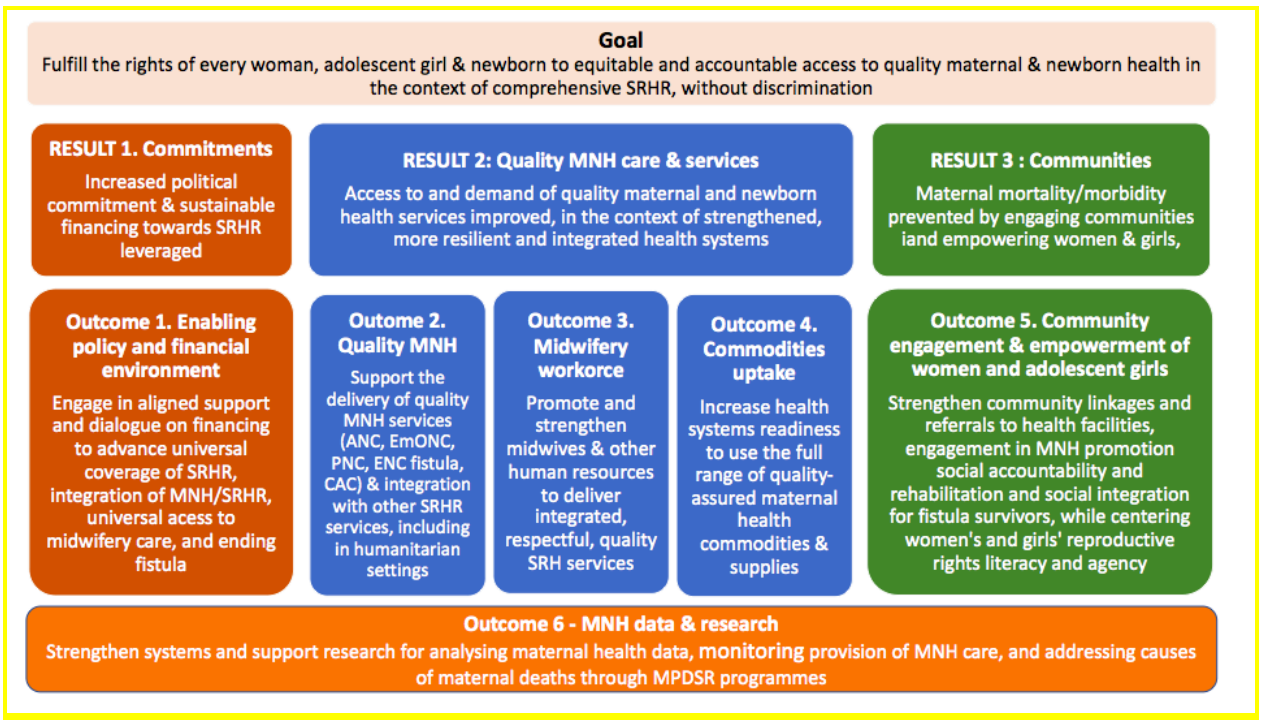
The challenges to sustainably increasing access to quality assured MH medicines being of diverse nature, increased and coordinated efforts are needed to disseminate knowledge about the range of life-saving maternal health products, and to ensure their availability in high burden countries. Expanding synergies between the MHTF and UNFPA's Supplies will facilitate partner countries' access to the full range of recommended MNH commodities as articulated in the MNHW strategy. In March 2023, a global summit dedicated to PPH called for accelerating the roll out of life saving medicines and devices for the prevention and treatment of PPH[18], the leading cause of maternal mortality worldwide. Based on available resources, the MHTF phase IV, intends to build partner countries' readiness to uptake new and/or underutilised WHO-recommended maternal health products, notably the life-saving commodities to prevent and treat PPH (these include tranexamic acid, health stable carbetocin and misoprostol) and the new easy-to-use tools for the diagnosis of preeclampsia. This specific focus on PPH is initiated in alignment with the of the **'Stop PPH Africa'** (title TBC), a joint Unitaid-UNFPA regional programme funded by the EU in five high burden countries and in partnership with ECOWAS, SADC and EAC. If further resources become available, the MHTF will expand its support to the prevention and management of PPH to more countries.

[18] https://www.who.int/publications/i/item/9789240081802

4. Strategic framework and interventions

The MHTF prioritises aspects of the MNHW strategy from a health systems approach, recognizing that other complementary UNFPA strategies such **UNFPA's strategy for family planning 2022-2030,**[19] **UNFPA's strategy for adolescent and youth,**[20]**UNFPA's gender strategy**[21] and the forthcoming sexual health strategy all have a critical role to play towards ending preventable maternal deaths.

4.1 Change Story – the impact MHTF will deliver 2024-2028



[19] *(Expanding Choices - Ensuring Rights in a diverse and changing world)* https://www.unfpa.org/publications/unfpa-strategy-family-planning-2022-2030

[20] *My Body, My Life, My world* https://www.unfpa.org/youthstrategy

[21] (*Agency, Choice and Access: Strategy for Promoting Gender Equality and the Rights of Women and Adolescent Girls 2022-2025*) https://www.unfpa.org/genderstrategy

Contributing to…	**Transformative Result: End preventable maternal mortality and morbidities by 2030**				
At the core of Business Plan IV is the Goal:	**To fulfil the rights of every woman, adolescent girl & newborn to equitable and accountable access to quality MNH in the context of comprehensive SRHR, without discrimination**				
To achieve these 3 Results:	1. **Commitments: Increased** political commitment & sustainable financing towards SRHR/MNH in the MHTF countries and at regional and global level 2. **Care and services:** Improved access to quality SRHR/MNH services the context of strengthened, more resilient and integrated health systems 3. **Communities:** Increased integration of SRHR/MNH health into community health and accountability systems				
To advance these 6 Outcomes:	1. **Strengthened policy and financing advocacy for SRHR:** engage in aligned support and dialogue on policy and financing to advance universal coverage of SRHR, and on integration of MNH/SRHR 2. **Improved access to quality of SRHR/MNH services:** Support the delivery of quality MNH services and integration with other SRHR services, including in humanitarian settings 3. **Promote and strengthen midwifery and other human resources** to deliver integrated, respectful, quality SRHR services 4. **Increased availability of MNH commodities:** Increase health systems readiness to ensure availability of the full range of quality-assured maternal and newborn health commodities & supplies 5. **Prevent maternal mortality and morbidity and promote maternal and newborn health** by engaging communities to empower women and girls, ensuring their agency over their reproductive choices and well-being 6. **(Crosscutting) Improved MNH data & research:** strengthen systems for analysing and using maternal health data, monitoring provision of MNH care, and addressing causes of maternal deaths through MPDSR programmes and support implementation research in MNH				
Working through these modes of engagement	Advocacy and policy support	Partnerships	Surveillance systems, data and evidence generation	Technical support & implementation guidance	Capacity and leadership
Propelled by the UNFPA accelerator.	• Human rights and Gender transformative • Leave no one behind		• Innovation and Digitalisation • Humanitarian-development nexus / Resilience • Development effectiveness		
In the contexts of	Humanitarian and Fragile settings		Development	Nexus	
Targeting	Countries with high burdens of maternal and newborn mortality and morbidity				
Understanding the future scenarios (megatrends)	Population Dynamics	Climate change	Covid, current and future pandemics	Migration	Digitalization
Considering the structural issues, root causes & gaps of ending preventable maternal deaths and morbidities (Causes)	**Causes to be addressed by MHTF:** • Deficiencies in healthcare systems • Quality of care - antenatal, intrapartum, postnatal, delivery and management of basic emergency obstetric care, abortion service provision (post abortion everywhere and comprehensive where legal) • Direct causes (eg. PPH, obstructed labour, infections, pre-eclampsia, unsafe abortion) • Indirect causes (eg. malnutrition/anaemia, HIV, malaria, TB, diabetes, hypertension) • Persistent 3 delays (delay in recognizing and deciding to seek care, delay in reaching a healthcare facility, delay in receiving adequate, quality care at the facility) • Availability and access barriers (physical, cultural and financial)				

For the core problem of….	Ending preventable maternal and newborn deaths and morbidities amidst stagnating progress in achieving SDG 3.1 and 3.2 targets

4.2 Outputs and Strategic interventions

The MHTF aims to contribute meaningfully and decisively to fulfil the rights of every woman, adolescent girl & newborn to equitable and accountable access to quality maternal & newborn health in the context of comprehensive SRHR, without discrimination. To achieve this goal in countries with a high burden of maternal and newborn mortality and morbidity, the MHTF phase IV will focus its contribution around three results related to:

I. Finance and policy **Commitments**
II. Health systems, services and **Care**
III. **Community** engagement.

Clustered under the three results areas, six outcomes have been selected based on experience and lessons learned about what works for countries to accelerate action and scale evidence-based, cost-effective strategies and innovations for MNH, in line with global guidelines[22], and in line with recommendations from the 2022 evaluation.

The outcomes are interdependent and mutually reinforcing as the normative impact delivered under commitment results area is necessary to create the enabling environment to strengthen the health and community systems. Finally, the sixth, cross-cutting, outcome to ensure data and evidence informed advocacy, health systems and services delivery, and accountability.

RESULT 1 - Increased political commitment & sustainable financing towards SRHR/MNH in the MHTF countries and at regional and global level

The high priority and commitment of most governments to improve maternal health is clearly reflected in their endorsement of targets, strategies and declarations at global, regional and country levels. However the gap between the commitments made at high level and the reality of their limited operationalization on the ground is well known. The political will often fades in front of the multiple competing priorities that need to be addressed with limited domestic resources. The MHTF will join policy dialogue processes focusing on financing to advance universal coverage of SRHR, and on integration of MNH/SRHR into UHC and PHC. This section adopts evidence informed policy advocacy strategies and tactics, and as such no specific programmatic strategic interventions are articulated as under Result 2 and 3. These policy and advocacy priorities will also inform the MHTF strategic communications approach.

[22] WHO MNH Guidance, The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 etc

Outcome 1 - Strengthened policy and financing advocacy for SRHR

Output 1.1 - Advocate increasing domestic financing for MNH

While contributing to the efforts to raise steady external health financing for MNH, SRHR and UHC, mindful of the importance of additionality, the MHTF team will engage at global, regional and national level dialogues with governments and partners around the provision of catalytic support to unlock additional and sustained domestic resources for comprehensive SRHR. It will also direct its efforts towards increasing the efficiency in the spending of MNH funds. The following list constitutes a menu of relevant activities in this new area of work of the MHTF. Some will be piloted in coordination with like-minded partners involved in the UHC agenda and in a handful of countries only, before considering expanding them to all MHTF countries:

- ➔ **Provide technical assistance** to partner governments in integrating essential SRHR interventions in UHC benefit packages, financial risk protection mechanisms, quality assurance and delivery systems, investment cases, and measurement and accountability frameworks.
- ➔ **Contribute to the national dialogues on health financing reforms** leveraging additional financing for SRHR; support evidence generation, including data disaggregating to operationalize the principle of LNOB, to inform these dialogues and domestic health financing policy development and reforms.
- ➔ **Support the engagement** of civil society partners **with policy makers,** including parliamentarians, advocating for sufficient public budget allocations for SRHR services and for tracking resources allocation and progress against ENAP-EPMM and other key targets and commitments.
- ➔ **Support the development of tools** to conduct cost benefit analyses of midwifery models of care, service delivery redesign (eg. EmONC network) and tools for measuring the cost of inaction; support the roll out of needs assessments, monitoring and planning through digital health tools.

Output 1.2 - Expand political commitment and deepen integration of MNH/SRHR across policies, strategies and programs

At country level

The MHTF will continue supporting partner countries to uphold their commitments and ensure access to comprehensive SRHR services in the context of UHC, with particular attention to respectful and safe maternity care of high quality. The margin of progression is significant: among 115 countries with data, countries had in place an average of 76 per cent of the laws and regulations needed to guarantee full and equal access to SRHR, including maternity care[23]. In high burden countries that are developing their UHC legal frameworks (not the case in a

[23] SDG 5.6.2 in https://unstats.un.org/sdgs/report/2022/The-Sustainable-Development-Goals-Report-2022.pdf

significant number of MHTF countries facing a fragile or humanitarian context), UNFPA will work with partners to ensure an approach that is human rights-based and gender transformative. Similarly, the following menu of relevant activities will be supported in some MHTF countries only, their generalisation will depend on available resources:

- ➔ **Support countries to prioritise MNHW** as part of a comprehensive SRHR and PHC approach. This will include raising attention to new emerging challenges such as the link between maternal health and NCDs or climate change, and facilitating technical dialogues on best practices and innovative approaches.
- ➔ **Support social participation** and where possible broker engagement **in key SRHR/MNH and UHC policy processes** by midwifery associations, women's rights and youth organisations and representatives of marginalised and discriminated communities; support stakeholders to ensure SRHR/MNH interventions are included in health system reforms and national health strategies (existing or under development).
- ➔ **Support engagement with human rights based accountability mechanisms** such as National Human Rights Institutions, judiciary, as well as administrative and social accountability for rights related to MNH.
- ➔ **Support strengthened legal protection** against discriminatory practices in the health settings. This will include supporting the enactment of strengthening patients' rights charters, client feedback mechanism to improve quality of care and access to means of redress for women who experience mistreatment, abuse, and other forms of discrimination in accessing care, and supporting advocacy to dismantle legal and policy restrictions on SRHR including who can access services, excluding for example, minors, non-citizens or women who have not secured spousal consent.

At regional level

Regional collaboration enables to promote regional/continental ownership, the implementation of region-specific strategies and normative frameworks,, improving coordination and facilitating South-South learning and cooperation. Particularly in Africa, the MHTF's focal points in ESA and WCA regional offices as well as UNFPA's Representation Office to the Africa Union intend to deepen collaboration with Member State-based regional organisations, with the objective to expand commitment, accountability and good practices at continental and regional level:

- ➔ **Engage with CARMMA[24], the regional health platforms of the African RECs[25] working on health, and regional parliamentarians' fora.** These platforms and fora are critical for promoting advocacy towards gender and human rights frameworks increasing accountability and ensuring policy support and legislative backing.

[24] CARMMA is the Campaign on Accelerated Reduction of Maternal Mortality in Africa of the African Union. It was launched in 2009 and aimed at lowering the unacceptably high levels of maternal and child deaths on the continent. It was designed to use policy dialogue, advocacy and community mobilisation to enlist political commitment, increase resources and societal change in support of Maternal, Newborn and Child Health (MNCH).

[25] Currently 8 Regional Economic Communities (RECs) are recognized as the building blocks of the African Union: AMU, CEN-SAD, COMESA, EAC, ECCAS, ECOWAS, IGAD and SADC. The MHTF will engage particularly with WAHO, the West Africa Health Organisation of ECOWAS (WCARO and WAHO signed a MoU in 2023), EAC and SADC.

- ➔ **Encourage and support regional collaborations and south-south learning** for harmonisation and standardisation training curricula, indicators, knowledge management, increasing efficiencies through coordination and synergies with technical and financial partners

At global level

The MHTF team in HQ will continue bringing its technical expertise and implementation experience in key global normative and technical partnerships with the aim to advance integrated, quality SRHR/MNH. This will include:

- ➔ **Strengthen global health partnership and alignment for MNH including co-chair the ENAP-EPMM,** SDG GAP and H6, PMNCH**, coordinated research under HRP**
- ➔ **Contribute to the activities of key global technical working groups:** the Quality of Care Network, the Prevention of Unsafe Abortion Partners Group, the International Obstetric Fistula Working Group, the global MPDSR technical working group, and various midwifery working groups, including AIME.

Output 1.3 -Enhance national leadership, ownership and accountability to ensure universal access to quality midwifery care

- ➔ **Co-lead the Development and Implementation of the Global Midwifery Acceleration Plan** to advance the Midwifery models of care and midwife-led continuity of care.
- ➔ **Strengthen national, regional and global advocacy alliances**
- ➔ **Advocate for the creation of a Chief Midwife (or a Senior Midwife) position**[26] **within the Ministry of Health and establish or strengthen a national midwifery task force.** Strengthen alliances between midwifery associations, regulatory bodies and other relevant stakeholders through the formation of a national taskforce to further the development of the critical midwifery workforce and to act as leaders in critical policy processes as well as engagement with the parliament to help create an enabling policy environment for midwives to practise their profession.
- ➔ Support the development o**f national midwifery strategies** - either stand-alone or as part of the national human resources for health strategies.

Output 1.4 - Enhance national leadership, ownership and accountability for ending fistula and other obstetric morbidities

- ➔ **Support high burden countries to develop and implement costed national fistula strategies** with the aim to strengthen coordination, maximise resources, and sustain national prevention and response efforts:

[26] The WHO Global Strategic Directions for Nursing and Midwifery (2021–2025). WHO 2021, Geneva.

- ➔ **Support assessments of needs** in fistula prevention and treatment based on incidence and prevalence estimates; **Support the development, implementation and monitoring** of national fistula strategies and programmes
- ➔ **Support the generation of evidence** to inform programs and resource mobilisation and strengthen monitoring mechanisms for tracking progress
- ➔ **Support the establishment and functioning of a dedicated national task force** tocoordinate, guide and monitor the implementation of national fistula action plans

RESULT 2 - Improved access to and demand for quality SRH/maternal and newborn health services is, in the context of strengthened, more resilient and integrated health systems

Three outcomes and seven outputs will support the objective of strengthening health systems for increasing access to quality MNH services. The three outcomes are interdependent.

Outcome 2 - Quality SRHR/MNH: Support the delivery of quality MNH services and integration with other SRHR services, including in humanitarian settings

Building on its extensive expertise in health systems redesign for MNH, UNFPA will continue supporting countries to revise their national network of EmONC health facilities to optimise the access, cost effectiveness, and quality of MNH services, including emergency obstetric and newborn care (EmONC). The MHTF will also continue to support countries implementing a package of interventions proven to effectively improve quality of care: midwifery led delivery care, mentorship, routine supervision, data quality management, maternal death reviews, staff continued training, referral analysis. Respectful Maternity Care (RMC) and Respectful Newborn Care (RNC) being an essential element of quality of care, they will be included in all support to facilities.

Output 2.1 - Access to and delivery of comprehensive and quality MNH care, including EmONC

To achieve this output, the MHTF will support the following strategic interventions:

- **Intervention 2.1.1 Support countries to redesign their national network of health facilities providing comprehensive MNH care, including EmONC:** This intervention aims to support countries to identify or refine their national network, based on health facility data from EmONC assessments and/or from routine health systems, and using evidence-based prioritisation criteria and geographic access.
- **Intervention 2.1.2 Strengthen the capacities of skilled health personnel in health facilities to provide quality, respectful, people-centred MNH services[27].** The MHTF will support countries to design, strengthen, and implement on-site evidence-based in-service training, such as supportive supervision and mentorship programmes, for improving the provision and the experience of care. These in-service training will particularly focus on midwives deployed in EmONC health facilities and anaesthetists, including nurse anaesthetists.
- **Intervention 2.1.3. Strengthen the functioning of EmONC health facilities, including improving referral links between comprehensive and basic EmONC facilities[28], and with peripheral (non EmONC) health facilities.** This aims to analyse and fill gaps in delivering

[27] ANC, intrapartum care, PNC, ENC, EmONC, CAC, fistula prevention and treatment

[28] Basic EmONC health facilities are health facilities expected to perform the seven basic EmONC signal functions for managing obstetric and neonatal complications. The comprehensive EmONC health facilities are expected to perform the seven basic signal functions plus C-section and blood transfusion

the key obstetric signal functions[29]. The MHTF will specifically support the reduction of gaps in signal functions in the EmONC health facilities in UNFPA's focus regions (identified in collaboration with the Ministry of Health).

- ➔ **Intervention 2.1.4. Improve service delivery for quality of care in EmONC and in peripheral health facilities.** This will promote the implementation of national protocols and standards (eg. recommendation on the assessment of postpartum blood loss and use of a treatment bundle for postpartum haemorrhage - PPH), support health facility staff and district/sub-national stakeholders to implement quality of care improvement cycles (PDSA) and to have a work environment conducive for quality of care improvement (eg. no blame culture).

Output 2.2 - Support the integration of quality SRH services

Midwives and staff in maternity units should provide high quality SRH care and associated SRHR information, counselling and services for women through the antenatal, intrapartum and postnatal period. All staff should create a friendly environment for women and families, provide human-centred respectful care and create quality improvement loops interacting with women's and communities' feedback.

- ➔ **Intervention 2.2.1. Strengthen the provision of quality SRH information and services in EmONC and peripheral health facilities.** Support the provision of family planning counselling, postpartum and post abortion family planning, eMTCT, clinical response (clinical care, and referrals and treatment) for victims of sexual and gender based violence, and the implementation of the secondary prevention approach for cervical cancer ("screen and treat' approach) in particularly the functioning EmONC health facilities, to implement the secondary prevention approach for cervical cancer ("screen and treat' approach).
- ➔ **Intervention 2.2.2 Integrate comprehensive abortion/post abortion care care as part of SRHR information and services.** Support health systems to deliver quality, comprehensive abortion care, including through training, supervision and mentorship of midwives, community health workers and others along the continuum of care, ensuring the availability of commodities and supplies in facilities, engaging communities and creating an enabling environment for women and girls to access care and exercise their rights.

Output 2.3 - Support prevention and treatment of fistula and other obstetric morbidities.

The MHTF will continue working to ensure that quality SRHR information and services are available and accessible to prevent and treat fistula and other obstetric morbidities, through the

[29] EmONC signal functions are: (1) Administer parenteral antibiotics (2) Administer uterotonic drugs (3) Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (4) Manually remove the placenta (5) Remove retained products (6) Perform assisted vaginal delivery (7) Perform basic neonatal resuscitation (8) Perform surgery, e.g. caesarean section (9) Perform blood transfusion

EmONC and midwifery working streams. The focus will be on enhancing the availability and quality of treatment, and follow up mechanisms to ensure the continuum of care and reduce the risk of maternal morbidity for women including for subsequent pregnancies.

- **Intervention 2.3.1. Strengthen health systems' capacity for the prevention and treatment of obstetric fistula.** This intervention will support health facilities to prevent obstetric fistula through intervention of labour complications and timely referral. It will also strengthen capacities of healthcare providers, particularly midwives in obstetric fistula prevention, management and rehabilitation, and surgeons, urologists, and surgical teams in repair surgery, rehabilitation.
- **Intervention 2.3.2. Strengthen the follow up of obstetric fistula patients** and the monitoring of treatment outcomes
- **Intervention 2.3.3. Strengthen capacities of EmONC health facilities and peripheral health facilities to prevent and treat other obstetric morbidities.** This intervention will strengthen the capacities of the health facilities to address prolonged obstructed labour, prevent and treat pelvic organ prolapse, iatrogenic fistula , severe anaemia, and chronic pelvic inflammatory disease.

Outcome 3 - Promote and strengthen midwifery and other human resources to deliver integrated, respectful, quality SRHR services

Output 3.1 - Support the high-quality education of midwives

A competent midwifery workforce is essential for delivering quality SRHR/MNH services. The MHTF will continue building the competencies of the midwifery workforce, educated according to global standards. Education will be holistically addressed to include pre-service education and and in-service training; strengthening of midwifery schools; faculty development programmes; school accreditation, continuous professional development programmes, among others. Digital, virtual reality and AI solutions will be used to accelerate quality training of midwives (e.g state of the art simulation methods, mobile apps among others)

- ➔ **Intervention 3.1.1. Strengthen midwifery educational institutions to provide quality pre-service competency-based education:** All midwifery training institutions should follow national standards and be accredited in accordance with ICM/WHO standards. Other initiatives would include, developing or updating national midwifery curricula to align with ICM/WHO standards; Introducing professional career pathways (bridging courses, Bachelor, Masters and Doctorate); and equipping the schools with necessary teaching and learning materials, books and simulation labs. Strengthening the capacity of pre-service midwifery educators (teachers and preceptors) particularly on clinical skills practice, and teaching skills will remain a priority area of focus.
- ➔ **Intervention 3.1.2.Strengthen national continuing professional development (CPD) programme:** Support with the establishment of continuous professional development (CPD) frameworks, Develop and/or disseminate training tools (e-learning, Safe Delivery App, hybrid course, Low-Dose-High-Frequent trainings, mentorship programmes,

transition into practice programmes), Strengthen the capacity of midwifery educators (mentors and preceptors), build capacity in perinatal mental health care including supportive supervision and mentorship.

- ➔ **Intervention 3.1.3. Enhance respectful care and gender transformative approaches in the health system through empowering midwives:** Include gender and human rights considerations in the midwifery curriculum and trainings as a way of improving respectful care in the health system, specially by addressing stigma and discrimination; Ensure that a cadre of midwives in each facility is trained on GBV response and able to provide information and referral to appropriate services, when needed.Introduce VCAT and behavioural change workshops to provide respectful care to all.

Output 3.2 - Support conducive/enabling midwifery workforce policies, regulation and environment

This output will support countries to strengthen their midwifery workforce policy and regulatory mechanisms and develop an enabling conducive environment for midwives to practise their profession. Conducive midwifery workforce policies are essential to ensure that educated midwives are properly recruited, deployed, distributed, retained and can practise to their full scope:

- ➔ **Intervention 3.2.1. Support countries to develop or update their national midwifery workforce policy/strategy** that promote an enabling and resilient working environment to provide the quality of care: This includes: Updating midwifery workforce needs assessments that can feed national health workforce strategies, develop or improve deployment and supporting mechanisms for midwives in humanitarian settings
- ➔ **Intervention 3.2.2. Support governments and health facilities to promote an enabling and gender transformative work environment for midwives**: -Engage in gender analysis to better understand both the barriers and the opportunities for midwives within the healthcare workforce support the development/revision of protocols or SOPs to empower midwives within the health system; support activities that empower midwives within their communities;
- ➔ **Intervention 3.2.3. Strengthen midwifery regulatory bodies:** Support development of national midwifery acts, comprehensive regulatory frameworks; broader scope of practice for integrated SRHMNH service delivery; autonomous practice; (re)licensing, examination, school accreditation standards, grievance/ complaint redressal mechanisms among others;, Ensure that midwives are interconnected in the functioning referral network and work within interdisciplinary teams with clearly defined scope of practise for the different cadres.

Output 3.3. - Strengthen midwifery workforce leadership

This intervention will support countries to strengthen midwifery leadership, notably for policy advocacy. This will be done through building leadership within midwifery associations to

promote their profession, having midwifery leaders placed in management positions in relevant ministries like the Ministry of Health and building capacities of young midwifery leaders.

- ➔ **Intervention 3.3.1. Strengthen the capacity of national midwifery associations and young midwifery leaders.** This would include building and youth leadership through supporting: institutional and organisational capacity of the association (e.g. expanding membership); building Leadership capacities, including engagement of young midwifery leaders; strengthening Communication, advocacy and resource mobilisation capacities; and building Capacity to provide continuous professional development.
- ➔ **Intervention 3.3.2. Advocacy for strengthening midwifery models of care** and for creating senior policy level positions for midwives in key government departments (e.g possibly Chief Midwife position[30] in the Ministry of Health). This is in line with the recommendations of SOWMy 2021 and the WHO 2021 Strategic Directions for Nursing and Midwifery.

Outcome 4 - MNH commodities uptake - Increase health systems readiness to ensure availability of the full range of quality-assured maternal and newborn health commodities & supplies

In 2012, the UN Commission on Life-Saving Commodities for Women and Children (UNCoLSC) had identified 3 maternal health commodities (oxytocin, misoprostol, and magnesium sulfate) and 4 newborn health commodities (injectable antibiotics, antenatal corticosteroids, chlorhexidine, and resuscitation equipment) which, if more widely accessed and properly used, could save millions of lives. Since 2012, WHO has recommended additional life-saving MNH commodities. These are, notably the life-saving commodities to prevent and treat PPH (Tranexamic Acid (TXA), Heat Stable Carbetocin (HSC) and misoprostol), as well as the new easy-to-use tools for the diagnosis of pre-eclampsia, medicines to prevent sepsis (antenatal and peripartum infections), and commodities for quality comprehensive abortion care (misoprostol, mifepristone-misoprostol combination regimen, manual vacuum aspiration).

The MHTF will support partner countries' access to quality assured new and/or underutilised WHO-recommended maternal and newborn health commodities whose uptake has been slow until now for a number of reasons related to availability, affordability, health workforce capacity and regulation and in some cases, stigma. This will be mainly done by strengthening national level readiness and capacity to use the not-yet-utilised diagnostics and treatments through technical support, notably to scale up delivery of the updated PPH protocol, in line with WHO Guidelines. The scaling up of new commodities will be through the national EmONC networks *(link with outcome 2*) and the midwifery workforce *(link with outcome 3)* as well as holistic programmes jointly implemented with the Supplies Partnership.

This work links with the ENAP-EPMM, the recent Technical Convening on WHO-recommended maternal and newborn health commodities (November 2023), and the WHO/HRP/UNFPA chaired Global Action Plan on Medical Abortion, a co-developed and co-owned roadmap that

[30] The WHO Global Strategic Directions for Nursing and Midwifery (2021–2025). WHO 2021, Geneva.

aims to improve access to medical abortion globally by tackling key barriers across supply, regulation, procurement, distribution and research domains and developed through extensive engagement with international NGOs, social marketing organisations, donors, supplies partnership platforms and research entities.

Output 4.1. Support the introduction of new WHO-recommended MNH products and related protocols

- ➔ **Intervention 4.1.1. Support partner countries to update their national lists of essential MNH medicines and protocols**, including by using evidence to advocate for alignment with global standards
- ➔ **Intervention 4.1.2. In-service training for health personnel, particularly midwives** to increase the practical use of new/underused diagnoses and treatments, including VCAT to support willingness and capacity to work with CAC commodities.
- ➔ **Intervention 4.1.3. Document critical success factors** for introducing of new MNH commodities through bottleneck analyses and implementation research to inform national and regional experience sharing and learning.

Output 4.2. Strengthen health system capacities for scaling-up the use of essential, including new and/or underutilised WHO-recommended MNH products

- ➔ **Intervention 4.2.1 Strengthen the health workforces capacities in supply chain and logistic** at national, sub-national and health facility levels (eg. pharmacists, stock managers, health care providers and others), including VCAT to support willingness to ensure the availability of quality essential MNH commodities, including those for CAC, to the last mile
- ➔ **Intervention 4.2.2. Strengthen health facility capacities** to procure and store essential MNH commodities, including blood products

RESULT 3 - Prevent maternal mortality and morbidity and promote maternal and newborn health by engaging communities to empower women and girls, ensuring their agency over their reproductive choices and well-being

The MHTF aims to empower women, adolescent girls and their communities to create an enabling social and cultural environment, conducive to uptake of quality MNH services. A set of initiatives are proposed to ensure that women and girls not only have access to crucial information about their reproductive health, but are in contexts where they have agency to make informed decisions about their well-being, and access quality health services.

To achieve this, the MHTF will implement interventions to enhance health and rights literacy, while addressing gender and human rights barriers to accessing care, and promoting autonomy in reproductive choices.

Outcome 5 - Community engagement and empowerment of women and girls

The MHTF will engage communities to support linkages between health facilities and communities, referrals, MNH education and promotion, including WASH, identification of danger signs of pregnancies to increase demand for services and social accountability mechanisms. The MHTF will also continue to support rehabilitation/social integration programs for fistula survivors in the context of strengthening women's and girls' reproductive rights literacy and agency.

Output 5.1. - Strengthen communities' access to quality MNH information and services and linkages and referrals with health facilities

- ➔ **Intervention 5.1.1. Strengthen the competencies and equip community and frontline health workers and relays** (including through e-learning) to provide key MNH rights-based information; recognition of danger signs in pregnancy; respectful maternity care; and to link pregnant women with healthcare providers, including through birth plans to improve both uptake and access to quality MNH services.
- ➔ **Intervention 5.1.2. Strengthen linkages between health facilities and community gatekeepers,** including local authorities and traditional and religious leaders, youth-serving and women-led organisations to support an enabling, non-discriminatory environment within which women are able to access quality care.
- ➔ **Intervention 5.1.3 Develop low cost, easy access rights-based information, education and communication (IEC) materials on MNH/SRHR,** including leveraging radio, SMS-based and digital technology, tailoring content to the needs of specific groups. Advance and develop evidence-based approaches towards shifting harmful gender social and cultural norms.
- ➔ **Intervention 5.1.4 Support community-led monitoring** of quality and availability of MNH services: establish community accountability mechanisms, holding health services accountable for ensuring access to quality care and ensure feed-back loop to appropriate decision-making processes to ensure response.

Output 5.2- Support rehabilitation and social reintegration programs for obstetric fistula survivors

A holistic approach that addresses the psychological and socioeconomic needs of fistula survivors is required to ensure their full recovery and healing. The follow-up and the social reintegration of survivors are major gaps in the continuum of care. This strategic intervention will:

- ➔ **Intervention 5.2.1. Support evidence-based reintegration and rehabilitation programmes for fistula survivors to ensure their full recovery.** This includes development of reintegration guidelines, monitoring, and evaluation of programs.
- ➔ **Intervention 5.2.2. Support advocacy and partnership initiatives to strengthen, scale up and sustain social reintegration programs and strengthen patient engagement** via supporting the establishment and functioning of fistula survivor networks for safe motherhood advocates and client identification and linking with community health and women empowerment interventions.

CROSSCUTTING - Outcome 6 - Improved maternal and newborn health data and research

The MHTF will strengthen health information systems and support capacities for analysing and using MNH data and addressing causes of maternal deaths through MPDSR programmes

Output 6.1 - Identify and address causes of maternal and perinatal deaths through MPDSR

Phase IV will continue supporting and consolidating MPDSR programmes:

- ➔ **Intervention 6.1.1. Strengthen the MPDSR programme framework and coordination:** Supporting the Ministry of Health's validation of the MPDSR programme framework; Supporting multisectoral, operational links at national, regional and local levels
- ➔ **Intervention 6.1.2. Strengthen the national capacity for improving the number and quality of maternal and perinatal deaths reviews and implementation of responses:** Provide technical support to health care professionals conducting reviews; Provide technical and financial support for local, subnational and national meetings to analyse MPDSR data and to develop responses to address gaps across sectors.
- ➔ **Intervention 6.1.3. Strengthen reporting and monitoring of the MPDSR programme**: Support the development of annual reports on the MPDSR process and results; Support the monitoring of the quality of the reviews and of the implementation of the recommendations from the reviews.
- ➔ **Intervention 6.1.4. Strengthen MPDSR in crisis and humanitarian settings** (or basic maternal mortality related data collection and analysis), in collaboration with the Humanitarian Response Division.

Output 6.2 Support MNH surveys and strengthen Health Management Information Systems (HMIS)

- ➔ **Intervention 6.2.1. Support health facility and community level surveys on MNH:** Provide technical and financial support for EmONC needs assessments, patient satisfaction survey assessments; and other health facility assessments; support collection, analysis and dissemination of midwifery data, for example through global and regional State of the World's Midwifery reports; and support situational analysis and needs assessments on obstetric fistula and other obstetric morbidities

- ➔ **Intervention 6.2.2. Support the monitoring of MNH data and strengthen health management information systems, specifically for midwifery, EmONC, obstetric fistula data**: Support the monitoring of the national network of EmONC health facilities; strengthen the integration of quality metrics within HMIS for integrated services like comprehensive abortion care, Support the continuous generation, digitisation and use of midwifery-specific workforce data, Support regular monitoring data on midwifery workforce availability, capacity, distribution, deployment and retention,

Output 6.3 - Improve data for the Minimum Initial Service Package (MISP) for SRH in Crisis Situations

In close collaboration with the UNFPA Humanitarian Response Division:

- ➔ **Intervention 6.3.1. Support MISP readiness assessments** and contribute to the development of emergency preparedness plans
- ➔ **Intervention 6.3.2. Improve data, measurement and evidence for humanitarian response** by incorporating new subnational population and reproductive health data as part of a MISP 3.0, upgrading the MISP Calculator 2.0. This version now goes beyond national estimates, and incorporates provincial- (ADM1-) and district-level estimates of key reproductive and maternal health measures.

Output 6.4. Support implementation research on MNH

- ➔ **Intervention 6.4.1. Support research for improving the implementation and data of MNH programmes:** Contribute to research on quality of care indicators for MNH (including respectful care); on implementing effective midwifery models of care (for example a global mapping of Faculty Development needs/ assessment; understanding barriers to implementing full scope of practice; effective deployment policies); on obstetric fistula and other obstetric morbidities (including incidence, prevalence, situational analysis and needs assessments, pathways for obstetric fistula survivors)
- ➔ **Intervention 6.4.2. Support research on the impact of climate change on women, newborns, and the health system** with the view to develop programmatic guidance for countries
- ➔ **Intervention 6.4.3 Explore innovative digital solutions,** such as telemedicine and mobile health applications, and other innovative solutions and equipment to improve access to maternal healthcare services, especially in remote or underserved areas.

To execute the interventions, the MHTF applies UNFPA's corporate accelerations as outlined in UNFPA Strategic Plan:

Human Rights-Based and Gender Transformative Approaches The MHTF is guided by the human rights based approach (HRBA) and principles of Availability, Accessibility, Acceptability and Quality. A gender-transformative approach (GTA) addresses the underlying social structures, policies and norms that perpetuate gender inequalities.	**Leaving no one behind** UNFPA recognizes that ending all preventable maternal and newborn deaths requires identifying certain population groups who are marginalised, and therefore, likely to be "left behind" or "pushed behind", due to age, culture, ethnicity, race, language, religion, disability, HIV status, location, gender identity, migration status or any other factor.
Innovation and Digitalisation Opportunities offered by digitisation and artificial intelligence (AI) will be widely explored and mainstreamed in MNH programmes for scale up. This will be balanced while ensuring safety and security for women and girls and appropriate use of technology enabled interventions.	**Humanitarian-development nexus / Resilience** Through the humanitarian-development- peace nexus approach, UNFPA promotes systems strengthening, preparedness using policy, programmatic and operational entry points. In the context of the MHTF, support for MISP readiness assessments and to ensure emergency preparedness as well as developing guidance and supporting countries to strengthen MPDSR in crisis and humanitarian settings at large (or basic MM related data collection and analysis).
Development effectiveness Committed to enhancing the impact, efficiency, coherence, sustainability and accountability of its support, the MHTF will ensure country ownership and alignment with national led priorities. The MHTF country multi-annual proposals will be developed in close collaboration with national health authorities (and other relevant national partners).	

5. Partnerships to deliver

The MHTF's first essential collaboration will remain with **the health authorities of the partner countries as well as other relevant ministries for a multi-sectoral response including finance, planning, women and gender, social protection, community etc,** with particular focus on MoH departments in charge of medical services and care, public health, human resources/health care workforce, health information, health planning and research, and the regulatory body accrediting the midwifery profession. The MHTF through UNFPA's COs will also continue its fruitful collaboration with national midwifery associations, midwifery schools, and naturally the Ministries of Higher education overseeing midwifery (bachelor, masters and PhD) curricula. The MHTF will also deepen its partnership with civil society and academia in all partner countries, notably women's and youth-based organisations. In each partner country, the MHTF through UNFPA COs will also naturally join and engage with all relevant sectoral/multi-sectoral coordination platforms and mechanisms (including relevant working groups) led by health authorities or by technical and financial partners.

Through the new tiered approach, the MHTF will deliberately build on **South-South partnerships** between countries that have transitioned out of Tier I to Tier II and from Tier II to Tier III. Countries where significant progress has been made these past two decades partly due to MHTF support such as Bangladesh, Mozambique and Zambia[31], will be designated as learning grounds in consultation with regional offices, country offices and country partners.

The MHTF will also expand commitment, accountability and good practices through working closely with the African Union's CARMMA, African RECs working on health and their respective regional policy arenas and platforms, including convenings of Ministers and Ministries of health at political and technical levels. Through these **continental and regional platforms** set up to implement regional-specific strategies and normative frameworks, improve coordination and facilitate South-South learning and cooperation, the MHFT will support the sharing of high impact practices and learnings, and their scaling up across the region. The MHTF will also engage through UNFPA's ROs with regional parliamentarians' fora, critical for promoting gender norms change, increasing accountability and ensuring policy support and legislative backing.

At global level, in close collaboration with WHO, UNICEF and other UN agencies and multilateral organisations, the MHTF team will leverage its technical expertise and convening role at both global and regional level to contribute to an aligned global MNH community in support of country priorities. The MHTF will also further support the development and dissemination of. global public goods through its technical leadership and involvement in a set of technical working groups.

[31] In Bangladesh MMR point estimate dropped from 441 in 2000 to 123 deaths per 100 000 living births, in Mozambique MMR point estimate dropped from 532 in 2000 to 127/100 000 in 2020, and in Zambia MMR point estimate dropped from 419 in 2000 to 135/100 000 in 2020.

Result area	UNFPA takes a leading role	UNFPA contributes
Commitments: political commitment & sustainable financing towards SRHR leveraged	The Global Midwifery Acceleration Roadmap The Alliance on Midwifery Education The Global Campaign To End Fistula	The H6 partnership focusing on SRH The Global Action Plan SDG 3 PHC working group The UHC2030 multi-stakeholder platform PMNCH
Care and services: access to quality maternal and newborn health services improved in the context of strengthened, more resilient and integrated health systems	The ENAP-EPMM partnership The International Obstetric Fistula Working Group The Prevention of Unsafe Abortion Partners Group The 10 Million Safer Births Initiative	The Quality of Care network,
Communities: maternal mortality/morbidity prevented in the context of empowered women & ado girls and engaged communities		Strategic alignment with global, regional and country SRHR/MNH advocacy funding mechanisms and alliances to support national and grassroots advocacy for Maternal and Newborn Health as part of gender equality, women's rights and universal SRHR.
Maternal and newborn health data and research	HRP[32] (to support a coherent research agenda inclusive of MNHW), and The global MPDSR technical working group	WHO-Mother and Newborn Information for Tracking Outcomes and Results (MoNITOR) technical advisory group.

The MHTF will also continue collaborating closely with the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) to

[32] *HRP (Human Reproduction Program): Special Programme of Research, Development and Research Training in Human Reproduction co-sponsored by UNDP/UNFPA/UNICEF/WHO/World Bank*

enhance and standardise the training of health professionals in maternal health, collaborate on research and data analysis in this field.

New partnerships that will be pursued during phase IV include the global health initiatives such as GFF and the Global Fund, and scaling up partnership with communities will be critical, including women's rights groups, faith based groups and other accountability actors. The MHTF will also seek to further expand partnership with the private sector building on successful experiences such as the UNFPA-Takeda Partnership, as well as partners working in the nexus between health and climate change.

MHTF will also seek alignment with other critical SRHR/MNH initiatives as outlined below.

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	MHTF Tier 1 country *(see section 5.2)*	UNFPA Supplies Partnership	2gether 4SRHR	SWEDD	Other key UNFPA MH programs	ENAP EPMM focused countries (Phase I)	GFF	Global Fund	French Muskoka Fund
Tier 1 countries (25)	**Benin**	x			Takeda		Eligible	x	x
	Burkina Faso	x		x		x	x	x	
	Burundi	x				x	Eligible	x	
	Cameroon	x					x	x	
	Chad	x		x	GFF grant	x	x	x	x
	Côte d'Ivoire	x		x	Takeda GFF grant EU PPH	x	x	x	x
	DRC	x					x	x	
	Ethiopia	x	x			x	x	x	
	Ghana	x				x	x	x	
	Guinea Conakry	x					x	x	x
	Kenya	x	x			x	x	x	
	Liberia	x				x	x	x	
	Madagascar	x			EU PPH	x	x	x	
	Malawi	x	x			x	x	x	
	Mali	x		x		x	x	x	
	Niger	x		x			x	x	
	Nigeria	x				x	x	x	
	Rwanda	x				x	x	x	
	Senegal	x					x	x	x
	Sierra Leone	x				x	x	x	
	South Sudan	x					Eligible	x	

	Sudan	x					Eligible	x	
	Togo	x			Takeda		Eligible	x	x
	Uganda	x	x		EU PPH	x	x	x	
	Zimbabwe	x	x			x	x	x	

As part of phase IV, the MHTF will develop a partnership engagement strategy in coordination with UNFPA's Public and Private Partnerships Branches.

6. Operating Model

6.1 Modes of Engagement

UNFPA's modes of engagement are defined by the UNFPA's Strategic Plan, MNHW strategy, and form an organisation-wide approach to classify activities in UNFPA's integrated Results and Resources Plan. Partnership is also one of UNFPA' modes of engagement and is covered in more detail in chapter 5

- **Advocacy and policy support at national, regional and global levels**

UNFPA will leverage its normative mandate and role to contribute to global public goods, such as the ENAP-EPMM common strategies and targets, and systematically ensure that these global products are leveraged at regional and national level for policy dialogue, advocacy and coordinated technical assistance. While this mode of engagement is critical across all outcomes, it will be particularly relevant to advance MHTF Outcome I on commitments, together with key partners engaged in advancing universal SRHR and UHC.

The MHTF team will provide global leadership and stewardship through the Global Midwifery Acceleration Plan together with partners of the Alliance to Improve Midwifery Education (AIME) to support countries to transition to effective midwifery models of care and rally all stakeholders and global partners around the global Campaign to End Fistula (CEF) and implementation of a global roadmap to end fistula.

- **Capacity and leadership strengthening**

Through working with existing Universities, professional associations and national governments the MHTF will continue to strengthen existing capacities of global, national and regional staff and stakeholders and build their leadership ability. This would include among others, dissemination of technical guidance, resources and strategies; capacity building workshops on innovative approaches in strategically strengthening programmes (e.g AIME work in the roll out of the 7-Step Approach to Strengthening Quality Midwifery Education); In its capacity development, the MHTF streamline gender transformative and human rights based approaches and also ensure that megatrends like climate change and population dynamics are taken into account while effectively programming resources.

- **Data and evidence generation**.

Under the new MNHW Strategy, UNFPA will develop an internal research agenda to analyse and prioritise critical evidence, data and measurements gaps in consultation with key partners, not least HRP. This will strengthen the MHTF ability to develop cutting edge research and technical

guidance including on emerging areas of importance to MNH, for example, impact of climate change, demographic shifts, urbanisation.

As part of the Global Campaign to End Fistula, the MHTF will also support the establishment of an UN inter-agency working group on obstetric fistula estimates, something that has been sorely lacking. Given that 70% of all maternal deaths occur in Sub-saharan Africa, UNFPA will seek out and strengthen academic partnerships with African public health and research institutes.

- **Technical support and implementation guidance**:

The MHTF will continue providing technical and implementation guidance to Ministries of Health, technical working groups and global/regional/country partners across a wide set of SRHR issues. A few examples of the guidance include undertaking EmONC assessments, Global Midwifery Curriculum resource; rollout of a Global Midwifery Acceleration and Humanitarian Strategy, Policy Briefs, High Impact Practices and supporting the development of corporate programmatic guidance for UNFPA in support of the implementation of UNFPA's wider MNHW strategy.

- Knowledge management

The MNH team will work across thematic areas to develop a guide on and support scaling up of high impact and evidence informed MNH practices across all pillars of the strategy towards sustainability. In conjunction, UNFPA will systematically review relevant technical guidance against the strategy to identify where updates are needed to ensure state of the art knowledge is brought to bear in UNFPA:s programming approaches.

To ensure high impact practices as adopted across the organization and global normative standards, technical and clinical guidelines and tools are implemented and taken to scale, UNFPA will optimise its approach to knowledge management including south-south cooperation as articulated above. Through the MHTF, and as part of UNFPA's corporate approach to knowledge management, UNFPA will support a centralised platform for sharing documented experiences, high impact practices and lessons learned from implementing the MNH strategy.

As an agile learning organization, institute a decentralised UNFPA maternal and newborn health expert community of practice, with each region convening a MNH thematic center of excellence based on regional priorities. Through this network, together with country and regional offices, UNFPA will co-create and curate a MNH research agenda, based on implementation bottlenecks outlining key gaps in data, evidence and measurements, and commission additional research to fill critical, policy and programmatic relevant gaps.

6.2 Countries prioritised for support

Maternal mortality ratio (MMR) is one of the criterias guiding UNFPA's prioritisation of **resources** support to countries. The threshold linked to SDG target 3.1, that is MMR above 70 per 100 000 live births is one of the indicators together with the need for Family Planning satisfied with modern methods (-75%) and a gender inequality index (1 inequal - 0 equal, threshold 0.3) which guide prioritisation.

During its phase III (2018-2023), the MHTF provided support and allocated its resources to 32 high-burden countries, selected on the basis of 'needs based' (MMR above 200) and 'performance based' criteria related to the partner countries' demonstrated commitment to improve durably maternal health, a commitment measured by their concrete results in delivering quality MNH services since the launch of the MHTF[33]. Five years later, a number of countries have significantly improved maternal health and decreased MMR, a positive trend to which the MHTF has contributed: Bangladesh, Mozambique, Zambia, and Lao in particular. After 'graduating' five countries in phase III, we propose to 'graduate' these four countries and progressively phase them out from the full support that they received in phase III. An exit strategy with specific timelines and milestones will be developed in collaboration with the concerned ministries of health and local partners to ensure efforts and results are sustained.

Given that it is designed to catalyse action on maternal and newborn outcomes among countries most in need, the MHTF will continue prioritising countries with the highest burden of maternal mortality and morbidity, measured by the MMR as well as the numbers of maternal deaths. For categorisation purposes, it will use the following thresholds,

- MMR is below or above 250 maternal deaths per 100 000 live births.
- The number of maternal deaths is considered low if the number of maternal deaths are below 450, significant if it is 450-1000, high if they are between 1000-2800, highest if above 2800.[34]

For phase IV, the MHTF proposes the following methodology to prioritise countries and determine country allocations. It is proposed to categorise countries into three tiers :

➢ **Tier 1** includes African countries that have a high MMR and/or a high/very high number of maternal deaths. However, it is suggested to exclude a number of countries with active national humanitarian crises from Tier 1[35], namely Afghanistan, Central African

[33] measured by the following indicators: EmONC availability, maternal death notification rate, proportion of midwifery schools using the national curriculum based on ICM/WHO standards, national costed strategies for ending fistula, and expenditure rate

[34] https://www.who.int/publications/i/item/9789240068759

[35] FY23 List of Fragile and Conflict-affected Situations. Washington: World Bank; 2023 (https://thedocs.worldbank.org/en/doc/69b1d088e3c48ebe2cdf451e3028 4f04-0090082022/original/FCSList-FY23.pdf).

Republic, and Somalia given that the main funding channel for such countries is UNFPA's humanitarian thematic fund. In countries with humanitarian emergencies and in fragile settings, UNFPA will provide support using a nexus approach. Tier I countries would be eligible for MHTF funding for implementation of MHTF workplan and technical assistance in line with multi-year proposals.

- **Tier 2** includes a diverse group of countries: diverse geographically (Asian, Latin American and African countries), diverse level of burden, and diverse context: countries with a moderate MMR but still with a significant or high total number of maternal deaths, and high burden countries facing national humanitarian crises (Afghanistan, Somalia, CAR, Haiti) where, in a nexus approach, MHTF's advocacy, health systems strengthening and community engagement work can only be very tailored and modest, in liaison and complementarity with the core assistance provided by UNFPA's Humanitarian Branch. These countries would be eligible for catalytic funds administered by the regional offices for tailored technical assistance (to both governmental and civil society partners), studies and implementation research, on a needs based approach.

- **Tier 3** includes countries with a moderate burden (eg. Timor Leste), including those having 'graduated' (i.e. having seen a significant reduction in MMR and total number of deaths - eg. Lao) but who need continued funding to avoid reversal of achieved gains in earlier MHTF Phases.

Finally, a number of countries which are taking high impact practices to scale and where there are significant learnings to share with countries furthest left behind will be identified in consultation with RO/COs and partner RECs and designated learning grounds. The experience sharing by these 'good practice countries" will be supported through south-south learning activities.

Tier	Number of maternal deaths	MMR	MHTF Support
Tier 1 Countries with a very high burden (high MMR and/or high-very high number of deaths), not including a number of very high burden countries with protracted national humanitarian crisis ongoing (supported mainly through UNFPA's Humanitarian Fund)	>= 1,000 (high or very high number)	> 250 (high or very/extremely high MMR)	Countries eligible for MHTF's main funding for implementation of multi annual work plans and tailored technical assistance developed by COs in close collaboration with Ministries of health and other key governmental, academic and civil society partners

Tier	Number of maternal deaths	MMR	MHTF Support
Tier 2 Countries with moderate MMR but still a significant or high number of deaths), and countries with a high burden and facing a protracted fragile/ humanitarian context	>= 450 (significant or, high/very high number)	Between 100-250 (moderate MMR)	Countries eligible for MHTF's catalytic funds, administered by ROs, for tailored technical assistance (to both governmental and civil society partners), studies, implementation research, South-South cooperation and learning activities
Tier 3 Countries with a moderate burden, including those having 'graduated' (i.e. having seen a significant reduction in MMR and total number of deaths)	< 450 (low)	<100 (very low, low)	Countries eligible for south-south partnership and learning activities, coordinated by ROs in partnership with RECs

Based on the above criteria, the following countries are included in the phase IV. In Tier 1 there are 25 total countries of which 21 were included in phase III and 4 are new. In Tier 2 there are 19 countries included of which 9 counties have graduated from Tier 1 to Tier 2 and where an additional 10 countries have been identified as in need of additional support.

	Countries (* new)	MMR	Number of deaths	Tier 1 (* new)	Tier 2 (* new)
Asia	Afghanistan *	620	8,700		√ *
	Bangladesh	123	4,500		√
	Cambodia *	218	710		√ *
	Nepal	174	1,100		√
	Pakistan *	154	9,800		√ *
	Papua New Guinea *	192	490		√ *
	Vietnam *	124	1,800		√ *
Latin America	Venezuela	259	1,200		√ *
	Haiti	350	959		√
Arab States	Somalia	621	4,500		√
	Sudan	270	4,100	√	
East & Southern Africa	Angola *	222	2,900		√ *
	Burundi	494	2,200	√	
	DRC	547	22,000	√	
	Ethiopia	267	10,000	√	
	Kenya	530	7,700	√	
	Madagascar	392	3,500	√	
	Malawi	381	2,500	√	
	Mozambique	127	1,500		√

	Rwanda	259	1,000	√	
	Uganda	284	4,700	√	
	South Sudan *	1,223	3,800	√ *	
	Tanzania *	238	5,400		√ *
	South Africa *	127	1,500		√ *
	Zambia	135	890		√
	Zimbabwe *	357	1,700	√ *	
West & Central Africa	Benin	523	2,500	√	
	Burkina Faso	264	2,000	√	
	Cameroon *	438	4,100	√ *	
	CAR *	835	1,900		√ *
	Chad	1,063	7,800	√	
	Congo Brazza	282	500		√
	Cote D'Ivoire	480	4,400	√	
	Ghana	263	2,400	√	
	Guinea Bissau	725	460		√
	Guinea Conakry	553	2,600	√	
	Liberia	652	1,100	√	
	Mali *	440	3,900	√ *	
	Mauritania	464	700		√
	Niger	441	4,900	√	
	Nigeria	1,047	82,000	√	
	Senegal	261	1,400	√	
	Sierra Leone	443	1,200	√	
	Togo	399	1,100	√	
		Total MHTF countries		25 Tier 1	19 Tier 2

Of the 10 countries with the highest maternal mortality ratios, **South Sudan, Chad, Nigeria, Liberia**, **Lesotho**, **Guinea, DRC, Kenya** are Tier I counties and **Afghanistan, CAR, Guinea Bissau, Somalia** are Tier II countries. In these countries with protracted national humanitarian crises, the MHTF will focus its support to complement support from the Humanitarian Response Division with a particular focus on strengthening the nexus approach.

6.3 Resource management and planning

The MHTF resources complement UNFPA core and other non-core resources, which are allocated to regional and country level as part of UNFPA's regular and other resources planning process coordinated by Strategic Resource Planning Branch (SRPB) with the approval of the Resource Management Committee (RMC). The RMC is co-chaired by UNFPA's deputy director for management and deputy director for programmes. This ensures the MHTF alongside other UNFPA Thematic Trust Funds, is integrated into overall UNFPA resource planning processes, to foster integration among various funding streams, and timely allocation decisions.

The SRPB, which also serves as the secretariat for the RMC, will support the MHTF financial planning and management, through review of budgets, timely allocation of available resources,

monitoring of budget utilisation and support to offices in budget planning and monitoring. Allocation of budgets is done yearly in line with the proportional allocation mechanism based on the initial annual planning figures consolidated by the MHTF team and approved by the RMC. This ensures that all tier 1 countries receive adequate and timely funding in order to carry out the programmatic functions detailed under their individual plans. Any changes to the initial MHTF funding figures approved by the RMC can be done subsequently in the case of forecasted availability of additional funding. The RMC meets once a month.

The MHTF intends to streamline both work planning and reporting requirements for ROs and COs in phase IV. Improvements were already made in 2023, with early decisions on planning figures, in accordance with pre-defined, transparent criteria based on country needs, and timely allocations of available resources to all offices. The MHTF will continue to prioritise the countries where the need for MNH interventions is the greatest.

UNFPA leadership across the organisation and in particular Regional and Deputy Regional Directors, Country Representatives and Deputy and Assistant Representatives, Heads of Offices and operations managers have critical roles to play to ensure a coherent approach to resource management and planning across different funding streams at country level. Through UNFPA's new integrated Results and Resources Platform, project based funding will also increasingly be aligned to strategic plan outcomes, outputs and indicators and endable joint reporting.

The MHTF follows the existing UNFPA accountability lines. Country office teams will operate under the leadership of the UNFPA Country Representative, who reports to the Regional Director, who then reports to the Deputy Executive Director, Programme and the Executive Director. This also includes accountability for adherence to UNFPA policy and procedures for implementation modalities including the corresponding due diligence.

The MNH team which coordinates the MHTF, has one integrated budget and plan in the Sexual and Reproductive Health Branch (SRHB), including core and non-core resources, which is approved as part of the annual integrated Results and Resources Plan approved by the chief of SRHB, in the TD/PSD.

MHTF BP IV Multi year proposal and annual work plans

In line with UNFPA's Thematic Trust Funds Guidelines[36], the CO of each Tier 1 country will submit a high level multi-year proposal at the start of phase IV. This planning exercise in close collaboration with health authorities and other local partners will further articulate a strategic vision on maternal and newborn health, in line with national strategies and plans and UNFPA's Country Programme Document, towards specific, realistic, and measurable milestones in line

[36] The UNFPA Policy on Thematic Trust Funds will be revised during the MHTF Phase IV.

with the MHTF Results Framework. The proposal will also include baseline data and targets for the MHTF results framework.

Regional offices will similarly be requested to submit a high-level, multi-year proposal containing specific activities and technical support to countries under the Tier 2 regional envelope, as well as support for south-south partnerships.

The country work plans will be reviewed by the MHTF regional focal points and MNH technical team. The regional work plans will be reviewed by the MNH technical team. Annual work-plans will be approved by the UNFPA country representatives, the UNFPA regional directors, and by the MHTF-coordinator no later than the end of February.

The MHTF country, regional and global focal points will have two global meetings during the implementation of phase IV for the purpose of planning and end phase evaluation. The first meeting will ensure shared vision and plans for implementation of the fourth phase as well as to share learnings from phase III. This meeting will take place in 2024. A second meeting will be held following the finalisation of the mid-term review expected in 2026 to allow for adjustment and learning, as well as co-creation of a possible phase five of the MHTF should such a phase be recommended.

The MHTF work-planning will include an annual planning retreat with the regional office focal points, either virtual or in-person if resources are available.

Country, Regional and HQ resource allocation

Continuing the transparent process set up in the previous phases for the allocation of resources across countries, needs based and performance-based criteria defined in collaboration with UNFPA's regional offices will be followed for specific funding and technical assistance. The countries in the MHTF differ significantly in size and context (political stability, commitment towards MNH and capacity of the public health system notably), reason why a differentiated and flexible approach is needed to set regional and country ceilings (annual budget envelope). The MHTF budget is also expected to grow, and as such the model will be reviewed as part of the mid-term evaluation to ensure it is fit for purpose.

Country level allocation

In line with the TTF Policy, 80 per cent of the MHTF resources will be allocated to regional and country offices. This will include global and regional activities that take place in or support regional and country level capacity strengthening.

It is estimated that around 56 percent will be allocated to activities at CO and RO, including implementing partners, with no more than 19 percent of the country ceiling allocated to HR costs by the end of phase IV. Global implementing partners are almost always engaged to

support country level capacity building and as such is included in the country level allocation. For example, UNFPA worked closely with the University of Geneva to build national capacity on GIS mapping using the ACCESS MOD, open access programme for EmONC networks.

In Tier 1 countries, the MHTF will support both HR costs and activity costs, where eligible costs are those that are in line with the MHTF outcomes and corresponding UNFPA SP Outcomes.

Three out of the four countries with a large population where half of all maternal deaths occur are MHTF tier 1 countries -Nigeria, DRC and Ethiopia -, the MHTF will prioritise the funding in these 3 countries including support for HR, to ensure a sufficient capacity to provide technical support and leverage its normative role as well as provide technical support.

In the first year of the MHTF 2024-2028, if the MHTF reaches its resource mobilisation goal the country envelope will be on average USD 369 000 per country. The exact amounts of funds for each country will be determined based on availability of funding and an allocation model combining several criteria (related to the health systems' capacity, the political commitment to improve maternal health and the size of the population of the country as well as risk-assessment). If the MHTF reaches its resource mobilisation target by 2028, the average country envelope would be USD 1 603 738. Given that the MHTF is expected to grow, the detailed country allocation model will be tabled for the MHTF Advisory Board in April 2024, and once approved will be annexed to the MHTF BP Phase IV. As the MHTF grows, budget proportions will also be revisited including the proportion allocated to HR.

Regional level allocation

5 percent of the total budget will be allocated to regional budget envelopes designated to support tier II countries. The first year this includes the five regional offices included in phase III but as of 2025 all six regional offices will be allocated a regional budget. This budget will vary depending on need up to USD 600 000 per region inclusive of regional level catalytic activities, such as south-south partnerships, policy advocacy, and accountability.

HQ level allocation

8 percent of funds at HQ and Regional level will be allocated to technical assistance to countries and 2 percent allocated to MHTF contribution to global public goods. This includes support to global partnership, global stewardship and advocacy and support for the development of global public goods/norms and standards, and support for their translation into national commitments and updated national policy.

In line with the TTF Policy, 10 percent of funds will be allocated to the management of the MHTF including visibility and accountability. This encompasses costs associated with secretariat functions of the advisory board, global communications, annual narrative and financial report,

end line report and mid-term evaluation. It also encompasses HR costs associated with coordination of the fund and quality assurance of country and regional multi-year proposals, annual work plans, narrative and financial reports at CO, RO and HQ levels.

Key internal linkages for the MHTF

The MHTF and the UNFPA Supplies Partnership will seek and operationalize synergies. The teams from both programs will maximise the opportunities to complement and support their common objectives: beyond access to FP commodities, UNFPA Supplies provides countries with access to maternal health commodities, including Oxytocin, Misoprostol, Magnesium Sulphate, Calcium gluconate, Heat stable carbetocin, TXA, Mifepristone, combined regiment of Misoprostol and Mifepristone which are essential for MHTF's success. While UNFPA supplies increases this access by strengthening countries' quantification and procurement management of MH commodities and encouraging them to include them in their requests[37], the MHTF will strengthen the countries' readiness and capacity to uptake and use appropriately the full range of life-saving MH commodities (*Output 4)*.

The MHTF mid-term Evaluation 2022 noted that integration happens at the country level - where MHTF programmes, Adolescent SRHR and the Supplies Programme are often united in the same unit. This makes coordination easier, improves efficiencies and ensures opportunities to build synergies that are less likely to be overlooked.

As outlined in the MNHW strategy, in Phase IV these synergies will be further strengthened. To maximise resources and increase efficiencies, as of 2024, MHTF and the UNFPA Supplies Partnership will function in a more coordinated and coherent process such as evidence-based commodity quantification, needs assessments, performance monitoring and operations will be implemented through the coordination of the relevant regional offices. Furthermore, both programmes will co-fund, where possible, human resources at regional and country offices, align internal capacity-building efforts, and promote joint annual strategic planning. Going forward, HQ and regional office technical support to countries in health system strengthening will also increasingly be aligned.

A scale up plan has been developed and is attached in Annex 1. This is a living document and will be adjusted annually to adapt and respond to changes in the context and within UNFPA. . The

[37] National requests to the UNFPA Supplies core Fund and new and lesser used Fund

6.4 Governance and Management

The MHTF is a thematic trust fund and is governed under UNFPA Thematic Trust Fund Policy[38] (2010). As a pooled fund, the MHTF is able to provide flexible, multi-year funding to ensure catalytic investments are fully leveraged to achieve sustainable results. The flexible funding also enables the MHTF to respond to crisis and shocks, as well as address emerging issues as demonstrated by the MHTFs ability to reorient its training of healthcare workers from physical to online trainings during covid,[39] and rapidly approve reprogramming of funds in South Sudan in 2023 in response to the humanitarian crisis.

The MHTF as a pooled fund offers reduced transaction costs due to the shared management, monitoring and reporting mechanism compared to project based funding. The pooled funding mechanism allows MHTF to amplify delivery and results not just for the countries included in the MHTF, but catalyze and share learnings across the UNFPA ecosystem of country offices. It also enables joint oversight by donors through the Advisory Board, experiencing greater impact for the contributions.

Thematic trust funds carry a lower indirect cost rate at 7% compared to 8% for project based funding. The difference in indirect cost rate does not take into consideration the additional direct project management costs of project based funding, such as establishing, monitoring and reporting. The pooled fund thus offers value for money by keeping administrative and direct overhead costs low.

UNFPA, through its structured funding dialogue encourages all Governments to increase their contribution levels to core resources and other high-quality funding instruments, such as the UNFPA thematic funds, inclusive of the MHTF[40] inline with donor commitments under the UN Funding Compact.

Advisory board

The MHTF is benefitting from improved leadership and vision through its Advisory Board established in 2020 for structured engagement with partners/donors.

The Advisory Board is currently chaired by the Director of UNFPA's Technical Division and co-chaired by the Chief of the Sexual and Reproductive Health and Rights Branch, who reports to the Director of the Technical Division. The Board includes donor representatives who currently contribute to the MHTF at global level, UNFPA's Global MHTF Coordinator, relevant MNH team

[38] This policy is likely to be updated during the implementation of phase IV. The MHTF will inform the Advisory Board of any changes needed such the policy be updated.
[39] https://www.unfpa.org/publications/maternal-and-newborn-health-thematic-fund-annual-report-2021
[40] *https://www.unfpa.org/sites/default/files/board-documents/main-document/ENG%20-%20DP.FPA_.2023.8%20-%20Structured%20funding%20dialogue%2C%202022-2023%20-%2019Jun23.pdf*

members and representatives from UNFPA's Policy and Strategy Division, Resource Mobilization Branch, Strategic Partnerships Branch and Strategic Resource Planning Branch.

The MNHglobal team serves as the secretariat of the Advisory Board. Currently, the Board meets twice a year (or as required) to discuss progress and results achieved, and to provide strategic directions and guidance. Whenever possible, meetings will be organised in person, else in virtual or hybrid mode. The board will aim to meet at least once a year back-to-back with the UNFPA Supplies Partnership Steering Committee to ensure alignment on outcome 4.

The MHTF will evolve the Advisory Board into a platform for strategic dialogue including alignment to other MNH initiatives and resource mobilisation in line with the MHTF Evaluation recommendation. The Terms of References will be updated in the first year of phase IV.

The MHTF Advisory board will be complemented by a high level network of influencers, a group of allies to advance the goals of UNFPA/MHTF toward ending preventable maternal deaths. The group will be a network of networks, aiming to leverage already established advocacy platforms for example PMNCH Global Leaders Network, UNFPA private sector partnerships, Philanthropists etc. The network would aim to amplify UNFPA policy priorities and programmatic shifts towards ending preventable maternal deaths.

MHTF in the UNFPA Architecture

The MHTF is coordinated in the Maternal and Newborn Health team in the Sexual and Reproductive Health Branch (SRHB). As of August 2024, the SRHRB will also include the Family Planning Team, which coordinates the UNFPA Supplies Partnership and the Sexual Health Team which coordinates the UNAIDS UBRAF. In addition the new SRHRB will have an operational team that serves both UNFPA Supplies and MHTF.

The Sexual and Reproductive Health Branch reports to the deputy-director of the division of the new Programme Branch which will be established in August 2024. A majority of this new division will relocate to Nairobi, Kenya in 2025 where UNFPA will establish HQ function. The division reports to the Deputy Executive Director, Programmes.

The MNH team coordinates the MHTF and provides strategic direction for UNFPA's Maternal and Newborn Health agenda. The MNH team is made up of the MHTF coordinator, technical experts that, together with the Regional Advisors in each of the UNFPA Regional Offices, provide focused and catalytic technical support to the MHTF TI and TII countries, and support and facilitate south-south learning and partnership across all MHTF countries including Tier III.

As part of the phase IV the MHTF proposes to strengthen the capacity of regional offices in the area of midwifery, MNH financing and knowledge management to support back-stopping to countries across all three tiers and ensure south-south cooperation.

The MNH Team will ensure coherence, harmonisation and proper integration of strategic MNH issues in all SRHR dimensions, including with the UNFPA Strategic Plan and Country Programme Document development processes, and across HQ for coherent and integrated programmatic guidance to countries.

UNFPA MNH team functions

- Global stewardship and development of global public goods for MNH (contribute to norms, standards, strategies, implementation guidelines, measurement tools etc)
- Ensure MNH strategic priorities and high impact practices are embedded in UNFPA architecture (Strategic Plan and Results Framework, Country Program Documents, Global Advocacy and Communications)
- Ensure alignment, harmonization and technical soundness of MHTF funding to RO and CO work plans.
- Technical support and back-stopping to ROs and COs MHTF and non-MHTF countries
- MNH/Global health advocacy and partnerships
- Documentation of good practices, knowledge management and research

As the new MNHW Strategy will guide UNFPA's MNH work, the MNHadvisors and specialists at HQ will guide the operationalization of the new Strategy within UNFPA including through the development of coherent programmatic and technical guidance through a set of high impact practices and working to ensure these are reflected in Country Programme Documents where addressing maternal mortality and morbidity is a priority.

Implementation structure

The MHTF will utilise implementation modalities in line with UNFPA Policies and Procedures Manual. MHTF may implement under the modality National Execution, where Government or NGOs are the Implementing Partners. Partnerships can be also established at regional and global level under Implementing Partner Agreements.

Under the Direct Execution modality, UNFPA implements the programme, following all programmatic and financial policies including procurement policies. UNFPA may also under the MHTF sign an individual contract agreement to perform functions required to fulfil MTHF objectives where UNFPA Human Resources Policies apply. To ensure value for money, UNFPA will strive to use Long-Term Agreements (LTA). The use of LTAs is included as a value for money indicator in the Results Framework.

UNFPA may also sign grant agreements with grantees, for example national midwifery associations, under the UNFPA Grant Policy for institutional capacity building. For specific

strategic collaborations and complementary expertise, UNFPA may sign an UN Agency to Agency Contribution Agreement to achieve the expected results.

6.5 Monitoring, Evaluation and Learning

Monitoring

The new MHTF Results and Indicator Framework will contribute to the SDGs at impact level and UNFPA's Strategic Plan at goal level. At outcome and output level, Strategic Plan indicators are used if assessed as relevant to the MHTF outcomes. In some instances, the MNH team will support further analysis of composite indicators to extract the relevant data. Where Strategic Plan indicators inadequately capture the integrated MNH/SRHR approach of the MHTF, additional indicators are included. At output level, a set of MHTF specific indicators are tracked. The results framework also includes a result area of Management, efficiency and catalytic impact (MEC)

Given the diverse country contexts and required health system strengthening through different technical streams - the country needs to shift over time. Therefore, for MHTF to be responsive to the country team needs, the list of interventions should be seen as a menu, rather than a list that all countries will take on. As such, all MHTF country offices will be expected to report on impact, goal and outcome indicators, but only the output indicators relevant to the strategic interventions being implemented.

The Results and Indicator framework will be complemented by an annual narrative report template for narrative reporting for country and regional level as well as work-plan tracking at intervention level with qualitative progress reporting.

The MHTF phase IV M&E framework will be tabled for approval by the MHTF Advisory Board in April 2024 and will subsequently be annexed to the BP. A review of progress towards work plan milestones will take place twice per year, one at midterm implementation (June) and one at the end of the year (December). A global MHTF annual narrative report is available no later than 30 June for the previous year as is the certified financial statement. A final report will be completed no later than 30 September, following the calendar year that the MHTF Phase IV ends.

Evaluation

The MHTF will launch a midterm evaluation in 2026-2027 providing an independent assessment of the results achieved in Phase IV. The evaluation will be a tool for the MHTF to support learning amongst the key stakeholders, inform adjustments necessary for the remaining 2 years of Phase IV, and serve as an accountability mechanism.

The evaluation will identify lessons and successful practices, and opportunities to strengthen planning, program formulation and implementation. It will also generate better understanding of

the innovations that have been supported by the MHTF and the catalytic impact of MHTF on UNFPAs efforts toward ending preventable maternal deaths.

The midterm evaluation will be led by the Independent Evaluation Office at UNFPA,[41] with the support of a multidisciplinary team of externally recruited experts in technical areas relevant to the MHTF.

Adaptive management and learning

UNFPA:s maternal health team will actively promote UNFPA's corporate adaptive management model within the MHTF Network. A-compass [link] , a first as a comprehensive adaptive management model within the UN, as part of its approach to implement this strategy. The tool supports systematic approach to learning and adaptation to achieve the transformative results

- **Leadership to** develop the mindset and behaviours that allow a person to motivate themselves and others towards achievement of a common shared purpose and goals articulated in the MNH strategy.

- **Collaboration** across all levels of staff members and teams to co-create value within teams and engage and cooperate with broad networks of diverse stakeholders that commit and align to achieve a common purpose or desired results despite having different interests or perspectives.

- **Agility** to rapidly address complex problems efficiently and deliver timely solutions amid fast-changing environments.

- **Learning** to sense, capture, reflect and use the information (from the past and the future) to generate and achieve desired results.

6.6 Budget and Resource Mobilisation

Resource Requirements for MHTF Phase IV – 2024 -2028

The MHTF Phase IV will work towards a significant acceleration of proven maternal and newborn health interventions to support low and middle-income countries with poor SRHR/MNH indicators to come as close to achieving their SDG3 target as possible.

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

The MHTF is requesting **USD 209 900 million** from 2024-2028 for SRHR/MNH programme implementation, acceleration and scale-up as specified in the Business Plan in targeted countries across all six regions.

Draft MHTF budget phase IV						
MHTF Phase IV Budget USD	**2024****	**2025*****	**2026**	**2027**	**2028**	**Total for 2024-2028**
Programme budget*						
Country level						
Activities in line with MHTF IV outcomes tier I countries 56%	$7,840,000	$13,084,112	$20,934,579	$34,018,692	$34,018,692	$109,896,075
Regional catalytic funds to tier II countries 5%	$700,000	$1,168,224	$1,869,159	$3,037,383	$3,037,383	$9,812,150
Human Resources 19%	$2,660,000	$4,439,252	$7,102,804	$11,542,056	$11,542,056	$37,286,168
Head quarters and regional level						$0
Global public goods - 2%	$280,000	$467,290	$747,664	$1,214,953	$1,214,953	$3,924,860
Human Resources technical assistance - 8%	$1,120,000	$1,869,159	$2,990,654	$4,859,813	$4,859,813	$15,699,439
Fund management, visibility accountability - 10%	$1,400,000	$2,336,449	$3,738,318	$6,074,766	$6,074,766	$19,624,299
Total programme costs	**$14,000,000**	**$23,364,486**	**$37,383,178**	**$60,747,664**	**$60,747,664**	**$196,242,991**
IC Indirect cost 7%	$980,000	$1,635,514	$2,616,822	$4,252,336	$4,252,336	$13,737,009
Total Budget	**$14,980,000**	**$25,000,000**	**$40,000,000**	**$65,000,000**	**$65,000,000**	**$209,980,000**

** Budget proportion prior to IC*

*** Transition year from MHTF country allocation model in phase IV including 6 months of support for countries transiting out of the MHTF*

**** New model fully operational*

Integrated strategic communications and resource mobilisation plan

MHTF Phase IV funding target of USD 145 million, UNFPA aims to engage with both public donors and private sector strategic partners (hereinafter referred to collectively as “partners”). The MHTF has established an interdepartmental working group between SRHB, Resource Mobilization Branch, Strategic Partners Branch and Communications Branch which has co-created an integrated communications, partnership and resources mobilisation action plan.

UNFPA estimates an optimal annual operating budget of the MHTF at $65 million and aims to reach this target by the end of phase IV. The growth of the MHTF is expected to be gradual and the Phase IV Business Plan will include a scale up plan to allow for flexible implementation according to well-defined funding scenarios.

2024 and 2025 would constitute the first two years of MHTF Phase IV which is an acceleration phase to reverse the trends on MMR and get back on track to reach the SDGs by 2030. Current estimated revenue, based projections, for $15 million in 2024 and $25 million in 2025, $40 million in 2026, $65 million in 2027 and $65 million in 2028 These rolling targets will be adjusted annually toward the ideal funding level of $65 million.

Core to the MHTF resource mobilisation strategy is:

- Clear and measurable and sustained results at output and outcome level with systematic approaches for measuring contribution to impact level goals and transparency in estimation models and assumptions
- Regularly and reliably communicate results tailored to different audiences as part of global positioning of the MNH agenda and in that context the MHTF including with donors
- Donor relationship management excellence and ensure all deliverables are shared in line with contractual obligations with functional and effective strategic partnership platform through the revised advisory board
- Develop policy briefs, briefing notes, standard talking points and key messages to ensure coherent communication about the MHTF value proposition
- Measure and communication operational effectiveness and efficiencies and effective risk management
- Ensure 80% of resources allocated to countries and focus on countries most in need
- Flexibility and scale to support catalytic results and responsiveness to fragile contexts

The integrated communications, partnership and resources mobilisation action plan is an internal document to UNFPA. The strategy will be presented and further refined in partnership with the advisory board.

6.7 Risks

UNFPA’s Enterprise Risk Management (2022) policy and procedures outline the process and requirements for effective identification, assessment, and response to risks at UNFPA. UNFPA's risks' are organised in an integrated risk framework by key risk categories from the risk appetite perspective (external, delivery, operational, reputational, fiduciary, and safeguarding) and are classified under different IRF components (strategic, programme, funding proposals, processes, projects, ICT, and humanitarian) that provide further granularity through key risk areas and subareas and risk factor. Risk appetite is the amount of risk that UNFPA is prepared to accept, differentiated by risk category, to achieve its objectives on a four point scale: high risk, medium risk, low risk and zero risk. Once risks are identified, an appropriate risk response is selected between: reduce, share, accept or avoid.

The MHTF has undertaken a risk assessment of the MHTF in line with the policy and has a custom risk-register. The risk register is an active tool for MHTF management, updated once a

year with the MNH team annual retreat. All country offices submitting multi-year proposals to the MHTF will also be requested to undertake an MHTF specific risk-assessment to complement the risk assessment part of UNFPA Country Programme Document and Country Office Management. Country risk assessment will inform country ceiling allocation. Risk management will be a standing agenda item on the advisory board and management of risk included as part of the operational effectiveness and efficiency indicators in the results frameworks.

Annex 1. Scale up plan

The MHTF scale-up plan indicates how the new model will be gradually bolstered to ensure adequate capacity to implement an expanded MHTF. The scale up plan is a living document and will be adjusted annually to adapt and respond to changes in the context and within UNFPA. This table will be updated on an annual basis for long term strategic planning for the MHTF and scale up. Introduction of new elements of the new MHTF will depend on available resources. .

Year	2024	2025	2026	2027	2028
Budget	$14,980,000	$25,000,000	$40,000,000	$65,000,000	$65,000,000
Evolving the MHTF model	Transition year from MHTF country allocation model in phase IV, 6 months of support for countries transiting out of the MHTF. No new countries in Tier I or Tier II Regional office support to Tier II countries from phase III only	New model fully operational, new countries added in tier 1, regional envelopes developed to all six regional offices for tier II support. Integrated work-planning with UNFPA supplies for health system readiness to scale up MNH commodities including for PPH and CAC based on country demand	If RMO targets are met, consider including additional countries in Tier 1.	Update MHTF BP based on evaluation findings, prepare for a possible phase V	Prepare for transition to phase V
Scale up MNH HR capacity	August 2024, the MHTF team becomes consolidated MNH team leading UNFPA MNH agenda under the MNHW strategy	Midwifery capacity in ESARO Increase HR capacity in Nigeria, Ethiopia and DRC for	Increase Midwifery capacity in regional offices Increase SRHR/health financing		

	Identify RO thematic centre of excellence for decentralised approach to knowledge management and learning	normativeup-stream policy work RO thematic centre of excellence operational	capacity in regional offices Increase HQ capacity for community engagement		
Introduction of new strategic interventions	Gender Transformative approaches to MNH Community-led monitoring Data and evidence MNH and climate change	Test and demonstrate new approaches for sustainability and scale up in new areas of work Community-led monitoring Development of programmatic guidance MNH and climate change	Document and develop high impact practices.		
New implementing partners		New African research partnerships New community led-monitoring partnerships			
Global advocacy	Launch of Global Midwifery Acceleration Roadmap				

	Launch of Roadmap to Eliminate Obstetric Fistula				
MNHW 2023-2030 strategy	Launch of MNHW strategy	Launch of MNH high impact practices and align Country Programme Documents Further refine MNH indicators to inform UNFPA strategic plan 2026	Increasingly align UNFPA Country Programme to high impact practices		
Key UNFPA Corporate Process	Merger of TD and PSD, merger of SRH and FP branches. Pooling of some operational functions between UNFPA Supplies Partnership and MHTF	MNH team move to Nairobi with new HQ function. Last year of UNFPA Strategic plan 2022-2025, development of new UNFPA Strategic Plan and results framework	New UNFPA Strategic Plan		Mid-term review of UNFPA Strategic plan