



**FONDS FRANÇAIS
MUSKOKA**

For health and well-being of women,
newborns, children and adolescents



2010-2020

of the **10 YEARS
FRENCH FUNDS
MUSKOKA**



“

I know that with you, the French Muskoka Fund, we will find a better future for our female patients and newborns, and the staff will work in better conditions.

And you, as partners, especially the Muskoka Fund, support us by making us competent and motivating, and for that we can only thank you.

”

Prof. Mady Nayama,

Chief Medical Officer of the Issaka Gazobi Maternity Hospital,
Niamey, Niger



ACKNOWLEDGMENT

Since 2010, the French Muskoka Fund has helped building and strengthening an effective coordination and support mechanism. This is the result of a fruitful collaboration between multiple partners who have contributed their expertise, commitment and passion to the French Muskoka Fund over the past 10 years. We would like to thank in particular:

- The French government through the Ministry for Europe and Foreign Affairs for its continuous political, technical and financial support throughout the past 10 years, as well as Minister Jean-Yves Le Drian for renewing France's commitment until 2026;
- The governments of the nine countries where the French Muskoka Fund implements its programmes (Benin, Burkina Faso, Tchad, Cote d'Ivoire, Guinea, Mali, Niger, Senegal and Togo);
- The Regional Directors of UN WOMEN, UNFPA, UNICEF and WHO for their leadership;
- The other UN agencies who have participated in some programmes of the French Muskoka Fund over the years (UNESCO and UNAIDS in particular);
- Parliamentarians from all countries for their support ;
- The Danish government for its contributions in 2019 and 2020;
- The members of the Steering Committee (COPIL) for their strategic guidance;
- The members of the Technical Committee (COTECH) for their coordination and follow-up ;
- The members of the Secretariat for their daily work and liaison with all the teams;
- Our interagency country teams for their tireless efforts on the ground and contributions;
- All our implementing partners at country level;
- All the staff on the ground, and more specifically the caregivers, community health workers, traditional leaders and community radio presenters;
- All our partners from the civil society, youth organisations, bloggers, influencers and activists;
- Our media partners;
- Dr Alimou Barry, Dr Gilles Landrison and Ms. Jade Maron for all their work on data gathering and on putting together this clear and concise report;
- And eventually to all those who have supported and contributed to the efforts of the French Muskoka Fund to help improve the health, well-being and nutrition of women, newborns, children, adolescents and youth in Central and West Africa.



ACRONYMS

AFD	French Development Agency
AFOG	African arm of the International Federation of Obstetrics and Gynaecology
ANC	Antenatal care
ARI	Acute Respiratory Infections
AYSRH	Adolescent and youth sexual and reproductive health
CBD	Community-based distribution
CEEAC	Economic Community of African States Central
CHW	Community Health Worker
CHW	Community Health Worker
CSE	Comprehensive sexuality education
CSO	Civil society organization
DHS	Demographic and Health Survey
DPMED	Directorate of Pharmacies, Medicines, and Diagnostics (Benin)
DREN	Regional Directorate of National Education (Côte d'Ivoire)
EB	Exclusive Breastfeeding
ECD	Early childhood development

ECOWAS	Economic Community of African States Central
EFP	Essential Family Practices
EmONC	Emergency obstetric and neonatal care
EPI	Expanded Programme of Immunization
FFM	French Muskoka Fund
FP	Family planning
GBV	Gender-based violence
HC	Health center
HD	Health district
HHA	Harmonization for Health in Africa
IDSR	Integrated Disease Surveillance and Response
IHC	Integrated Health Center
IMCI	Integrated management of childhood illnesses
IMNCI	Integrated Management of Newborn and Childhood Illness
INFAS	National Institute of Health Workers
IYCF	Infant and Young Child Feeding
KMC	Kangaroo mother care

MA	Marketing Authorization
MDSR	Maternal death surveillance and response
MEAE	Ministry of Europe and Foreign Affairs (France)
MMR	Maternal Mortality Ratio
MNCH	Maternal, newborn and child health
MNDSR	Maternal and Neonatal Death Surveillance and Response
MPDSR	Maternal and Perinatal Death Surveillance and Response
NGO	Non-governmental organization
NHPD	National Health Development Plan
SRMNIA-Nut	Sexual, Reproductive, Maternal, Newborn, Infant and Adolescent Health and Nutrition
PHC	Primary health care
PMTCT	Prevention of Mother-to-Child Transmission
PPIUD	Postpartum intrauterine device
PPPAFP	Post-partum and Post-abortion Family Planning
PSBI	Possible Severe Bacterial Infection in Young infants
RDT	Rapid Diagnostic Test

RED	Reaching Every District
RHC	Regional Hospital Center
RMNCAH	Reproductive, Maternal, Newborn, Infant and Adolescent Health
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SUN	Scaling Up Nutrition
SWEED	Sahel Women's Empowerment and Demographic Dividend
TDC	Technical Director of Centre (of health)
UAC	African Union Commission
UH	University Hospital
UHC	Universal health coverage
WAHO	West African Health Organization
WCA	West and Central Africa
WHO	World Health Organization



PROLOGUE

The French Muskoka Fund celebrates its 10th anniversary this year. As France's contribution to the commitments for maternal and child health made by the G8 countries in 2010 in Muskoka, Canada (after which it was named), this effective partnership relies on the complementary expertise of four United Nations agencies: UN Women, UNFPA, UNICEF and WHO.

Its rare longevity can be explained by its innovative approach, its ability to adapt to the local context, and above all by the results it has achieved in reproductive, maternal, neonatal, child and adolescent health as well as nutrition – as many issues that are at the center of France's development strategy. This initiative also contributes to the implementation of the “great cause” of France's diplomacy: equality between women and men.

The French Muskoka Fund implements “high-impact interventions” (whose effectiveness has been carefully reviewed and which help leveraging the impact of national policies) in nine countries of Central and West Africa: Benin, Burkina Faso, Chad, Cote d'Ivoire, Guinea, Mali, Niger, Senegal and Togo.

In line with the 2030 Agenda and the Global Strategy for Women's,

Children's and Youth Health (2016-2030), this partnership aims at achieving sustainable results through a multi-sectoral approach and health systems strengthening (including community health systems).

The French Muskoka Fund supports its beneficiaries in both urban and rural areas throughout their life cycle: from pregnant women and mothers to newborns, children, adolescents and youth. In 10 years, this inclusive approach has allowed the French Muskoka Fund to achieve significant results. As example, more than 70,000 health workers have been trained; infant and child mortality has decreased by more than 30%; the rate of births attended by qualified personnel has increased from 50 to 70% in Côte d'Ivoire; and 1.6 million children have been treated for malaria, diarrhea and respiratory infections in Guinea.

The COVID-19 pandemic has strained the resilience of health systems in West and Central Africa. More than 300,000 cases have been officially diagnosed since March 2020 - affecting many health workers and there are probably many more. There has also been a sharp decline in the use of health care services. As example, children's consultations for infectious diseases have declined by 25% in Senegal. To limit the impact of the pandemic and help maintain essential services for women, children and

adolescents, the French Muskoka Fund is supporting governments with innovative responses, such as in Niger where mobile teams (midwives, nurses and gynecologists) are being deployed to decentralize pre- and post-natal care, or in Chad where community health workers have been helping monitor women victims of gender-based violence. Funding dedicated to health systems strengthening has also been increased and now accounts for a quarter of the Fund's budget.

France is convinced that this partnership is a relevant response to the challenges of reproductive, maternal, neonatal, child and adolescent health and nutrition in West and Central Africa. This is why the French Muskoka Fund was showcased throughout the Generation Equality Forum organized in Paris in July 2021, and especially under the Action Coalition on sexual and reproductive health and rights. France has also renewed its commitment by extending its 10 million Euro financial contribution for another five years (until 2026). The Fund itself has committed to investing more in the development of edutainment tools to act on social norms and to accompany behavioral changes in a sustainable and equitable manner - capitalizing on the successful initiative «C'est La Vie!/That's Life» (a TV and radio show that it is produced and broadcast in local languages throughout West and central Africa).

I therefore wish a long life to the French Muskoka Fund, encourage all its actors to continue their efforts, and thank them for contributing to improving the health and wellbeing of the populations in West and Central Africa by providing more equitable life opportunities to all women and their newborns.

Philippe Lacoste

Director of Sustainable Development
Ministry of Europe and Foreign Affairs





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2011-2020

and **OBJECTIVES
BACKGROUND**

As a partnership between the French Ministry of Europe and Foreign Affairs, four United Nations agencies (WHO, UN Women, UNFPA, UNICEF) and nine countries in West and Central Africa, the French Muskoka Fund (FMF) aims to reduce maternal, neonatal, child and adolescent mortality and morbidity among targeted countries, as well as the vulnerability and inequities faced by these populations. The FMF strategy is based on the implementation of high-impact health interventions, within the framework of continuity of care, in line with the national health development plans of the relevant countries.

This Fund was implemented by France during the G8 Summit in Muskoka, Canada, in June 2010, for an initial duration of 5 years (2011-2016). Extended for two additional years (2017-2018), then renewed for 5 years (2018-2022). France has invested 143 million euros to support the joint work of four UN agencies to improve the health and well-being of mothers, newborns, children and adolescents in the region. In 2021, the FMF is celebrating its 10th anniversary, during which the fund has successfully demonstrated its relevance and sustainability:

- The FMF targets the most vulnerable populations (women, girls, mothers, newborns, children, and adolescents) in nine West and Central African countries (Benin, Burkina Faso, Chad, Côte d'Ivoire, Guinea, Mali, Niger, Senegal, and Togo) whose maternal and child health indicators remain of concern.
- It is based on an H4+/H6 modus operandi (United Nations agencies with health mandates), operational since 2011, and which strengthens coordination with all technical and financial partners, and induces leverage effects with other institutions involved in health development, through activities it can initiate.
- It is a highly stable "UN task force", with a team of experts from four agencies of country, regional and headquarters offices, who have been working together for several years, meeting regularly for methodology, programming or reporting methods they have in common, in front of interlocutors and policy makers whose mandates are not always long-term. The multiannual character of the French funding mechanism for the FMF and the securing of its budget contribute to the sustainability

and accountability of the programme. The stability of the FMF team is a guarantee of efficiency, visibility and credibility.

The 2010-2020 decade saw a growing awareness among policy-makers about the importance of focusing on vulnerable populations, such as women, mothers, newborns, children and adolescents, who are at the heart of human capital development. The FMF, along with other TFPs, has largely contributed to this through its actions and its communication policy (see below).

This focus on reproductive, maternal, newborn, child and adolescent health (RMNCAH-Nut) has created an enabling environment for the development of FMF activities. For example, for the year 2019, the following can be noted:

- **In Benin:**

- The organizational reform of the Ministry of Health is implemented through the creation of a National Agency for Primary Health Care, which brings together all the entities involved in maternal health and child survival, including response to outbreaks.
- One of the key events of 2019 in RMNCAH-Nut was the implementation of the initiative to promote and protect sexual and reproductive health and rights in the country.

- **In Côte d'Ivoire:**

- A priority action plan for the reduction of maternal, neonatal and infant mortality was developed by the country to accelerate efforts in this area.
- A promotion campaign for maternal, neonatal and child health was initiated and conducted by the Minister of Health, involving the commitment of the entire prefectural body of the country.
- The implementation of Kangaroo Mother Care (KMC) units for the management of low-weight newborns to reduce neonatal mortality.

- The definition and implementation of the government's Social Plan, which places particular emphasis on maternal and neonatal health through the improvement of the supply of care, increased monitoring of the free delivery and C-section policy and the management of newborn and child illnesses.
- The effective operationalization of the national health insurance called Universal Health Coverage (UHC).
- The establishment of a national committee for the fight against maternal death presided over by the Minister of Health.

• In Guinea:

- Setting up of the multisector nutrition committee in August 2019 led by the Prime Minister's Office; launching of the budgeted national FP action plan;
- Adoption of the communication and advocacy plan for the mobilization of nutrition resources with the support of the SUN Movement.

• In Mali:

- Elaboration of the investment case for the operationalization of the RMNCAH-Nut plan.

• In Niger:

- The country has a new national population policy, the main objective of which is "to have a well-educated, skilled, Healthy population with job opportunities". It is against this backdrop that the Muskoka 2019 funding action plan was implemented.

• In Senegal:

- Within the framework of the fight against violence against women, Senegal reported a significant progress with the adoption, in December 2019, of the law criminalizing rape and pedophilia.

• In Chad:

- A ministerial order was signed on 22 August 2018 and completed by that of 14 March 2019 establishing the Technical Platform for Coordination and Monitoring of Interventions in Reproductive, Maternal, Neonatal, Child, Adolescent Health and Family Planning (RMNCAH-Nut/PF) to contribute to the improvement of the RMNCAH-Nut through the coordination and implementation of activities. The chair is held by the Deputy Director General of the Ministry of Public Health

Regarding communication and visibility, for 10 years, the FMF took part in and contributed to many national and international events. (See infra).

The FMF model was a groundbreaking work. In 2018, the Danish government expressed interest in getting involved in the development of RMNCAH-Nut and called on the FMF, its teams and methodology to develop specific identified activities. Therefore, an additional funding of 3 million euros per year for a period of 2 years (2019-2020) was granted.

Global Context for Maternal, Newborn, Child and Adolescent Health

If countries want to achieve the Sustainable Development Goals (2030), women's, newborn, child and adolescent health should remain central. Today, the framework for action is set with the Global Strategy for Women's, Children's and Adolescent's Health, 2016-2030 (an unprecedented global movement spearheaded by UN Secretary-General Ban Ki-moon that mobilizes and intensifies international and national action by governments, the UN, multilaterals, the private sector and civil society to address the major health challenges facing women, children and adolescents) and the necessary knowledge is available to end all preventable deaths of women, children and adolescents. These deaths are preventable because their causes can be recognized and analyzed, and required medical interventions already exist, are well known and are applicable.

In terms of RMNCAH-Nut, there is a major imbalance between high and low income countries.

Women's and girls' health needs special consideration. In many societies they are disadvantaged due to discriminations rooted in socio-cultural factors. For example, they are more vulnerable to HIV/AIDS. In sub-Saharan Africa, six out of seven new HIV infections among adolescents aged 15-19 years are noted among girls. Young women aged 15 to 24 are twice as likely to be infected with HIV as men (UNAIDS sources).

Socio-cultural factors preventing women and girls from having access to quality health services and achieving the best possible health status include:

- **unequal relationships between men and women**
Within the region, 9 million girls aged 6 to 11 will never attend school compared to 6 million boys, according to UIS data. 23% of girls do not attend primary school compared to 19% of boys. During adolescence, the exclusion rate for girls is 36% compared to 32% for boys;
- **social norms that reduce their opportunities for education and gainful employment;**
- **a vision of the woman exclusively centered on her procreative and reproductive role;**

Seven West African countries, including five in the FMF intervention areas, are among the 20 countries with the highest rate of early marriage in the world (Niger (1), Chad (3), Mali (5), Guinea (6), Burkina Faso (8), Sierra Leone (13) and Nigeria (14)].

- **threats or actual physical, sexual, psychological and economic violence.**

In 2020, the humanitarian needs overview and associated humanitarian response plans for Burkina Faso, Mali and Niger identify 2.3 million women and girls in need of GBV services.

While poverty is a significant barrier to improving both men's and women's health, it tends to put an even greater burden on women's and girls' health due to, for example, their dietary habits (malnutrition).

The future of any society lies with its children, whose health, growth and development should be guaranteed. Children are likely to be victims of malnutrition and infectious diseases, often preventable or effectively treatable. According to the UNICEF, WHO, World Bank joint child malnutrition estimates (2020 edition), 7.3 million children were suffering from wasting (severe and moderate) in West and Central Africa in 2019. An additional 20% are at risk for 2020 due to Covid 19 pandemic, i.e. 15.4 million cases of acute malnutrition among under-five children, one third of which will be in the severe form. Vulnerable children tend to suffer from multiple and overlapping deprivations frequently associated with poverty, residency in rural areas, and lack of education. In Sub-Saharan Africa, children do not yet benefit from cross-sectoral services that should help address overlapping deprivations such as health, nutrition, water and sanitation, early childhood development, and protection services, thereby promoting survival and

Adolescents, i.e. young people aged 10 to 19, are often thought of as a healthy population group. However, many die prematurely from accidents, suicides, violence, pregnancy-related complications and other preventable or treatable diseases. 50% of ever married adolescent girls aged 15-19 and physically or sexually abused never shared it with someone. Only 29% sought help.

Many more suffer from chronic diseases and disabilities. In addition, many serious diseases in adulthood have their roots in adolescence. Smoking, sexually transmitted infections, including HIV, poor dietary habits, and sedentary lifestyle, for example, lead to morbidity and premature death later in life.

The countries of the South, and in particular those of sub-Saharan Africa, present the most alarming indicators. The countries of the South, and in particular those of sub-Saharan Africa, present the most alarming indicators in RMNCAH-Nut. As an example, the cumulative lifetime risk of dying from a pregnancy or childbirth-related complication in 2017 varied widely across countries and continents. In Chad, this risk is the highest: 1/15 and much lower 1/65 in Senegal. Among world regions, women in sub-Saharan Africa face the greatest risk 1/38 followed by South East Asia 1/240. Globally, the risk in poor countries is 1/45 compared to 1/5400 in developed countries with a global average of 1/190.

Regional context of RMNCAH-Nut

The current situation in West and Central Africa, and more specifically among the French Muskoka Fund' partner countries, remains worrisome, even though ahead of the MDGs of 2015, Niger achieved MDG 4 and two countries targeted by the FMF, Burkina Faso and Côte d'Ivoire, are among the 20 African countries that have tripled their annual child mortality reduction rates and reversed the child mortality trend between 2000 and 2017.

The area of intervention of the French Muskoka Fund in 8 West African countries (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Niger, Senegal and Togo) and in one Central African country (Chad) represents a total population of approximately 150 million inhabitants, one of the most disadvantaged in the world.

Beyond the cyclical shocks experienced by the region (conflicts, epidemics, natural disasters), most of women and children are affected by vulnerability and chronic poverty. Among the world's 10 countries with the lowest Human Development Index, 4 (Mali, Chad, Central African Republic, Niger) are from the "FMF" region (2016 HDI), the remaining 4 are in the 25 countries with the lowest HDI. This part of the world is known for its poor levels of access to basic social services, poor levels of education, especially among young girls, one of the highest levels of maternal and infant mortality in the world, persistent gender-based violence, etc.

The countries targeted by the FMF represent the region with the highest levels of maternal mortality with an estimated 31500 maternal deaths in 2017. This is attributable to inadequate management of the main causes of maternal mortality: hemorrhage, hypertension and infections. The coverage of maternal health services is also still low and the quality of care does not meet the expected standards.

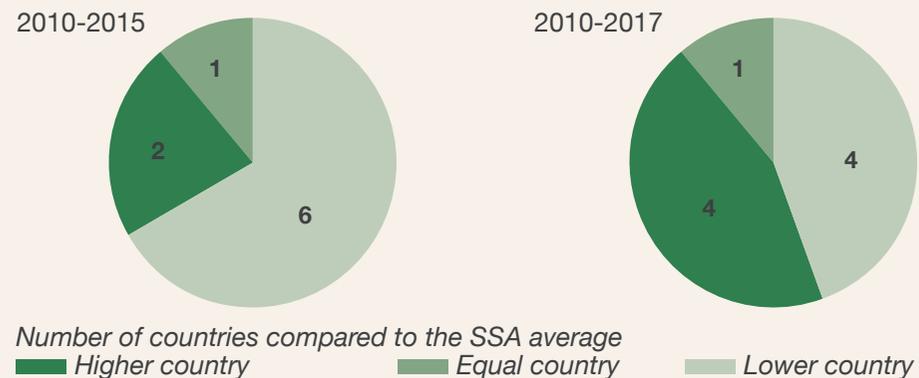
Observed reduction rates in maternal mortality ratios show significant progress with reductions ranging from 23% to 6% between 2010 and 2015 in the first five years of the FMF and greater progress in the first seven years of the project with double-digit reductions for all countries except Chad [see tables].

Table 1: Evolution of MMR rates by country and observed rates of change for 2010-2015 and 2010-2017

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo	SSA	World
1990	576	727	745	1040	1010	873	540	1450	568	996	380
2000	520	516	704	1020	836	813	553	1420	489	878	342
2010	464	385	701	747	660	663	447	1240	440	635	293
2015	421	343	658	699	620	555	346	1160	398	566	219
2017	397	320	617	576	562	509	315	1140	396	542	211
2010/2015	-9%	-11%	-6%	-6%	-6%	-16%	-23%	-6%	-10%	-11%	-26%
2010/2017	-14%	-17%	-12%	-23%	-15%	-23%	-30%	-8%	-10%	-15%	-29%

Sources: (1) Executive summary, trends in MM 1990-2015 pour l'année 1990, (2) Trends in Maternal mortality 2000-2017 Estimates by WHO, UNICEF, UNFPA World Bank and the United Nations Population Division

Figure 1: Distribution of FMF countries in relation to the average reduction in MMR in Sub-Saharan Africa for 2010-2015 (-11%) and for 2010-2017 (-15%)



Under-5 mortality

Considering the 2015 countdown, data collected from the estimates of UN Interagency group for Child mortality/childmortality.org show that Niger with a 71% reduction (328 deaths per 1000 to 80 per 1000 births between 1990 and 2015) had achieved the target, while all the other countries of the FMF made significant progress ranging from a minimum of 39% in Chad to an appreciable 62% in Senegal. These were deemed insufficient for the target.

As a whole, regarding under-five mortality in the African region:

- the probability of dying before the age of 5 is 24 times higher in European countries;
- the neonatal mortality is the most important cause (31%) among under 5 children;
- infectious and preventable diseases are still killing children. The epidemiology of child mortality has not changed significantly in comparison to 1990 - malaria, respiratory infections and diarrhea are still major leading cause of death among under 5 children representing 10%, 16% and 10% of child deaths respectively;

It should be noted that non-communicable diseases and trauma (road accidents, domestic accidents) account for a large proportion of the causes of death (15% in total), but also that healthcare seeking behavior remains one of the major factors limiting early management of childhood diseases.

Under 1 mortality

Progress in child survival in FMF target countries since 1990 has been significant. The under-five mortality rate has declined significantly, with a reduction of by 61% in Niger [133/1000 to 52/1000 between 1990 and 2015] despite all the challenges faced by this region, both chronic (political instability, conflicts, etc.) and acute (Ebola epidemic, recurrent cholera, measles, meningitis, etc.). The minimum reduction in under-1 mortality observed for the 1990-2015 countdown was 32% in Chad with a maximum of 61% in Niger. However, the region's high fertility rate and

increasing need for quality child care are increasing the pressure on health services and may slow progress.

Almost two-thirds of the population of West and Central Africa are under the age of 24, 32% between 10 and 24. In the countries targeted by the FMF, each woman has an average of 5 children (7.6 for Niger) compared to an average of 2.5 in the world, and only 14% of women aged 15 to 49 use a modern contraceptive method. The teen pregnancy rate (149/1000) is three times higher than global rate, with more than one in ten girls aged 15-19 giving birth.

In the developing world, WCA is the region with the highest percentage of childbirth among girls aged under 15 - 6% - yet these girls (14 and under) are the most vulnerable and most at risk of complications and death as a result of pregnancy. 80% of unintended pregnancies among 15-19 year age group occur among adolescent girls who do not use modern contraceptive methods or rely on traditional methods. 16% of girls, compared to 7% of boys, have sexual intercourse for the first time before age of 15. Compared with other age groups, adolescents who are married or living with a partner have the lowest rates of modern contraceptive use.

Two out of five girls in Sub-Saharan Africa are married before the age of 18. The consequences of early marriage in terms of maternal health, particularly through early pregnancy, are manifold. Pregnancy-related complications are the leading cause of death for girls aged 15 to 19. Fistula, resulting from harmful practices (early and forced marriage) and lack of access to care, is a physical, psychological and social tragedy.

Adolescent girls are the first victims of the lack of access to and quality of maternal and reproductive health care, too often out of school, vulnerable to early marriage, facing unwanted pregnancies and the primary victims of HIV/AIDS.

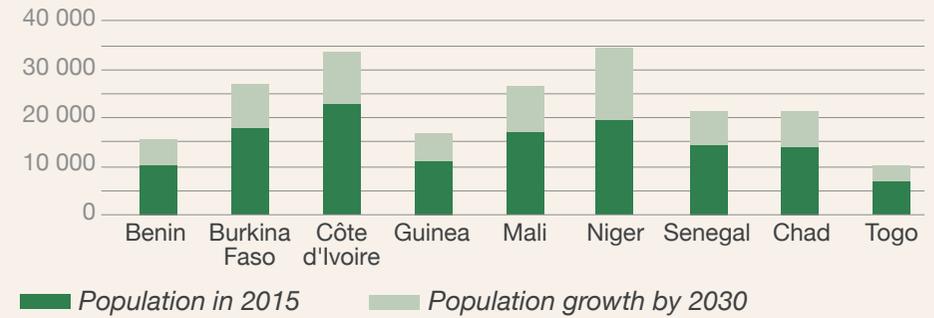
Health Human Resources

Globally, Africa had a shortage of 2.7 million doctors, nurses, and midwives in 2013, well below the critical threshold of 4.45 doctors, nurses, and midwives per 1,000 indicated in the Global Strategy on Human Resources for Health Workforce 2030. The total deficit is 4.1 million health workers, with a projected deficit of 6.1 million health workers by 2030.



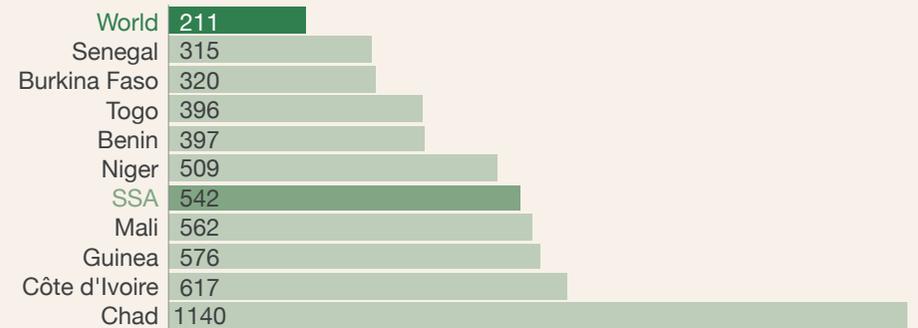
The FMF target countries

Figure 2: Current Population of Muskoka Countries and Projections by 2030 (in thousands)



Maternal, Newborn, Child and Adolescent Health in Muskoka countries

Figure 3: Maternal Mortality Ratios per 100,000 births for FMF countries, Sub-Saharan Africa and World in 2017

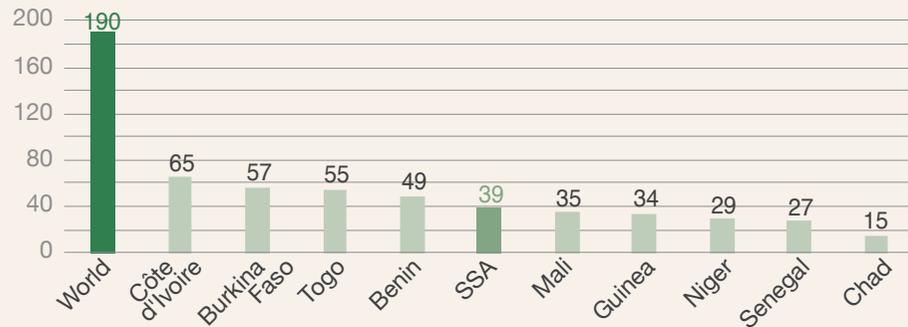


Source: Trends in Maternal Mortality 2000-2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations population Division

Lifetime risk of maternal death

On average, in the 9 FMF countries, the risk of maternal death decreased from 4.83% in 2000 to 3.86% in 2010 to 3% in 2017. Better still, 4 countries (Benin, Burkina Faso, Côte d'Ivoire, and Togo) out of 5 are doing better than the average for Sub-Saharan Africa [Figure 5] for a percentage of 0.53% for the world average. Only Niger and Chad have higher risks than the average for West and Central Africa.

Figure 4: Lifetime risk of maternal death in 2017



Pregnancy rates among teens aged 15 to 19 ((149/1000) is three times higher than global rate, with more than one in ten girls aged 15-19 giving birth¹.

Under-five mortality remains very high, but has experienced downward trends in all FMF countries. In 2010, it was 66% in Senegal and 149% in Chad compared to 45% in Senegal to 134% in Chad in 2019.

Figure 5: Under-5 mortality rate per 1,000 births in 2019

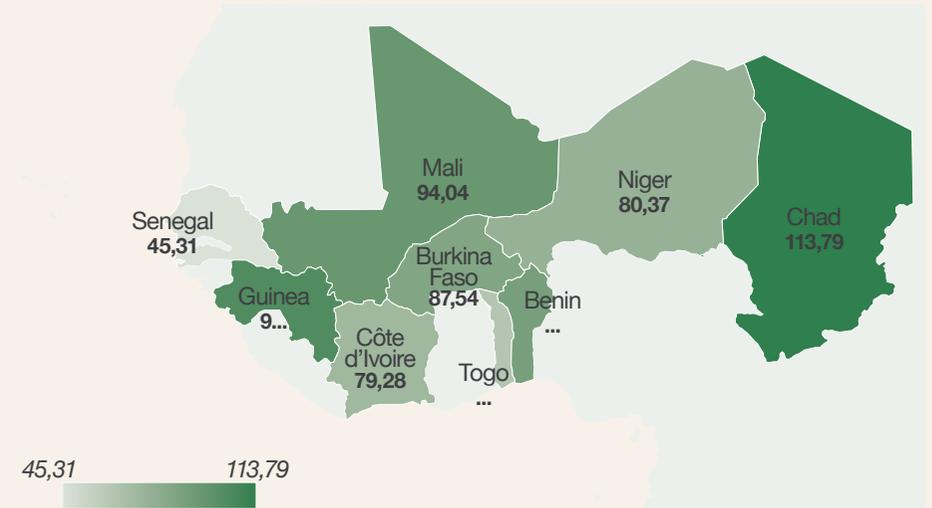
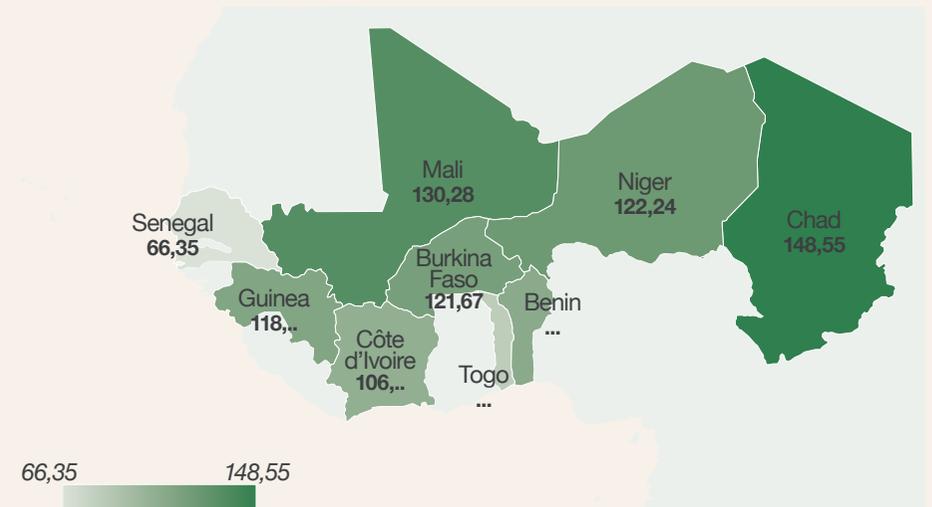


Figure 6: Under-5 mortality rate per 1,000 births in 2010



Under-1 mortality ranged from 43% to 32% between 2010 and 2019 in Senegal compared to 84% to 69% in Chad for the same period.

Figure 7: Infant mortality rate per 1,000 births in 2019

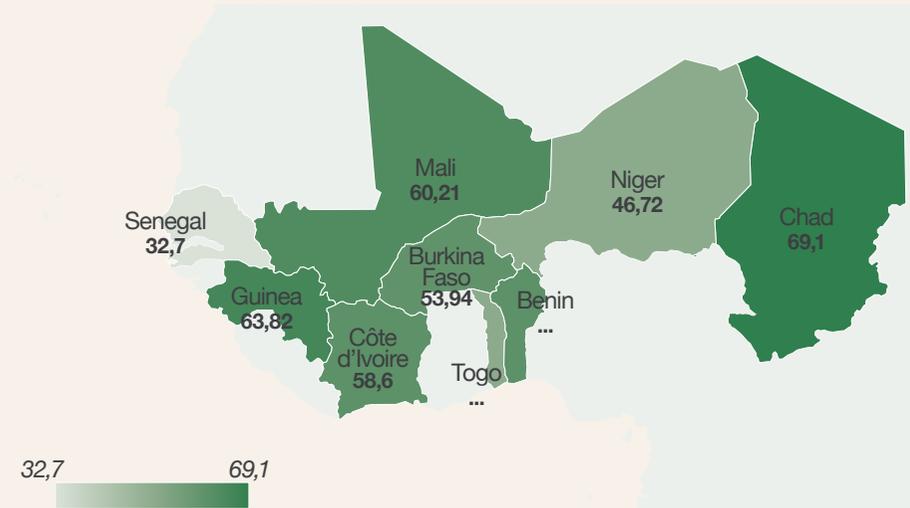
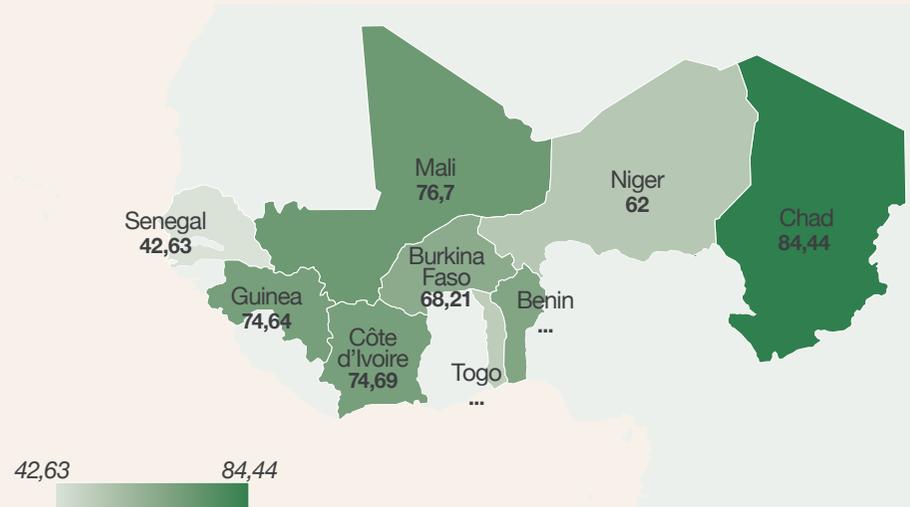


Figure 8: Infant mortality rate per 1,000 births in 2010



Global evolution between 2010 and 2019

Since the inception of the FMF programme, there has been a decrease in maternal mortality ratios and infant and child mortality rates, to which the FMF has contributed through the establishment and implementation of its high-impact interventions.

Progress on maternal mortality is encouraging but still insufficient. Among the 9 FMF countries, the maternal mortality ratio fell from 541 to 402 per 100,000 live births between 2015 and 2017, a 26% reduction. This average ratio remains very high as it is 1.9 times higher than the global rate of 211 and 33.5 times higher than those of industrialized countries (402 versus 12).



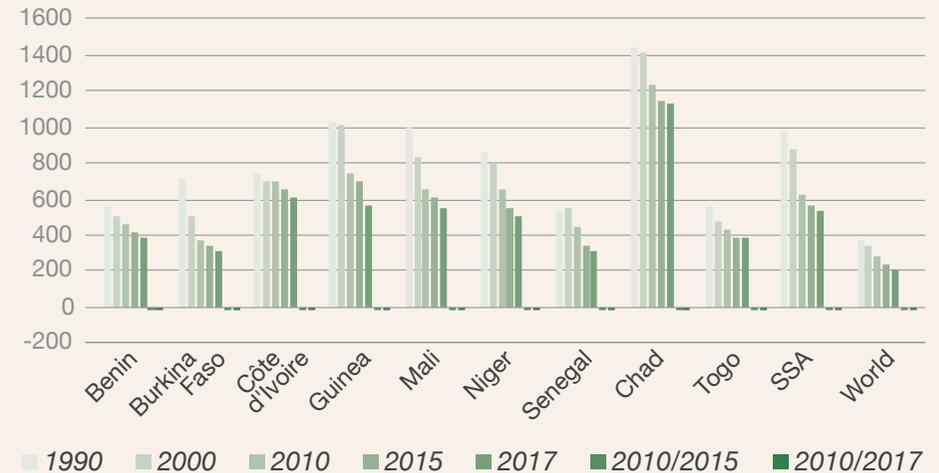
“

Obviously, the French Fund has contributed significantly to the acceleration of maternal and neonatal mortality impact indicators.

”

Dr Amadou Doucouré,
Director of Maternal and Child Health,
Ministry of Health and Social Action, Senegal

Figure 9: Distribution of maternal mortality ratios between 1990 and 2017



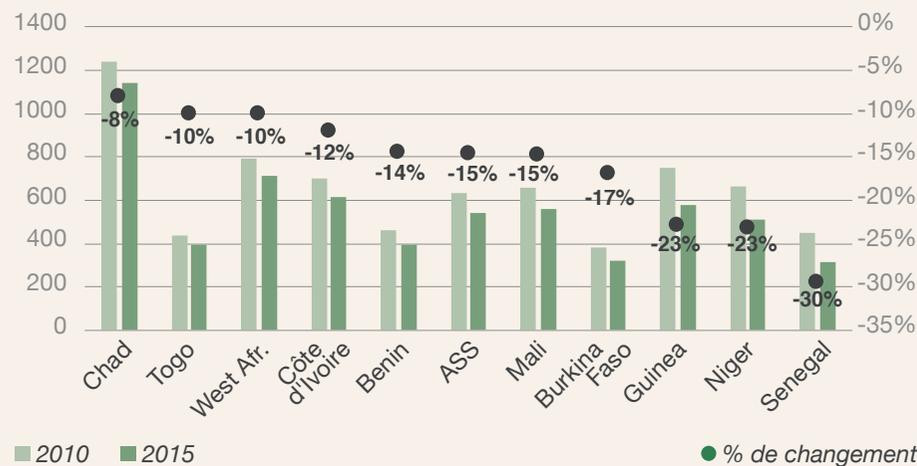
Sources: [1] trends in Maternal Mortality 1990-2015, [2] Trends in Maternal Mortality 2000-2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations population Division

	Ben	BF	CI	Gui	Mal	Nig	Sen	Ch	Tog	SSA	World
1990	576	727	745	1040	1010	873	540	1450	568	996	380
2000	520	516	704	1020	836	813	553	1420	489	878	342
2010	464	385	701	747	660	663	447	1240	440	635	296
2015	421	343	658	699	620	555	346	1160	398	566	248
2017	397	320	617	576	562	509	315	1140	396	542	219
2010/2015	-9%	-11%	-6%	-6%	-6%	-16%	-23%	-6%	-10%	-11%	-16%
2010/2017	-14%	-17%	-12%	-23%	-15%	-23%	-30%	-8%	-10%	-15%	-26%

Figure 10: Maternal mortality ratios per 100,000 births in FMF-supported countries, SSA and West Africa, 2010-2017



Figure 11: Maternal mortality ratios per 100,000 births in FMF-supported countries, SSA and West Africa, 2010-2015

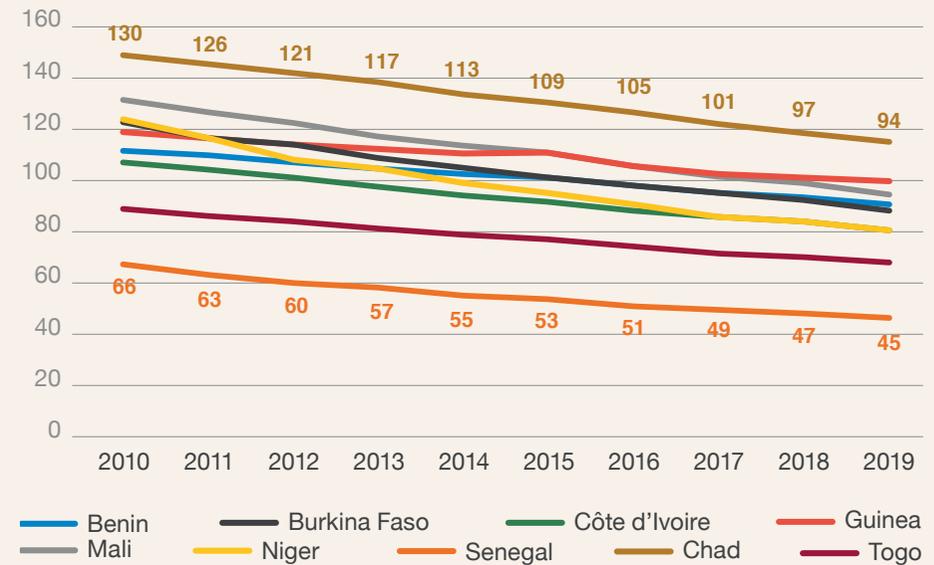


The two figures above clearly show the progress made during the first phase of the FMF and two years later with greater levels of MMR reduction.

The status of children has improved:

The general trends observed in under-five mortality among the FMF countries show a decline between 2010 and 2019, as illustrated in the following figure, with two statistically significant declines for Mali and Senegal.

Figure 12: Evolution of under-five mortality rates, 2010-2019



During the 2010-2019 FMF phase, the % of reduction ranged from 16% in Guinea to 34% in Niger. Benin (19%) and Guinea were the two countries that recorded reductions of less than 23%.

These reductions in under-five mortality rates per 1,000 births led to statistically significant differences as illustrated in the graphs below for Senegal and Mali.

Figure 13: Under-five mortality in Senegal, (80% safety), 2010-2019

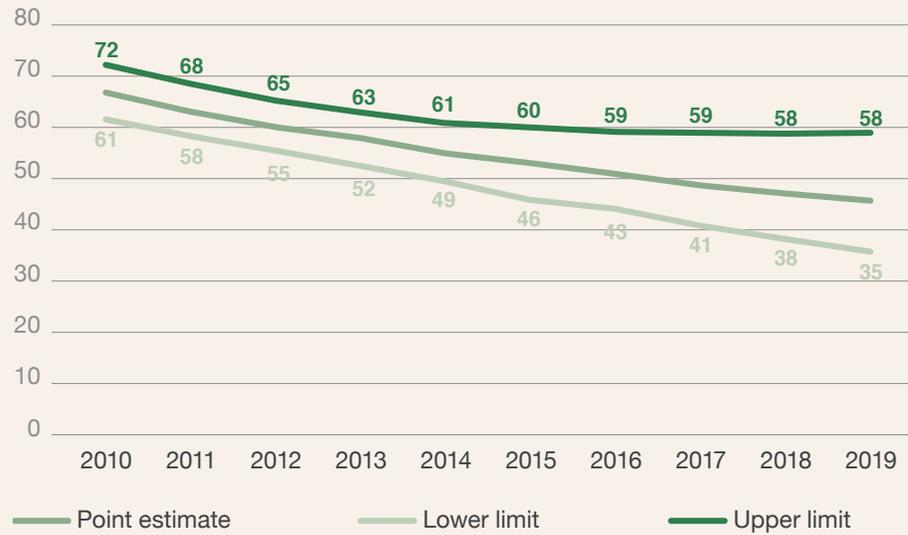


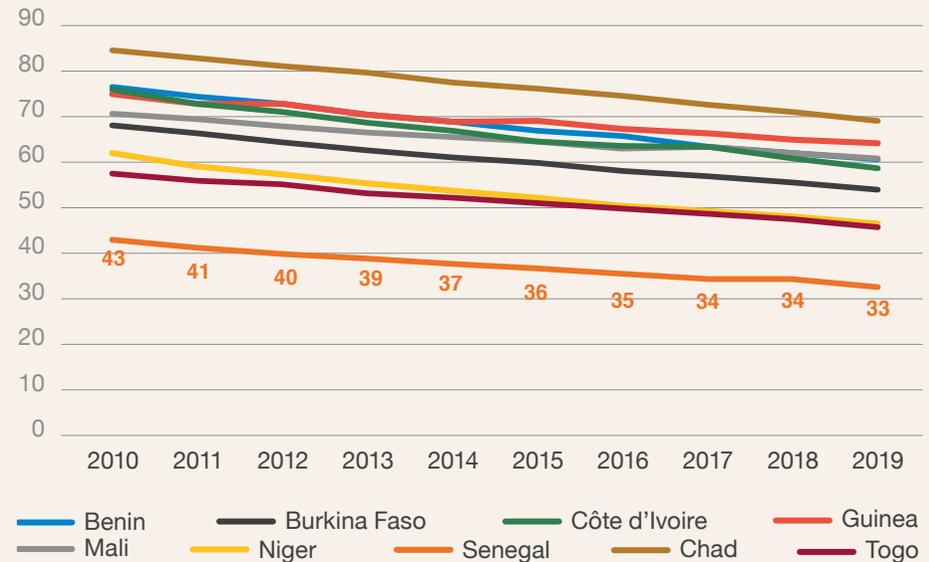
Figure 14: Under-five mortality in Mali, (80% safety), 2010-2019



Mortality <5years	Years	Point estimate	Lower limit	Upper limit	Statistical situation
Senegal	2019	45	35	58	SS
	2010	66	61	72	SS
Mali	2019	94	76	117	SS
	2010	130	120	142	SS

For children under 1 year old, if we compare 2019 to 2010, the start of the project, we observe reduction levels of at least 20% for the majority of FMF countries, with the exception of Guinea (14%) and Benin (16%).

Figure 15: Evolution of under-one mortality rates, 2010-2019



Analyses taking into account the confidence intervals of the estimates indicate statistically significant differences for Mali and Senegal for this indicator with strong trends of reduction close to 80% significance for some countries.

Figure 16: Under-one mortality in Senegal, (80% safety), 2010-2019



Figure 17: Under-one mortality in Mali, (80% safety), 2010-2019



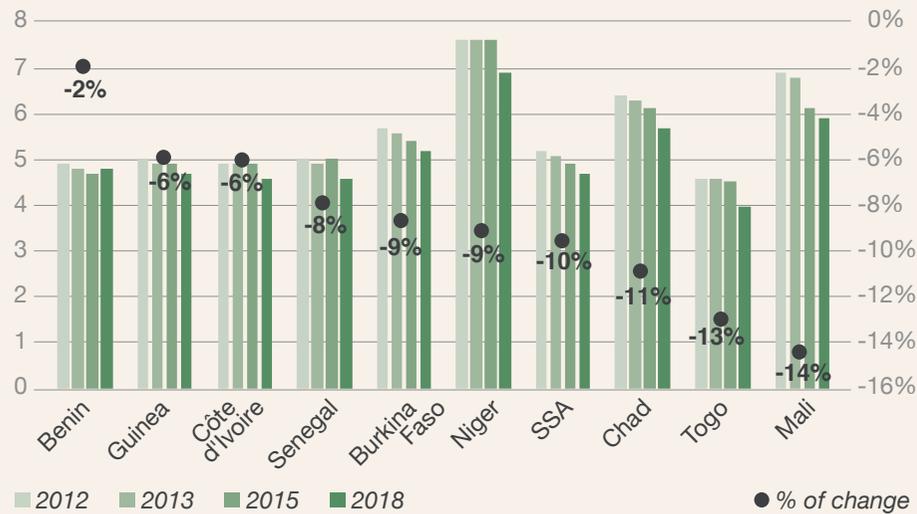
Maternal mortality	Years	Point estimate	Lower limit	Upper limit	Statistical situation
Senegal	2019	33	27	39	SS
	2010	43	40	45	SS
Mali	2019	60	51	71	SS
	2010	77	72	82	SS



Family planning

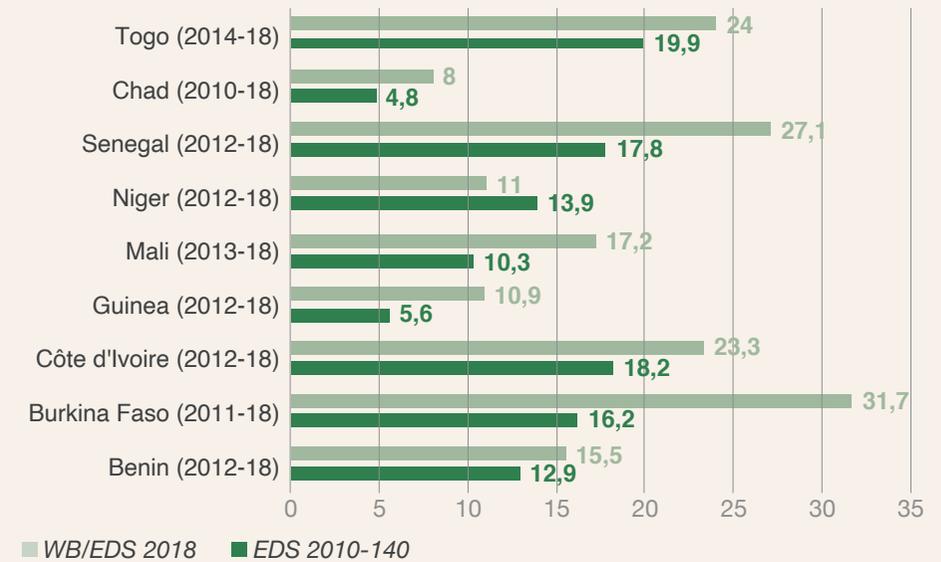
In all countries except Niger, the number of children per woman is steadily declining, with reduction rates of up to 14% in Mali between 2012 and 2018 (from 6.9 to 5.9 children per woman) followed by Togo with a 13% reduction (from 4.6 to 4 children per woman). Niger has the highest number of children per woman: 6.9 in 2018, compared to an average of 4.7 in Sub-Saharan Africa (10% reduction) for the same year. There was a slight improvement in Benin and Chad with reduction rates of 2% for each country.

Figure 18: Evolution of fertility rates and percentage of reduction 2018/2012 in FMF and SSA countries



Sources: Situation des enfants dans le monde/United Nations iLibrary/ www.un.iLibrary.org

Figure 19: Evolution of contraceptive prevalence in FMF countries (all methods)



Source: World contraceptive use 2020, The United states/www.un.org



FONDS FRANÇAIS MUSKOKA



2010-2020

INTERVENTION MECHANISM *of the* FMF

The French Muskoka Fund (FMF) targets the population consisting of women, children, pregnant women and newborns, and adolescents in West and Central African countries.

This is an innovative mechanism for coordination, technical support, and implementation at the regional and national levels of high-impact interventions to fight against morbidity and mortality and improve access and quality of care for this highly vulnerable population. It is aligned with national policies, supports coordination mechanisms, ensures synchronization of inter-country activities, and provides synergies with regional initiatives.

The FMF brings together the complementary mandates and distinct comparative advantages of four UN agencies: WHO, UN Women, UNFPA, UNICEF.

The joint work of the four UN agencies helps to develop complementary interventions that can have a positive and rapid impact on the health of women and children, while avoiding duplication. The technical responsibility of the agencies is based on their respective mandate:

WHO maternal, newborn and child health norms and standards

UNICEF child health, nutrition and development

UNFPA maternal, sexual and reproductive health including adolescents and youth, family planning and support for quality midwifery care

UN-Women gender equality and women's empowerment

Over the past 10 years, the FMF has demonstrated the reality and relevance of an H4+/H6 (Partnership of UN Agencies with health-related mandates) mechanism, the only truly operational and functional example in the world of development partners for health. Similarly, the Harmonization for Health in Africa (HHA) initiative is a collaborative regional mechanism involving the African Development Bank, the Global Health workforce Alliance, JICA, NORAD, USAID, UNAIDS, UNFPA, UNICEF, WHO and the World Bank. Its objective is to provide regional support to African governments in strengthening their health systems. The HHA facilitates

and coordinates all aspects of country-led processes for health systems strengthening (including: health financing; human resources for health; supply chains and pharmaceuticals; governance and procurement services; infrastructure and ICT).

Coordination and consultation mechanisms

It is based on three levels:

<p>STEERCOM Steering committee</p>	<p>Provides strategic guidance, adopts and endorses action plans, budgets and reports from the FMF's Agencies and beneficiary countries.</p> <p>Is made up of the directors of the different Agencies, the MFA health officers and the MFA regional health advisors in West and Central Africa.</p>
<p>TECHCOM Technical committee</p>	<p>Ensures the technical monitoring and implementation of the SteerCom guidelines.</p> <p>Gathers the focal points of the Agencies, technical experts of the Agencies and representatives of the MFA, including the regional health advisors in West and Central Africa.</p> <p>UNICEF WCARO facilitates the work of the technical committee in terms of secretariat, facilitation, report drafting, monitoring and evaluation.</p>

Following a formative evaluation conducted during 2019, the MEAE made recommendations to improve the operation of the FMF. Presented as part of the SteerCom of March 2020 specified the modes of strengthening the governance of the management bodies, roles and responsibilities, the SteerCom, the TechCom, the Secretariat at the regional level and the Interagency Coordination Groups and the Lead Agencies at the country level.

STEERCOM

- Possibility of membership in the SteerCom of the representatives of the beneficiary countries
- Ensure civil society representation within the SteerCom

TECHCOM

- Define the terms of reference of the TechCom, including the composition of the membership and its operation. Maintain the MEAE's representation at the level of Paris and the regional advisors.
- Define the role, responsibility and rotation mechanism for the position of Chair of the TechCom.

Secretariat

- Strengthen the secretariat for coordination-partnership, communication-visibility and monitoring-evaluation
- Set up a RMNCAH-Nut dashboard
- Support the TechCom in its activities, (webinar technology)
- Strictly follow up on the implementation of decisions taken by the SteerCom and TechCom meetings

Inter-agency coordination groups

- Redefine the role and responsibilities of interagency coordination groups and coordination agencies;
- Enhance the involvement of representatives to ensure active participation of all agencies

Partners

Initiate civil society and national bodies' engagement work leading to a detailed strategy, possibly by an external partner.

Common working methodology at country level

- designation of a lead agency to manage the process,
- implementation of an inter-agency coordination mechanism, extended to the national side,
- holding regular meetings for close monitoring of the activities' implementation, possibly with the heads of agencies to assess the level of implementation, and with the ministry's focal points
- establishment of permanent contacts between regional and country offices, as well as with agency headquarters.

Coordination with the French Development Agency (AFD), exchanges and information sharing with the French embassies of the involved countries have been strengthened in all countries through the network of regional advisors in global health operating in the area.

Coordination mechanism: example of Togo

1. for equitable access to the health workforce:

PLANNING	
Projection of MNCH staffing needs Quality assessment of training schools	WHO
Definition of training, recruitment, deployment and retention strategies	UNFPA
IMPLEMENTATION	
Recruitment of midwives and nurses	UNICEF
Deployment of recruited staff to underserved areas	AFD

2. for the fight against maternal, neonatal and infant mortality, and for the strengthening of care systems at the community level:

PROGRAMME 1 Fight against maternal and neonatal mortality	
FMFSO 1.1 Improving adolescent and youth reproductive health	UNFPA, WHO
FMFSO 1.3 Repositioning Family Planning	UNFPA, WHO
FMFSO 1.2 Increase coverage of essential quality interventions in: pregnancy monitoring, delivery assistance, emergency obstetric and neonatal care and post-abortion care, post-partum follow-up	UNICEF, UNFPA, WHO
PROGRAMME 2 Fight against infant and child mortality	
FMFSO 2.1 Repositioning community and family care	UNICEF, WHO UN Women
FMFSO 2.2 Strengthening the delivery of curative services related to child and youth health (IMCI, management of acute malnutrition)	UNFPA WHO
PROGRAMME 5 Strengthening health system and community system	
FMFSO 5.1 Strengthening the governance and management of the health system	UNICEF, UNFPA, WHO
FMFSO 5.2 Strengthening access to essential medicines, vaccines, blood products and medical technologies	UNICEF, WHO
FMFSO 5.3 Strengthening the health information system, research and knowledge management	UNICEF, WHO, UNFPA, UN-Women
FMFSO 5.4 Strengthening sector financing	UNICEF, WHO
FMFSO 5.5 Development of human resources for health	UNICEF, WHO, UNFPA

3. for the synergy of the FMF with other partners:

The actions supported by the FMF are reinforced by interventions supported by other partners, notably: the French Development Agency (AFD), which is involved in the process of strengthening the EmONCs; the NGO Plan in Togo, which is involved in the fight against adolescent girls' pregnancies and marriages; the North Star Alliance and WADB, which support the establishment of school infirmaries; and EngenderHealth and JHPIEGO, which support the development of FP. The Global Fund's support for the fight against HIV/AIDS, malaria and tuberculosis and the support of GAVI, the Vaccine Alliance, should also be noted.



Gender and youth markers

Throughout their lives, women face many discrimination factors that occur in all areas of both private and public life. Gender inequities in maternal and child health and sexual and reproductive health - to the detriment of women, adolescents, and girls - have a particularly negative impact. Women are more isolated, with limited access to education or information in the midst of a health crisis for example, limited freedom, mobility and autonomy, and very limited control over family and community resources. They may have limited access to food resources. Women's status keeps them out of the decision-making process, especially when it comes to care, with life-threatening consequences in the event of an obstetrical emergency. It is also the lack of autonomy for family planning, but also the harmful traditional practices and gender-based violence that make it essential to take gender into account in health development programmes.

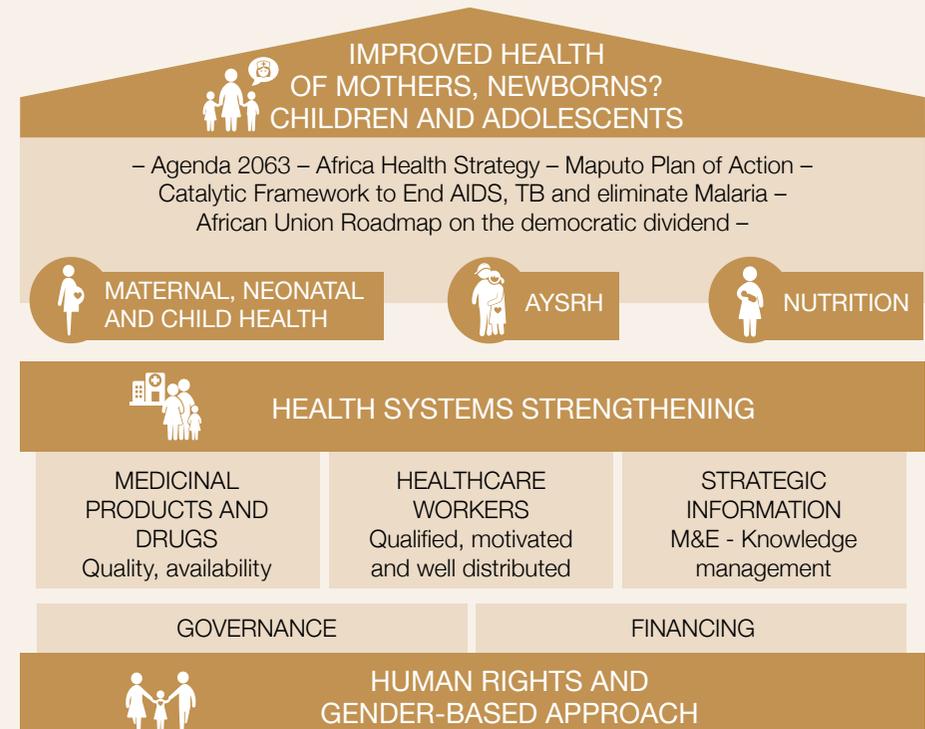
Adolescents are not simply "older children" or "young adults". Individual, interpersonal, community, organizational, and structural factors make adolescent girls a specific target for health development programming, particularly in reproductive health because of their vulnerability.

To gain a better understanding of and ensure the healthy development and care of adolescents, healthcare providers and workers should have the appropriate knowledge, skills, and attitudes.

Complementary support of the French Committee for UNICEF to the FMF

In order to develop or strengthen the promotion of Essential Family Practices (EFPs) in countries, the French Committee for UNICEF has been supporting the UNICEF West and Central Africa regional office since 2011 for a total amount of 6,585,000 euros in support to activities carried out by the French Muskoka Fund.

Since it is primarily the responsibility of families to care for their children, results can only be achieved through collaboration between health workers and families and support from their communities. Improving family and community practices is one of the three components of the IMCI strategy promoted by UNICEF. It is about engaging, developing and supporting family practices that are essential to child survival and development.



Brief background of strategic guidelines since the beginning of the system

The Steering Committee (SteerCom), mainly composed of the Regional Directors of the 4 agencies (WHO, UNICEF, UNFPA, UN Women), the directors of the departments involved at WHO headquarters and senior representatives of the French Ministry of Europe and Foreign Affairs (MEAE), meets every year to review the progress of the project, define the vision and priorities for the medium term, and decide on strategic guidelines. The Technical Committee (TechCom), the technical arm of the SteerCom, composed of technicians from the 4 agencies and the MEAE, systematically organizes its work around these strategic guidelines, mainly based on:

- **The methodological framework for intervention monitoring in line with the global accountability frameworks for the RMNCAH-Nut.**
- The first year of FMF implementation helped to develop a common set of planning, monitoring and reporting tools, and to perform baseline analyses of the situation of RMNCAH-Nut in the target countries.
- In Year 2, the focus was placed on the alignment of the FMF with the national programming cycles to ensure the contribution of FMF interventions to the objectives of the national plans in RMNCAH-Nut.
- In Year 3, country and regional activities were met on high-impact interventions to increase the focus of interventions and facilitate the readability of FMF-supported interventions.
- In Year 4, an identification and documentation processor best practices was initiated for the final FMF restitution.
- In Year 5, attention was focused on a few priority areas, including Health System Strengthening (HSS), nutrition, and Adolescent and Youth Sexual and Reproductive Health (AYSRH).
- In Year 7, high-impact interventions (HIIs) were implemented with a view to scaling up to national level. The FMF activity planning is aligned with national planning cycles.

The geographical scope of intervention

- Years 1, 2 et 3: Interventions were focused on countries where the added value of Muskoka programmes is the most significant, with a particular focus on the Sahel countries, which face both demographic challenges and high maternal and child mortality.
- Year 4: For the sake of consistency and efficiency, two countries that were supported by only one agency and for a small amount of money (DRC and Haiti)¹ left the Muskoka programme in Year 4.
- Year 5 and beyond: A programmatic and financial focus was placed on the three Sahelian countries (Chad, Niger and Mali) and Guinea from year 5. In year 6, these 4 countries received 19% (Chad), 21% (Niger), 21% (Mali), and 21.5% (Guinea) of the total Muskoka country budget.
- Burkina Faso was eligible from 2011 to 2014. It then reintegrated into the group of beneficiary countries in 2020.

The topics

For the FMF to meet other strategic challenges championed by France, including issues related to population dynamics and the priority given to youth, a larger proportion of grants were allocated to interventions designed to improve the sexual and reproductive health of adolescents and the nutritional status of young children (year 5).

1. While the 9 countries, Benin, Burkina Faso, Chad, Côte d'Ivoire, Guinea, Mali, Niger, Senegal and Togo, have populations ranging from 10 to 20 million in 2015, and therefore present a homogeneous whole in terms of demography, the DRC has 76 million inhabitants. As a result, with the same average budget per country, the impact of FMF's engagement in DRC was much less significant. Similarly, for Haiti, the FMF has positioned itself when the humanitarian crisis related to the earthquake occurred. With France's strong commitment to Haiti for the management of the crisis, specific FMF activities became more difficult to coordinate and align with all of the FMF's homogeneous programmes in West and Central Africa. Nevertheless, during the three years that these countries benefited from FMF programmes, the same vulnerable populations were targeted, for identical RMNCAH-Nut access and quality care improvement interventions (see Chapter IV).

- For AYSRH, there was a significant increase from 6% in year 4 to 16% in year 5 and 24% in year 6, thanks to a programmatic and technical strengthening of interventions targeting youth and adolescents.
- Regarding interventions on the nutritional status of children and mothers, we note an evolution from 10% in year 4, to 17% in year 5, to 19% in year 6. In a context where more than 50% of women (except in Chad where it is around 13%) give birth in health facilities, the focus of the RMNCAH-Nut-FP-HR-Nutrition interventions funded by the FMF on maternities is totally relevant.
- For HSS and MNCH FP, we note 26% and 31% of interventions in year 6 respectively.



“

In terms of progress, I would say that there is better coordination between the UN system agencies.

The French Funds helped build the capacity of field actors, increase knowledge of high-impact interventions, and improve the availability of products of vital importance for mothers and children by including some missing products in the list of essential medicines.

”

Dr. Geneviève Saki-Nekouressi,
Former WHO Mother and Child Programme Advisor,
Côte d'Ivoire

Types of interventions funded

From year 5 onwards, priority was given to component 1, i.e. interventions in beneficiary countries, and funding for coordination and other regional activities was reduced.

- Increase in the share allocated to countries from 70% (year 3) to 76% (year 4), to 80% (year 5) and 85% (year 6).
- As a result of the priority given to in-country activities, the regional component of the FMF has suffered a significant budget cut. However, thanks to the experience gained over the years since the creation of the FMF, the operational mechanism has greatly strengthened technical coordination between agencies beyond the areas financed by the FMF.
- In year 10, the Covid-19 crisis had an impact on the implementation of interventions (see Chapter V).

Communication for a good visibility

In order to ensure the visibility of the FMF, to establish a communication reflex among the different actors and to have a common vision in terms of advocacy with African governments concerned, the four agencies worked together to establish and implement an integrated and harmonized communication strategy. This strategy is reviewed every year, with the development of a communication plan that integrates a set of communication channels and tools to reach the defined objectives and targets. This has led to significant results in terms of visual identity, media presence (Le Monde Afrique, RFI/Priorité Santé, France24, TV5Monde Afrique), international conferences (ICASA, Health in HR, EU-AU, etc.), and social networks, with a strong focus on programmes and results achieved at the regional and country levels. The year 9 was particularly rich in national and international activities and events to which the FMF contributed and participated in (see chapter VII).

Partnerships

- The implementation of the inter-agency communication strategy has had a strong impact on the visibility of the FMF's activities and has facilitated inter-agency communication as well as with other partners.
- Coordination with the French Development Agency (AFD), exchanges and information sharing with the French embassies of the involved countries have been strengthened in all countries since year 6 through the involvement of Regional Global Health Advisors.
- Programming and implementation of the French Committee for UNICEF's catalytic support² are integrated, particularly for the promotion and development of Essential Family Practices from the beginning of the programme.
- In year 8, the Danish government expressed interest in getting involved in the development of RMNCAH-Nut and called on the FMF, its teams and methodology to develop specific identified activities.

Evaluation of the FMF

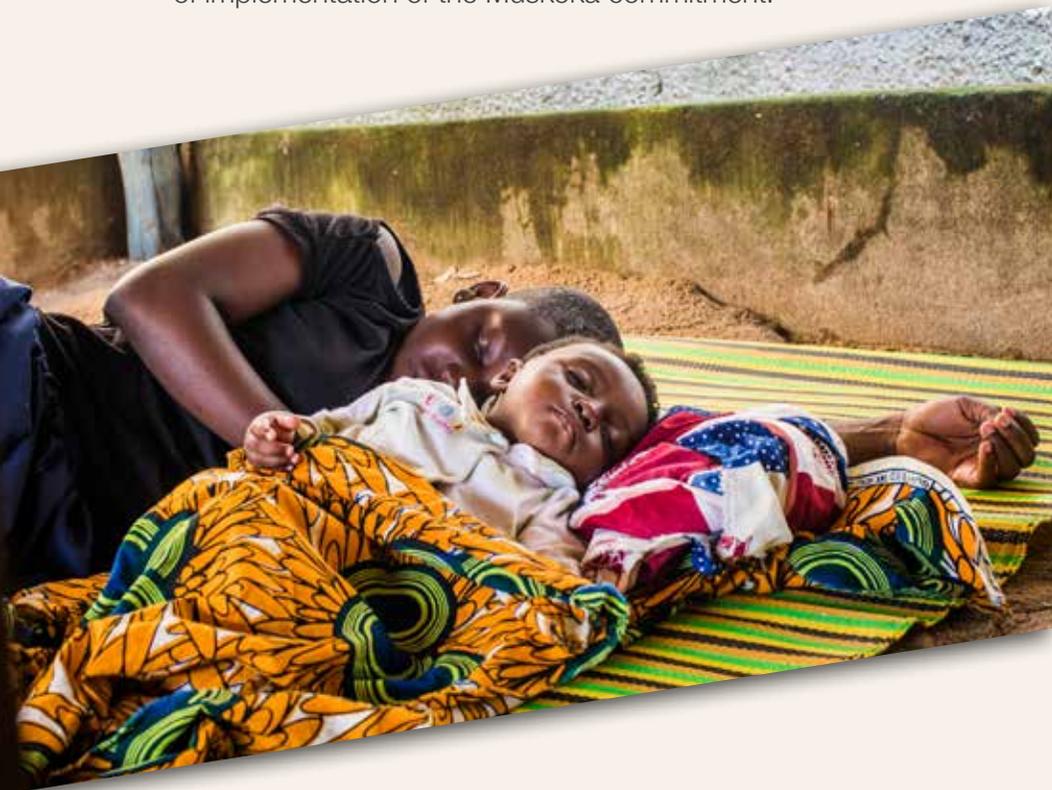
An evaluation of Muskoka was conducted in 2014 by Ernst & Young at the request of the Ministry of Foreign Affairs. Following the Muskoka G8 summit in June 2010, France's commitments, for a period of 5 years, were implemented through different channels: the bilateral channel, with AFD (French Development Agency), and the multilateral channel (French Muskoka Fund, Global Fund and GAVI, Aga Khan Development Network).

From this evaluation, after interviews with the different stakeholders in France, Switzerland, Senegal, Togo and the DRC, the following elements emerged for the FMF:

- **The relevance** of the commitment to SMIA (with particular reference to the rights of girls and women, to sexual and reproductive health and to the prevention or management of sexual violence) and the choice of the defined geographical scope.

2. Since the beginning of Muskoka, the French Committee for UNICEF has contributed 1.2 million euros annually to help develop or strengthen the promotion of Essential Family Practices in seven countries: Benin, Côte d'Ivoire, Guinea, Mali, Niger, Chad and Togo.

- **The consistency** of the actions implemented in a coordinated way by the four agencies within a common framework and in line with the national health development plans. (Country-level coordination with AFD was perceived as something that could be more active.)
- **The effectiveness**, with the implementation of common planning and monitoring and evaluation tools and mechanisms and the added value of working with UN Women and UNFPA to improve women's rights.
- **The efficiency**, with the FMF operating mechanism based on the technical committee and the steering committee as well as regional coordination (which could also be more operational and shared with the AFD).
- **The impact** with a monitoring methodology whereby effects are measurable for a set of indicators, in terms of attribution or contribution, at the country or regional level, and more clearly than for other channels of implementation of the Muskoka commitment.



- **The sustainability**, uncertain at time of the evaluation when the FMF was entering its fourth year (but, in hindsight, strong as the FMF, unlike other implementation channels, continues into its tenth year of programme).

The final evaluation of the Muskoka Global Initiative was submitted in September 2019. Regarding its multilateral component represented by the FMF, we note the following elements:

The FMF has strengthened an already existing dynamic of collaboration between the 4 UN Agencies at the regional and national levels i) within the Agencies themselves; ii) between national Agencies and national Ministries of Health; and iii) between Agencies at the international level.

The FMF is recognized by the Agencies as the **first Fund to have laid the groundwork to implement the “One UN”** reform and apply it to RMNCAH-Nut.

The FMF contributes to the implementation of the “One UN” principles of one leader, one programme and one voice.

According to the United Nations agencies (WHO, UNFPA, UNICEF), the FMF framework facilitated the implementation of joint programming H4, then H6, involving the World Bank, WHO, UNFPA, UNICEF, UN Women, UNAIDS, with the support of Canadian and Swedish funding. The FMF would “serve as a foundation” for the H6 programme, which would adopt the same work philosophy as the FMF (joint programming, implementation, and reporting, with a focus on high-impact interventions, HII).

The FMF is an example of a useful tool for France in its negotiations with the United Nations to assert its positions

Currently, the mechanism is **well known among French representations to the United Nations and is used as a model before the UN General Assembly**, as well as in the boards of directors of UN agencies. The FMF was valued during the 3rd Social, Humanitarian and Cultural Commission of the General Assembly by UN Women on the issue of access to sexual and reproductive health rights (access to abortion and the fight against genital mutilation).

According to France's representatives in the United Nations in New York, on such sensitive issues, which sometimes generate very tense positions from some conservative states, the FMF is a very important tool for ensuring that French positions are supported by concrete actions and funding.

The evaluators did not observe sufficient progress in synergies between the FMF and the bilateral channel since the 2014 mid-term evaluation.



2010-2020
**FINANCIAL
ASPECTS**

Methodology

Data used for this report were extracted from the official reports of the FMF/Denmark 10-year initiative (2011-2020).

For the final year (2020), this is an interim report for which data used is not yet complete (2020 annual report expected by July 2021).

Financial analysis Tables

Table 2: Distribution of the French Muskoka Fund/Denmark budget by year and by agency for the period 2011-2020 (in euros)

Years	UNICEF	UNFPA	WHO	UN-Women	Total allocated
Year 1 (2011 - 2012)	8'500'000	4'875'320	4'500'000	1'000'000	18'875'320
Year 2 (2012 - 2013)	8'500'000	6'192'635	4'500'000	1'000'000	20'192'635
Year 3 (2013 - 2014)	8'765'000	4'700'000	4'620'000	915'000	19'000'000
Year 4 (2014 - 2015)	8'500'000	4'700'000	4'850'000	950'000	19'000'000
Year 5 (2015 - 2016)	6'250'000	3'600'000	3'700'000	700'000	14'250'000
Year 6 (2016 - 2017)	3'500'000	3'000'000	3'000'000	500'000	10'000'000
Year 7 (2017 - 2018)	3'500'000	3'000'000	3'000'000	500'000	10'000'000
Year 8 (2018 - 2019)	3'500'000	3'000'000	3'000'000	500'000	10'000'000
Year 9 (2019 - 2020)	3'901'669	3'890'494	3'241'002	901'670	11'934'835

Year 10 (2020 - 2021)	3'808'465	3'455'851	3'401'079	807'500	11'472'895
Grand Total (2011 - 2020)	58'725'134	40'414'300	37'812'081	7'774'170	144'725'685

Table 1 above shows the following key elements:

- The total amount of funds allocated under the French Muskoka Fund by the MEAE/France (2011-2020) and Denmark (2019-2020) is €144,725,685.
- 63% of these funds were made available to the agencies involved during the initial five-year stage.
- The funds were allocated to the countries through the UN agencies: WHO, UN Women, UNFPA, UNICEF who also provided coordination and technical assistance (the distribution of funds among the agencies being defined by the MEAE/Denmark).

Table 3: Distribution of resources used by country for the period 2011-2019 (in euros)

Countries	2011 et 2012	2013	2014	2015	2016	2017	2018	2019	Total
Benin	1'165'000	2'130'173	1'932'131	1'848'732	1'229'704	418'892	627'640	746'179	10'565'173
Burkina Faso	299'280	254'760	211'015	0	0	173'474	115'920	0	1'054'449
Côte d'Ivoire	357'400	1'101'922	902'584	807'937	662'596	386'687	906'291	756'958	6'332'867
Guinea	2'451'244	2'050'595	2'314'120	2'261'713	1'662'481	1'603'894	963'560	1'545'897	15'829'104
Haïti	170'957	134'152	176'195	0	0	0	0	0	481'304
Mali	2'056'650	1'833'688	1'520'241	1'391'374	1'487'013	1'595'729	659'707	1'284'899	12'254'000
Niger	1'272'857	1'469'638	1'693'091	1'710'491	1'413'933	1'424'198	923'193	1'363'444	11'708'867
Senegal	365'500	494'598	427'212	703'266	507'938	318'268	687'131	579'880	4'717'460
Chad	2'096'757	1'803'030	1'854'979	1'861'515	1'548'499	1'344'421	787'320	1'218'110	13'355'226
Togo	2'220'457	1'918'523	1'998'633	1'955'464	1'410'650	474'399	711'400	641'129	11'556'845
RCA	97'857	0	147'728	0	0	0	0	0	245'585
RDC	347'960	324'240	176'822	0	0	0	0	0	849'022
Other countries Mauritania, Niger and Senegal (UNFPA)	277'014	36'739	0	745'232	29'071	0	0	0	1'088'056
Expenditures for activities at regional/ headquarters level (WHO)	1'143'723	0	0	0	0	0	0	0	1'143'723
Total Component 1 (Strengthening health systems in target countries)	14'322'656	13'552'058	13'354'751	13'285'724	9'951'885	7'739'962	6'382'160	8'136'496	91'181'682

Component	2011 and 2012	2013	2014	2015	2016	2017	2018	2019	Total
Component 1 (Strengthening health systems in target countries)	14'322'656	13'552'058	13'354'751	13'285'724	9'951'885	7'739'962	6'382'160	8'136'496	91'181'682
Component 2 (Support to inter-country and regional activities) / Denmark's contribution	1'425'280	3'417'084	2'635'333	3'002'466	2'527'971	1'795'127	2'342'478	2'339'328	21'062'410
Component 3 (Management, Monitoring, Evaluation and Documentation)	1'625'738	1'616'169	1'498'195	1'077'643	563'000	776'094	450'000	437'926	8'738'770
Administrative costs (8% UNICEF and UNFPA, 7% UN-Women, 13% WHO)	1'525'652	1'607'324	1'592'911	1'634'167	1'207'144	706'371	825'361	1'026'804	11'142'598
Total Year	18'899'326	20'192'635	19'081'190	19'000'000	14'250'000	11'017'554	9'999'999	11'940'554	132'125'460

Table 2 above shows the following key elements:

- 85% of the funds allocated to UN agencies were used directly by countries to support the implementation of high-impact interventions.
- 58.5% of the total country budget was used in the four FMF priority countries: Guinea, Chad, Mali and Niger.
- During the first three years, following countries: Haiti, DRC and CAR have benefited from FMF funds.
- Burkina Faso was eligible from 2011 to 2014. It then reintegrated into the group of beneficiary countries in 2020.



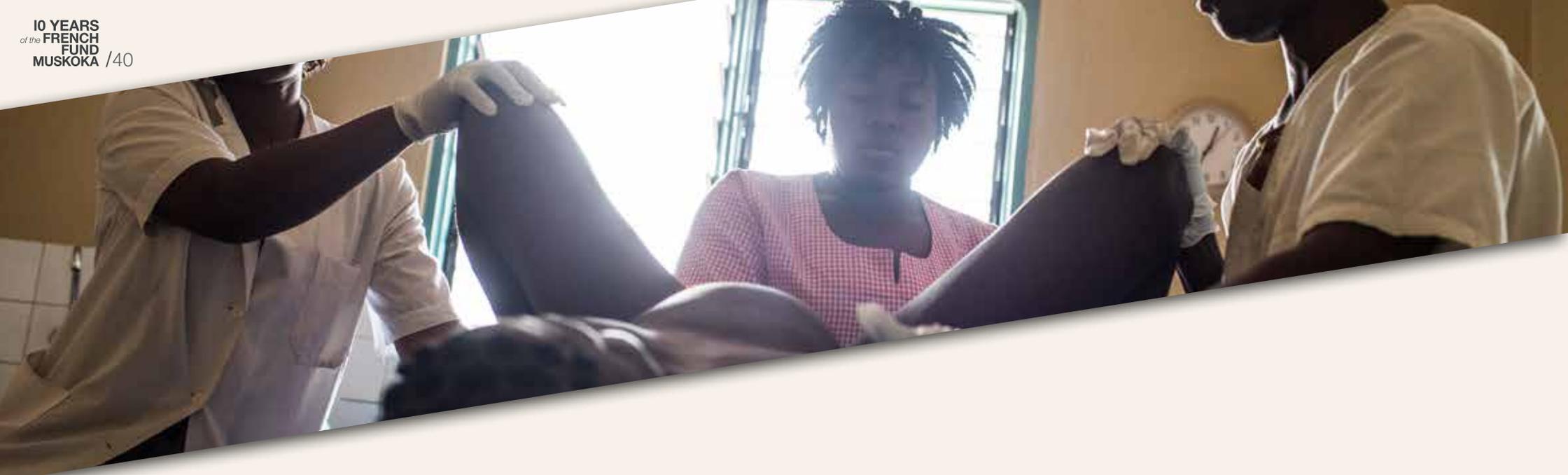


Table 4: Performance of MUSKOKA funds utilization by agency for the period 2011 - 2019 (in euros)

Years	UNICEF		UNFPA		WHO		UN Women		Total		
	Allocated	Used	Allocated	Used	Allocated	Used	Allocated	Used	Allocated	Used	Ratio
Years 1-6 (2011 - 2016)	46'681'296	45'897'050	29'821'271	29'493'326	25'235'447	24'556'357	6'188'690	6'003'029	107'926'704	105'949'763	98.2%
Years 7 and 8 (2017 - 2019)	7'000'000	6'444'380	6'800'603	6'342'520	6'000'000	5'650'318	1'154'512	1'097'543	20'955'115	19'534'761	93.2%
Year 9 (2019 - 2020)	3'901'669	3'877'394	3'890'494	3'621'021	3'241'002	2'503'045	901'670	482'711	11'934'835	10'484'171	87.8%
Grand Total (2011 - 2020)	57'582'965	56'218'824	40'512'368	39'456'867	34'476'449	32'709'720	8'244'872	7'583'283	140'816'654	135'968'694	96.6%

Tableau 3 shows a high performance of over 96% in the implementation of French Muskoka Fund throughout the 10 years of the initiative.

This was a strong recommendation of the MEAE, which was endorsed by all stakeholders in the countries involved as well as UN partner agencies (note that funds used in 2020 are not included in Table 3).

Table 5: Budget breakdown by High Impact Intervention (HI) areas)

IHI	2011-2013	2014	2015	2016	2017-2018	2019	2020*
HII 1 RMNCAH-Nut Maternal, newborn and child health, FP	-	35%	38%	35%	30%	28%	26%
HII 2 AYSRH Adolescent and youth sexual and reproductive health	-	10%	5%	16%	29%	28%	31%
HII 3 HSS Health Systems Strengthening, Human Resources and Medicines	-	7%	6%	31%	21%	26%	23%
HII 4 NUT Nutrition	-	48%	51%	17%	20%	18%	20%

* For year 10 (2020) this is an interim report and comprehensive data will be provided in the final report (expected after July 2021)

Table 4 above reflects the evolution of the breakdown of expenditures by high-impact intervention areas: maternal, newborn and child health and family planning (RMNCAH-Nut/FP); adolescent and youth sexual and reproductive health (AYSRH); health systems strengthening, including human resources and essential medicines (HSS) and nutrition (NUT).

The second stage of the FMF was shaped by a prioritization of AYSRH and NUT activities in addition to RMNCAH-Nut/FP and HSS, with implications in terms of financial allocations.

In 2018, Denmark provided the FMF with funds to support the specific area of comprehensive sexuality education with €3 million/year for a two-year period (2019-2020). These funds were used and reported in the annual reports.

Estimates of the contribution of the FMF to the financing of RMNCAH-nutrition services in West African countries: example of Niger and Senegal

In addition, it was necessary to estimate the contribution to in-country RMNCAH-Nut expenses by the French Muskoka Fund compared to the countries' equity capital for which data were available.

Niger, National Health Accounts (2011 & 2017)

- Expenses related to reproductive health, including nutritional deficiencies, were estimated at 14.59 billion CFA francs (21.39 million euros), i.e., 7.26% of total health expenses; among these expenses, perinatal disorders rank first with 31.35%, followed by nutritional deficiencies with 26.57% and finally maternal disorders with 17.65%.
- In Niger, in 2017, external financing ranked first in terms of sources of funds for reproductive health and nutrition with 6.5 billion FCFA (9.9 million euros) or 44.53%. The public administration managed 6.4 billion CFA francs (9.7 million euros) or 43.94% of the funds. It is followed by households with 1.53 billion FCFA (1.6 million euros) or 10.50%.
- **The contribution of the Muskoka Fund is estimated at 9% in 2011 and 21% in 2017 of the total amount of external funds allocated to reproductive health in the country.**
- Despite a significant change in the volume of per capita health expenses (\$26 per capita in 2011 compared to \$18 in 2009), the health sector remains underfunded. Compared to the country's growing health needs (the annual population growth rate is 3.3%) and in light of the Macro-Economic and Health Commission's 2001 recommendation of a minimum of \$34 per capita per year to cover essential health care and services, Niger falls far short of the minimum required to provide health care to the majority of its population.
- Over five (5) years (2013-2017), the share of the state budget allocated to health has hardly reached 10%, far from the 15% commitment made by the African Heads of State in Abuja in 2001. It averages 5.74% per year.

Years	Total annual budget used by reproductive health (RH)/nutrition programmes	Percentage of RH budget in relation to the national health budget	Estimated FMF contribution to RMNCAH-Nut-Nut budget
2011	14.6 billion CFA: • 63% (External funds) • 26% (Public funds) • 11% (household contribution).	7,26%	1.272.857 Euros (or 795.535.625 CFA = 9% of external funds)
2017	33.4 billion CFA: • 55% (household contribution) • 23% (External funds) • 22% (Public funds)	9,14%	2.347.391 Euros (or 1.467.119.375 CFA = 21% of external funds)

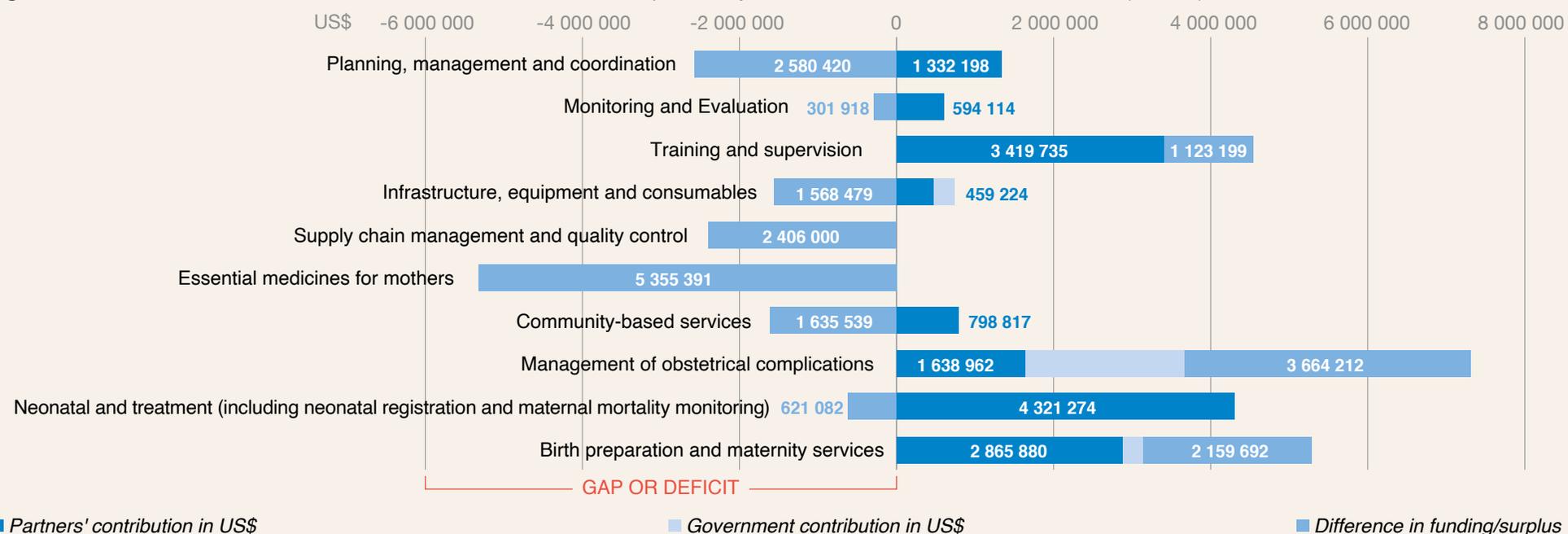
**The share of the state budget allocated to health has hardly reached 10%, far from the 15% commitment made by the African Heads of State in Abuja in 2001. It averages 5.74% per year*

Senegal, Muskoka Report 2014

Figure 20: Contribution of the government and all partners in the financing of RMNCH for 2014 and 2015 (in XOF)



Figure 21: Maternal and Neonatal Health financial deficits and surpluses by intervention area for 2014 and 2015 (in US\$)



This analysis of the Senegalese case was used as a basis for the planning of the plan to secure vital commodities, but also to mobilize additional resources to cover the identified gaps.

Conclusion

- Within the framework of the French Muskoka Fund, France/MEAE (2011-2020) and Denmark (2019-2020) have provided the nine West and Central African countries with a funding of €144,725,685.
- 85% of the funds allocated to UN agencies were used directly by countries including four priorities (Guinea, Chad, Mali and Niger) to support the implementation of high-impact interventions.
- The implementation of the funds was marked by a strong performance at more than 96%.
- 63% of these funds were made available to the agencies involved during the initial five-year stage.
- At the level of the countries concerned, the support needs in the area of RMNCAH-Nut remain important and their domestic funding limited, which constitutes a major challenge for these countries, exacerbated by the Covid-19 pandemic context, in relation to the achievement of universal health coverage and the Sustainable Development Goals (2030).



2010-2020

Implementation of
INTERVENTIONS
BY TARGET POPULATION,
pregnant women and newborns,
children, adolescents

Interventions were defined, programmed and implemented according to target populations - pregnant women, newborns, children, adolescents, and women - in line with the countries' national health development plans. These different activities were implemented either at the country level or at the regional level.

1. Pregnant women and newborns

1. Equitable access to care

Child health is closely linked with maternal health. A poor health condition of the mother-to-be will affect the future of her unborn child. Child survival is also correlated with pregnancy spacing.

Across the nine FMF countries, pregnant women represent 3.6% of the population overall, and 5 % of the population in Niger, where the fertility rate is the highest.

In Niger, in 2018, there were 954,000 births for a population of 19 million (by comparison, 750,000 in France the same year).

The total number of births for the 9 countries in 2017 was 7.8 million, and the number of maternal deaths was approximately 31,500, with an overall maternal mortality ratio (MMR, number of maternal deaths per 100,000 live births) of 402, the highest being in Chad with an MMR of 1140 (by comparison, it is 10 in France).

Every year in Muskoka countries

- Approximately 30,000 women die from pregnancy-related and postpartum causes
- 160,000 newborns die within the first 28 days of life
- 180,000 pregnancies end in stillbirth, 45% of which are related to inadequate management of childbirth

	Number of births (x1,000) 2017	MMR 2017	Number of maternal deaths 2017
Benin	403	397	1 600
Burkina Faso	750	320	2 400
Côte d'Ivoire	875	617	5 400
Guinea	451	576	2 600
Mali	783	562	4 400
Niger	1002	509	5 100
Senegal	540	315	1 700
Chad	640	1140	7 300
Togo	252	397	1 000
TOTAL FMF	7 835	402	31 500

Sources: (1) UN Maternal Mortality Estimation Inter-Agency Group 2017 for MMR; (2) Unicef data MMR and Statistics 2017 for number of Maternal deaths.

The FMF's high-impact interventions for women and newborns are simple, high-impact, scientifically proven, life-saving interventions. If scaled up to national level, they can significantly reduce maternal, neonatal and infant mortality.

They are as follows:

- 1 Develop effective Emergency Obstetric and Neonatal Care (EmONC);**
- 2. Establish a maternal death surveillance and response system;**
- 3. Improve access to skilled health personnel;**
- 4 Improve nutrition;**
- 5 Improve access to quality essential products and medicines for maternal and newborn health.**
- 6 Evaluer et améliorer la qualité des soins.**

2. Development of emergency obstetric and neonatal care (EmONC) for the management of pregnant women and newborns,

To reduce maternal mortality, emergency obstetric and neonatal care (EmONC) services should be available and accessible for every woman. EmONCs play a critical role in the event of complications during pregnancy, childbirth and post-natal care, to save the life of both mother and child.

The strategy deployed consists of the effective establishment of EmONC structures in the countries, with the aim of managing the greatest number of obstetrical emergencies.

Basic EmONC (BEmONC): 7 functions

1. Administration of antibiotics
2. Administration of anticonvulsants
3. Administration of utero tonics
4. Artificial delivery of the placenta
5. Assisted vaginal delivery
6. Extraction of residual products
7. Neonatal resuscitation

Comprehensive EmONC (CEmONC): 7+2 functions

1. C-section
2. Blood transfusion

High-impact maternal health interventions implemented in Muskoka countries through the FMF

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
EQUITABLE ACCESS TO A COMPETENT PROFESSIONAL									
Support for the training of health care workers (design, validation, evaluation of curricula)	•		•	•	•	•	•	•	•
Support to training schools	•		•	•		•		•	
Evaluation and revitalization of midwives' professional practices	•		•	•		•	•		•
Implementation of accreditation mechanisms for midwifery schools		•							
EMPOWER MATERNITY WARDS TO BE CLASSIFIED AS EFFECTIVE BASIC EMONC									
Conducting EmONC surveys, supporting EmONC mapping, needs assessment			•	•	•	•	•		
Monitoring	•	•			•				
Capacity building of BEmONC and CEmONC providers			•	•	•		•	•	•
Equipment, materials, inputs and facilities, training, dissemination of documents	•	•	•	•	•	•		•	•

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE									
Advocacy on institutionalization of maternal death review and reporting	•	•	•	•	•	•	•	•	
Integration of maternal death data into information systems	•	•	•	•	•	•	•	•	•
Use of new technologies, especially cell phones, for reporting maternal and infant deaths		•		•			•		
Pilot testing of a community-based maternal death registration system	•		•		•		•		
Training and supervision in monitoring			•	•	•			•	

• **Example of Guinea, 2013 – 2020**

2013. The national EmONC assessment was validated, EmONC recommendation guides were disseminated in 3 regions, and EmONC training was conducted in 16 health centers and 4 general hospitals, with 20 trainers and 40 doctors trained in essential newborn care and resuscitation, as well as capacity building in 3 midwifery schools.

2014. The national EmONC assessment was validated, EmONC recommendation guides were disseminated in 3 regions, and EmONC training was conducted in 16 health centers and 4 general hospitals, with 20 trainers and 40 doctors trained in essential newborn care and resuscitation, as well as capacity building in 3 midwifery schools.

2015. 155,390 pregnant women received 3 post-natal consultations out of the 207,187 pregnancies expected during the year (75%). Among these pregnant women, 80,448 gave birth in a health facility (51%)

Thus, the number of health facilities that can claim to be BEmONCs has increased from almost none in 2012, to 3 EmONCs in 2013, 47 BEmONCs in 2014, to 72 in 2015, representing a potential increase in coverage of needs of 41% in 3 years, making it possible to improve the provision of EmONC services to a population of 5.5 million inhabitants.

Thus, according to international standards, a network of EmONC maternity hospitals includes four BEmONCs and one CEmONC for every 500,000 inhabitants, so the EmONCs available in 2015 cover a population of 5,500,000 out of the country's 10,628,972 inhabitants.

2016. Emphasis was placed on access to health care workers and the provision of equipment and consumables: 140 midwives and 3 gynecobstetricians recruited and deployed in 70 health centers, maternities and hospitals in the regions of Kindia, Kankan, Labé Faranah and N'Zérékoré This allowed 34,666 pregnant women to benefit from 4 ANC out of 47,178 expected pregnancies and 32,315 deliveries performed in health facilities by these midwives. 390 health centers, 38 district hospitals and 2 national hospitals have been provided with medicines, equipment, materials and consumables;

The prioritization of reference maternity units remains a major challenge, which, as in most of the countries, should be maintained and reinforced. Indeed, many constraints lead countries to retain a higher number of reference maternity units than recommended standard, this results in the development of a network too large to focus sufficient resources on each of the maternity units of the network.

2017 saw the completion of the EmONC quick survey with the aim of taking stock of the situation, measuring efforts, progress made and considering avenues for improvement. Thus, the prioritization process for EmONC maternity wards is currently being reviewed and as of the date of the rapid survey in 2017, 34 BEmONCs and 25 CEmONCs were Functions available 24/7.

2018. Although relatively low, according to 2012 and 2018 DHS, the proportions of women receiving skilled care during delivery increased from 44% in 2012 to 55% in 2018, a 25% increase. The coverage of postnatal consultations for mothers increased from 37% to 49% during

the same period, a 32% increase. The contraceptive prevalence rate increased from 5% to.

Antenatal care	ANC1	ANC4
2019	502 248	345 906
2020	512 137	377 749

There has been an increase in the number of newborns managed in the 9 neonatal units and 165 newborn corners: 11,932 newborns were managed in 2020 compared to 22,578 in 2019. During the year 2020, out of 11,932 newborns managed, there were 520 deaths or 4, 35% of lethality.

The newborn corner consists of a resuscitation table, a ventilation bag, a mouthpiece with mask, a mucus suction pump and aspiration catheters. This system provides for the management of some types of respiratory complications at birth or for rapid resuscitation

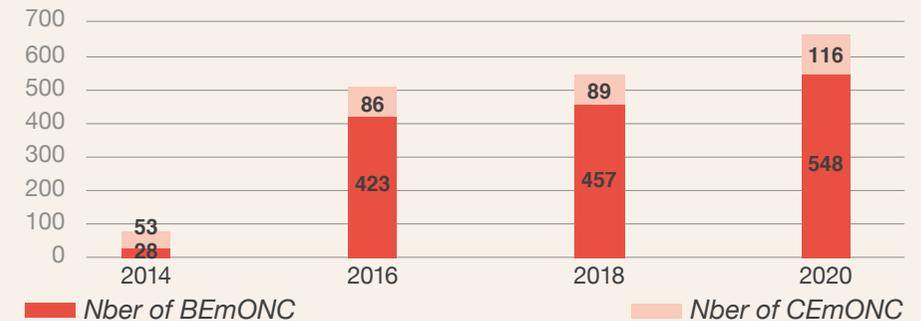
• Examples from Mali, year 10

In 2020, the coverage in EmONC facilities reached following levels: The number of BEmONC facilities has increased from 10 for 3,337,000 inhabitants in 2016 to 105 for 3 736 000 inhabitants in 2020;

The number of CEmONC facilities has increased from 12 for 3,337,000 inhabitants in 2016 to 13 for 3 736 000 inhabitants in 2020;

The BEmONC/CEmONC ratio increased from 0.5 in 2014 to 5 in 2016, 5.13 in 2018 and 4.7 in 2020.

Figure 22: Increase in the number of BEmONC and CEmONC in Mali between 2014 and 2020



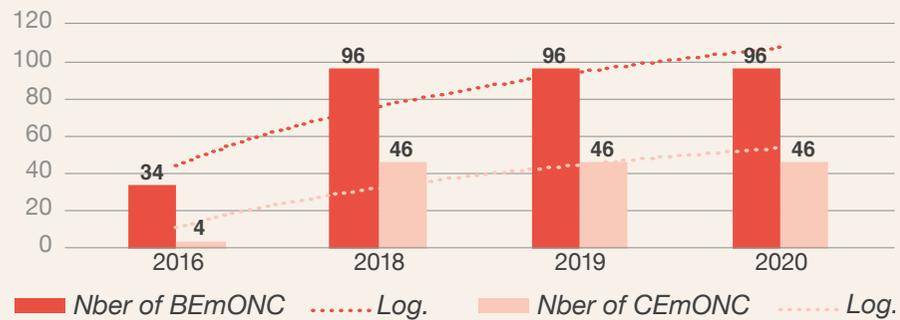
Indicators	Mali - Districts supported by the FMF				
	2016	2017	2018	2019	2018
ANC1 rate (%)	403	397	1 600	1 600	1 600
ANC4 rate (%)	750	320	2 400	2 400	2 400
FP rate (%)	875	617	5 400	5 400	5 400
Delivery rate in EmONC facilities (%)	451	576	2 600	2 600	2 600
C-section rate (%)	783	562	4 400	4 400	4 400
EmONC lethality (%)	1002	509	5 100	5 100	5 100
Number of newborns resuscitated	540	315	1 700	1 700	1 700
Number of low birth weight babies managed in EmONC facilities	640	1140	7 300	7 300	7 300
Stillbirth rate (‰)	252	397	1 000	1 000	1 000
Proportion of newborn deaths in 24 hours (%)	7 835	402	31 500	31 500	31 500
Cure rate for MAM	252	397	1 000	1 000	1 000
Cure rate for SAM	252	397	1 000	1 000	1 000

In 2020, indicators related to delivery in EmONC facilities, FP, recovery from MAM and SAM improved thanks to programmes implemented with the contribution of the FMF.

• **Example of Senegal**

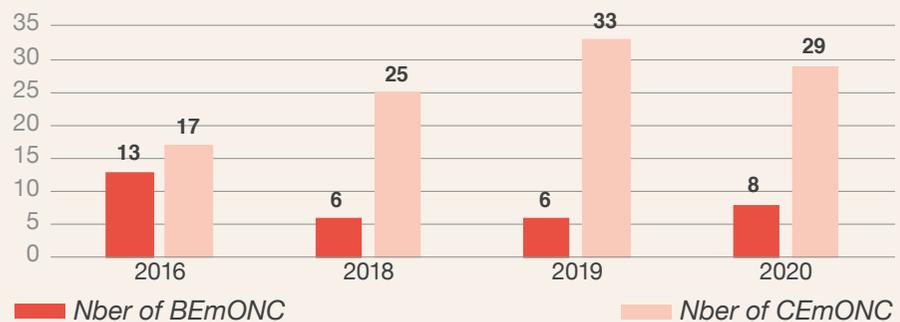
The BEmONC and CEmONC sites have evolved with a BEmONC/CEmONC ratio ranging from 8.5 in 2016 to a constant ratio of 2 since 2018.

Figure 23: Evolution of BEmONC and CEmONC in Togo 2016-2020



• **Example of Togo**

Figure 24: Evolution of BEmONC and CEmONC in Togo 2016-2020



Department of Neonatology of Sikasso hospital in Mali: all this equipment was acquired with the support of FMF



FMF technical support for the functionality and monitoring of EmONC maternity networks in countries

• **Example of Chad**

The number of BEmONCs increased from 3 in 2013 to 4 in 2018 and the number of CEmONCs increased from 20 to 25 for the same period

• **Example of Niger years 9 and 10**

Four health districts (HDs) in the region of Maradi have introduced the approach of management of potentially severe bacterial infections among newborns in integrated health centers when referral to reference facilities (in particular district and regional hospitals) is not possible (for reasons of distance, financial means, etc.). A fifth health district, Tessacoua HD, has begun the process of integrating the PSBI, and will continue and be completed in 2020.

Note that the integration of this approach in these five pilot health districts is co-funded by the Bill and Melinda Gates Foundation and the UNICEF's equity funds. During the first eight months of the implementation of this approach: 3,871 PSBI cases were received from the health facilities in the four health districts, representing 42% of the expected cases. According to the PSBI approach, about 10% of newborns are estimated to present a PSBI case.

• **Example of Senegal**

Penta 3 increased from 73% to 100% in 2019 and then back to 96% in 2020



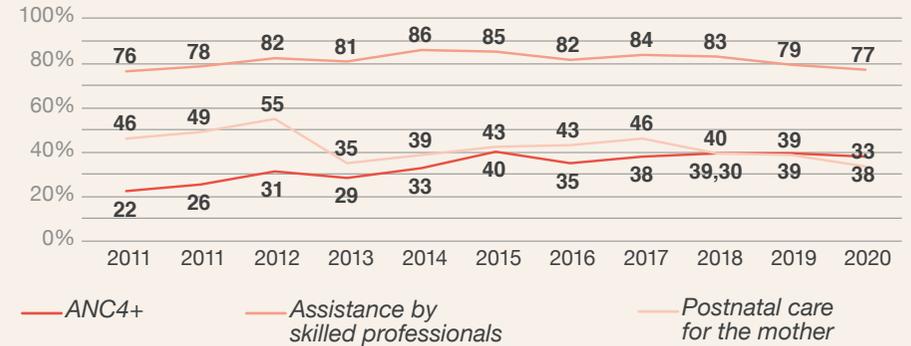
ITP 3+ increased from 14% in 2014 to 56% in 2020

Chronic malnutrition was reduced to 56% while severe acute malnutrition remained below 2% critical threshold

The rate of exclusive breastfeeding for infants under 6 months of age remains constant at 100%.

• **Example of Burkina Faso**

Figure 25: Coverage of ANC4+ services, skilled attendance at delivery and postnatal visits in BF



Développement des réseaux nationaux des maternités offrant les soins obstétricaux et néonataux d'urgence (SONU)

Résultats clés

- Identification d'un réseau national de maternités SONU notamment Bénin, Guinée, Sénégal et Togo.
- Développement de nouveaux indicateurs opérationnels (couverture de population par les réseaux de maternités SONU en maximum 2 heures de trajet, déficit en sages femmes dans les maternités SONU, qualité des liens de référence) disponible notamment au Bénin, Guinée, Sénégal, et Togo.
- La mise en œuvre du développement du réseau national SONU est monitoré notamment au Togo.

Analyse de situation
Dans de nombreux pays, les maternités SONU - notamment les maternités SONUB - se développent mal en raison de problèmes de planification ainsi que de mise en œuvre

Processus national
Processus adapté et utilisé dans chaque contexte national pour adresser ces problèmes

The 3rd Edition of the pocket guide “CPR EmONC” available in the countries

Recommendations for clinical practice obstetric and neonatal care
Emergency

This small pocket guide, popular with health students and practitioners, brings together in a practical format the main protocols and clinical recommendations in maternal health. This guide was developed in collaboration with AFOG and as part of an inter-agency effort by WHO, UNFPA and UNICEF. In 2019

- Printing and widespread dissemination of the guide in FMF beneficiary countries
- Distribution of the electronic version to all teams and partners

Blood transfusion

Blood transfusion is a life-saving intervention in response to postpartum hemorrhage, which is responsible for one-third of maternal deaths.

Thus, for health facilities that provide care to a population of one million people, there are potentially 50,000 pregnant women to manage. In a country where the maternal mortality ratio is 600 deaths per 100,000 births, 300 of these women will die each year of pregnancy or delivery complications. Among these 300 women, 100 will die of hemorrhage.

In this context, for a global population of one million inhabitants, an operational blood transfusion system means 100 preventable maternal deaths each year

During the 10 years of the programme, the FFM has improved and strengthened the blood product collection and storage system at the level of the CNTSs in all Muskoka countries, thereby reducing the risk of deaths due to hemorrhage: staff training, supply of equipment (bags, refrigerators, etc.), norms and protocols, quality standards.

Prevention of mother-to-child transmission (PMTCT) of HIV

Sub-Saharan Africa remains one of the regions most affected by HIV infection in the world. Compared to men, more women (58%) are infected with HIV/AIDS and many of them discover their HIV status during pregnancy. In resource-limited countries, Prevention of Mother-to-Child Transmission (PMTCT) programmes began about ten years ago, to which the FMF has contributed since the beginning of the Muskoka programme.

• **Example of Côte d'Ivoire**

Only 34% of pregnant women receive prenatal care during the first trimester of their pregnancy.

Only 52% of pregnant women gave birth in a health facility in 2019.

80% of pregnant/lactating women living with HIV are on ART.

94% of public health facilities provide PMTCT services, and the integration of these services in private clinics is inadequate.

The FMF contributed to improving coverage of antenatal care and HIV screening for pregnant women in the first trimester; HIV screening for exposed children; and screening of partners of pregnant and lactating women.

2. Reduce pregnant women and newborn mortality through maternal death surveillance and response (MDSR) system

Maternal death surveillance and response (MDSR) system performs routine identification, reporting, quantification, and determination of the causes of maternal deaths and their preventability. It allows the use of this information to implement corrective actions, both immediate and long term, to prevent death and thus reduce maternal mortality.

Therefore, it is crucial to know how many women are dying, where they are dying, and why they are dying, information that is not usually available in a satisfactory way. The areas of intervention in maternal health are closely linked: a functional network of EmONCs can only be established if the MDSR is implemented at the same time, as these activities are linked to the reduction of maternal mortality.

Assessing the magnitude of maternal mortality forces policy and decision makers to pay attention to the tragedy of a mother's death and to provide appropriate responses. The aim is to translate health data into policy language and to fuel advocacy for maternal health.

The MPDSR is an evaluation process of care quality.

The agencies maintained their joint work from 2011 to 2020 to integrate MPDSR into country development strategies and to develop the MDSR process at the health facility level, while providing support to strengthen national health information systems.

Much has been achieved in all Muskoka countries in terms of audit training, institutionalization of the MPDSR, and creation of ad hoc committees. The focus was placed on reporting. Now, the priority should be the review and the response. Rather than an objective of 100 % of reporting, the FMF should aim for 100% response on what is reported, as the only way to reduce preventable deaths.

• Example of Niger

Le premier bulletin de rétro-information national sur la mise en œuvre The first national feedback bulletin on the implementation of Maternal and Perinatal Death Surveillance and Response (MPDSR) was completed in 2019:

1,000 copies were produced and distributed to all facilities. An electronic format is planned to be issued on the website of the Ministry of Public Health.

Reporting of maternal deaths remains very low. With 5,138 maternal deaths expected in 2019, 970 maternal deaths were reported, of which 698 were audited, i.e., respectively 19% and 71% for the maternal death report and review rates. As part of the response, each region worked on one or two thematic priorities in its area of responsibility. The causes of maternal death (hemorrhage, eclampsia, infections, and anemia) and/or the dysfunctions identified following the review of maternal deaths were the subject of interventions ranging from raising community awareness of blood donation through community radios, to organization of blood collection including the purchase of blood bags, staff awareness on the prevention of infections and the reorganization of services.

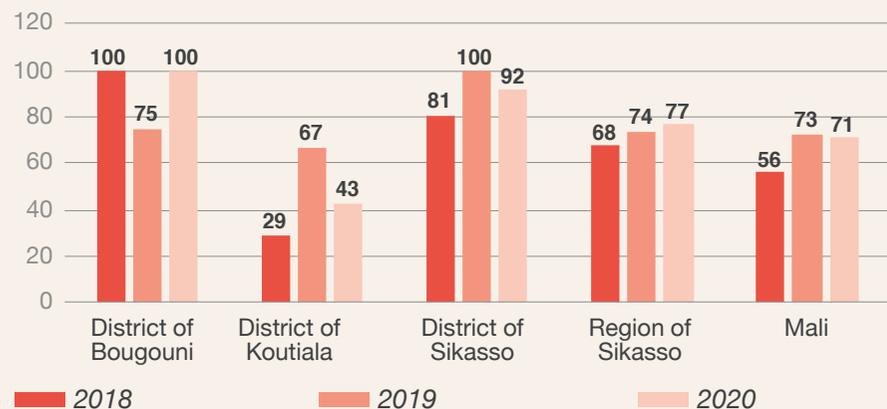
• Example of Mali

In Mali, maternal deaths have been regularly measured since 2018, and the proportion of audited maternal deaths increased from 56% in 2018 to 73% in 2019 and 71% in 2019.

In the region of Sikasso, regarding the FMF in Mali, we looked at the three Muskoka districts (Sikasso, Bougouni and Koutiala), two of which (Bougouni and Sikasso Districts) performed very well over the three years.

considered, which were found to be higher than the regional and national averages. By contrast, the District of Koutiala seems to be lagging behind and deserves special attention.

Figure 26: Proportion of maternal deaths audited in the FMF target districts of Sikasso, the region of SIKASSO and Mali (%)



• Benin

Available data show a trend toward a reduction in the number of maternal death audits performed.

Figure 27: Annual proportions of maternal deaths audited in Benin from 2014-2020)



• Côte d'Ivoire

100% of the country's Departmental districts have been trained in maternal death review and response.

• Niger



3. Improve access to skilled health workers for pregnant women and newborns

Health human resources: number, quality, training, motivation, distribution, are essential to ensure a quality care provision. For pregnant women and newborns, the midwife is at the heart of the care system. Nevertheless, the whole health workforce (nurses, doctors, community health workers, midwives) contributes to the reduction of morbidity and mortality of pregnant women and newborns.

Through the combined action of the 4 FMF agencies, over 70,000 health professionals (doctors, nurses, midwives and CHWs) have benefited from technical and financial support, training and capacity building over the 10 years of the Muskoka programme.

The rate of births attended by skilled professionals (midwives) is the most telling indicator of the state of maternal and neonatal health. It reflects the level of care supply as well as the level of care demand, and is an excellent benchmark for assessing the quality of care.

On average, under optimal conditions, a midwife performs between 100 and 200 deliveries per year, and monitors 300 to 500 pregnancies.

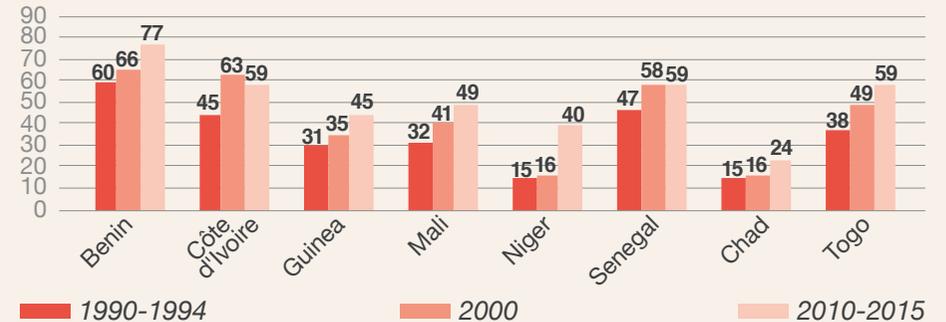
- **Niger** experienced a 115% increase from 139 midwives in 2012 to 300 in 2016, with a density of 1 midwife for 2125 inhabitants in 2016.
- **Senegal** the number of midwives increased from 1,222 in 2012 to 2,300 in 2016, an 88% increase for a density of 1 midwife per 1,426 inhabitants in 2016.

As part of its training programmes, in initial training or in capacity building, three areas of focus were developed in particular:

- The adoption of accreditation mechanisms for midwifery and nursing schools.
- The evaluation of the labor market and productivity of the health workforce.
- The improvement of healthcare professionals' practice in maternal and child health services.

The development of national midwifery and nursing policies has been carried out under the auspices of the FMF. Assessments (2013, 2014, 2015) of the quality of midwifery practice and the quality of midwifery training in the countries targeted by the French Muskoka Fund enabled to develop in 2016 (Côte d'Ivoire) or review (Niger) their midwifery and nursing policies

Figure 28: Evolution of skilled birth attendants since 1990



Sources: (1) Countdown to 2015; (2) UNICEF, Situation des enfants dans le monde, 2016

FMF impact on skilled birth attendance

- **Examples of Benin, Côte d'Ivoire, Guinea, Mali and Niger, year 10**

- **Benin**

Increase in the number of deliveries performed in health facilities by skilled workers:

2018: 73,5 % **2020:** 85,4 %

- **Côte d'Ivoire**

Increase in skilled attendance at delivery from 50% in 2012 to 70% in 2019.

Capacity building for health care workers in maternal and child health

In 2020, despite the COVID-19 pandemic, the clinical training of students at the internship sites provided support to 333 3rd year midwifery students at the INFAS branch of Abidjan. The training sessions focused on the management of antenatal care (ANC), childbirth, post-partum care, family planning (FP) and immunization. Convincing results were noted. Following supervision, 80% of the midwifery students validated the practical examinations.

Subsequently, 5 digital pedagogical capsules were produced and published on the INFAS online training platform. This allowed 1891 INFAS students to benefit from online individual training capsules on 5 thematic areas: i) Childbirth, ii) Management of hemorrhage by balloon, iii) Postpartum intrauterine device (IUD) placement, iv) Newborn care, v) Examination of the placenta for a better care supply and optimal care for populations.

• Guinea

Increase in the number of deliveries performed in health facilities by skilled workers:

2019: 291 863

2020: 318 431

Development of the training curriculum for community health technicians.

Evaluation of the operation and cost of training schools.

In 2020, of the 512,137 women completed ANC1 in the integrated facilities, 297,684 were tested for HIV, i.e., 58%, of whom 4,375 were positive and 4,200 on ARV treatment.

The active file of children put on ARVs is 2,312 following the screening of 3,768 children.

• Mali

The rate of skilled birth attendance increased from 15, 58% in 2016 to 27, and 54% in 2020 among the FMF-supported health districts. These rates in the other health districts range from 17.63% in 2016 to 23.51% in 2020. We observe an improvement in this indicator during the implementation period of the FMF.

Lethality due to the 3 main causes of neonatal death (asphyxia, prematurity, and infection) was significantly reduced between 2016 and 2020 in the supported districts, from 16.8%, 23%, and 19.9% to 15.8%, 8.6%, and 8.7%, respectively. This reflects the improvement in the quality of newborn care thanks to the capacity building of district and hospital neonatology units.

• Niger

Assistance to women during delivery by skilled workers has increased from 21% in 2010 to 35% in 2019, a 67% increase, although still very low.

FMF intervention areas	Rate of assisted delivery in 2018	Rate of assisted delivery in 2019	Development of the rate
Diffa	45%	49%	+ 4%
Maradi	29%	35%	+ 6%
Tahoua	36%	41%	+ 5%
Tillabéry	35%	37%	+ 2%
Zinder	26%	27%	+ 1%

In the region of Maradi, free assisted deliveries are maintained, as well as the monthly bonus of 34€ paid to midwives to enhance their motivation and performance.

The FMF co-financed and maintained (with Norwegian and Danish funds) the organization of mobile clinics to promote access to integrated reproductive health services for rural and nomadic populations, with a particular emphasis on preventive services and family planning. The monthly field presence of the mobile clinic teams increased from 10 to 20 days, and each mobile clinic is provided with a full-time midwife, nurse and driver. 23 health districts are provided with mobile clinics.

Although low, there has been an increase in the rate of assisted delivery in all regions of intervention. With the exception of the region of Zinder, all other regions exceeded the national average for the year 2012, which was 30%. With 11,636 C-sections performed in the first three quarters of 2019 in the five regions of the program; the C-section rate is 2% for a standard set around 10%.

- **Senegal**, assistance to women during delivery by skilled workers has increased from 65% in 2010 to 75% in 2019, a 15% increase.
- However, a slight decrease was observed in **Togo** from 71% in 2010 to 64% in 2017.

4. Fighting malnutrition among pregnant women and newborns

Exclusive breastfeeding and minimum dietary diversity for children aged 6 to 23 months are respectively

29% and 18%. Improving breastfeeding uptake can reduce the number of child deaths by more than 10%.

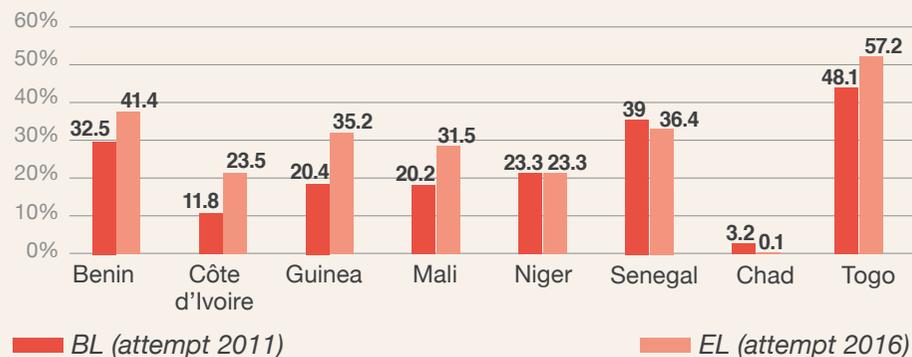
The Muskoka funding has contributed to foster synergies between the RMNCAH-Nut and nutrition interventions in the target countries. For example, in a context where more than 50% of women give birth in health facilities, the focus of the RMNCAH-Nut-FP-HR-Nutrition interventions funded by the FMF on maternity facilities in favor of promoting optimal breastfeeding practices was recommended.

The following essential nutrition interventions were implemented:

- Optimal maternal nutrition during pregnancy:
 - Prevention of anemia among pregnant women
- Infant feeding
 - Protection, promotion and support of optimal breastfeeding practices, including early initiation and exclusive breastfeeding up to 6 months



Figure 29: Exclusive breastfeeding rates for children under 6 months



• Niger

Exclusive breastfeeding for infants under 6 months remained low with 6% reduction or 27% in 2010 and 21% in 2020.

Chronic malnutrition remained stable at around 45% over the entire 2010-2020 period. The rate of severe acute malnutrition has slowly evolved below 2% (critical threshold) in 2020.

Figure 30: Evolution of the nutritional status of children in Niger 2010-2020



• Togo

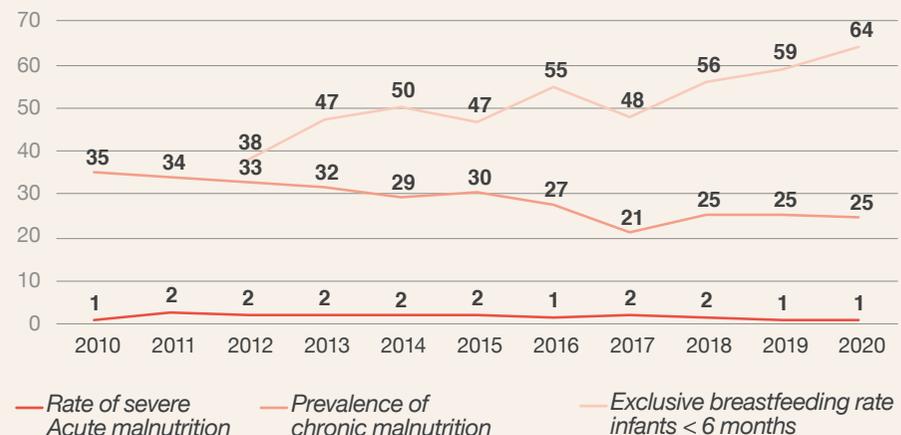
Slight reduction in chronic malnutrition and maintenance of severe acute malnutrition below the critical threshold of 2%.

Figure 31: Evolution in child feeding and nutritional status in Togo 2010-2017



• Burkina Faso

Figure 32: Evolution of the diet and nutritional status of young children in Burkina Faso



- In **Tchad**, there has been a slight reduction in severe acute malnutrition (12% in 2015 compared to 8% in 2018) which remains well above the critical threshold
- In **Senegal**, there has been a reduction in chronic malnutrition by 32% (from 27% in 2012 to 18% in 2019) Severe acute malnutrition remains at the same level as Chad in 2019
- In **Mali**, severe acute malnutrition is contained at around 2% with chronic malnutrition at around 25%.
- In **Guinea**, severe acute malnutrition is 4% in 2019 > the critical threshold of 2%. Although chronic malnutrition has seen a 25% decrease (from 40% in 2012 to 30%), it still remains a concern.
- In **Burkina**, there has been a 29% reduction in chronic malnutrition between 2010 and 2020.
- In **Benin**, severe acute malnutrition decreased from 5% to 1% between 2012 and 2018 with a 28% decrease in chronic malnutrition for the same period from 45% to 32%.

5. Access to essential medicines and health products for pregnant women and newborns

Through its programmes, the FMF provides direct support to ministries of health in the implementation of their pharmaceutical policies to ensure access to and rational use of quality and affordable essential medicines for the population. These Ministries also work closely with the Ministries of Finance and partners to secure the necessary funding for supplies. It also provides support for strengthening the legal and regulatory framework and compliance with norms and standards for the manufacture, distribution, access and rational use of medicines.

All health development partners benefit from the normative role played by the FMF, particularly through WHO's actions. These normative actions underpin UNFPA's and UNICEF's interventions to increase the availability of maternal and child health medicines and commodities in health facilities.

Complementarity of the UN agencies' action

To improve access to essential medicines and priority health products for mothers, adolescents and children, two complementary approaches were used by the partners involved in this project: the supply of medical products in the countries and their delivery to health facilities or communities, particularly involving UNICEF and UNFPA, but also strengthening the pharmaceutical systems in the countries, an approach favored by WHO. While the first approach has improved the availability of products and thus the supply of services, the second approach is absolutely essential to ensure that systems are in place to guarantee the sustainability, quality, and affordability of service provision.

- In **Guinea** and **Mali** the stockout rates of tracer medicines for the management of specific RMNCAH-Nut interventions showed a sharp reduction from 31% to 8% in Mali between 2013 and 2020 and a stability around 5-6% in Guinea from 2018 to 2020

6. Improved quality of care for mothers and newborns

Assessing and improving the quality of care means identifying weaknesses, gaps and dysfunctions in key areas of maternal, neonatal and child care, in order to make recommendations and take action to address issues and optimize patient care, based on the expected guidelines and standards.

In other words, it is measuring the difference between what is observed and what is expected, this difference corresponding to a lack of quality in the care provided. This lack of quality explains the discrepancy between the improving coverage indicators and the slower improvement in status indicators in all target countries.

Improving the quality of care involves clinicians as well as medical-technical providers, managers as well as leaders in the different branches of the department.

The process is carried out at the level of health care services and maternity wards, in close collaboration with the health care teams and administrative staff of the health care facilities involved, and in connection with the focal points of the Ministry of Health.

Assessing and improving the quality of care is one of the key strategies of the FMF

The three FMF agencies, WHO, UNFPA and UNICEF are working together around a joint tool designed by WHO.

Mobilize and inform

Regional Inter-Agency Workshop on Quality of Maternal and Neonatal Health Care in West and Central Africa. (Dakar, 17-20 July 2017)

- Data analysis from the “Demographic and Health” and “MICS” surveys shows limited direct relationship between the rate of deliveries in health facilities and neonatal mortality, reflecting a very low level of quality of care, including in training centers. WHO and UNICEF have defined standards and criteria for quality maternal, newborn and child care for health facilities.

- WHO, UNFPA, and UNICEF jointly organized a workshop in July 2017 to inform the 17 French-speaking countries in sub-Saharan Africa about quality of care assessment methods and develop action plans.
- Forum on quality of care with a focus on the experience of care held in Dakar, 21-25 October 2019

The new WHO quality standards for maternal and newborn care, which include 3 standards on the experience of care, were presented and disseminated among all countries, as well as the Respectful Maternity Care Charter.

Assess quality of care for mothers and newborns

This assessment and quality of care improvement process was performed in seven French-speaking African countries (including Burkina Faso, Benin, Côte d’Ivoire, Niger and Chad), with a total of over 50 maternity units visited, recommendations disseminated and some corrective actions implemented following the recommendations (better allocation of human resources, creation of newborn corners, better monitoring and quality control of essential medicines and supply mechanisms, etc.). Implementation of the recommendations should remain a priority for the continuation of the Muskoka programme (see Perspectives section).

The FMF helped to disseminate WHO norms, standards and guidelines, particularly at regional meetings, implemented by countries as part of the joint actions by the partnership agencies.

WHO guidelines disseminated in Muskoka countries through the FMF

2012	<ul style="list-style-type: none"> • Maternal and Perinatal Death Surveillance and Response (MPDSR)
2013	<ul style="list-style-type: none"> • WHO recommendations on postnatal care of the mother and newborn • Pocket book of hospital care for children, WHO 2013. • Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach
2014	<ul style="list-style-type: none"> • WHO Recommendations for Augmentation of Labor • WHO, Clinical Practice Handbook for Safe Abortion
2015	<ul style="list-style-type: none"> • WHO, recommendations for prevention and treatment of maternal peripartum Infections. • The prevention and elimination of disrespect and abuse during facility-based childbirth. • WHO recommendations on interventions to improve preterm birth outcomes, 2015. • WHO, Medical eligibility criteria for contraceptive use, 5th ed., 2015. • WHO guidelines for the treatment of Malaria, 2015. • WHO statement on caesarean section rates, 2015. • WHO Policy statement on intermittent preventive treatment of Malaria in pregnancy using Sulfadoxine-Pyrimethamine (IPTp-SP), WHO 2015.
2016	<ul style="list-style-type: none"> • WHO recommendations on antenatal care for a positive pregnancy experience, 2016. • Approaches & standards for improving the quality of maternal and newborn health care (2016) • C-section : Robson classification (2016)
2017	<ul style="list-style-type: none"> • Recommendations on the use of tranexamic acid for the treatment of postpartum hemorrhage
2018	<ul style="list-style-type: none"> • WHO recommendations on intrapartum care for a positive childbirth experience • Recommendation on obstetric fistula (2018)

Train and equip: an essential intervention to improve the quality of care

For more efficient training of health care workers, the agencies funded the purchase of mannequins adapted to each group of pathologies, both for the mother and the newborn. These mannequins and their accessories (childbirth, postpartum hemorrhage, breastfeeding, newborn, premature baby) were used to equip national and regional training centers. Teachers in the training schools were trained in the competency-based approach (Benin, Chad, Côte d'Ivoire, Guinea (photo), Niger, and Togo) using mannequins and on-site clinical tutoring.



“Low-dose, high-frequency on-site training associated with the equipment: essential care and newborn resuscitation, kangaroo mother care

Following the training of maternity wards’ staff, “newborn corners” were set up in all maternity wards in the targeted regions, allowing professionals to put their skills into practice.

A clinical training in mother-kangaroo care for neonatal teams is being held in June 2018 at Kalafong Hospital in Pretoria, a referral center for sub-Saharan Africa. Côte d'Ivoire, Niger and Togo sent two teams of caregivers (neonatologists, midwives, head nurses) to train in mother-kangaroo care with the goal of creating national reference and training centers in each of the Muskoka countries to improve management and reduce the mortality rate of premature and/or low-birth-weight babies (30% of neonatal mortality).

2. Children

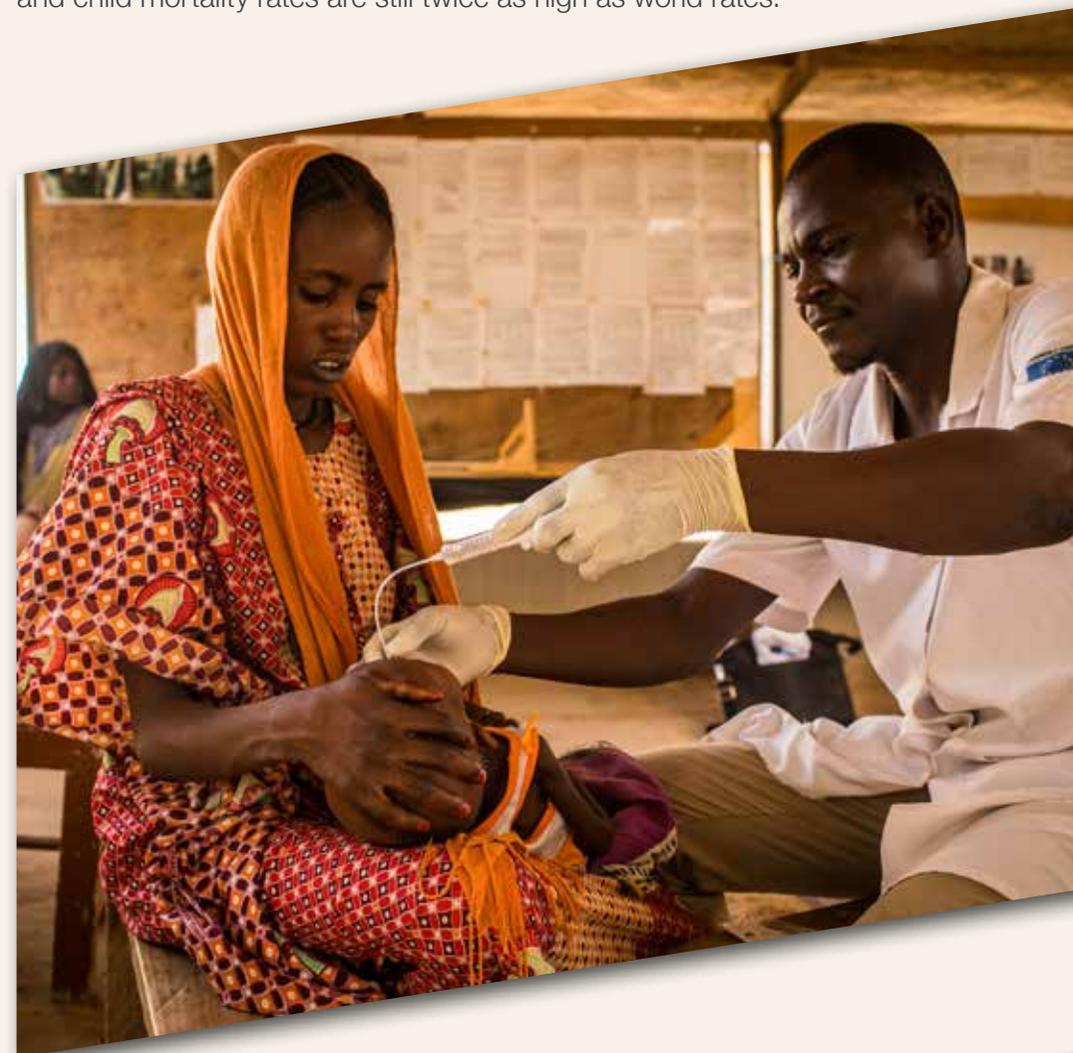
1. Equitable access to care

	Total population (x1,000)	Under 5 children (x1,000)	% under 5
Benin	10 880	1 708	17
Burkina	17 915	3 088	17
CIV	21 295	3 389	16
Guinea	12 348	1 945	16
Mali	16 259	3 129	19
Niger	19 268	3 991	21
Senegal	14 967	2 494	17
Chad	13 606	2 560	19
Togo	7 171	1 135	16
TOTAL	133 709	23 439	18

Progress in child survival in FMF countries since 1990 has been significant. Under-5 mortality rate has declined by 55%, passing from 213/1000 in 1990 to 96/1000 in 2015, despite all the challenges faced by this region, both chronic (political instability, conflicts, etc.) and acute (Ebola epidemic, recurrent cholera, measles, meningitis, etc.) compared to an average of 18% in Sub-Saharan Africa.

It should be noted that, in this global context, Niger (which ranks as the second poorest country in the world) is one of the very few countries in sub-Saharan Africa to have achieved MDG 4. Two FMF target countries, Burkina Faso and Côte d'Ivoire, are among the 20 African countries that have tripled their annual rate of reduction in child mortality rates and reversed the child mortality trend between 2000 and 2015.

In the FMF region, there was an annual rate of reduction in infant and child mortality between 1990 and 2015 of 3.1%, which is substantially the rate observed in other regions of the world (3.0%). However, this burden of death is still very high in the FMF countries, with approximately 500,000 children still dying each year before their fifth birthday, and nearly 1,000 child deaths from largely preventable causes occurring each day. Infant and child mortality rates are still twice as high as world rates.



“

The Muskoka Fund have been instrumental in improving accessibility and access to care. Accessibility in relation to the construction and equipment of some facilities. Access to care in relation to the availability of inputs and medicines.

”

Dr Rabi Maitourna,
MP, National Assembly, Niger

Considering the duration of the FMF, the decline mentioned earlier in 2015 has persisted beyond that. More specifically, it was confirmed between 2010 and 2019 and became statistically significant for Mali and Senegal and with very large reductions for the other countries of the project that are on the edge of statistical significance (see figure above).

The largest declines in mortality between 2010 and 2019 are 34% in Niger followed by Senegal with 32% for under 5s and 25% in Niger and 23% in Senegal for under 1s. However, statistically significant differences were observed for Mali and Senegal for both the under-5s and the under-1s. The FMF programmes contributed to these results.

The first phase of implementation of the French Muskoka Fund focused on reducing child mortality by scaling up community-based health interventions to address issues of access to health services and poor human resource allocation. This FMF strategy has brought health care services closer to remote populations by strengthening the skills of Community Health Workers (CHWs) for health promotion, the provision of both preventive and curative health services, and better involvement of target populations through a better understanding of health issues::

1. The promotion of essential family practices for child survival and development has been the focus of community-based interventions to support health care and the adoption of behaviors that foster RMNCAH-Nut. Studies on knowledge, attitudes and practices have been initiated to better understand the limiting and enabling factors for their adoption. Although it is difficult to attribute the results solely to the interventions implemented by the FMF, we can nonetheless observe, through the example below on Exclusive Breastfeeding, an increasing trend in most countries, with the exception of Niger, Senegal and Chad.
2. The 4 UN agencies of the FMF have united to contribute to the efforts in providing preventive care. Prevention interventions are implemented at community level, with the support of CHWs as regular services offered to the population in the most remote areas such as the distribution of micronutrient powders, or as a contribution to the organization of campaigns such as Vitamin A supplementation and deworming (Togo

and Chad), or seasonal malaria chemoprevention (SMC) in Benin, Niger, Chad and Togo among others.

3. The provision of curative care is crucial to reduce child mortality and has played an important role in the efforts supported by the FMF. Under this funding, services focused on the integrated management of the three killer diseases of under-five children (pneumonia, malaria, and diarrhea), thereby strengthening the link between management of these diseases and prevention of severe acute malnutrition (SAM). Only CHWs in Togo provide community-based care for children with SAM. In other countries, the CHW is empowered to screen for SAM and refer children in need of appropriate care to nutritional rehabilitation centers (CRENI and CRENAS). For example, this community-based strategy enabled the management of malaria, diarrhea, and pneumonia among under-five children throughout the Muskoka programme in Guinea and Togo.
4. Decentralized monitoring has also made it possible to strengthen community participation in issue identification for better management of health services. This approach was developed and implemented in two countries (Benin, Togo).
5. Support to the development of community health policy documents (policies, strategies and national guidelines). All Muskoka countries have at least one community health policy framework document that empowers Community Health Workers to provide care, diagnosis and treatment when appropriate. These policies are gradually evolving towards institutionalization of health systems (a policy and programme review was conducted and funded by Muskoka in 2018 Policy report and community- health programmes in WCA.pdf ffmuskoka.org), greater government ownership and commitment, and more effective coordination among technical and financial partners.

Finally, studies, research, and evaluations have been conducted in Muskoka countries to assess, document, and evaluate the progress achieved through the implementation of community-based interventions. The majority of the countries targeted by the intervention have conducted studies on the underlying causes, barriers and enabling factors for adoption of behaviors that foster RMNCAH-Nut.

2. Improving the quality of care for under 5 children through community and clinical IMCI

To reduce infant and child mortality, access to care should be facilitated. The IMCI strategy empowers community health workers (CHWs) with the necessary skills to provide outreach care, thereby significantly reducing morbidity and mortality among the under-five population. This strategy effectively addresses the issue of access to care for a large segment of the population living in remote or hard-to-reach areas, a major challenge for most countries where morbidity and mortality among children are high.

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
EQUITABLE ACCESS TO A COMPETENT PROFESSIONAL									
Implementation and expansion of Integrated Management of Childhood Illness (IMCI) and Capacity building for IMCI (training, inputs, supervision)	•	•	•	•	•	•		•	•
Development of essential family practices for child survival	•	•	•	•	•	•		•	•
Awareness-raising and communication actions	•	•				•	•	•	
Interventions that improve the nutritional status of young children	•	•	•	•	•		•		•
Preventive chemoprophylaxis of malaria	•	•	•			•		•	•

Management of malaria, diarrhea and respiratory infections

For the 2011-2020 period, with the FMF, in total nearly six million children have been treated as part of the management of the three diseases, malaria, diarrhea and respiratory infection

• **Example of Guinea year 2 to 10, 2011-2020**

In Guinea, with the FMF, in total nearly 1,6 million children have been treated from 2011-2020 as part of the management of the three diseases, malaria, diarrhea and respiratory infection. This corresponds to about 8% of the population of children in this country.

year 2

The FMF made it possible to introduce clinical and community IMCI in 11 health districts (Dubreka, Coyah, Forécariah, Boffa, Fria, Dabola, Mandiana, Beyla, Mali, Labé, Koubia), to strengthen the capacities of 220 community agents on the implementation of the integrated package of prevention and management of pneumonia, diarrhea, and malaria in five districts out of 38 (Coyah, Dubreka, Forécariah, Boffa and Fria).

year 3

Clinical and community IMCI trainings have resulted in the management of:

55,000 children for malaria,

14,000 children for diarrhea,

45,000 children for acute respiratory infections

year 4

Management of:

63,832 children for malaria,

17,207 children for diarrhea

10,443 children for pneumonia

year 5

526 community health workers benefited from capacity building on home-based newborn care and referral of severe cases.

288 health workers benefited from capacity building in essential care and resuscitation of newborns, preventive maintenance of equipment and the provision of materials/equipment.

136 community health workers benefited from capacity building on the screening and management of malnutrition.

2,961 CHWs were strengthened in community-based IMCI on Essential Family Practices.

34,400 (20%) children for malaria,

15 600 (9%) pour la diarrhea,

14,300 (8%) for cough/pneumonia

were managed:

year 6

61,000 children for malaria,

13,000 children for diarrhea,

4,000 children for acute respiratory infections

year 7 -8

236 health care providers were trained in clinical IMCI, 1850 community relays and 185 community health workers were reinforced on the essential packages in RMNCAH-Nut.

These interventions contributed to the management of 109,330 cases of diarrhea and 40,912 cases of malaria

year 9

Management of:

40,912 cases of malaria

109,330 cases of diarrhea.

year 10

896,606 under-five children were treated in health facilities and at community level, i.e.

416,150 cases of malaria

93,326 cases of diarrhea

287,130 cases of pneumonia

Within the framework of the management of childhood illnesses at community level, it was reported

11,927 cases of pneumonia treated with an antibiotic and

4,219 cases of diarrhea treated with Zinc ORS by the Community Relays in 40 Convergence Communes.

• Example of Togo year 1 to 10, 2011-2020

In Togo, with the FMF, in total nearly 850,000 children have been treated from 2011-2020 as part of the management of the three diseases, malaria, diarrhea and respiratory infection. This corresponds to about 7 % of the population of children in this country.

year 1

SIJ: Implementation of the community health care package in deprived areas: training (n=740) and equipment for CHWs (\$10/M) (UNICEF, WHO) deployed in target areas: training of 150 supervisor IDEs (nine districts), clinical IMCI: 48 providers trained: 48 HC in two districts, 24 health workers: trained in nutrition in 24 HC in one district

More than 775,000 people receive community-based care, including more than 135,000 children living more than seven kilometers from a health center. Provider skills in clinical IMCI and malnutrition management are improved in two and one district respectively

year 2

1,255 community health workers (CHWs) trained in the integrated management /64 pneumonia and malnutrition)

960 CHWs are deployed and equipped (reference module, medicines and management tools)

242 CHWs are also trained in Essential Family Practices

Rapid screening test for children with fever at 93.3% in the Savanes region and 97% in the Kara region

In Savanes, 71.8% of children treated for malaria with ACT (Artemisinin-based combination therapy) and 63.4% received paracetamol; in Kara, 76.7% and 51.9% respectively

The child was checked by the CHW 24 hours later in case of a cold or simple pneumonia and 48 hours later in case of malaria in 85.3% of cases in Savanes and 92.3% of cases in Kara

More than 60,000 sick children treated in 2013 (Jan-Oct) by the 960 CHWs already deployed for potentially lethal diseases if left untreated:

Malaria: 36,466

Diarrhea: 16,951

Pneumonia: 4,806

year 3

Deployment of nearly 1,300 CHWs in the 12 districts. Thus, were managed:

70,000 cases of malaria (24% of the target),

17,500 cases of diarrhea (59% of expected episodes),

8,000 of pneumonia (58% of expected cases)

year 4

As part of the promotion of curative care at the community level, the 1,289 community health workers (CHWs) deployed in the 12 districts managed:

65,252 cases of malaria (22% of expected cases),

4,887 cases of diarrhea (50% of expected episodes),

5,949 cases of pneumonia (44% of expected cases)

year 5

Through investment, CHWs have managed:
82,348 cases of malaria (33% of expected cases),
12,633 cases of diarrhea (49% of expected episodes),
7,912 cases of pneumonia (94% of expected cases) and

year 6

68,000 cases of malaria
16,000 cases of diarrhea
9 000 cases of pneumonia

year 7 - 8

In the 12 health districts of the Kara and Savanes regions in the north of the country, 1,224 community health workers (CHWs) are deployed through the Muskoka Fund.

96,381 cases of uncomplicated malaria in children (or 32% of expected cases were managed);

7,960 cases (26%) of diarrhea

11,011 (68%) cases of uncomplicated pneumonia were managed.

There is a downward trend in the number of childhood illnesses managed by CHWs, which could be explained by better adoption of preventive behaviors by parents, thanks to the promotion of essential family practices (EFPs) and the community-led total sanitation (CLTS) approach in both regions.

The Muskoka Fund's support enabled the CHWs to be regularly supplied with inputs (ACTs, ORS, zinc, amoxicillin, rapid diagnostic tests), ensured the payment of their incentive bonuses, as well as their supervision by health professionals.

It should be added that in collaboration with the Global Fund, UNICEF has technically and financially supported the implementation of seasonal malaria chemoprevention (SMC) in the Savanes region, covering 96%, 97% and 99% of children aged 3 to 59 months respectively during the three rounds

year 9

In collaboration with the Global Fund, UNICEF has technically and financially supported the implementation of seasonal malaria chemoprevention (SMC) in the Savanes Region, covering 98% (101,690) and 99% (102,727) of children aged 3 to 59 months during the two rounds respectively.

year 10

46389 cases (76%) of malaria

8836 cases (30%) of diarrhea

24,063 cases of pneumonia (78%) were managed by community health workers (CHWs) among under-five children.

- In 2020, in **Niger**, the management of diarrhea and acute respiratory infections at the community level was provided in 42 health districts. In total, during the first three quarters (only data available at the end of 2020):

76,428 cases of diarrhea were treated by the relays, and 64,563 were treated with ORS (84%);

83,038 cases of cough were diagnosed, of which 63,825 were classified as pneumonia, and 58,941 were treated with amoxicillin (71%).

Community-based monitoring of sick infants in Niger

	T1	T2	T3	october
Total	3 099	3 300	3 464	2 155
Cases treated	3 090	3 300	3 405	2 155
Cases referred	84 (3%)	88 (3%)	26 (1%)	5 (0.2%)
Cases followed at D4	2 812 (91%)	2 925 (89%)	2 979 (86%)	1 924 (89%)
Cases cured	2 959 (95%)	3 151 (95%)	3 249 (98%)	2 125 (99%)
Deaths	36 (1%)	32 (1%)	32 (1%)	8 (0.4%)

Vitamin supplementation

Vitamin A supplementation is essential for child survival. However, an analysis of available data indicates that there are significant disparities in the level of effective vitamin A supplementation coverage among Muskoka countries and effective coverage has declined in recent years. To address this, countries have committed to intensify vitamin A supplementation among children aged 6-59 months through the organization of vitamin A supplementation and deworming campaigns with Albendazole. Strengthening these initiatives should help to improve the effective coverage of children with vitamin A across all Muskoka countries.

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Benin	98	99	99	99	95	94	99	-	-
Burkina	102	102	105	101	100	103	98	92	105
CIV	-	23	-	-	95	103	94	102	-
Guinea		68	80	85	88	70	80	90	95
Mali	96	93	98		88	99		93	
Niger	16	30	102	96	99	104	100	-	-
Senegal	-	-	98	89	29	58	-	-	-
Chad	-	-	91	96	85	67	70		
Togo	-	-	82	-	-	-	85	88	89

• **Example of Benin, year 9**

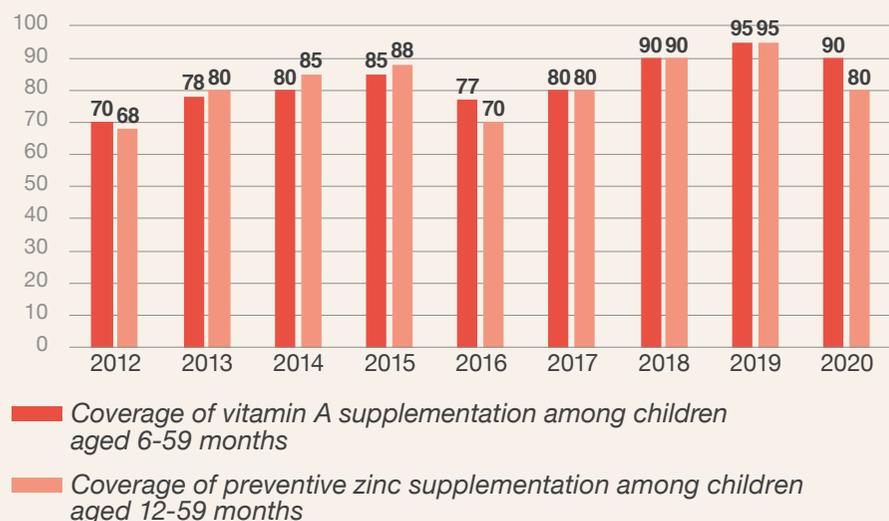
Contribution to coverage for Vitamin A supplementation and deworming of 91% of children aged 6-59 months and 93% of children aged 12-59 months respectively. It consisted in offering a package of services to children aged 6 to 59 months including:

- Immunization of children aged 0-11 months;
- Vitamin A supplementation for children aged 6 to 59 months;
- Deworming of children aged 12 to 59 months;
- Screening for malnutrition among children aged 6 to 59 months.



• **Example of Guinea**

Figure 33: Vit A and Zinc coverage for children in Guinea



Immunization

• **Example of Mali, year 9**

38,273 children aged 0-11 months were followed up for immunization.

• **Example of Chad, year 9**

80% of children aged 0-11 months received their 3rd dose of pentavalent vaccine and

69% their measles vaccine dose by the end of October 2019 for targets of 70% and 90% respectively. In addition 52% (66 /126) of the districts have at least 80% of children aged 0-11 months who received 3 doses of pentavalent vaccine for the period January to October 2019.

• **Example of Guinea, year 9**

Intervention beneficiaries	Achievements	Proportion of the target
Children aged 0 to 23 months caught up for BCG vaccine:	31 099	16%
Children aged 0 to 23 months caught up for penta 3 vaccine:	52 665	32%
Children aged 0 to 23 months caught up for VAA vaccine:	71 058	42%
Children aged 0 to 23 months caught up for VAR vaccine:	55 541	33%
Children aged 6-11 months supplemented with vitamin A	267 624	77%
Children aged 12-59 months supplemented with vitamin A	1 522 212	82%
Vaccinated pregnant women (VAT1)	22 975	4%
Vaccinated pregnant women (VAT2)	40 794	7%
Pregnant women who received iron/folic acid supplementation	218 469	39%
Pregnant women who received intermittent preventive treatment for malaria	72 523	50%

Trends in DTP3 (diphtheria-tetanus-pertussis vaccine) coverage and vitamin A supplementation.

DTP3 coverage at the age of 12 months is a key indicator of the performance of immunization programmes.

Antigen coverage with DTP3

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Benin	76	74	74	77	74	74	76	73	
Burkina	104	103	102	103	105	103		105	99
CIV	62	64	-	-	-	100	98	98	95
Guinea	64	63	57	50	44	47	47	47	47
Mali	72	74	-	-	-	-	-	95	97
Niger		93	97	96	90	85	93	100	100
Senegal			73	81	89	93	94	82	100
Chad	33	40	39	36	42	41	41	41	46
Togo	85	84	84	84	82	82	83	81	84

3. Access to skilled health professionals for child health

Health human resources: number, quality, training, motivation, distribution, are essential to ensure a quality care provision. For children, at community level, the community health worker is at the center of the care and management system. Nevertheless, the whole health workforce (nurses, doctors, community health workers, midwives) contributes to the reduction of child morbidity and mortality.

Strengthening the skills of community health workers for the management of under-5 children

At the training level: 'ICATT – IMCI Computerized Adaptation and Training Tool'

- **Example of Togo, 2011-2020**

year 1

SIJ: Implementation of the community health care package in deprived areas: training (n=740) and equipment for CHWs (\$10/M) (UNICEF, WHO) deployed in target areas: training of 150 supervisor IDEs (nine districts), clinical IMCI: 48 providers trained: 48 HC in two districts, 24 health workers: trained in nutrition in 24 HC in one district

year 2

1,255 community health workers (CHWs) trained in the integrated management of childhood illnesses (malaria, diarrhea, cough/pneumonia and malnutrition)

year 3

Deployment of nearly 1,300 CHWs in the 12 districts

year 4

As part of the promotion of curative care at the community level, the 1,289 community health workers (CHWs) deployed in the 12 districts managed.

year 5

526 community health workers benefited from capacity building on home-based newborn care and referral of severe cases.

288 health workers benefited from capacity building in essential care and resuscitation of newborns, preventive maintenance of equipment and the provision of materials/equipment.

136 community health workers benefited from capacity building on the screening and management of malnutrition.

2,961 CHWs were strengthened in community-based IMCI on Essential Family Practices

year 7 - 8

In the 12 health districts of the Kara and Savanes regions in the north of the country, 1,224 community health workers (CHWs) are deployed through the Muskoka Fund.

year 9

Through FMF support to community-based interventions, 69% of children aged 0-5 in the Savanes Region and 33% in Kara continue to have access to basic care. The proportion of villages beyond 5 km from a health facility with a Community Health Worker (CHW) trained on integrated care remained at the level reached in 2018, i.e., 72% in Kara and 65% in Savanes.

The FMF contribution also made it possible to ensure the payment of incentive bonus for the 1220 CHWs deployed in the 12 health districts of the two regions.

Over the year, 72% of the expected 21411 cases of children with pneumonia in remote communities were managed with an antibiotic by CHWs in these areas.

year 10

This year the percentage of children who have access to high-impact interventions at the community level in the Savanes and Kara regions has increased from 69% in 2019 to 79% in 2020, thanks to the training of new community health workers (CHWs). Indeed, the number of

households with access to a community health worker (CHW) trained in the integrated management of the most lethal diseases among children in Togo has increased from 73200 in 2019 to 84180 in 2020, thanks to the training of 183 new CHWs in the districts of Kpendjal and Bassar during the last quarter of the year, with technical support from the FMF. A total of 1403 CHWs are now deployed in the 12 health districts of the Kara and Savanes regions.

Through the combined action of the 4 FMF agencies, over 70,000 health professionals (doctors, nurses, midwives and CHWs) have benefited from technical and financial support, training and capacity building over the 10 years of the Muskoka programme.



4. Improving child nutrition

In West and Central Africa, 33% of under-five children are stunted. Malnutrition is associated with nearly half of all under-5 deaths, or nearly 400,000 deaths per year in Muskoka countries. This is linked to the lack of means of the families but also to non-optimal feeding practices for young children.

Better complementary feeding can prevent more than 10% of deaths associated with diarrhea or acute respiratory infections. It can also enhance resistance to disease, including measles. In their early years, malnourished children have more difficulty completing school, growing up normally, and then leading active adult lives.

At the community level, the implementation of a complete package for the management of young children's illnesses, including screening for malnutrition and the promotion of optimal feeding practices for infants and young children, was promoted.

The following essential nutrition interventions were implemented:

- **Infant and Young Child Feeding (IYCF)**
 - Protection, promotion and support of optimal breastfeeding practices, including early initiation and exclusive breastfeeding up to 6 months
 - Improved complementary feeding practices for children aged 6 to 23 months, in particular dietary diversification
- **Vitamin and mineral supplementation among at-risk children**
 - Vitamin A supplementation among children aged 6 to 59 months
 - Preventive zinc supplementation among children aged 12 to 59 months
- **Management of severe acute malnutrition**

• Examples of Mali, Niger and Chad in year 9

• Mali

Support to the DRS of Sikasso in the framework of the response to chronic and acute malnutrition in 3 HDs of Bougouni, Sikasso and Koutiala in synergy with the Italian and Spanish funds.

51,178 children aged 6-59 months were screened for malnutrition with the MUAC by GSAN members, including 532 severe cases referred to the CSCOMs for appropriate management

Organized 1,365 nutritional demonstrations for 48,297 persons, 12,525 of whom were men (26% or 41.7 tons of cereals, 6.2 tons of legumes

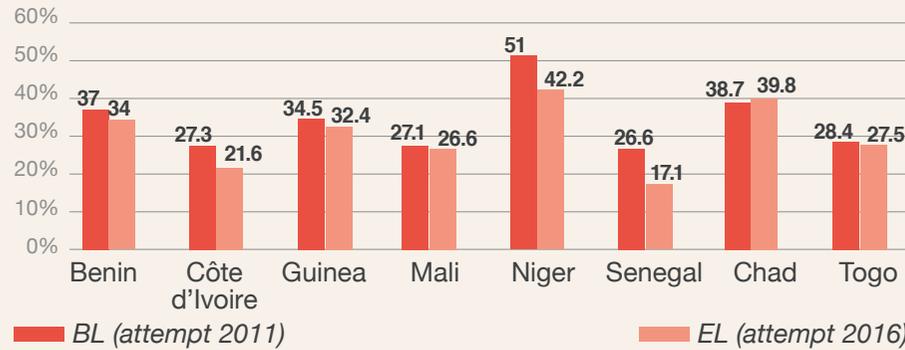
For the management of severe acute malnutrition, the 2 URENI and 86 URENAS of 2 districts of Sikasso and Bougouni will be provided with kitsof psycho-cognitive stimulation (local toys) for the stimulation of severely malnourished children, which will help to improve their care.

A total of 12,987 severely malnourished children were managed and benefited from psycho-cognitive stimulation in the 3 districts of Koutiala, Bougouni and Sikasso. A cure rate of 89.4%, a death rate of 2.0% and a dropout rate of 8.6% were reported (for th region, 19283 discharged, a cure rate of 89.4%, a dropout rate of 9.2% and a death rate of 1.4%). The 3 districts manage 67.3% of SAM cases in the 10 health districts of the region; 90 health district providers of Sikasso were trained on the new growth standards in order to improve the nutritional surveillance of under-5s.

• Chad

In order to reduce child malnutrition and its impact on mortality, the Ministry of Public Health, with the support of partners, has promoted the implementation of vitamin A supplementation and deworming among children aged 6 to 59 months. The first round of the supplementation campaign resulted in the supplementation of 4,089,777 out of 4,511,667 children (91%) aged 6-59 months with vitamin A and deworming 89% of children aged 9-59 months

Figure 34: Trends in the prevalence of stunting among under-5 children



Sources: SMART/NNS; MICS; DHS; AGVSAM

Figure 35: Exclusive breastfeeding rates for children under 6 months

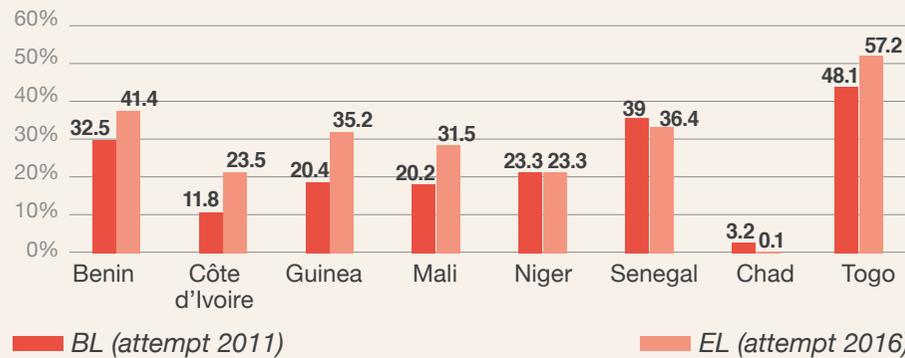
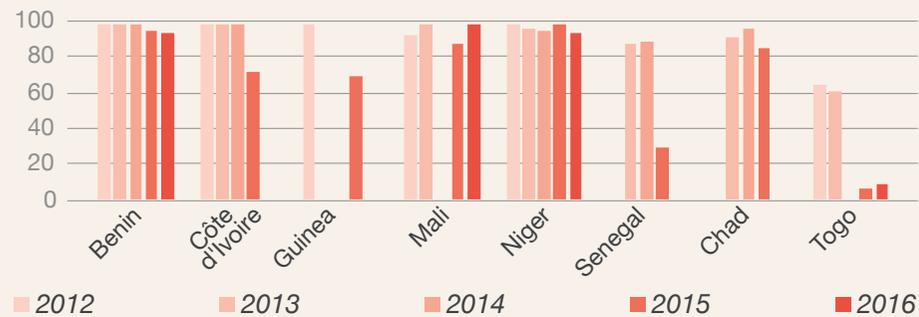


Figure 36: Exclusive breastfeeding rates for children under 6 months



Sources: The state of the world's children 2017.

5. Access to essential medicines and health products for children

As for pregnant women and newborns, the FMF provides direct support to ministries of health in the implementation of their pharmaceutical policies to ensure access to and rational use of quality and affordable essential medicines for the population. These Ministries also work closely with the Ministries of Finance and partners to secure the necessary funding for supplies. It also provides support for strengthening the legal and regulatory framework and compliance with norms and standards for the manufacture, distribution, access and rational use of medicines.

All health development partners benefit from the normative role played by the FMF, particularly through WHO's actions. These normative actions underpin UNFPA's and UNICEF's interventions to increase the availability of maternal and child health medicines and commodities in health facilities

3. Adolescents and women

1. Equitable access to family planning, sexual and reproductive health, and prevention and management of gender-based violence

Family planning

Family planning (FP) is one of the most effective interventions for improving maternal and child health. FP allows for birth planning, avoiding unwanted pregnancies and thus reducing the number of unsafe abortions.

It is estimated that approximately 30% of maternal deaths can be prevented through family planning services. More broadly, FP helps to achieve better maternal health, women’s equity, child survival, prevention of HIV and other STIs, women’s empowerment, and family well-being.

The main interventions were as follows:

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
THE MAIN INTERVENTIONS WERE AS FOLLOWS:									
Advocacy on family planning repositioning	•					•			•
Integration of family planning data into information systems						•		•	
Pilot testing of a community-based family planning data recording system					•				•

“

Thanks to the Muskoka Fund, we managed to equip two internship centers for students, Anono and Blockhaus.

We have mentored midwives so that they speak the same language as the tutors of the NGO Sauvons 2 Vies.

”

Kadidia Sow,
President of the NGO Sauvons 2 vies,
Abidjan, Côte d'Ivoire

	Benin	Burkina Faso	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
Training of community relays in family planning
Free family planning and screening campaigns
Active search strategy for dissatisfied customers
Curriculum development for community stakeholders to scale up the use of family planning services
PROVISION OF COMPLETE RANGES OF MODERN CONTRACEPTIVES									
Provision of modern contraceptives, service delivery, logistical support
Assessment of family planning needs
Review of the multi-year family planning plan
ORGANIZING INFORMATION ON FAMILY PLANNING AND GENDER ISSUES									
Awareness-raising and communication actions in family planning (community campaigns, social mobilization, radio, TV)

• **Example of Guinea and Niger, year 9**

• **Guinea**

The national week of free family planning services raised awareness among 50,052 women, counseled 75,156 women and put 47,647 women on all methods of contraception, including 3,409 new users and 8,238 regular users.

Thanks to the campaign of service provision by the midwives' association in 15 health centers, 2,120 new users were able to benefit from long-acting contraceptives.

A total of 221,818 people, including 129,994 women, were informed and educated about the benefits of FP and

69,181 women aged 15-49 received a modern contraceptive method as opposed to the expected 24,500 women.

Of the 69,181 women who received a modern contraceptive method, 50,609 were new users.

Among the female beneficiaries, 15,655 were aged between 10 and 19 years, i.e. 22.62%, 23,239 were aged between 20 and 24 years, (33.59%) and 30,287 were aged between 25 and 49 years (43.77%).

• **Niger**

515 health care providers supervised by 28 tutors in 94 Integrated Health Centers (IHCs) in the 5 target regions have seen their skills in EmONC and FP strengthened.

Organization of social mobilization campaigns for behavior change to end child marriage, enrollment and retention of young girls in school, and provision of RH/FP services in the regions of Maradi and Tahoua. These activities have created a large demand for the use of RH/FP services, with 36,107 FP acceptors, including 19,172 new acceptors (53%), with 9,025 and 10,147 in the Maradi and Tahoua regions respectively

• **Togo**

Community-based Distribution (CBD) of FP products, substantial achievements thanks to the Muskoka Fund (2012 - 2017):

Family planning has benefited from a repositioning plan in Togo. Among the innovative strategies implemented in this regard, Community-Based Distribution (CBD) of FP products has enabled the country to demedicalize the prescription of injectable methods. CBD has provided an adequate response to the issues of geographic and financial accessibility to FP services.

The results achieved through the CBD prove enough its effectiveness over the years as shown in the figures below:

Figure 37: Evolution of the number of CBD-PF users from 2012-2017



Figure 38: Evolution of KAP CBD-PF users from 2012-2017



Strategic result: Building on the success of CBD and in light of the challenges of coordinating community-based initiatives, the Ministry of Health has initiated the development of a National Policy and a new Strategic Plan for Community-Based Interventions (CBI) 2016-2020.

The introduction of the postpartum intrauterine device (PPIUD) is a promising intervention made visible through the Muskoka Fund (2014 - 2016):

The introduction of the postpartum intrauterine device (PPIUD) has been a major innovation in enhancing the availability of FP services. The PPIUD has been progressively integrated into the 109 health facilities offering Emergency Obstetric and Neonatal Care (EmONC): 6 health facilities in 2014, 14 health facilities in 2015 and 33 health facilities in 2016. The proportion of PPIUD to deliveries was 24.7% in 2015.

Over the past 3 years, 2,510 women have had an IUD inserted immediately postpartum: 194 in 2014, 801 in 2015 and 1515 in 2016.

The integrated effect of this result is that the PPIUD was introduced in the EmONC facilities also supported and strengthened by the Muskoka facility, demonstrating the continuum of care approach

At regional level, the gradual scaling up of high quality postpartum family planning (PPFP) services over the past 5 years is detailed as follows:

2013 - Intensive and practical training of providers in FP counseling and practical training in IUD insertion in 6 countries (Benin, Ivory Coast, Guinea, Niger, Senegal, Chad).

2014 - Follow-up and strengthening of on-site practice of the teams trained in 2013 in the 6 countries as well as identification of those who joined the pool of regional trainers in 2015. Also in 2014, of these six countries, two (Benin and Niger) benefited from support for the extension of this training to maternity wards in rural areas.

2015 - Constitution of the regional pool of trainers and training workshop for these 18 providers (Obstetricians, Gynecological Surgeons and

Midwives) trainers on the insertion of the postpartum Intrauterine Device (IUD) coming from five countries of the region (Benin, Ivory Coast, Niger, Senegal, Togo).

2016 - Qualification of trainers through in site visits and practical exercises assessed in two countries (Togo and Benin).

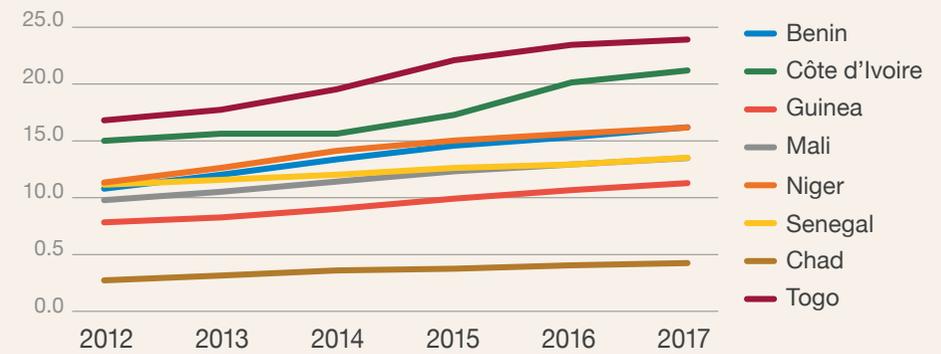
2017 - Documentation of work done over the past 4 years to “improve access to postpartum family planning (PPFP) services in West Africa. Measuring efforts and contributing to the scaling up of PPFP services”

Evolution of modern contraceptive prevalence (%) in Muskoka countries (all women)

	2012	2013	2014	2015	2016	2017
Benin	10,5	11,6	13,0	14,1	14,9	15,7
Côte d'Ivoire	14,6	15,1	15,2	16,8	19,6	20,6
Guinea	7,6	8,1	8,8	9,6	10,3	11,0
Mali	9,5	10,2	11,1	11,9	12,5	13,1
Niger	10,8	11,3	11,6	12,3	12,5	13,1
Senegal	11,0	12,3	13,7	14,6	15,1	15,7
Chad	2,7	3,0	3,4	3,7	3,9	4,1
Togo	16,3	17,3	19,0	21,5	22,7	23,2
Togo	84	84	84	82	82	83

Source: Family Planning Estimation Tool (FPET), using all available household surveys such as DHS, PMA2020, MICS and comparable national sources, including service statistics where possible.

Prevalence rate of modern contraception (all women)



2. Adolescent and youth sexual and reproductive healths

The FMF target region has the highest adolescent birth rate in the world. Compared to women over the age of 20, young girls (including 14 and under) and adolescents are still at greater risk of pregnancy-related complications



Each woman has an average of 5-6 children, and the teen pregnancy rate is more than twice the global rate, with more than 1 in 10 girls aged 15-19 giving birth.

West and Central Africa has more than 65% of the population aged less than 24 years, 32% of whom are aged between 10 and 24 years, and an adolescent pregnancy rate more than twice the global average, with more than one in ten girls aged 15 to 19 giving birth. In the developing world, WCA is the region with the highest percentage of childbirth among girls aged under 15 - 6% - yet these girls (14 and under) are the most vulnerable and most at risk of complications and death as a result of pregnancy.

Adolescent girls are the first victims of the lack of access to and quality of maternal and reproductive health care, too often out of school, vulnerable to early marriage, facing unwanted pregnancies and the primary victims of HIV/AIDS. In fact, adolescents are the only group today that is experiencing an increase in mortality from the disease

Key data:

- A girl married at the age of 15 has already 2 or 3 dependent children at the age of 20-24.
- Children born to teenage mothers are more likely to be less healthy (premature, low weight, nutritional difficulties..) and have a higher risk of infant mortality. This also represents a risk for the mother: anemia, difficulties of exclusive breastfeeding..
- Every hour, in the West Africa region, 7 adolescents aged 15 to 19 are newly infected with HIV, 70% of whom are girls
- Nearly 1 in 3 adolescent girls report incidents of physical abuse since the age of 15.
- 1 in 10 girls have experienced sexual violence in their lifetime.
- In the West African region, 45% of girls believe that wife beating is justified under certain circumstances.

In this context, AYSRH is more than ever a public health priority and a key intervention axis of the FMF in the reduction of maternal, neonatal, infant and adolescent mortality. The priority given to AYSRH in the Muskoka initiative is a strong signal from France, confirming its strategic³ and operational commitment to this issue.

Two main types of interventions have been implemented in countries:

- Implementing sexual and reproductive health services in school and out-of-school settings and enhancing access to comprehensive sexuality education.
- Awareness sessions and conference-debates on gender-based violence.

In addition, in 2019, many activities were implemented on menstrual health and hygiene.

	Benin	Côte d'Ivoire	Guinea	Mali	Niger	Senegal	Chad	Togo
IMPEL A SUSTAINABLE CHANGE OF SOCIAL HABITS AND LAWS MORE SUITABLE FOR YOUNG GIRLS IN PARTICULAR IN VULNERABLE SITUATIONS								
Develop and document innovative approaches for direct interventions in favor of girls, particularly for their retention in school					•		•	•
Develop and document innovative approaches for awareness raising, information and communication for behavior change, especially for the most vulnerable, including young girls, and particularly through work with parents	•	•	•	•	•	•	•	•
Develop, strengthen and review campaigns, programmes, strategies and national plans to reduce/end early pregnancies and marriages and fight against GBV (green line, etc.)	•	•	•	•	•	•	•	•
Mobilize A&Y through new technologies, youth networks and the "C'est la vie" cross-media campaign to inform and sensitize and promote leadership, participation and empowerment of youth, especially girls	•			•	•	•		•

Building AYSRH as an HII within the FMF

Programmatic retrospective

2011-2012: UNFPA/WHO advocacy for the integration of AYSRH as a strategic pillar within the FMF.

November 2012: Cotonou Workshop - "Advancing Adolescent Sexual and Reproductive Health in the Muskoka PSF Programmes of Action" in collaboration with the NGO Equilibres et Population

2013-2014: 3 studies are undertaken in Benin, Niger and Togo by our partner Equilibres et Population "Sexual and reproductive health and rights of adolescents: analysis of policies and programs: opportunities and challenges for UNFPA".

Country teams develop AYSRH activities in their inter-agency plan.

September 2014: A first version of the theory of change on the reduction of early pregnancies was developed following the Cotonou workshop and the country surveys.

2015: Follow-up of the implementation of the recommendations of the studies conducted in the countries and strengthening of the regional technical support to the countries on the issue.

May 2015: SteerCom – Desire for a greater proportion of interventions to improve adolescent sexual and reproductive health, particularly through enhanced access to contraception.

November 2015: The TechCom validates the proposal of a common intervention framework for the 4 agencies in AYSRH, the creation of an ad-hoc working committee.

2016: Continued country technical support and close monitoring for greater focus on AYSRH and increased financial allocation in inter-country and regional PTAs.

May 2016: SteerCom – Desire to see 30% of 2017 budget allocated to AYSRH.

June 2016: TechCom – proposal for the AYSRH concept note - early pregnancy reduction

December 2016: Validation of the AYSRH concept note - early pregnancy reduction

2017: Sharing the concept note with countries for 2017 planning and implementation

2017: Holding of the joint regional workshop on AYSRH on: “Reducing Early Pregnancy in West and Central Africa: Assessment, Prospects and Key Interventions for Adolescent and Youth Sexual and Reproductive Health and Rights”.

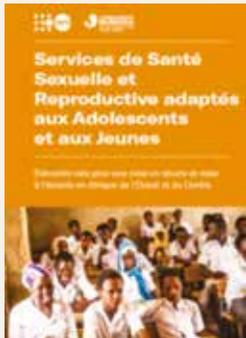
2020: 7-month digital campaign on menstrual health and hygiene entitled #soyonsreglos reaching over 16 million people

• Côte d’Ivoire



Menstrual health and hygiene (MHH) during interagency programming

• Guinea



Resource mobilization strategy for CSE.

Continuation of the production of technical guides and documentation of promising practices in AYSRH

Regional Intervention Frameworks and Advocacy to Accelerate the Achievement of AYSRH in the West and Central Africa Region -

Since 2018, UNFPA and UNESCO have been leading the preparatory process leading to a high-level regional commitment to CSE and SRH services in WCA by 2020.

The collaboration with UNESCO demonstrates the interaction of the regional inter-agency team around AYSRH and the catalytic effect of Muskoka in both programmatic and financial terms.



Regional Programmatic Results

1. Design and implementation of the first joint regional framework to fight against early pregnancy

This is the first joint regional strategy to reduce early pregnancy implemented in the target countries and on a regional scale, maximizing the added value of the Muskoka mechanism through the synergy and complementarity of the expertise of the different agencies, each one involved by their mandate and regional context in social and health activities for adolescents and youth.

The proposed key interventions build on the interventions already established in the Muskoka resource and results framework, namely:

- Implement SRH services (including FP) in school and out-of-school settings;
 - Establish a protective and supportive environment for the development of young girls and boys in schools and communities, including CSE in school and out-of-school settings;
 - Impel a sustainable change of social habits and laws more favorable to young girls, especially in vulnerable situations.

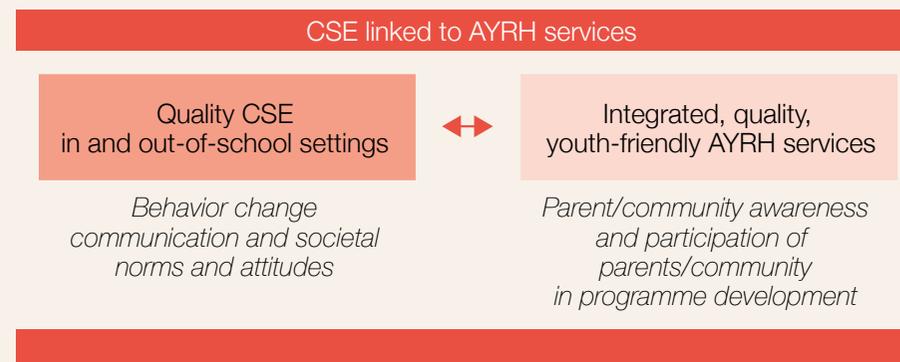
3 strategic axes have been developed:

- Adolescents and youth, a prime target for reducing rarely and unwanted pregnancies: review, evidence and perspectives.
- Enhancing adolescent and youth involvement to reduce adolescent pregnancy - Towards programmatic design
- Taking action: Identifying joint interventions and next steps to ensure greater involvement of adolescents and youth

2. Production of technical reference documents of best practices in AYSRH

- CSE
- Sexual and reproductive health services adapted for A&Y

CSE is an integral part of AYSRH policies in-school and out-of-school settings. Coupled with the availability of youth-friendly health services, it allows for the demand and supply of quality sexual and reproductive services for adolescents and youth.



Major results achieved at the country level in terms of AYSRH, example of Togo, Côte d'Ivoire and Guinea

• Togo

A situation analysis on early pregnancy and marriage that led to the development of a national programme to fight adolescent pregnancy and marriage

23 school health services were operational by 2014.

A study in facilities with school infirmaries revealed that 82% of students do not know that a girl can get pregnant on her first sexual experience.

Training of the 28 providers in the infirmaries and youth centers has been enhanced for the provision of family planning services.

Behavior change communication was enhanced with the production of several materials (posters and signs, pamphlets on early pregnancy and sexual violence), interactive media programmes with youth, and the broadcasting of spots on sexual rights and reproductive health.

A total of 50% of the students surveyed said they had already benefited from the infirmary services.

Approximately 100,000 adolescents and youth sensitized each year since 2014.

The provision of integrated services in youth centers and high schools and villages has resulted in the introduction of modern contraceptive methods for approximately 3,000 girls aged 15-24, and the screening and treatment of more than 3,000 cases of STIs each year.

Pregnancy cases have decreased significantly in facilities over the past two years. The dropout rate due to pregnancy, initially around 50%, is currently around 20% in these schools. A total of 50% of the students surveyed said they had already benefited from the infirmary services.

• Côte d'Ivoire

The FMF contributed substantially to the dissemination and supervision of CSE "life lessons" courses targeting all schools and reaching 676,131 new students. The distribution is as follows: 63.9% and 71.4% of primary and secondary students respectively.

In addition, an agreement is signed by the DREN with 30 local radio partners. 1 presenter is designated in each of the 30 partner radio stations to ensure the animation of the broadcasts. 6 topics on SRH are currently being aired.

Côte d'Ivoire has developed and validated the first national reference document on menstrual health and hygiene. A validated national menstrual health document with the following aspects: (i) Puberty in girls and boys, (ii) Menstrual management, (iii) Taboos, misconceptions and misinformation.

The Ministry of Youth, with technical and financial support from UNFPA in particular, capitalizes on major youth gatherings to raise awareness about RH/FP/HIV and risky behaviors (tobacco, alcohol, drugs) and to offer STI/HIV testing and family planning services.

Thus during the Youth Health Caravan:

- 178,732 youth aged 10 to 24 who were reached (74,900 young girls and 103,832 young men)
- Among them, 7,549 young women and 8,922 young men were tested for HIV, with 2 positive cases among young women;
- Young girls benefited from modern contraceptive methods;
- 84,574 condoms were distributed to youth under the age of 24 .

In total, 23,263 adolescents and youth received RH/FP/HIV services as a result of the youth ministry's interventions.

• Guinea

Significant increase in AYSRH services

Number of facilities integrating SRH services for youth



Findings

• At country level

- Institutionalization of CSE in progress in most countries
- Progressive implementation of SRH services adapted to adolescents and young people
- Sustainable change of social habits and laws more favorable to young girls, especially in vulnerable situations

- **At regional level**
 - **Creation and implementation of the first regional inter-agency strategic framework on early pregnancy reduction**
 - **Technical guidance and sharing the latest evidence with countries**
 - **First 7-month digital campaign in West and Central Africa entirely dedicated to menstrual health and hygiene, #soyonsreglos, reaching over 16 million people**
- **Strategic result**
 - **Muskoka Fund recognized as a catalyst fund for AYSRH in the region**



Educational talk in a school in Guinea

Prevention and management of violence against women and girls

Despite an undeniable increase in conservatism on some issues related to women's rights, the promotion of gender equality is now widely perceived within the FMF as an essential step to strengthen the effectiveness of development and poverty reduction policies. Women are the first victims of poverty. They face many barriers that limit their social, economic and political empowerment. They represent nearly 70% of people living on less than \$1 a day and about 2/3 of non-literate adults. Although they are heavily involved in economic production, they derive little benefit from it due to their lack of control over resources and production factors.

Millions of women are also unable to fully and freely exercise their sexual and reproductive rights, an essential dimension for their empowerment. The new 2030 Agenda for Sustainable Development recognizes these multiple barriers as obstacles to achieving the Sustainable Development Goals (SDGs) and therefore recommends addressing the structural causes of gender inequality. In this context and within the framework of the FMF, 7 studies were conducted in several countries, namely Guinea, Haiti, Mali, Niger, Central African Republic, Chad and Togo. These studies resulted in a consolidated report on "Links between Violence and Maternal Health. They resulted in a particular interest from other agencies in addressing violence in the response to maternal and child mortality.

- Four studies on violence in hospitals were conducted in Haiti, Togo, Mali and Côte d'Ivoire. Their results were used to enhance training modules for health care workers and to inform national strategies for improving reception in health services (Côte d'Ivoire, Mali)
- Four sociocultural audits analyzing positive and negative sociocultural norms influencing maternal and child health were conducted. They served as a basis for negotiation and advocacy with community leaders to end harmful practices,
- The skills of thousands of health and social workers have been strengthened in human rights, communication, ethics and patient rights. Gender, equity, and family planning issues have been integrated into several EmONCs. They have resulted in improved demand in several countries (Togo, Guinea, Côte d'Ivoire).

Training modules on violence and health have been integrated into 10 midwifery schools.

- Within the framework of the partnership with WAHO of ECOWAS, gender and violence have been integrated into the training curricula of midwives and nurses.
- Knowledge was also improved through south-south cooperation, during which Guinea trained the CAR on the management of complications of violence during pregnancy and childbirth and the management of sexual violence.

- Advocacy in Chad and Togo enabled the integration of provisions regarding GBV in the penal code.

In Mali, Senegal, Chad, Togo and Niger, hundreds of community leaders have been trained and guided on their roles and responsibilities in the fight against GBV and maternal and infant mortality through communal committees for the fight against maternal, neonatal and infant morbidity and mortality

- About a hundred community platforms mobilized, trained and sensitized religious leaders, local and traditional leaders, women's organizations, health providers, paralegals, community radio stations, and youth associations.
- 700 religious leaders have been reached by awareness-raising and training on gender, GBV and discriminatory practices. Many religious arguments about RH and violence have been produced and disseminated in the region.



- In Togo, a total of 78,500,000 people were reached through radio broadcasts with youth, women and religious and traditional leaders.
- In Niger, 450 radio broadcasts have cumulatively reached more than 21,000,000 people per year.
- Thousands of people have been reached by the preaching in churches and mosques. Preaching or religious talks, social mobilization and awareness-raising activities on GBV and AYSRH helped strengthen the synergy of interventions to fight violence and protect youth,

The influence of the community has led to a reduction in rape, a reduction in forced marriages in most countries, particularly in Niger and Chad, and the adoption of community orders against rape.

• Togo

The integration of the management of gender-based violence in health facilities in Togo

This intervention highlights a collaborative model between NGOs, CBOs engaged in the fight against violence against women and health facilities, and a partnership model between civil society, the public sector and the private sector in the promotion of women's rights and health.

This action was implemented through a strategy based on capacity building for health professionals on reception techniques, quality of services and medical care for women and girls victims of violence, the establishment of a referral system for victims to health facilities, and the involvement of the police and judicial authorities.

This intervention allowed for the management of 432 cases of sexual violence in the referral health facilities (CHR, CHP, Polyclinics) in the 18 health districts of the intervention area.

Result in terms of thematic integration between maternal health and the gender approach, including the management of GBV.

- **Benin**

In Benin, these actions are possible thanks to the collaboration with the Institut des Filles de Marie Auxiliatrice (IFMA) - Salesian Sisters of Don Bosco, which is the only UN WOMEN partner facility committed to implementing the actions of the French Fund MUSKOKA. Its interventions cover six (06) areas

Broadcast messages: Rape and all forms of violence are punishable by law; in case of violence, call the following toll-free numbers: 7344 and 96000001; in case of rape, the issuance of the medical certificate is free.

- **Mali**

Capacity building for 40 police officers and 45 civil society actors in the region of Sikasso regarding the new guidelines.

The capacities of 60 peer educators and 40 women and girls of reproductive age were strengthened on the concept of gender, GBV, human rights, AYRH and social behavior change communication in the region of Sikasso.

- **Niger**

The capacities of eight multi-stakeholder platforms and eight active men's clubs were strengthened through the NGO (non-governmental organization) Association of African Communication Professionals (APAC NIGER),

Several interactive radio broadcasts through community radios, including roundtables, debates and interviews on gender-based violence issues related to maternal and child health, have been organized.

A total of 1,391,160 people (men, women, girls and boys) were reached by the different broadcasts with a strategic and participatory approach.

“

Our mission is to guarantee the rights of women in our environment.

We should not leave no room for gender-based violence. In the case of rape, we should do everything possible to bring the perpetrator to justice.

Through our work, we are witnessing many changes.

Child trafficking has been significantly reduced, as well as early marriage

”

Salamatou Alidou,
Initiative Fionson, Wife of the Chief of Vogon, Togo

• Senegal

The Ministry of Women, Family, Gender and Child Protection has an operational action plan for the implementation of the essential services package for the management of victims. The synergy between civil society and the MFFGPE has been strengthened in order to promote awareness and community dialogue and social mobilization for behavior change.

Youth activist movements recognized and supported. Youth activist movements have flourished this year and have developed social media campaigns such as “me too” to denounce violence against women and girls.

A synergy of civil society committed and recognized by the authorities: The 35 women’s associations have been strengthened and 100 paralegals trained. The latter were deployed in 4 departments of Senegal to raise awareness in the communities about women’s access to legal aid.

Women and girl victims supported and managed:

2,000 women and girls victims of violence have access to multisectoral prevention and management services through interventions at the level of maternal, neonatal, child and adolescent health improvement projects. The project on women’s access to justice has built the capacity of legal, health, and police and social service providers. These providers are currently able to offer quality services and referrals to other services. This has enabled 2000 women and girls and youth to benefit from services and address their issues. For this year 1500 victims have benefited from the service of legal aid, health and social and economic integration.

Psychosocial assistance to women victims: 500 women victims have received psychological support and medical care for themselves and their children and have been rehabilitated. They carry out economic activities and have reintegrated into society, regaining their dignity and thus ensuring their resilience and self-esteem.

Chad

The listening center of the Association for Women Jurists in Chad (AFJT) recorded 83 cases of violence between January and December.

The AFJT provided 50 girl mothers with hygiene kits. In addition, 100 women, including 50 in Mao and 50 in N’Djamena, received support to implement income-generating activities (IGA) for their empowerment.

Two training sessions for leaders in Mao and Ndjamenana trained 50 leaders on masculinity, violence and the provisions of the new penal code relating to gender-based violence.

Togo

71 health professionals (doctors, midwives in charge of SRH/FP and district nurses) and 87 members of community dialogue platforms participated in discussions on the status of prevention activities and psychosocial, legal and medical care for victims. A total of 239 victims received medical care (medical consultations, analyses and medication), including 73 cases of rape of minors in the 18 health districts of the project.

29 cases of female genital mutilation on children were handled in the prefectures of Cinkassé, Tône and Kpendjal. A new financial allocation is made available to the eighteen (18) health districts for the management of cases of sexual and physical violence. In addition, 140 community actors from 7 prefectures have improved their skills in the area of men’s involvement in the promotion of sexual and reproductive health and the prevention of gender-based violence (GBV)



4. Pregnant women, Newborns, Children and Adolescents

1. Equitable access to trained professionals

Improving access to skilled professionals has been a major focus of the programme over the past ten years, with each agency working in a complementary way to disseminate norms, standards, and protocols of care, to assess the quality of care provided, to train staff and accredit schools, to retain health workers and improve their distribution throughout the country, and to provide essential medicines and equipment. The progress made, to which the joint work of the four agencies contributed, is reflected in the evolution of mortality and morbidity indicators in the countries targeted by the FMF.

In total, from year 1 to year 10 of the FMF programme, through the combined action of the 4 partnership agencies, more than 70,000 health personnel, doctors, nurses, midwives, and CHWs were supported through targeted interventions: technical and financial support, capacity building, training and recruitment of health workers according to the needs of RMNCAH-Nut, improvement of the quality of practice through supervision, and improvement of working conditions.

Midwives for the management of mothers and their newborns

Recent estimates suggest that countries need a minimum of six health workers with obstetric skills per 1,000 births to ensure that 95% of women give birth with skilled attendants and to accelerate the reduction of maternal and newborn mortality. Depending on the context and the country, a midwife performs on average between 100 and 200 deliveries per year, and monitors 300 to 500 pregnancies. **Providing support to these skilled personnel therefore has a strong impact on the target populations.**

Community Health Workers (CHW)

In Benin and Mali, responsibilities were defined according to the number of households (between 25 and 50 per agent), villages (1 to 2/ASC) or inhabitants (1500 inhabitants). The aim was to deploy an average of one CHW per 650 rural residents.

During these 10 years, the main lines of intervention have been as follows

1. Facilitating access to quality midwifery education

The interventions focused on improving initial and ongoing training

Current situation of maieutics in Africa

French Muskoka Fund supported the production and dissemination of the State of the World's Midwifery report published in 2014 by UNFPA. The release of this report has increased knowledge about the role of maternal and newborn health care providers. Indeed, the report showed that 80% of the continuum of maternal and child care could be managed by the midwife if she proved to have mastered the relevant skills.

Midwifery profession reform

Following the release of the global report on the State of the World's Midwifery, several workshops were organized through the FMF at the regional level to reflect on the future of midwifery. These workshops enabled to validate the upgrading of midwifery training to university level. The FMF has been a catalyst for mobilizing funding for midwifery education reform in the beneficiary countries (Côte d'Ivoire, Mali, Senegal, Niger, Guinea, Burkina Faso, Benin, Togo).

Organization of the first congress of the federation of French-speaking midwives in Africa

This congress was held in Mali in October 2015 with the participation of a hundred French-speaking African midwives. Issues related to the quality of their training and the regulation of their profession were addressed.



At the youth center, I was taught that I have rights and that at 15 years old, I was not yet of age to get married.

They taught me my rights that I did not know. What I knew at home was submission.

I will get married at the right time. It is no longer a forced marriage or an early marriage.

And thanks to the center, we will fight unwanted pregnancies.



Roubatou Tchagaou,
student, Tabligbo, Togo

Initial training

A review of midwifery training programmes has been undertaken in all FMF beneficiary countries to improve the quality of training at the professional and university levels. The upgrading of midwifery education to university level has been taken into account in the development of curricula, training for the new master's degree and doctorate of teachers who deliver midwifery courses.

Training in remote and rural areas

Vocational training programmes have been reviewed and adapted to the context of rural and underserved areas to improve the availability of skills for populations living in rural areas.

Accreditation systems for initial training

These systems have been developed and implemented in most countries to ensure the quality assurance of midwifery education. Mali and Togo are the countries that have made the most progress in this process.

2. Plan and accelerate the recruitment of health personnel for RMNCAH-Nut services

To achieve this goal, the FMF has conducted several advocacy actions at the regional level: Mobilization of decision-makers in the West African Economic and Monetary Union (WAEMU) countries (Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Togo, and Senegal) to invest more in the RMNCAH-Nut health workforce. Thus a regional investment plan in the health workforce has been designed by the WAEMU countries. This plan will promote the creation of additional jobs in health and social services, in particular for young people and women. The plan was validated in 2018 by the ministers of health, employment and finance of the WAEMU area and its implementation was entrusted to the West African Health Organization.

Advocacy efforts have led to the development and implementation of investment plans for health workforce recruitment: All Muskoka

countries have adopted a five-year national health human resource investment plan for the next five years 2018-2022. Thus, more than 40,000 jobs in the health sector, particularly for the care of mothers, children and adolescents, will be created thanks to the advocacy carried out with WAEMU decision makers. More than 25,000 jobs for health care workers have already been created between 2019 and 2020.

3. Improving the quality of RMNCAH-Nut services by strengthening the technical skills of health workers in health facilities

Interventions under this objective have been one of the highlights of the FMF programme over the past six years. Each agency was involved in a complementary way, in the dissemination of norms, standards and protocols of care, in the evaluation of the quality of care provided, in the continuous training of personnel, and in the supply of essential equipment and medicines. The progress made, to which the joint work of the four agencies contributed, is reflected in the evolution of MMR in the countries targeted by the FMF.

• Senegal

In the district of Keur Massar in Senegal in 2016, for example, with an estimated population of 533,200, 4,626 deliveries were performed, 4,414 newborns benefited from the immediate care package, and 110 were resuscitated at birth following joint support from the FMF and the RMNCH Trust Fund.

• Côte d'Ivoire

In Côte d'Ivoire, in 2016, coaching of all 609 3rd year midwifery students (100% of the students trained, for a 3-year study cycle) from the 5 branches of the National Institute of Health Workers Training (INFAS) in the "Helping Mothers Survive" technique was organized for adequate management of immediate postpartum hemorrhage (IPPH) and newborn respiratory distress.

4. Contributing to and participating in the Commission on Health Employment and Economic Growth for the implementation of the SDGs

The UN Secretary General established the High Level Commission on Health Employment and Economic Growth in March 2016. This commission was co-chaired by French President François HOLLANDE and South Africa President Jacob ZUMA. For key recommendations to address the global health and social care workforce shortage. The Commission produced a report entitled "Working for health and growth: investing in the health workforce" which was transformed into a five-year action plan for 2017-2021 to achieve SDGs. The FMF beneficiary countries were involved in the preparation of the Commission's recommendations that were reflected in the final report.

5. Planning

All Muskoka countries have improved the planning process by adopting a five-year national health human resource investment plan for the next five years 2018-2022. Thus, more than 40,000 jobs in the health sector, especially for the care of mothers, children and adolescents, will be created as a result of the findings of these various economic studies which have shown that investment in health personnel can improve economic growth.

6. Facilitating a community of practice for better leadership

A community of practice for maternal, child and youth health workers was established in 2012. This community of approximately 350 members has contributed to the implementation of different activities, including the organization of meetings of the Federation of French-speaking midwives of Africa in different forums.

- **Example of Senegal**

Overview of actions in favor of midwives

In Senegal the number of midwives increased from 1,222 in 2012 to 2,300 in 2016, an 88% increase for a density of 1 midwife per 1,426 inhabitants in 2016.

1000 health workers including 500 midwives have been recruited.

The traveling midwife project began in two pilot regions: Sédhiou and Matam.

5 midwives from the medical region of Tambacounda were trained in ultrasound.

26 midwives), and 12 providers (midwives and head nurses) were then trained with FMF funds to facilitate the lifting of emergencies (focused on the practice of essential gestures in the resuscitation of the newborn and the patient suffering from a postpartum hemorrhage).

36 providers (midwives and nurses) in the region of Tambacounda were trained in postabortion care (PAC) combining manual vacuum aspiration and postpartum FP.

The FMF supported capacity building for 120 state midwives and doctors in the region of Dakar on essential newborn care. “Helping Babies Breathe” and the Kangaroo method.

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- **Example of Niger**

Impact of the FMF for skilled birth attendance

Evolution of skilled birth attendance rates in Niger, 2006 - 2019:

2006	2012	2015	2016	2017	2018	2019
17,2 %	29%	40%	39,06%	40,7%	38,54%	33,35%

The number of skilled birth attendances increased by 38% from 2012 to 2015, contributing to a decline in the MMR from 657 to 580 per 100,000 births, or over 15%. This rate remained at 40% until 2017 and will decrease slightly to 35% in 2019.

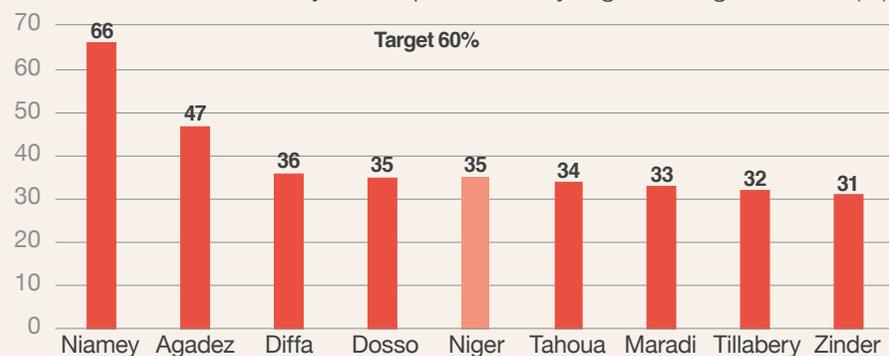
Part of the FMF’s activities focused on the capital, Niamey, which has the highest assisted delivery rate in the country (66.37%). The target of the referral hospital has been the focus of evaluation and quality improvement activities. In addition to the implementation of the recommendations from the on-site assessments, efforts should also be made on 5. https://extranet.who.int/prequal/content/prequalified-lists/medicines_peripheral_areas due, in particular, to the unequal distribution of human resources between urban and rural areas.

It is in this context that the rural pipeline approach has been adopted by Nigerien authorities to train, recruit, and maintain maternal, child, and adolescent health care teams in rural and disadvantaged areas.

Thanks to French Muskoka Fund, a pilot project in the region covering the Lake Chad and Niger was designed by local officials to implement the rural pipeline

Niger saw its ratio of midwives per woman of childbearing age increase from 1:4418 to 1:3126 for a WHO standard of 1:5000 between 2010 and 2019. For the Niamey region, the ratio increased from 1/1400 to 1/791 for the same period.

Rate of births attended by skilled personnel by region in Niger in 2019 (%)



2. Access to medicines and health products for the FMF target populationé

The provision of quality health services requires the consistent availability of essential medicines and quality health products and their rational use by health workers and ultimately by the patient.

These products should be affordable in countries where cost-recovery policies most often lead patients to pay for treatment or for health systems where governments decide to subsidize these treatments or where they are covered by a reimbursement system.

Complementarity of agencies' action

To improve access to essential medicines and priority health products for mothers, adolescents and children, two complementary approaches were used by the partners involved in this project: the supply of medical products in the countries and their delivery to health facilities or communities, particularly involving UNICEF and UNFPA, but also strengthening the pharmaceutical systems in the countries, an approach favored by WHO. While the first approach has improved the availability of products and thus the supply of services, the second approach is absolutely essential to ensure that systems are in place to guarantee the sustainability, quality, and affordability of service provision.

Synergy - leverage effect

The work done through the French Muskoka Fund complements other initiatives aimed at strengthening pharmaceutical systems in Africa such as the EU/ACP/WHO Renewed Partnership and the MSH/SIAPS project, as well as initiatives put in place by partners to achieve MDGs 4 and 5 such as the UN Commission on Life-Saving Commodities for Women and Children and the RMNCH Trust Fund, as well as the Sustainable Development Goals, which place access to health commodities as a top priority, an essential pillar of the strategy to achieve Universal Health Coverage by member states.

Over the past 10 years, the countries that have most effectively leveraged Muskoka support to improve access to health products have been Benin, Côte d'Ivoire, Guinea, Mali, Niger and Senegal. Togo and Chad, for structural or organizational reasons, had more difficulty absorbing the assistance, which was therefore more punctual and less structural.

The country support work has focused on five main areas of intervention to strengthen national pharmaceutical systems:

1. selection of essential medicines,
2. strengthening of the availability,
3. improving the quality, efficacy and safety of essential medicines,
4. better control of treatment costs and
5. rational use of medicines.

All of the activities carried out within the framework of the “Access to Medicines” component contribute to strengthening national pharmaceutical systems, which are essential for the smooth functioning of health systems, and, in synergy with other programmes, help to improve the quality and continuity of health care delivery in general. These activities have been developed and implemented throughout the 10 years of the programme, either directly at country level or at regional level.

Selection of medicines

At country level, the most significant result is that 7 of the 8 beneficiary countries have reviewed their National Essential Medicines List (NEML) at least once during the past period, guided by the Model List developed by WHO and the technical assistance for the implementation of therapeutic committees. This list aims to streamline resources and prioritize the selection of medicines for the public health system and ensure better availability at central supply facilities and service delivery points.

In 2014, Niger also reviewed the “Therapeutic Guide + Mother & Child Health” and trained 30 professionals on the management of essential medicines for maternal and child health

Impact

Although greatly insufficient, the improved availability of contraceptives has contributed to an increase in the modern contraceptive prevalence rate from 2012 to 2019 in Niger, from 11% to 33%.

Regarding access to medical devices, a regional workshop co-funded by the Dutch government was held in 2017 with representatives from seven Muskoka countries, WAHO/ECOWAS and five other French-speaking African countries. This workshop was in close keeping with the activities carried out within the framework of the RMNCH Trust Fund since 2013 and allowed the validation of a roadmap targeting priority actions for participating countries.

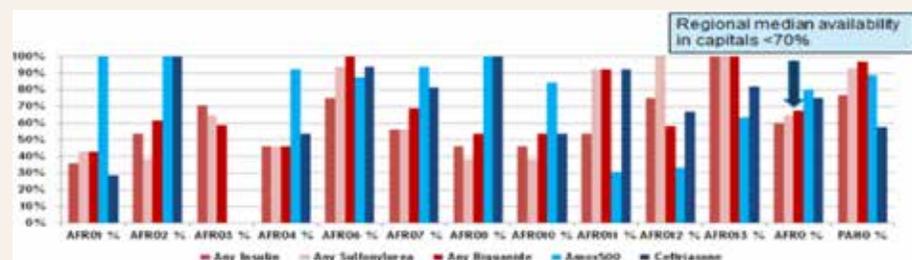
Improved availability of medicines and supply mechanisms

The availability of medicines and health products for mothers and children is fundamental to the development of health systems and, consequently, to the achievement of the objectives of Universal Health Coverage by 2030.

Although availability is improving, the results are still fragile and illustrate the need for continued effort and investment.

The table below displays the findings of surveys conducted in 2016 and 2017 measuring the availability of key anti-diabetic and antibiotic products, instrumental in ensuring maternal and child health, at the central and hospital levels in 13 African countries including several FMF beneficiary countries. The median availability is around most often 50%, which reflects the fact that half of the time these products are not available to patients.

Availability of key anti-diabetic and antibiotic products



Source: OMS

As far as Zinc Sulfate is concerned, the results are still quite worrying, especially since it is a cheap and often subsidized product. This important product, recommended by the WHO for the management of childhood diarrhea, is even unavailable in several countries at different levels of the system. A study conducted as part of the FMF in 2017 highlighted the main barriers to the use of Zinc Sulfate in countries and proposed solutions to improve availability and adherence.

The FMF has enabled strengthening the collaboration of WHO with the ACAME (African Network of Medicines Purchasing Centres) and the recognition of this entity as partners in official relationship with WHO since January 2018. Under the priority collaborative activities, the development and launch of the ACAME Strategic Plan 2017-2021 in May 2017 at WHO premises, the development of a performance framework aimed at improving the quality of management at the level of Purchasing Centers.

The FMF has also contributed to greater awareness among stakeholders on the need for mainstreaming medical devices into the healthcare supply: the “Dakar Roadmap” established in 2017 formalized the commitment of signatory countries and articulated collaboration with bilateral partners and coordination with mechanisms such as the RMNCH.

It should also be noted that the FMF helped improve the response to the Ebola health emergency in Guinea in 2015, particularly through the availability of strategic inputs.

Improving the quality of medicines

Les activités visant à renforcer les autorités de réglementation pActivities aimed at strengthening pharmaceutical regulatory authorities contributed to improving the quality of products available from the point of entry into the country to health facility level and minimizing the negative effects of counterfeit or substandard products circulating in many African countries, which remains a scourge. It is still estimated that more than 10% of medicines in circulation are counterfeit. This percentage is more dramatic in most African countries due to weak or immature regulatory systems; the African continent is the region that reports the most to the WHO global alert reporting mechanism, which is a very positive point in itself. Contraceptive products and pediatric formulations of antibiotics are among the most falsified therapeutic classes.

The improvement of pharmaceutical regulatory systems, including the implementation of quality assurance and quality control mechanisms, requires a synergy of action and a process for harmonizing regulatory procedures. In this regard, the involvement of the Regional Economic Communities, particularly ECOWAS, is an important step that will eventually contribute to the establishment of an African Medicines Agency. The FMF was instrumental in laying the groundwork for an African blood and blood product regulation network, a critical component in reducing maternal mortality.

Through its objectives, the FMF has had a leverage effect on the WHO prequalification programme for pediatric medicines over the last few years, but also for reproductive health medicines⁴, including contraceptives, oxytocin, magnesium sulfate, Misoprostol and Mifepristone.

A quality assessment of some maternal and child medicines conducted by the WHO prequalification programme at the request of the UN Commission on Life-Saving Commodities for Women and Children showed a 23% non-compliance rate based on the specifications defined for this study. There was significant non-compliance in this study for oxytocin, gentamycin and ampicillin. Quality control of circulating medical products is an activity to be pursued in conjunction with the strengthening of supplier selection mechanisms (Quality Assurance).

4. <https://extranet.who.int/prequal/content/prequalified-lists/medicines>

Another important contribution of the FMF is the preparation for WHO prequalification of national quality control laboratories, particularly in Côte d'Ivoire and Senegal, which will allow these national facilities to have better control over the quality of medicines circulating in the country.

Medicine price control

Better control of medicine prices is important for mothers who have to pay out-of-pocket for their own or their child's treatment, but also when governments decide to put in place strategies to support care for under 5 children or if they are covered by a reimbursement system.

Benin, Burkina Faso, Guinea, and Senegal have reviewed existing regulations for setting medicine prices in the public sector, and the major challenge for the authorities is to ensure the implementation of these measures and their extension to the private sector. The expected effect is an improvement in the affordability of treatment.

Rational use of medicines

In order to guarantee the quality of the services offered to mothers and children, it is essential that once the products are made available in the health facilities, they should be prescribed correctly according to the indications retained in the national therapeutic protocols. This can be assessed through surveys as a basis for reviewing staff training tools.

Under the Muskoka project, Côte d'Ivoire, Guinea, Niger, and Togo reviewed treatment protocols to improve the quality of care for mothers and children. It should be noted that the FMF works in synergy with other projects funded for priority countries in Africa, notably through European Union funding, but also through multi- or bilateral initiatives, including the fight against antibiotic resistance and responsible antibiotic use.

The FMF's support to the e-med Essential Medicines and Pharmaceutical Policies Community of Practice has also been a major element in raising awareness of the issues related to the implementation of pharmaceutical policies within the medicine community



Conclusion

While the FMF, through its medicines component, has been able to contribute to improving the availability of affordable quality products in the health structures of French-speaking African countries and to their better use, in addition to other initiatives, there is still a lot to be done as countries enter the Sustainable Development Goals agenda, which requires through its objective

8. the implementation of Universal Health Coverage with access to essential medicines and vaccines by 2030, including of course for mothers and children. Improving the availability of quality and blood products at the delivery point should also be a priority for the coming years.

This requires continued strengthening of national regulatory and procurement systems, strengthening of state budgets for health commodity procurement, ensuring that procurement and distribution are controlled by strong supply chains, that health workers are available and trained, and that coordinated partner interventions contribute to strengthening existing systems. Collaboration with Regional Economic Communities (such as ECOWAS) to better target and harmonize priority interventions, engage key partners, and seek greater synergy of action remains essential.



2010-2020

The FMF in

CRISIS SITUATIONS

In crisis situations - health, humanitarian, political – faced by the target countries of the French Muskoka Fund, most vulnerable populations - pregnant women, newborns, children, teenagers, women - who are the most at risk: difficulty in accessing care, loss of autonomy, gender-based violence, worsening of pre-existing pathologies and for whom the FFM's programmes have provided special attention by adapting to the emergency situation to meet their needs.

1. Response to Ebola outbreak

The Ebola outbreak that affected West African countries in 2014, and in particular Guinea, target country of the FMF, impacted the implementation of some planned activities at regional and country levels, due to the redeployment of human resources and some activities.

More specific support was provided to Guinea by WHO and UNICEF to assess the impact of the outbreak on the national supply system and the availability of commodities in health facilities as well as to strengthen the work of the Ebola logistics unit to ensure the availability of personal protective equipment and medical devices required for the universal protection essential to maintain safe care in health facilities, particularly for mothers and children.

- In **Guinea**, the French Muskoka Fund, in support to other funds, contributed to the fight against the Ebola outbreak and to the prevention and control of infection in maternity wards for the benefit of six countries in French-speaking Africa:

The FMF funded products and inputs to enable 68 midwives to participate in the Mano River Union Initiative. Interventions were focused in the border prefectures most affected by Ebola, thus increasing the numbers of women seeking services

- Midwives' presence in the health centers has restored public confidence among pregnant women using the services.

Additional funds (100,000 Euros via WHO) have been allocated to Guinea for community-based management of children. Through these funds, the FMF contributed to maintaining the continuity of community-based services:

- by ensuring the safety of communities and community health workers (CHWs), by disseminating best practice guidelines to households, families, community health facilities and CHWs,
- through training or refresher training for CHWs on the “no-touch” C-IMCI approach, including delivering key messages on Ebola for mobilization and awareness-raising
- by supporting the provision of essential medicines, antibiotics, oral rehydration salts, zinc and antimalarial supplements for presumptive treatment, and materials needed for CHWs to provide services.

The FMF also supported the organization in Lomé of a training workshop on infection prevention and control in maternity wards for six francophone African countries, including two Muskoka countries: Democratic Republic of Congo and Togo. As a result of the training, the Region will have a critical mass of competent staff ready to be used to strengthen the prevention and control of the outbreak in the countries.

2. Response to Covid-19 pandemic

The impact and consequences of Covid-19 and the adaptation and response to the pandemic were the same in all Muskoka countries.

Impact of Covid-19

- Significant contamination of health care providers, reduction in supply and use of care
- Low use of RMNCAH-Nut services
- Overwhelmed HFs due to complicated forms of COVID-19
- Disruption and disorganization of essential care: in general, a decline in the use of services, a decline in antenatal care (ANC), a decline in patient follow-up, a decline in the management of emergencies (BEmONC/CEmONC, IMCI), insufficient follow-up in the management of chronic diseases, insufficient blood collection

Consequences

- Increase in the number of home deliveries
- Decline in contraceptive prevalence rate;
- Increase in unwanted pregnancies, abortions, STI/HIV/AIDS;
- Increase in maternal and neonatal deaths;
- Decrease in immunization coverage among under-5 children;
- Increase in self-medication;
- Decline in immunization coverage, especially among children;
- Increase in violence against women and girls.
- Impact on mental health

Regarding specifically the mother and her newborn, breaches of the “kangaroo mother” method, which implies close contact between the mother and the newborn child, increase these risks. Up to 125,000 newborns could be saved if the kangaroo method were implemented everywhere.

Adaptation and responses

- Mechanism for strengthening the safety of health care providers and users: ICP (Triage; screening and safety of users and staff: temperature measurement, hydro-alcoholic gel; masks, PPE, immunization)
- Integration of COVID-19 into patient management,
- Immunization of health workers and the population
- Promotion of safety measures
- Support to the introduction and implementation of the Covid immunization plan
- Strengthening community involvement, CSOs⁵
- Rumor management on all channels (Facebook, WhatsApp, radio and TV)
- Communication to maintain attendance at health services
- Update of the RMNCAH-Nut/Nut Continuity of Services Guide and Contingency Plan
- Mobilizing additional resources to fund the implementation of RMNCAH-Nut continuity of care activities in health emergency settings

These last three adaptations and responses are in line with the recommendations of the SteerCom in relation to the Muskoka allocation for 2020:

Additional participation in efforts to strengthen the health system to better control the outbreak:

- The Health System Strengthening component of High Impact Interventions (HII) increases to 25% of the country allocation from 20% in 2019;
- The other components are: nutrition 25%, maternal and child health and family planning 25%, and AYSRH 25%

Systematic prioritization of interventions to ensure access to essential health services for women, children and adolescents

- Prioritization reflected in the work plans of each country;
- Support of the Technical Committee in the prioritization work.

• Example of Niger

To support the government in responding to all these emergencies, the four FMF agencies have replanned the activities in their initial work plan to introduce Covid-19 activities, in close collaboration with each other to support governmental and non-governmental partners.

Provision of COVID-19 protective equipment to health professionals and users of EmONC maternity units for the continuity of RMNCAH-Nut

In response to Covid-19 pandemic:

- 150 young doctors have been recruited to strengthen the human resources of the care facilities for infected persons and contacts; and 75 tents with 160 beds have been set up in partnership with UNHCR to improve the capacity to receive and manage patients while respecting physical distance measures.
- During the 3 months of their contract, these doctors contributed to the management of 357 patients hospitalized in the different departments; to the follow-up of 663 patients confined and followed by the mobile teams; 705 patients confined at the level of the CENO, FENIFOOT and STADE KOUNTCHE sites. In addition, these young doctors made available to the Ministry of Public Health by UNFPA supported the SAMU in the referral of 364 confirmed positive COVID-19 cases to the different health care centers.
- Midwives and young doctors were provided with personal protective equipment (gowns, boots, gloves, bibs and goggles) and disinfectant to ensure continuity of RMNCAH-Nut services



Doctors available to the MSP in combination for inpatient follow-up

• Senegal



“

With the tablets and the modules inside, it allowed us to be trained, especially me and the matrons on how to perform resuscitation of the newborn, to reduce the mortality rates of newborns.

”

Diominè Bouaré,
Matron, M'Pessoba Health Center, Mali

3. Response to humanitarian crises: Chad, Mali and Nige

- **Chad**

In 2016, the Lake Chad region, in a humanitarian crisis, saw its already worrisome maternal health indicators deteriorate rapidly. Through the campaign called “All4Lakechad” for which the French Muskoka Fund contributed in complementarity with others, interventions were carried out to care for refugees and IDPs and returnees at the level of the health districts of Bol, Baga-sola and Liwa, from May to July 2016

The following strategies were implemented:

- Deployment of 160 midwives and three gynecologists in
- Supply of equipment, RH products, including contraceptives, consumables and management tools to health facilities.
- Involvement of traditional and religious leaders to promote community-based demand.
- Provision of fixed and mobile strategy services to reach populations in hard-to-reach areas.
- Facilitation of monitoring and active data collection on a monthly basis.

During the campaign, attendance increased by 69% and 6,078 pregnant women received antenatal care.

Months of June-July-August	2016	2015	Observations
Number of skilled birth attendance	940	591	Increase in 59%
Number of first antenatal care visits (ANC1)	3848	2020	Increase in 90%
Number of complications received and managed	74	33	Increase in 124%
Number of C-sections	31	11	Increase in 182%

• Mali

The northern part of Mali has experienced massive population displacement and suffers from very limited access to health care due to the destruction and/or looting of facilities and the disruption of health services. Under the Muskoka framework, agencies have been mobilized to ensure continuity of health care in health districts and hospitals in the regions of Gao, Timbuktu, Kidal, Mopti and Segou.

Between 2012 and 2013, multidisciplinary reproductive, maternal, newborn and child health (RMNCH) teams were deployed to conflict areas. A total of 217 specialists were deployed to the field, including 30 midwives and obstetric nurses, 8 obstetric gynecologists, and 26 Expanded Programme on Immunization (EPI) agents.

A total of eight missions were carried out. These interventions allowed the reopening of some health centers looted during the occupation of the North and to ensure the continuity of services. Emergency medicines (kits) and other medical and non-medical products were also provided.

Activities implemented:

- 956 surgical procedures, including 314 C-sections.
- 2,732 antenatal care and 878 assisted deliveries.
- 58,196 children aged 0 to 11 months immunized against EPI priority diseases.

• Niger

The year 2020 was particularly marked by an electoral political environment and by the occurrence of emergencies of different kinds, security, health and humanitarian.

On the political front, the preparations and organization of local, legislative and presidential elections have been the focus of all authorities. They set the pace of work and priorities at all administrative levels during the last quarter of the year. Elections were held without major incidents during the last month of the year but have affected the schedule for programme implementation.

On the security front, the number of attacks from often unidentified armed groups, especially in remote villages along the borders with Mali and Nigeria, has increased, with severe consequences. Several killings and hostage-takings have been reported this year. Women and children have paid a heavy price in this upsurge of insecurity, either as direct or indirect victims. Adolescents are particularly vulnerable to this increase in violence.

In addition to these morbid phenomena, there were floods and major population displacements. All of these crises have exacerbated the inequalities and poor access to health services that characterize the health sector in Niger, with less than 50% of the population living within 5 km of health services.



2010-2020

and **COMMUNITY OF PRACTICE
OPERATIONAL RESEARCH**

1. Communities of Practice

The 4 agencies collaborate to strengthen health systems under the Harmonization for Health in Africa (HHA) mechanism⁶.

The Harmonization for Health in Africa (HHA) regional mechanism coordinates technical support to countries to strengthen their health systems and promote better use of money for health (14 bilateral and multilateral partners and global initiatives).

The FMF has essentially provided support for the operation and coordination of the Communities of Practice (CP) supported by HHA.

The CPs aim to foster information management and experience sharing among individuals from all walks of life, but are also involved in the planning, monitoring and implementation of activities related to the pillars of the health system:

Health Systems Planning and Budgeting (HSPB)
> 500 members

Financial Access for Health Services (FAHS)
> 900 members

Health Systems Planning and Budgeting (HSPB)
> 900 members

Pharmaceutical (e-med forum)
> 1.900 members

Human Resources in Maternal, Newborn and Child Health (HR/RMNCH-Nut)
> 500 members

Quality of care in reference hospitals in Africa (QUAHOR)
> 70 members

Health care supply, district approach (HSD)
1.500 members

Knowledge sharing activities

Knowledge dissemination and on-line discussion on the themes of each CP: Blogs, webinars, discussion forums, social networks, bibliographic resources, article reviews and summaries, cartoon contest (FAHS), etc.

Participation and presentation of knowledge/results in conferences and meetings on the themes of each CP: the Congress of the Federation of Midwifery Associations of French-speaking Africa (Bamako, October 2015), the African Conference on the Health Information System and Collective Intelligence in the Health District (Cotonou, December 2015), etc.



6. The Health Harmonization for Africa (HHA) mechanism was created by the African Development Bank, the World Bank, the United Nations Population Fund (UNFPA), WHO, UNAIDS and UNICEF. HHA includes these UN agencies, bilateral partners including France, and partnerships and initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Its secretariat is provided by WHO Afro. The HHA mechanism facilitates and coordinates the African country-led development process in all aspects of health systems strengthening. Support focuses on health sector reform, monitoring health systems performance and aid efficiency, addressing implementation bottlenecks, building national capacity for planning training and efficiency-based budgeting, coordination and alignment of initiatives/partnerships, and resource mobilization for "more health for the money," as described in the Tunis Declaration (2012), including investment cases for health in Africa and the study of financing mechanisms.

Innovative link between CPs and operational research (OR) projects



2. Operational research

Methodological guidance by the FMF

- The Technical Committee developed a results framework based on the implementation of high-impact interventions selected according to the scientific evidence and their potential impact. This framework helps guide planning and facilitate monitoring of interventions, as well as follow the evolution of results and impact over several years.
- Through operational research, provide national decision makers and UN teams with strategic information aimed at reducing the major constraints observed at the country level. In 2013 five operational research projects were implemented via North-South partnerships of research teams (themes according to health systems pillars), with involvement of Communities of Practice.

Title of the operational research	Title of the operational research	Countries	Duration
Universal coverage in French-speaking African countries - how to articulate the different modes of financing? (UHC)	Institute of Tropical Medicine of Antwerp Community of Practice Financial Access to Health Services (FAHS)	Universal coverage in French-speaking African countries - how to articulate the different modes of financing? (UHC)	2013-2016
Strategies for retaining RMNCH staff in rural areas (FideliSante)	University of Montreal, HR CP in RMNCH, IDU 3189 Senegal - University of Aix France, CNRS Community of Practice Human Resources in Maternal, Newborn and Child Health (HR/RMNCH-Nut)	3 (Benin: Analysis Laboratory of Social Dynamics and Development studies, Burkina Faso: SF association, and Senegal: ENDSS)	2013-2016
Regional observatory of maternal mortality in West Africa (Infodos)	D UMR216 France, 7 African institutions: Mali, Burkina, Senegal (3), Benin (2) Community of Practice Quality of care in reference hospitals in Africa (QUAHOR)	3 (Benin: Mother and Child Hospital of the Lagoon of Cotonou, Burkina Faso: IRSS, Mali: URFOSAME)	2013-2016

Children, Health Care, and Pediatrics in West Africa (ENSPEDIA)	S et U. Dakar – Network UMI3189: 9 Institutions: Senegal (3), Mali (2), Guinea, Burkina, Niger, Benin + U. Lausanne Community of Practice Quality of care in reference hospitals in Africa (QUAHOR)	7 (Benin, Burkina Faso, Guinea Mali, Mauritania, Niger, Senegal)	2013-2015/16
The interface role of health committees in West and Central Africa (CoSa-I)	KIT Amsterdam, CdP Provision of care/district Community of Practice Health care supply, district approach (HSD)	3 (Benin: OSP, Guinea: U Sonfonia, RDC: ESP)	2013-2016

“

We are very pleased to say that the project we had through the Muskoka Fund fits fully into the government's concerns.

”

Pr. Moustafa Mijiyawa,
Minister of Health, Public Hygiene and Universal
Access to Health Care, Togo



2010-2020

COMMUNICATION *and* VISIBILITY

The importance of making France's commitment and the achievements of the French Muskoka Fund (FFM) visible and advocating for maternal, newborn, child and adolescent health in West and Central Africa is a strategic priority for the Ministry of Europe and Foreign Affairs (MEAE), since the effective implementation of activities related to the French Muskoka Fund with concrete results. This importance has been emphasized at each Technical Committee and Steering Committee meeting and during each follow-up mission with the countries since 2013.

Within this context, the four UN agencies (WHO, UNFEMMES, UNFPA and UNICEF) worked together to establish and implement an integrated and harmonized communication strategy, updated annually, with the development of a communication plan that integrates a set of communication tools to achieve the defined objectives and targets.

1. Strategy and actions for the period 2014 - 2018

1. Position the French Muskoka Fund as a major French contribution to maternal, newborn, child and adolescent reproductive health (RMNCAH-Nut)

This objective aims, on the one hand, to strengthen and ensure greater visibility of France's funding and the activities carried out by the four agencies supported by the FMF, in France, in the eight Muskoka countries and within the international community. And on the other hand, to bring out the theme of maternal, neonatal, child and adolescent health, in a context submerged by a very strong news.

Visual identity of the French Muskoka Fund

The creation of a graphic charter composed of a logo, a motto, and different templates allowed to give a visual identity to the FMF and to make it visible on all the communication materials produced and all visibility activities conducted.

Media presence

Inform, sensitize, interest and convince political decision makers of the need to invest in maternal and child health, and of the relevance of the FMF through regular, serious and qualitative coverage with in-depth articles.

In addition to press trips organized every year, long-term collaborations have been established since 2015 with major French and international media, demonstrating a particular interest in the African continent and development issues, with a strong audience both in African countries and in France. Working over time with the media allows us to give a more regular and broader echo to the issues but also to the solutions and results related to our thematic.

To date, the French Muskoka Fund, through its agencies, has signed a year-long collaboration agreement with Le Monde Afrique (5 million visitors and 10 million page views per month), RFI/Priorité Santé (3 million listeners/show), France24 (ActuElles and Journal de l'Afrique shows), TV5Monde Afrique (support for two health shows, "Bonne santé" and "Les Maternelles").

Presence in international conferences

Promote visibility and advocacy, introduce the French Muskoka Fund to partners and experts, share experiences, and organize side events to ensure a visible and credible representation of the FMM on the international scene of RMNCAH-Nut.

The FMF has evolved towards a more important participation in international meetings and high level events (Best Practices Forum, ICASA, Dublin, AU-EU Summit side event..).

Each year, the TechComH plans 4-5 major "must-attend" conferences in RMNCAH-Nut in which the FMF takes part by combining the 3 aspects of programming, visibility and advocacy.

2. Support action by policymakers and health officials in France and the eight Muskoka countries

This objective aims to advocate for reproductive, maternal, newborn, child and adolescent health (RMNCAH-Nut) to achieve the Sustainable Development Goals (SDGs) in France and in the countries.

Highlighting programmes and results achieved, and increasing visibility in countries

In order to consolidate links with local and international partners and actors, it is important to show the effective implementation of programmes and the progress made, to be transparent about the use of funds and thus gain the confidence of potential donors.

Official field visits with the French embassies were organized in several countries (Chad, Togo, Benin, Senegal, Mali).

Each year, a report is published highlighting the key results achieved.

A kit of visibility tools, including kakemonos, posters and stickers, has been produced to increase the visibility of the FMF in the countries, both internally and externally, via social networks and during the organization of events.

3. Generate commitment and mobilization for maternal, newborn, child and adolescent health

This objective is to give a human face and to place the mother, the newborn, the child, the teenager but also the father and the family, so that the FMF is incarnated and alive.

Being present and active on the Web and social networks in a context where our countries have a large majority of young people.

Giving voice and witnessing

Video clips have been produced in several of the countries supported by the FMF. Photo reports are currently underway in the eight Muskoka

countries (except for Burkina Faso, which was reintroduced in 2020), in order to feed the image bank, and life stories are collected regularly. All these materials make it possible to feed any communication activity with testimonies and to give a voice to the people concerned by our programmes and themes, whether they are the beneficiaries in the countries, the health actors, the partners or the political authorities.

Being present and active on the Web and social networks

In 2015 a webpage <http://ffmuskoka.org/> and a Twitter account @ffmuskoka were created so that the 4 UN agencies communicate and testify with one voice and through one channel. A LinkedIn account was launched in 2020. The choice of Twitter was made in order to have a direct intercation with media, politicians and any actor interested in the African continent and development issues. The number of followers on the Twitter account is more than 10 325 (doubled between 2019 and 2020) including a quality community, committed, composed of journalists, ambassadors, French and African politicians, UN agencies, group of young ambassadors, bloggers, influencers etc. .

The number of visitors to the FMF website increased by 5 times between 2018 and 2020.

4. C'est la Vie !

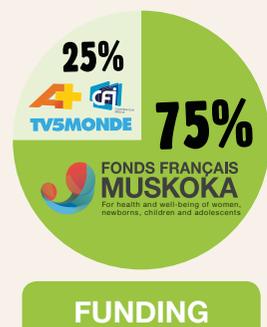
Support for the development of the TV series C'est la vie, the first soap opera on maternal and child health in West and Central Africa.

Programmatic, awareness and behavior change tool for RMNCAH-Nut and specifically for AYSRH

<http://cestlavietv.com/>

- Series produced by the pan-African NGO RAES thanks to the convergence and synergy of the technical, human and financial efforts of all FMF agencies
- Broadcast on A+ and TV5 Monde and many national channels

- Pan-African vocation of the series which takes place in a health center of an African city
- C'est la Vie ! also addresses the issue of human resources, promoting good practices among health professionals in French-speaking countries in Africa



C'est la Vie ! is a TV series created with the purpose of communicating in a different way to promote health and to facilitate access to information on:

- maternal, newborn and child health
- sexual and reproductive health rights
- health system operations
- adolescent and youth reproductive health
- gender-based violence

C'est la vie on the spotlight at the 1st French-speaking Summit on Communication for Social and Behavior Change (SBCC) - Abidjan, February 2019

C'est la vie ! confirmed its position as a unique, innovative and far-reaching tool in the region during the Summit which brought together 500 participants, 190 organizations, 33 countries represented.

2. Organization/participation to national regional, international meetings

Regional meeting in Cotonou

Save The Date

HIGH LEVEL REGIONAL MEETING
FROM 7 TO 9 MAY, COTONOU, BENIN

A regional meeting on Maternal, Newborn, Child and Adolescent Health in West and Central Africa.
Strengthening the commitment of the Muskoka partnership to achieve universal health coverage.

Four United Nations agencies (UNICEF, UNFPA, WHO and UNWOMEN), in partnership with the Governments of France and Benin, are organizing, from 7 to 9 May 2019 in Cotonou, Benin, a high-level regional meeting on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), to discuss the results and lessons learned from the 7 years of experience of The French Muskoka Fund in West and Central Africa.

This meeting also offers the opportunity to provide a platform for exchanges between Governments, technical and financial partners, civil society, academia and regional organizations on lessons learned and opportunities to optimize technical and financial RMNCAH investments in the region to better support target countries in achieving the SDGs.

The meeting aimed to provide a platform for exchange between governments, technical and financial partners, civil society, academia, youth and regional organizations on lessons learned from the FMF experiences and opportunities to optimize technical and financial investments for the RMNCAH-Nut in the coming years in order to better support the target countries towards the achievement of SDGs.

The meeting was held in Cotonou, Benin, and was attended by approximately 125 participants from the eight Muskoka countries, as well as representatives from the French government and UN agencies; youth organizations and international NGOs supporting these countries at global and regional levels; and professional associations (African gynecological and pediatric societies).

Different sessions addressed following topics:

- Key indicators and social and cultural determinants of RMNCAH-Nut;
- The contribution of the Muskoka grant to improving RMNCAH-Nut in recipient countries and lessons learned over the seven years of work.
- Strategic discussions on funding for RMNCAH-Nut in West and Central Africa.



The third day of the meeting consisted of a session between inter-agency and ministry Muskoka country teams and members of regional and headquarters UN agencies to discuss implementation and country plans.

Satellite event in conjunction with the 6th Global Fund Replenishment Conference - October, Lyon, France

“National and Regional Coordination for Reproductive Health and Maternal, Newborn, Child and Youth Health (RMNCAH-Nut): an approach to scale up implementation of Global Fund grants in West and Central Africa”

- Present the French Muskoka Fund on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH-Nut) and Nutrition as a practical model for coordinating and harmonizing partner support for more efficient investments in West and Central Africa.
- The Ministers present confirmed their full involvement in facilitating the coordination and strengthening of the RMNCAH-Nut package for all, particularly through the technical and financial tools available through the French Muskoka Fund and the Global Fund
- The Global Fund has confirmed that its 2017- 2022 strategy is very clearly articulated with RMNCAH-Nut and gender interventions.
- The UN agencies partners of the FMF represented by Dr. Anshu Banerjee, Director of the Department of Maternal, Newborn, Child and Adolescent Health at the World Health Organization proposed concrete responses that agencies can suggest to increase the effectiveness of the Global Fund’s investments in RMNCAH-Nut:
 - At global level, “Global Action Plan for healthy lives and well-being for all”
 - At continental level (Africa), the HHA platform

Family planning (FP) and the demographic dividend

West and Central Africa Regional Consultation

Objectives:

- Understanding the importance of ending unmet need for FP to needs in order to capitalize on the demographic dividend to achieve SDGs.
- Identify and align impact-oriented actions toward eliminating unmet need for FP in West and Central Africa

Participants in the regional consultation for the 23 countries of West and Central Africa: National FP programme directors, youth representatives, civil society representatives; representatives of the Regional Economic Communities (West African Health Organization, Central African Health Organization, etc.); communities of practice (AFOG, Federation of Midwifery Associations, etc.); technical and financial partners; and representatives of the UNFPA Country and Regional Offices in West and Central Africa. In total, the regional consultation brought together over 120 participants from multi-sectoral entities

Key recommendations from the consultation

- **Accelerating change: Enabling environments for human rights-based family planning**
- **Expanding rights: Increased demand for family planning based on an individual's reproductive health intentions**
- **Accelerating choice: availability of good quality, human rights-based family planning services**
- **Improving the availability and reliable access to good quality contraceptives**
- **Addressing the contraceptive needs of youth in the context of adolescent sexual and reproductive health and rights**

Muskoka is fully aligned with these guidelines and allows countries to contribute to their implementation.

1st Africa Regional Forum on Experience of Care for women, newborns, children and their families in Sub-Saharan Africa (Dakar, October 2019)

Objectives:

- **Develop effective Emergency Obstetric and Neonatal Care (EmONC)**

Improving the quality of care: the UNICEF Regional Office for Africa organized in collaboration with other agencies, the 1st Africa Regional Forum on Experience of Care for women, newborns, children and their families in Sub-Saharan Africa (Dakar, October 2019 (Dakar, October 2019). The Forum was also the occasion to officially launch the Charter for Respectful Maternity and Newborn Care by White Ribbon Alliance.

WHO, UNICEF/Health and UNFPA have organized several workshops to disseminate WHO guidelines, standards and benchmarks and guide countries in developing national programmes for quality of care. In 2018-2019, WCARO helped improve the quality of care in health centers by strengthening the availability of hygiene, water and sanitation services in the region of Diourbel

In terms of literature and research, some studies have been conducted and published including:

- The first multicenter formative research conducted by Professor Yannick Jaffré and his team of anthropologists from five universities in the region (UCAD in Senegal, Mauritania, Togo, Cameroon, Mali) on child health
- Research on the quality/experience of care for hospitalized children, with a focus on pain management, conducted by UMI ESS (International Joint Unit in Social Sciences)

First Regional Forum for Strengthening Community Health Systems (nov. 2019)

Objectives:

- Improving the quality of care for under 5 children through community and clinical IMCI and specific care for newborns

The UNICEF West and Central Regional Office, WHO - AFRO, ECCAS and ECOWAS, with the support of the Government of Benin, the Global Fund and MUSKOKA, the 1st regional forum on Strengthening community health systems to achieve key results for children, 12-15 November 2019 in the West and Central Africa region. The forum, which brought together 16 countries, aimed to better inform and influence policymakers, and to galvanize action in order to promote and increase investment in systems strengthening for PHCs. The forum resulted in the “Cotonou Declaration on Community-Based Primary Health Care” and the adoption of recommendations endorsed by the country delegations and the Ministers of Health of Benin and Liberia.

High Level Breastfeeding Events in Abidjan, Côte d'Ivoire 12-15 November 2019

The UNICEF regional office, WHO and the Alive & Thrive initiative, with the support of the government of Côte d'Ivoire, organized a series of events from 12-15 November 2019 on strengthening breastfeeding enabling systems in the West and Central Africa region.

Regional Parliamentary Dialogue

The regional parliamentary dialogue took place from 12 to 13 November 2019 and brought together some 60 members of parliament from 14 countries in West and Central Africa⁸.

Discussions focused on the benefits of breastfeeding, the costs of not breastfeeding, and the role parliamentarians can play in protecting, promoting and supporting breastfeeding.

The parliamentary delegations committed themselves by signing a joint declaration.



Parliamentary delegations in Abidjan - November 2019

Regional technical workshop on breastfeeding

Held from 13 to 15 November 2019, the regional workshop brought together delegations from 16 countries in the West and Central Africa region⁹. The main objective of the workshop was to strengthen the integration and promotion of breastfeeding within the global framework of maternal, newborn and child health.

The workshop resulted in action points around the following themes: Code of Marketing of Breastmilk Substitutes, Maternity Protection, “Stronger with Breastmilk Only” Campaign, Early Breastfeeding, “Baby Friendly Hospital” Initiative.

The launch of the regional “Stronger with Breastmilk Only” campaign

It was conducted by the Vice President of Côte d'Ivoire and the Regional Director of UNICEF. The regional campaign was launched in conjunction with Côte d'Ivoire's national campaign on exclusive breastfeeding and early childhood development.

8. Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Equatorial Guinea, Gabon, Mali, Mauritania, Niger, Nigeria, Senegal, Togo

9. Countries that attended the parliamentary dialogue in addition to Benin and Guinea



Vice President of Côte d'Ivoire and UNICEF Regional Director at the launch of the "Stronger with Breastmilk Only" campaign - November 2019 - © UNICEF/Frank Dejong

It is an advocacy and social and behavior change campaign to promote the practice of exclusive breastfeeding, giving infants breast milk only, on demand, and stop giving water (and other foods), from birth and the first six months of life.

ECOWAS Nutrition Forum in Monrovia, Liberia

The forum was held from 18-20 November 2019 in Monrovia, Liberia, under the theme "Adolescent nutrition: institutionalizing sustainable actions for improved outcomes in West Africa" This forum was organized by the West African Health Organization (WAHO) with the Government of Liberia, in collaboration with UNICEF, WHO, UNFPA.

The overall objective of the forum was to accelerate the adolescent nutrition agenda in the West African region, recognizing that adolescents remain a marginalized population in most public health programmes.

Discussions focused on the current status of adolescent health and nutrition services (data, initiatives, existing programmes and strategies) and approaches and funding to improve the situation of adolescents in the region.

At the end of the forum, recommendations were made to the 15 member states, to WAHO and other regional economic communities, and to partners.

Sub-regional forum of Central African parliamentarians on food and nutrition security (Nov 2019, Brazzaville)

It was held from 19 to 21 November 2019 in Brazzaville, Congo. The parliamentarians of the ECCAS countries, with the support of technical and financial partners, in particular the FAO, the WFP, the WHO and UNICEF, have committed themselves to putting the fight against food and nutritional insecurity in the sub-region and in their respective countries at the forefront of their actions.

The forum resulted in a declaration signed by the parliamentarians present¹⁰, in which they commit themselves to implement required actions in their respective countries to improve food and nutrition security. A Network of Central African Parliamentarians for Food and Nutritional Security (REPAC-SAN) was also created at the end of the forum.

Support to Chad for the Maternal and Perinatal Death Surveillance and Response (MPDSR)

The objective was to take stock of the situation of the maternal death surveillance and response (MDSR) in Chad. The Muskoka inter-agency team in Chad was supported by a data manager from the WHO regional office. The participants were, in addition to the representatives of the United Nations agencies (WHO, UNFPA, UNICEF), the district chief medical officer of N'Djamena, the Association of Gynecologists, Pediatricians, Midwives, the staff of the Technical Directorates of the Ministry of Public Health (DSRV, SDRS, DOSS, SURVEILLANCE, DSIS, DMTNT, HME, HGRN, HATC) and Programme Managers (Malaria, Tuberculosis, PSLS/HIV/AIDS, Cancer).

This mission made it possible to:

- Identify the level of implementation of the MDSR in Chad based on the performance indicators defined at the global level.
- Train participants on WHO monitoring tools and guidelines for an MNDSR database management system.
- Train participants on the WHO Application of ICD-10 to Deaths in Pregnancy, Childbirth and the Postpartum Period.

10. Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Gabon, Equatorial Guinea, Sao Tome & Principe, Chad

- Guide participants through the WHO/AFRO RMIS portal and the concept of Business Intelligence for MNDSR data

Regional orientation workshop for 10 French-speaking countries in West and Central Africa on early childhood development care held in Libreville from 9 to 11 July

An Orientation Meeting on Early Childhood Development (ECD) was organized for 9 French-speaking countries¹¹ in West and Central Africa and Sao Tome and Principe by WHO in collaboration with UNICEF, AfECN (African Early Childhood Development Network), ECDAN (Early Childhood Development Action Network) and other partners. The meeting took place from 9-11 July in Libreville, Gabon, and was attended by 80 participants from the 10 countries as well as UN agencies, NGOs and civil society organizations (LEGO Foundation, Plan International, USAID, ECOWAS, Alive & Thrive, PATH, World Vision and JACOBS Foundation).

The workshop provided the opportunity to:

- Guide participants on attentive care for ECD;
- Share country experiences in strengthening the role of the health sector in supporting responsive care at national and district levels and identify challenges.
- Present a monitoring framework and draft indicators for the assessment of attentive care at service, population and individual levels.
- Identify concrete actions to be implemented in the countries

Capacity building on methodology for assessing barriers to adolescent health services for universal health coverage with a focus on disadvantaged adolescents (24-27 September, 2019).

The overall objective of the workshop was to develop the capacity of countries to identify barriers that prevent adolescents, especially disadvantaged groups, from having effective coverage of health services and to initiate corrective action to overcome these barriers. The workshop was held to:

- Present the WHO Handbook for conducting an adolescent health services barriers assessment to national focal points and partners
- Train participants in the methodology for assessing barriers to adolescent health services and key concepts related to gender, equity and rights
- Provide hands-on training on key complementary tools such as WHO's Health Equity Assessment Tool (HEAT) and UNICEF's Equitable Impact Sensitive Tool (EQUIST) on adolescent health.
- Discuss next steps and explore opportunities to mobilize resources to support the AHSBA country adaptation and implementation plan

The workshop brought together senior government officials in adolescent health, principal researchers, and development partners (WHO, UNICEF, UNFPA, and local NGOs) from 11 priority countries¹² implementing the Priority Adolescent Health Programme, the French Muskoka Fund, and SRH initiatives. Facilitation was provided by WHO (HQ and AFRO) and UNICEF (HQ).

Country capacity building on the Reach Every District approach reviewed and assessment of coverage and equity, Lome, Togo, 14-16 October 2019

The capacity building workshop for French-speaking countries in West and Central Africa on Reaching Every District (RED) approaches and coverage and equity assessment was organized by the WHO Immunization Programme in collaboration with the UNICEF Regional Office.

The overall objective was to strengthen the immunization system to improve access to and use of immunization services in an equitable and sustainable manner in each country while integrating other child health and nutrition interventions.

The workshop brought together the national EPI managers at the Ministry of Health, the national managers in charge of child health and nutrition, the WHO and UNICEF EPI and routine focal points, the WHO and UNICEF focal points for child health and nutrition.

11. Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Gabon, Mali, Niger, DRC and Senegal

12. Chad, Ethiopia, Lesotho, Madagascar, South Africa, Mali, Namibia, Liberia, Togo, Uganda, and Zambia) facilitated by WHO (headquarters and AFRO) and UNICEF (headquarters)

This is a great opportunity to integrate child health and immunization interventions to increase immunization coverage and child health interventions in order to achieve universal health coverage.

3. Visibility and communication

The national and international events to which the FMF contributes and participates are an important factor of sustainability, creating expectation and demand on the part of the various stakeholders, and making the FMF a clear and strong part of the development aid landscape of countries.



Promotion of *C'est la Vie !* through media, social networks and event meetings and excellent visibility opportunity for the FMF.

• Côte d'Ivoire

Inauguration of the Kangaroo Mother Care Unit at Treichville University Hospital by Mr. MSHP in the presence of His Excellency, the Ambassador of France and Representatives of the United Nations System on 22 February 2019;

• Niger

African Union Summit in Niamey (July 2019)

The French Muskoka Fund contributed to the visibility of interventions in maternal, newborn, child and adolescent health during the African Union Summit in Niamey in July 2019. Illuminated boards, films and posters, radio and television spots were produced on maternal, neonatal and adolescent health. The international TV5 channel provided media coverage of all the events.

The FMF, in partnership with the “Sahel Women’s Empowerment and Demographic Dividend” project, has also contributed to the organization of a communication campaign on the repositioning of family planning (FP) in Niger and the provision of reproductive health services in the regions of Maradi and Tahoua.

Regarding the issue of adolescent girls, the FMF contributed to the organization of a side event at the African Union Summit on the fight against child marriage. This meeting brought together the First Ladies of ECOWAS countries in the presence of the President of the Republic of Niger, the Executive Director of UNFPA, representatives of UNICEF, UN-Women, WHO and UNDP.



First Lady of Niger and her fellow sisters, Prime Minister and UNFPA Executive Director supporting the protection of girls, Side Event Child Marriage, African Union Summit, Niamey, July 2019. Photo credit: UNFPA/Ollivier Girard

Visit of French MPs to Niger (November 2019) and Togo (January 2021)

Three French MPs visited Niger as part of the monitoring of the implementation of the Muskoka Fund Action Plan. The four UN agencies (WHO, UN-WOMEN, UNFPA and UNICEF), the Government’s technical services with the support of UNICEF and the French Embassy in Niger coordinated to organize and accompany the field visit of French parliamentarians to Niger.

The visit was an opportunity to demonstrate to the French parliamentarians the implementation of the Muskoka Program, the results, challenges and opportunities. A strong mobilization of stakeholders was ensured and meetings were organized to provide parliamentarians with the opportunity to discuss with administrative and customary authorities the contribution of the French Muskoka Fund in the areas of maternal, neonatal, child and adolescent health.



Visit of the French parliamentarians to the Space “SÛR” of Aguié in the area of Maradi-meeting with the parents of the adolescents in the presence of the mayor. Photo credit: UNFPA Niger



Visibility of the parliamentary visit on Twitter (Source: <https://twitter.com/Unicefniger>)

The MPs committed to organizing a restitution of this mission to highlight the actions carried out by France within the framework of the French Muskoka Fund (session scheduled for May 28, 2021);

- The parliamentarians are committed to systematize the integration of this theme during debates and decision-making. As such, the French Muskoka Fund has been integrated into the Development Act voted

in February 2021; an amendment highlighting the French Muskoka Fund as a “crucial programme to strengthen health systems and reduce maternal, newborn and child mortality and access to sexual and reproductive health rights, particularly for adolescents. This was proposed by one of the MPs who participated in the field mission to Togo and voted accordingly;

- The added value and effectiveness of the inter-agency mechanism as a platform for maternal, newborn, child and adolescent health and nutrition is recognized and valued;
- The French Muskoka Fund was promoted in Niger, Togo and France.
- The parliamentarians appreciated the way in which the United Nations system works in synergy and collaborates with the national authorities through the quality of the inter-agency mechanism, the operationality and efficiency of which have been widely demonstrated.

Visibility of FMF-funded initiatives

- “Capturing the Demographic Dividend in West and Central Africa and Leading Projects: SWEDD and MUSKOKA “, Jeune Afrique,
- “ Without the demographic transition, Africa has no chance “, RFI,
- “ Maradi: Niger’s First Lady and UNFPA Representative Inaugurate Health Center and Appeal for Improved Maternal Health, “ UNFPA West and Central Africa,
- Mission of the French ambassador to Niger, Mr. Alexandre Garcia, to Zinder from 2 to 4 October 2019, French Embassy in Niamey, France in Niger,
- “ Factsheet Niger “, Equipop.org,

• **Senegal**

A report on the neonatal unit of Roi Baudouin was conducted with the support of the UNICEF regional office and published in the newspaper Monde Afrique and widely disseminated on social networks.

A national forum under the effective presidency of the President of the Republic was organized to strengthen the commitment of Bajenu Gox in the fight against preventable maternal, newborn, child and adolescent deaths with support from the French Muskoka Fund.

In addition, the country team’s participation in the Regional Health Meeting on RMNCAH-Nut in West and Central Africa, held in May in Benin, provided an opportunity to share best practices, particularly in strengthening the leadership of young girls through the “New Deal” strategy.

• **Chad**

Media luncheon organized on 28 January 2019 and focused on the contribution of the “French Muskoka Fund” to the reduction of maternal, neonatal and child mortality in Chad with the participation of the Minister of Public Health, the French Ambassador, representatives of AFD, UNFPA, WHO, UN WOMEN/AFJT and UNICEF.

Participation of the Minister of Health of Chad in the Muskoka side meeting on the margins of the 6th Replenishment Conference of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria -08- 10 October 2019, Lyon, France This high-level side event organized by the French Muskoka Fund was held on 8 October 2019 during which Chad was invited to share its experience in reducing maternal, newborn and child mortality in partnership with UN agencies. Under the format of a panel, it brought together the Ministers of Health of Burkina Faso, Côte d’Ivoire, Mali and Chad and representatives of partners, including the Global Fund, to advocate for better partnership and collaboration between the French Muskoka Fund and the Global Fund, as well as other relevant actors.

A video reporting mission by 2 France 24 journalists took place from 16 to 26 January 2019 in N’Djamena and the Lake Region (Bol, Baga Sola, Dares Salam refugee camp, Kindjiri). This mission documented the activities of the French Muskoka Fund. Eight reports were produced and broadcast during France24’s Africa TV News on nutrition, sexual and reproductive health and child protection.

A press luncheon was held on Monday, 28 January 2019 on the achievements made in maternal, newborn, child, and adolescent and youth sexual and reproductive health in Chad under the French Muskoka Fund. These productions were presented to more than thirty of journalists present by the Minister of Public Health and the French Ambassador. Were also present the Minister of Youth and the first officials in Chad of the French Development Agency (AFD), WHO, UN Women, UNFPA, and UNICEF through the Association of Women Lawyers of Chad. A joint press release was elaborated and disseminated. Photos of the ceremony were also shared and a press review elaborated



- **Togo**

The country hosted a Radio France Internationale (RFI) reporting mission in early October 2019 focusing on different areas of interventions supported by the FMF. These reports covered a variety of topics, including traditional newborn care practices, infant health care, Kangaroo Mother Care, the role of fathers in maternal and child health, the dowry phenomenon, early marriage and pregnancy. These reports were broadcast during the first quarter of 2020 in two flagship broadcasts of RFI: *Priorité santé* and *7 milliards de voisins*. The dissemination of these reports by RFI allows the millions of listeners of this radio to be aware of the contributions of the FMF in improving the health and well-being of mothers, newborns, children and adolescents in Togo.

4. Coordination, follow-up, documentation of interventions

Under Component 3, the UNICEF Regional Office continued to coordinate the FMF Secretariat and the inter-agency management, monitoring, evaluation, documentation and visibility component of the FMF. Since 2019, WHO has been in charge of the monitoring and evaluation component under the coordination of the FMF Secretariat. To this end, the secretariat provided support to the coordination and monitoring and management bodies of the FMF through:

Coordination/secretariat

- Coordination, preparation and follow-up of 10 TechCom teleconferences and 2 physical meetings (June and October 2019, Dakar - Senegal)
- Preparation of the Steering Committee meeting (May 2019, Paris - France)
- Coordination, preparation and organization of a regional conference to review the first phase of Muskoka and launch the second phase (May 2019, Cotonou - Benin)
- Support to the preparation and organization of a high-level event in the margins of the 6th Global Fund Replenishment Round (October, Lyon-France)
- Coordination of the assessment of the governance mechanism and programmatic tools of the FMF (final report under approval).
- Coordination of inputs from the four agencies in the MEAE-led formative evaluation of Muskoka contributions

Monitoring and evaluation

- Monitoring
- Reporting: technical and financial report on the activities implemented and on the use of the contribution received;
- Documentation and sharing of best practices
- Contribution to the final evaluation of the FMF

Communication/visibility

The communication actions deployed in 2019 on the basis of the strategy adapted by the 4 UN agencies in 2019 were oriented to allow Fonds Français Muskoka to position itself as a major contribution of France in favor of reproductive, maternal, newborn, child and adolescent health (RMNCAH-Nut), to support the commitment and action of decision makers and to mobilize resources.

Thus, the 2019-2022 communication strategy has been somewhat readjusted in order to strengthen the positioning of the MFF as the operational and efficient regional inter-agency coordination mechanism for sexual, reproductive, maternal, newborn, child and adolescent health, and nutrition (RMNCAH-Nut) contributing to the achievement of the Sustainable Development Goals (SDGs), both on the United Nations scene (agencies, headquarters) and with other Technical and Financial Partners (TFPs) in the West and Central Africa region (H6 global, GF, UNAIDS, GAVI, etc.), with a particular focus on sexual and reproductive health rights (SRHR).

To ensure alignment with the perspectives and goals set by the SteerCom/TechCom for the FMF, the communication focuses for the 2019-2022 period are being reoriented and reworded as follows:

1. Position the French Muskoka Fund as a French initiative that has enabled the establishment of an operational and efficient regional and national inter-agency coordination mechanism for RMNCAH-Nut to achieve SDGs,
2. Strengthen the RMNCAH-Nut as a priority at national and international levels by enhancing the commitment of decision-makers/leaders/donors and national ownership by capitalizing on achievements, results and impacts, and
3. Optimize the mobilization of different stakeholders to align commitments to RMNCAH-Nut, and commitments to sexual and reproductive health and rights, in line with the Danish contribution since 2019.

The key findings are as follows:

- The Muskoka mechanism is known and recognized as a participant in the architecture of health harmonization in Africa and as an example of the articulation of the ONE UN reform.
- The programmes implemented by the four agencies in favour of the RMNCAH-Nut are identified
- The added value of the FMF for sexual and reproductive health and rights issues is understood

The communication action plan is based on 3 main components

- > Component 1: Documentation
- > Component 2: Dissemination, sharing and exchange
- > Component 3: Involvement, advocacy and influence

Strengthening of the institutional communication component through the production of dedicated materials:

- Production of an intentional booklet including 12 thematic sheets
- Production of the corporate film
- 2 Muskoka reports: 2017-2018 report & Phase 1 global report
- Quality of Care Report (October forum)
- Report on Community Health Care (November forum)

Key outcomes 2019-2020:

New identity positioning of the FMF

- Creation of a new signature “for the well-being and health of mothers, newborns, children and adolescents



Digital

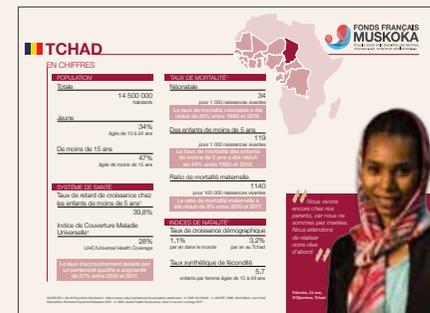
- A new, more result-oriented website, impacts www.fmuskoka.org



- Revitalization of social networks with the launch of the LinkedIn account and the development of digital campaigns such as the communication on caregivers during the Covid 19 outbreak, the institutional campaign on the results, the campaign on menstrual health and hygiene

Institutional communication

- Development of materials including a country version: reports (activity and workshop reports), brochures, posters, kakemonos, institutional videos



Country profiles



Thematic sheets



Newsletter

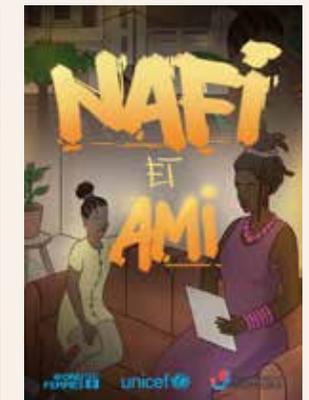
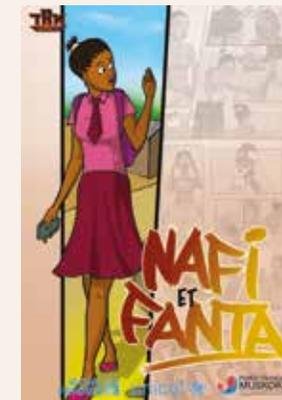
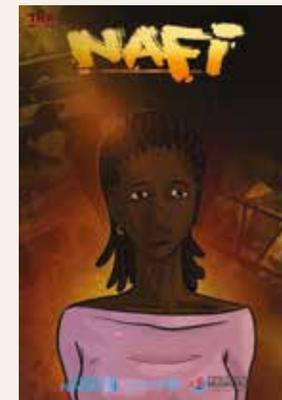


Intentional booklet

Kakémono

Development of thematic materials

- Publications dealing with the fight against gender-based violence



- 21 videos about nurses and midwives

Development of media partnerships to provide a media platform to promote the programmes and results obtained by the FMF through the joint and coordinated action of the 4 agencies in the different countries.

Several partnerships with strategic media have been developed such as Le Monde Afrique, RFI/France 24, TV5 Monde, Canal Plus (Canal Plus Elles), Ouest TV, Allodocteurs.Africa

- Le Monde Afrique
 - 2 pages in the newspaper Le Monde
 - 12 articles in Le Monde Afrique
 - Digital design of the Page Le Monde Afrique for 8 days
- RFI
 - 7 RFI broadcasts including 6 Priorité Santé (5 to come + 1 already broadcast) and 1 7 Milliards de voisins (broadcast on 20/01)
- TV5 - Ouest TV
 - 6 broadcasts on TV5 Monde
 - 18 broadcasts on Ouest TV: 12 in French version - 4 in English version and 2 in Portuguese version
- TV5
 - 2 partnerships in progress for the “Bonne santé” and “Les maternelles” broadcasts

Media visibility to offer a media exposure to the programmes set up by the agencies on the topics covered by the Forum (local press)

- Local press on Regional Quality of Care Forum
 - 7 articles (seneweb, APS, le soleil + ministry of health)
- Local press on the Regional Community Health Care Forum
 - 10 articles published (Matin, Fraternité, la Nation, L'économiste)
 - 55 media broadcasts (TV, radio, posters, press)
 - Press coverage in Togo of the parliamentary visit

Support to events to make visible the efficiency of the regional coordination on the themes preempted by the FMF, work on the appropriation and national visibility, involve political leaders and decision makers (advocacy)

- Programmatic events
 - Regional Forum on the Experience of Care in Africa: Towards Achieving a Positive Experience of Care in Health Facilities - 21-23 October Dakar/Senegal

- West and Central Africa Regional Forum on Community Health within the Context of Primary Health Care - Final Report - November 12 to 15 - Cotonou/Benin
- Programmatic events and advocacy
 - Regional Meeting on “Strengthening the Muskoka Partnership’s Commitment to Achieving Universal Health Coverage” - 7-8 may – Cotonou/Benin
- Advocacy Event
 - Side event on the sidelines of the replenishment conference of the Global Fund under the theme: National and Regional Coordination for Reproductive Health and Maternal, Newborn, Child and Youth Health: an approach to scale up implementation of Global Fund grants in West and Central Africa - 8 October – Lyon/France
 - Visits of 2 parliamentary missions to Niger and Togo

Capitalizing on the French Muskoka Fund’ news/programmes through a digital presence

- 3 tweets per week + enhancement during events for a total of over 5,000 tweets
- Update of the online blog (site) and the site with creation of a page dedicated to events
- Posting of the latest productions (Film, brochure and future reports)
- More than 10,300 followers on twitter including more than 5,000 new subscribers recruited in one and a half years

The recommendations of the MEAE in March 2020 on the visibility strategy and the planning and monitoring procedures of the FMF were as follows, consistent with the actions already developed:

Strengthening visibility and policy dialogue on RMNCAH-Nut via:

- strengthening international, regional and national policy advocacy
- strengthening of the visibility of the MFF in favour of the RMNCAH-Nut at international, regional and national levels

- Identification of some emblematic successes and outstanding results of the FMF and improvement of the communication on these successes, adapted to the target audience (general public, technical or political);
- Active participation on behalf of the FMF in international global health events, organization of international visibility events, with the participation of Embassies in the FMF countries
- Identification of a “champion”, a person with a high profile in the region who will act as an Ambassador for RMNCAH-Nut
- Review of the FMF’s intervention logic
 - Deepening the definition and prioritization of high-impact FMF interventions; analysis of national needs, bottlenecks and alignment with NHDPs

Strengthening the planning and monitoring of the FMF

- Review/clarify/redefine all components of the existing Theory of Change
- Strengthen the FMF monitoring indicators, Define a limited number of key performance indicators (results) in line with SDG indicators and those already existing in the countries
- Strengthen reporting and make it more strategic

Development of a learning agenda for the FMF and all its stakeholders in a monitoring and evaluation “roadmap

- Organize a series of workshops to discuss how to use new planning and monitoring tools,
- Identify, from the analysis of monitoring data, a number of themes that could be the subject of operational research
- Carry out a joint impact evaluation that brings together the agencies and state structures that are members of the FMF)
- Provide for the publication of a “monthly newsletter” identifying good practices in FMF-funded interventions

“

The Muskoka Fund has empowered girls to not only identify but also engage with our community.

Today, thanks to these activities, we are involved in decision-making bodies.

”

Awa Diassy,
President of the Club of young girls of Kolda,
Senegal



2010-2020

VADDED VALUE, LESSONS LEARNED, OPPORTUNITIES, CONSTRAINTS *and* CHALLENGES

Added value

In terms of methodology

It is a “One UN” type of operation as foreseen in the UN reform. In particular, it promotes joint programming and technical assistance at country and regional levels based on: the complementarity of the technical expertise of the four agencies; joint annual monitoring and reporting of results, activities and financial execution; and documentation of interesting practices;

mobilization of other partners and resources. The overall evaluation of the Muskoka initiative, presented in 2019, highlighted the FMF’s leading role in laying the groundwork for the implementation of the “One UN” reform and its principles of one leader, one programme and one voice.

In terms of programming

The synergy between the four UN agencies allows for the development of high-impact interventions adapted to each of the targeted population categories (pregnant women, newborns, children, adolescents) while taking into account the main socio-cultural determinants affecting maternal, neonatal, infant and adolescent mortality, as well as morbidity, vulnerability and inequities.

In terms of implementation strategies

The areas of intervention as well as the modus operandi of the Muskoka mechanism are aligned with France’s sector strategy papers, including:

- France’s global health strategy (2017-2021),
- France’s external action on population, sexual and reproductive health and rights issues (2016-2020),
- the roadmap for France’s international action to improve the nutrition of vulnerable populations (2016-2020);
- France’s international strategy for equality between women and men (2018-2022)

In addition, the French Muskoka Fund is fully aligned with the new Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) adopted by the UN Secretary General in 2015 to support the implementation of the Sustainable Development Goals,

In terms of management and finance

The establishment and operation for 10 years of a stable and strong Muskoka team, at country and regional levels, of about 100 experts who know each other, interact and share the same methodological tools is a real added value of the mechanism. This stability has made it possible to build the programme over time and to cope with the great institutional and political instability, illustrated in particular by the frequency of changes or renewals of the health authorities in the countries concerned.

The secure multi-year budget allocation has allowed countries to commit to ambitious multi-year interventions in the area of RMNCAH-Nut. For some countries, such as Togo, where there are few donors present in the country and little investment in health, this secure, multi-year envelope was crucial because it was one of the few TFP contributions devoted to RMNCAH-Nut.

In addition, the FSP tool, which is annual, imposes constraints of rapid disbursement, monitoring and close reporting. In this context, the FMF has an excellent utilization rate compared to other channels, with an overall utilization rate of over 96% for the entire ten-year programme.

Lessons learned and opportunities

- The personal involvement of the representatives of each agency in the system is essential for strategic support and for the visibility of the system in the countries. This relationship has deepened over the years, as the FMF has become an essential lever of influence and action for the Representative of the countries targeted by the FMF.
- At country level, the coordinating agency plays a crucial role in the smooth functioning of the system as a privileged interlocutor, an entry and exit point for communications with regional level, and an organizer and facilitator of meetings with the other agencies involved.
- The annual technical and financial report common to the four agencies is a very important tool in terms of accountability, visibility and advocacy. It is also a tool for evaluating and improving practices for country teams.
- In order to optimize the results achieved and the impact of the interventions, it is important to develop and maintain a multi-year vision and to operate within a stable framework of interventions containing clear orientations from the technical committee and the steering committee.
- The involvement of regional global health advisors in the Muskoka mechanism has proven to be a good practice in order to facilitate communication between country teams and embassies, to benefit from an additional channel of communication with agencies but also with the MEAE, and to carry out large-scale events in the countries with the support of the embassies, as was particularly the case in 2019.

Constraints

Annual calendar

- The annual nature of the programme creates a very dense period, from November to February (with an effective end of the year on December 15 and an operational start of the year on January 15), with the end of the implementation of activities, the reporting of the past year, the programming of the following year, the allocation of the budget for the beneficiary countries and the start of the activities
- The shortening of the implementation period (March/April-December) constitutes each year a challenge for the largest possible disbursement of the allocated funds. However, there is some flexibility: in year 7-8, funds were carried over from one year to the next.

Environment

- Elections, rainy season, epidemics, insecurity or terrorist risk represent an obstacle to the implementation of activities. Ebola and Covid 19 were a particular strain on operations.

Conflicting calendars

- The activities of the multiple partners collide and compromise the availability of national staff whose presence is essential for programming, implementation or monitoring of interventions.

Departmental Coordination

- In Niger, for example, there is little coordination of interventions between the ministerial departments involved in RMNCAH-Nut (Health and Population, Women's Promotion and Child Protection).

Health information and data

- In most of the target countries, the national health information system does not allow for timely annual reporting of basic indicators. The development of national health information systems remains a priority for countries for public health management.

Administrative procedures for implementation

- There are bottlenecks in the expenditure procedures for the release of funds and for the implementation of activities.

Human resources

- In most of the target countries, particularly Niger and Chad, implementation is hampered by the high mobility of health professionals and the qualitative/quantitative inadequacy of human resources compared to needs and standards. The FMF works to improve the number, quality, distribution and motivation of health workforce.

Essential medicines and health products

- The continuous supply of quality priority medicines for maternal and child health remains a major challenge in many countries due to weak supply chains, from the needs planning process to distribution from the point of service delivery.

Challenges

Demographic and socio-anthropological context

Working to improve the supply of and access to care in RMNCAH-Nut in a region with an unstable political, economic, social, security and climatic context is a real challenge every year. Added to this are the weight of socio-cultural determinants, high population growth, the high dependency rate of countries and the low national budgets allocated to health.

Multiplication of partners

The presence of multiple partners and initiatives in RMNCAH-Nut is a challenge for coordination, the risk of fragmentation of interventions and non-optimal use of resources and expertise, and the lack of alignment between interventions and country priorities. Within the UN system, the FMF has responded to this issue with the coordination of agencies around a common framework for action and with the role of lead agencies in countries. Coordination with AFD's actions has yet to be developed.

Methods of financing

Finally, the need to explore other funding opportunities is also an additional challenge in order to advance this programme and make it play a central role in current international public health issues. We have seen that in year 9, the Danish government joined the FMF partnership by contributing its own funds.



2010-2020

CONCLUSION

In 2021 the FMF celebrates its 10th anniversary. Such longevity for an international development programme in a constrained and unstable political and fiscal environment is rare. Among the different channels for implementing the Muskoka commitments made in June 2010, the FMF was able to set up and develop an adapted operating mechanism common to four UN agencies, in line with the countries' priorities and in close collaboration with the MEAE. This has allowed to disburse, implement, track, report, and adapt throughout this decade for documented RMNCAH-Nut outcomes that can be attributed to him or to which the fund contributed.

The perspective remains clear: keep women, mothers, newborns and adolescents at the center of the health development focus. This is the French government's priority in terms of international development, which the FMF is in line with. This target is specifically defined with the Sustainable Development Goals (SDGs), to which all development partners are committed, with the Global Strategy for Women's, Children's and Adolescents' Health 2016 - 2030 as a common roadmap.

In addition to its network of ITEs and regional health advisors, **the MEAE has developed with the FMF an operational and adapted tool** for implementing and monitoring high impact interventions (HII). The major types of HII implemented-maternal, newborn, and child health and family planning; adolescent and youth sexual and reproductive health; health systems strengthening and human resources; and nutrition-cover a very broad spectrum of activities. The traceability of the MFF's actions meets the requirements for accountability on the commitments made in favor of the RMNCAH-Nut.

This H6-type partnership mechanism, has proven its visibility and operability in the countries. The FMF, as was recalled in 2019 during the presentation of the overall evaluation of the Muskoka engagement, was the first H4+/H6 operational arrangement, particularly for its joint programming process which has become a benchmark. It should pursue the implementation of actions with other partners as well as with the AFD in the countries. This has been the case with the Danish government since 2019. Similarly, coordination mechanisms are being implemented with the

Ministries of Health between the FMF and the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis for a better impact of the RMNCAH-Nut actions.

The continuation of the joint work on behalf of mothers, newborns, children and adolescents, in the coming years is based on the solid foundation of the experience accumulated by the FMF. The common strategy is centered on the quality of care, the evaluation of which, in multidisciplinary and inter-agency teams, is done in each of the care facilities. It is through the actions taken as a result of the recommendations that the quality of care provided to the FMF target populations will be improved and preventable deaths will be reduced in each facility. It is important to take stock as we go along: lessons learned, successes, improved supply and demand for care are the best advocacy, "on a factual basis", for the continuation of the joint efforts born from the Muskoka programme.

In addition, the FMF's participation in major international scientific or policy events on RMNCAH-Nut - this was particularly the case in 2019 - contributes to its visibility and thus its effectiveness and will remain an important activity for years to come

This decade 2010-2020 has clearly seen the development of an enabling environment to act in favor of vulnerable populations such as women, mothers, newborns and adolescents, both at the international level, multilaterally with the major Strategies, government policies in terms of bilateral relations and human development, or at the level of the target countries, with legislative measures showing the consideration of these issues that are at the heart of the enhancement of human capital.

Coverage indicators have improved over this decade in FMF target countries. Status indicators are still a real concern. The work continues.



FONDS FRANÇAIS MUSKOKA

For health and well-being of women,
newborns, children and adolescents



2010-2020

of the **10 YEARS** **FRENCH FUNDS** **MUSKOKA**

