

COUNTRY CASE STUDY

END LINE EVALUATION OF THE H4+ JOINT PROGRAMME CANADA AND SWEDEN (SIDA) 2011-2016

# DEMOCRATIC REPUBLIC OF THE CONGO

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EVALUATION OFFICE

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*End line evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011-2016*

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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ABEF | Family Planning Association (*Association de Bien-être Familial*) |
| ADBC | Community based distribution agents *(Agents de distribution à base communautaire)* |
| AFK | Family Kit Approach *(Approche Kit Familial)* |
| ANC | Ante Natal Care |
| ASRH | Adolescent Sexual and Reproductive Health |
| BCC | Behaviour Change Communications |
| BCZS | Office of the Health Zone Team *(Bureau Central de Zone de Santé)* |
| BDOM | The Diocesan Office of Medical Works (*Le Bureau Diocésain des Œuvres Médicales*) |
| BEmONC | Basic Emergency Maternal, Obstetric and Neonatal Care |
| CAO 4&5 | MDG 4&5 Acceleration Framework (*Cadre d'Acceleration des OMD 4&5*) |
| CBA | Community based advocates |
| CBD | Community-Based Distribution (of contraceptives) |
| CCT | Technical Coordinating Committee (*Comité de Coordination Technique*) |
| CEmONC | Comprehensive Emergency Maternal, Obstetric and Neonatal Care |
| CHW | Community Health Worker (*Rélais Communautaire*) |
| CHW | Community Health Worker |
| CNP-SS | Health Sector Coordinating Committee (*Comité de Pilotage du Secteur de la Santé*) |
| CPR | Contraceptive Prevalence Rate |
| CTB | Belgian Technical Cooperation |
| CS | Health Centre*(Centre de santé)* |
| D1 | Division for General Services and Human Ressources (*Direction des Services Généraux et Ressources Humaines*) |
| D10 | Division for Family Heath and Special Groups (*Direction de la Santé de la Famille et de Groupes Spécifiques*) |
| DEP | Department for Plannng and Studies (*Direction d'Etudes et de Planification*) |
| DFID | Department for International Development of the United Kingdom |
| DHS | Demographic and Health Survey |
| DPS | Provincial Health Department (*Direction Provincial de la Santé*) |
| DPS | Provincial Health Department (*Direction Provinciale de la Santé*) |
| DRC | Democratic Republic of Congo |
| ECZ | Health Zone Team (*Equipe Cadre de la Zone de Santé*) |
| EMG | Evaluation Management Group |
| EmONC | Emergency Obstetric and Newborn Care |
| ERG | Evaluation Reference Group |
| ERG | Evaluation Reference Group |
| FOSA | Health Facility *(Formation Sanitaire)* |
| GAVI | Gavi, the Vaccine Alliance |

| | |
|---|---|
| GBV | Gender-Based Violence |
| GFF | Global Financing Facility |
| GIBS | Health Development Partners' Forum (*Groupe Inter-Bailleur pour la Santé*) |
| H4+ JPCS | H4+ Joint Programme Canada and Sweden (Sida) |
| HMIS | Health Management Information System |
| HSS | Health Systems Strengthening |
| HZ | Health Zone |
| IMNCI | Integrated Management of Newborn and Childhood Illnesses |
| ISTM | Higher Institute for Medical Techniques (*Institut Supérieur de Techniques Médicales*) |
| JICA | Japan International Cooperation Agency |
| KOICA | Korea International Cooperation Agency |
| M&E | Monitoring and Evaluation |
| MDG | Millennium Development Goal |
| MDSR | Maternal Death Surveillance and Response |
| MICS | Multiple Indicator Cluster Survey |
| MMEIG | UN Maternal Mortality Estimation, Inter-Agency Group |
| MMR | Maternal mortality ratio - Check if used more than once/twice |
| MNCH | Maternal, Newborn and Child Health |
| MoH | Ministry of Public Health |
| MVA | Manually Vacuum Assisted |
| MWH | Maternity Waiting Home |
| NGO | Non-Governmental Organisation |
| PARSS | Health Sector Rehabilitation Support Project |
| PDSS | Health System Strengthening for Better Maternal and Child Health Results Project (*French*) |
| PESS | Health Facility Equipment Project (*Projet d'équipement des structures sanitaires*) |
| PLWHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | Post Natal Care |
| PNDS | National Health Development Plan (*Plan National de Développement Sanitaire*) |
| PSM | Procurement and Supply Chain Management |
| RBF | Results-Based Financing |
| RECO | Community health worker*(Rélai communautaire)* |
| RMNCAH | Reproductive Maternal Neonatal Child and Adolescent Health |
| RMNCH | Reproductive Maternal Neonatal Child Health |
| SCOGO | Professional Association of Gynaecologist-Obstetricians (*Société Congolaise des Gynéco-obstétriciens*) |
| Sida | Swedish International Development Authority |
| SRH | Sexual Reproductive Health |

| | |
|---|---|
| SRHR | Sexual Reproductive Health Rights |
| ToC | Theory of Change |
| UN Women | United Nations Entity for Gender Equality and the Empowerment of Women |
| UNAIDS | Joint United Nations Programme for HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VHW | Village Health Worker |
| WB | World Bank |
| WFP | World Food Programme |
| WHO | World Health Organisation |
| YFS | Youth Friendly Services |

## GLOSSARY OF TERMS USED

**H4+ partnership:** the broad designation/ term used to describe the coordinated efforts of the six member agencies working together.

**H4+ members**: the six UN agencies that are part of the H4+ partnership (sometimes also referred to in the text as 'H4+ partners').

**H4+ country team**: the group of specific people from among the H4+ members who are tasked with the responsibility to plan, oversee the implementation of and account for the H4+ programme delivery.

**H4+ programme delivery:** any RMNCAH activities implemented under the coordination of the H4+ partnership regardless of funding source.

**H4+ coordination mechanism**: the designated processes, procedures and structures through which the H4+ country team fulfils its mandate.

# 1 INTRODUCTION

This note presents the results of field country case study of the Democratic Republic of the Congo (DRC), undertaken for the End Line Evaluation of the H4+ Joint Programme Canada and Sweden (H4+ JPCS). It is one of four field country case studies carried out during the evaluation (DRC, Liberia, Zambia and Zimbabwe). The remaining six countries supported by the H4+ JPCS were Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau, and Sierra Leone. Each of these six countries is covered in the evaluation by a document and telephone interview based case study. Nine of the ten programme countries were supported either by the Canada grant to the H4+ or by a grant from Sweden. Only Zimbabwe received funding from both.

## 1.1 Objectives of the field country case studies

The purpose of the field country case studies is to provide essential input useful to addressing six evaluation questions as they apply at country level.[1]

**Box 1: Evaluation questions**

1. To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH), especially by supporting the eight building blocks of health systems?
2. To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalized groups and in support of gender equality?
3. To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level?
4. To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?
5. To what extent has the H4+ JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities?
6. To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's and Children's Health (the Global Strategy) and the "Every Woman Every Child" movement?

The field and desk country case studies are the core of the overall evaluation. Together they cover all ten programme countries, which account for more than 80 percent of programme expenditures. By helping to answering the six evaluation questions, the country case studies serve to test the causal assumptions which underlie the programme theory of change (ToC). This, in turn, allows the study to credibly verify the programme contribution to results in RMNCAH.

## 1.2 Approach and methodology

Each field country case study uses a theory based evaluation approach which begins with the identification and subsequent refinement of an explicit theory of change (ToC) for the programme at country level. This country-specific ToC is a modified version of the overall country-level ToC for H4+ JPCS developed during the inception phase of the evaluation.[2] The ToC for the programme in DRC is presented in section 3.

[1] (UNFPA 2015: 33-34)

[2] (Global Affairs Canada, UNFPA et al. 2016: 11)

The country level ToC developed during the inception phase allows the evaluation to identify key causal assumptions essential to the achievement of results at each level of the chain of effects supported by the programme. These assumptions themselves can then be systematically tested for their validity, clarity and strength. The resulting assessment of the validity of key causal assumptions then forms the basis for identifying the contribution made by H4+ JPCS to outcomes in RMNCAH in DRC.[3]

The main data collection methods used in each field country case study are:

- Identification and review of core documents at country level including: annual workplans; results frameworks and results reports; minutes of H4+ planning, review and steering committee meetings; programme review and evaluation documents; monitoring mission reports, national plans and programmes in RMNCAH; and reports and documents produced by other bilateral and multilateral agencies supporting RMNCAH
- Review and profiling of quantitative data, including financial data on programme investments and data on results in RMNCAH indicators at national, provincial and district levels
- Key informant interviews with a wide range of stakeholders at national level (Annex 5)
- Site visits at provincial and district levels including: interviews and discussions with provincial and district health teams; group interviews with staff of district hospitals, rural health centres, health clinics and maternal waiting homes; and focus group discussions and group interviews with community members being served by health facilities supported by the programme. Group interviews included: specific groups of in-school and out of school adolescents and youth (male and female), mother support groups, adult and youth (male and female) consultative forums, village heath workers (VHW) and community based advocates (CBA), and traditional leaders
- Debriefings of key informants at district, provincial and national levels in order to present preliminary findings and receive feedback on any gaps in the data used, and on factual errors or misinterpretation of the available data.

In each field country case study, a national evaluation reference group (ERG) was formed and charged with an advisory role in support of the study. The draft field country case study note was submitted to the national ERG for review and comments prior to submission to the EMG.

## 1.3 Nature of the field country case studies

It is important to recognise that each field country case study was not designed to serve as a stand-alone evaluation of the H4+ JPCS in the country under review. It is, rather, a case study in the service of the larger evaluation of the programme as a whole. The findings and conclusions presented in the note are based explicitly on the experience of the programme in DRC as assessed by the evaluation. However, the lessons learned, as presented in section 5, focus on the implications of those findings for the ongoing operation of the H4+ (now H6) partnership.

## 1.4 Carrying out the field country case study in DRC

The country case study of the H4+ JPCS in DRC began with a review of key programme documents. This was supplemented further by a review of documents gathered during the main evaluation missions in August 2016 (Annex 6).

[3] For a full discussion of the analytical approach and methodology used in End Line Evaluation see the *Inception Report,* Chapters Three and Four (Global Affairs Canada, UNFPA et al. 2016).

A review of trends in quantitative indicators of outcomes in RMNCAH at national level (Annex 4) was carried out prior to the field missions. This was supplemented with a review of indicators gathered from Health Management Information System (HMIS) data on the nine target H4+ health zones (HZ)[4] in DRC. The HMIS data was provided by the H4+ coordinator who works with the department for planning and research (DEP) and the HMIS division of the Ministry of Health (MoH), as well as the provincial health departments (DPS), which are responsible for collecting and validating the data from the health zone level.[5]

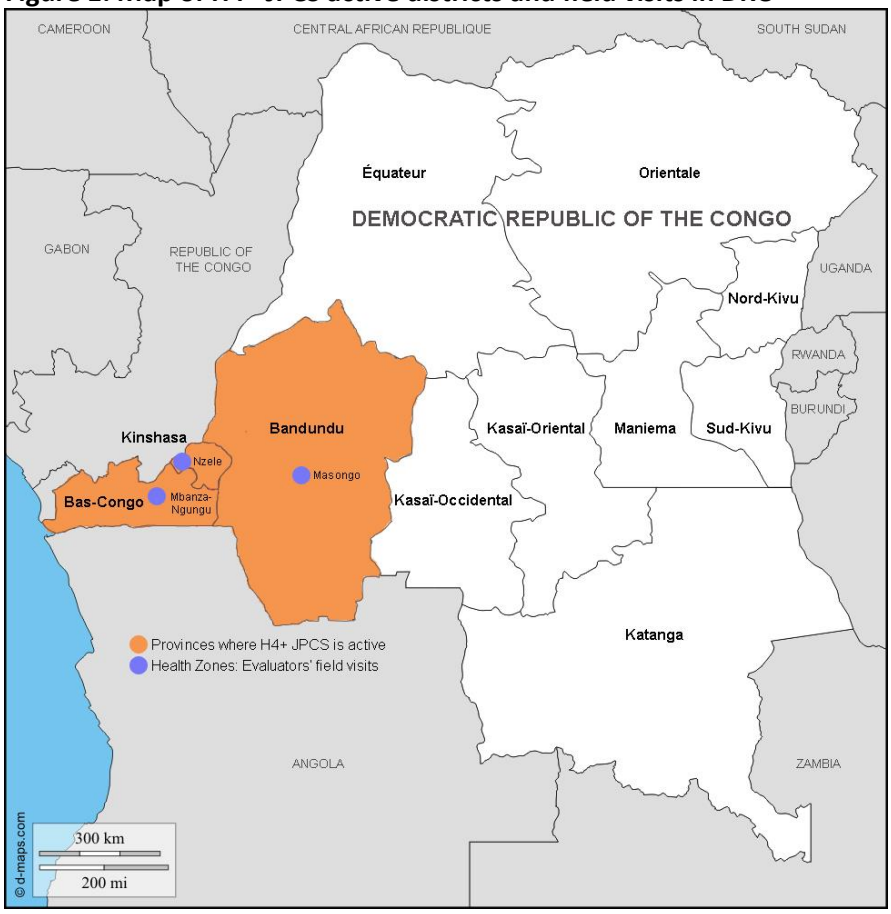
The DRC field mission took place from 8 to 23 August 2016. The team was comprised of one international and two national consultants. An evaluation reference group was convened by the H4+ partnership in DRC to oversee the process. The ERG was chaired by the Ministry of Health, and comprised of representatives from each of the H4+ member and of the Canadian and Swedish embassies.

At national level, the evaluators met with the H4+ country team, government, H4+ implementing partners, and international non-governmental organisations (NGOs) engaged in RMNCAH coordination in DRC (see Annex 5). Three field visits were undertaken; to Nsele (10 August), Mosango (15-17 August) and Mbanza-Ngungu (18-20 August) (see map in Figure 1). Meetings were held with the health zone teams (ECZ) in all three locations. During these trips, the team visited one youth centre, one maternity ward and eleven health facilities (seven primary health centres, two reference health centres, and two general referral hospitals). Due to the long distances and poor road conditions between the visited health zones and the location of certain provincial health departments (DPS), the latter were interviewed by phone. The team held discussions with community members in Mosango and Mbanza-Ngungu to supplement the visits to the health facilities, including: adolescent boys and girls; youth clubs; representatives of a community health insurance; women cooperatives; local leaders; and community health workers. In both counties, the evaluators collected data through a range of methods, including focus group discussions, key informant interviews, and a facility check-list assessing the availability of emergency obstetric and newborn care (EmONC) equipment and tools, essential maternal and newborn drugs, and staff trained in EmONC, family planning and prevention of mother to child transmission (PMTCT).

[4] To facilitate reading for those with knowledge of the DRC health system, the French acronyms are used for the most common terms in this report.

[5] In the DRC, health zone is the term used for the sub-provincial level of health administration (roughly equivalent to the district level in many countries).

**Figure 1: Map of H4+ JPCS active districts and field visits in DRC**




## 1.5 Limitations

The field country case study of H4+ JPCS in the DRC is grounded in documentary evidence, quantitative data, and qualitative information. The supporting evidence is presented in detail in the evaluation matrix (Annex 1). The methodology used for the case study aims to identify, to the extent possible, the programme contribution to improving outcomes in RMNCAH at national, provincial and district levels. It does not, however, include the use of counterfactuals, such as comparison communities and randomised sampling, to develop a quantitative impact analysis.

Quantitative data has been used to help provide the overall context of developments in RMNCAH in DRC; a financial profile of the H4+ programme; a mapping of the results reported by the programme, and an assessment of changes in the supply of, and demand for, RMNCAH services in the targeted districts. In every case, qualitative information gathered in key informant interviews, group discussions and site visits has been used to interpret and help triangulate the quantitative data.

It should be noted that key informants pointed out that HMIS systems in the DRC are limited in coverage and reliability. Due to acknowledged limitations in the collection and reporting of information through DHIS2 and other systems, care must be taken in interpreting trends in outputs and outcomes reported for H4+JPCS in the DRC.

An important issue arises regarding the availability of outcome data, as there is a tendency to under-report the number of maternal and neonatal deaths at county level as reflected in the HMIS data. This occurs partly because of apparent miscoding of maternal and neonatal deaths under other proximate causes, such as malaria and tuberculosis. It may also occur because maternal and neonatal deaths occurring in the community may not be reported. Either way, since the

Demographic and Health Survey (DHS) data is available only to the provincial level (and not below that), it is not possible to trace the main indicators of morbidity and mortality in RMNCAH to the health zones or facility levels. As a result, other indicators such as skilled delivery at birth or the percentage of pregnant women attending four antenatal visits are used.

Another limitation is related to the difficulty of conducting a thorough contribution analysis. In the DRC, H4+ JPCS was implemented in nine health zones (as well as at national level) in which the H4+ members also used other funding sources to support RMNCAH interventions, particularly the RMNCH Trust Fund and their own core funds. While there is evidence that some of these interventions were clearly complementary, it was not possible to obtain precise information on all the activities in RMNCAH supported by heath zone and by H4+ partners, which, of course makes it more difficult to clearly identify the specific H4+ JPCS contribution with precision. Nonetheless, it was possible (as illustrated in section 4) to critically test the key causal assumptions underlying the theory of change for the programme in the DRC. Whenever possible, the evaluators have identified complementarity between H4+ JPCS activities and these other interventions.

# 2 THE CONTEXT OF RMNCAH IN DRC

## 2.1 Trends in RMNCAH - 2011 to 2016

The DRC has one of the highest maternal mortality ratios (MMR) in the world (693 per 100,000 live births),[6] placing it among the six countries that count for 50 percent of all maternal deaths globally.[7] In the lifetime of a woman, her risk of dying in pregnancy is about 1 in 30.[8] Despite efforts to RMNCAH service delivery in recent years, the decline in maternal deaths has been slow, with only one percent annual change in MMR between 1990 and 2015.[9] Contraceptive prevalence rates (CPRs) are tracking upwards but remains very low at only eight percent among married women,[10] while unmet need is rising and currently estimated at 28 percent.[11] CPR is higher than the national average in two of the three provinces targeted by the H4+JPCS: Kinshasa (19 percent) and Bas-Congo (17 percent).

**Table 1: Selected Indicators of RMNCAH in the DRC - 2005 to 2015**

| Indicator | 2005 | 2010 | 2015 |
|---|---|---|---|
| Maternal Mortality Ratio* | 787 | 794 | 693 |
| Neonatal Mortality | 42 | --- | 28 |
| Contraceptive Prevalence Rate (Married Women/Modern Methods) | 5,8% | 5,4%* | 7,8% |
| Unmet Need for Contraception (Married Women) | 26.9% | 24,2%* | 27,7% |
| Exclusive Breastfeeding for First Six Months | 35% | 37%* | 48% |
| Births in a Health Facility | 70% | 75%* | 80% |

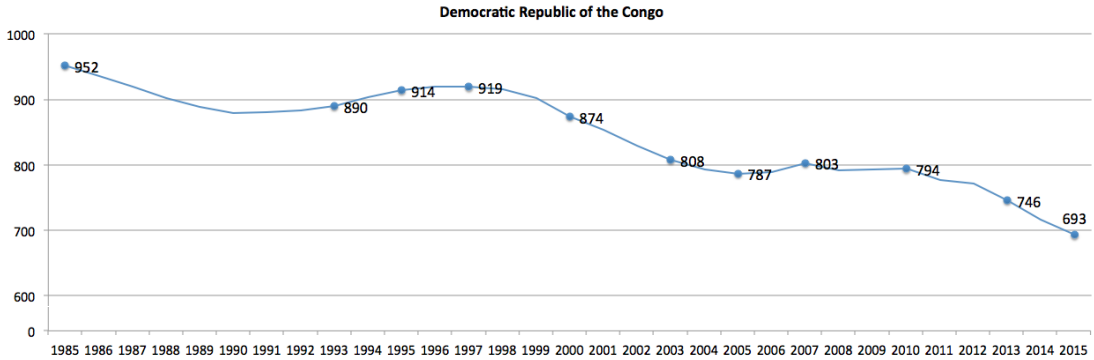
*Data from the UN Maternal Mortality Estimation, Inter-Agency Group (MMEIG). The DHS-II 2013-2014 (p.217) indicates that the MMR was under-reported in the DHS-I 2007 and that the MMEIG2005, 2010 and 2015 estimates should be used instead. These numbers are identical with Countdown to 2015 data. It was therefore decided to use the MMEIG numbers instead of the DHS data.

6 (WHO 2015)
7 (MoH 2013a: 5)
8 (MoH 2013a: 5)
9 (WHO 2015: 71)
10 (MPSMRM, MoH et al. 2014: 96)
11 (MPSMRM, MoH et al. 2014: 106)

*Sources:* DHS-I 2007; Multiple Indicator Cluster Survey (MICS) 2010; DHS-II 2013-2014; MMEIG 2015: *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.*

The main direct causes of maternal mortality are haemorrhages (34 percent), sepsis and infections (16 percent) and hypertensive disorders (9 percent).[12] These conditions are exacerbated by five main health systems gaps: (i) low availability of essential medicines caused by a largely dysfunctional supply chain system; (ii) insufficient quantity and inequitable distribution of qualified human resources; (iii) low quality of services; (iv) weak capacity to management the health zones; and (v) low financial and geographic access to health services.[13]

**Figure 2: Maternal mortality ratio trend in the DRC since 1985**




Some progress has been recorded in newborn mortality rates, which declined from 42 to 28 over the last decade. Although the under-five mortality rate declined from 97 to 58 per 100,000 live births between 2004 and 2011, each year 465,000 Congolese children still die before their fifth birthday.[14] The main causes include: malnutrition, malaria, pneumonia, and diarrhoea. Malnutrition alone counts for 50 percent of all under-five deaths.

Young adolescent girls in the DRC are particularly vulnerable as they are often exposed to early marriages, teenage pregnancies and gender-based violence (GBV).[15] Among unmarried sexually active young girls, only one in five use a modern contraceptive, while unmet need remains high at 48 percent among girls age 15-19.[16] The low use of condoms (27 percent) and family planning services (five percent), coupled with high abortion rates, puts adolescents at further risk.[17] Only 80 out of 516 (15 percent) health zones offer a minimum package of youth-friendly sexual reproductive health rights (SRHR) services.[18]

## 2.2 National plans and priorities

The DRC RMNCAH strategy is set out in several national strategies and plans. These include the National Health Systems Strengthening Strategy, the National Health Development Plan (PNDS) 2011-2015, and the Millennium Development Goals (MDG) 4 and 5 Acceleration Framework (CAO 4&5), which lay out the national priorities and strategies for the health sector development in general, and progress towards key RMNCAH indicators in particular. The PNDS 2011-2015 places a

12 (MoH 2013a: 5)
13 (MoH 2013a: 7)
14 (MoH 2010)
15 (MoH 2016b: 26)
16 (MPSMRM, MoH et al. 2014: 96, 107)
17 (MoH 2016b: 26)
18 (MoH 2016b: 26-27)

high priority on health systems strengthening (HSS) to scale up primary health care services.[19] As its development coincided with the advent of the H4+ JPCS in 2010-2011, programme interventions were designed based on the gap analysis and priorities of the PNDS.

*CAO 4&5* is a national action framework that aims to provide *"strategic, operational and innovative responses"* to reduce maternal and child mortality.[20] It proposes six strategic approaches to accelerate progress towards MDG four and five:

1. Universal coverage targeting vulnerable populations, including pregnant women and children under five years
2. Strengthening continuum of care at peripheral level including referral hospitals
3. Improving governance and management of health zones
4. Strengthening human resources (motivation, quality training, results-based financing (RBF))
5. Communication for development
6. Community engagement

The action framework is built on four pillars of maternal, newborn and child health: family planning, antenatal care, safe deliveries, and essential and comprehensive emergency obstetric and neonatal care (CEmONC). It also focuses on efforts to address the three delays that threaten the life and well-being of mothers and newborns: first, in making the decision to seek care; second, in reaching a health facility and third, in receiving appropriate care.

## 2.3 External support to RMNCAH

Several development partners provided external support to health systems strengthening and RMNCAH in the DRC between 2011 and 2016. The most significant contributions came from the Department for International Development of the United Kingdom (DFID), the United States Agency for International Development (USAID), the European Union, The Global Fund to fight AIDS, Malaria and TB, and Gavi, the Vaccine Alliance (Gavi), in addition to other funding sources of the H4+ members.[21] The RMNCH Trust Fund and the French government through the Muskoka Initiative also provided catalytic support to scale up RMNCAH interventions in selected health zones. The projects that were active in the H4+ provinces from 2011 to 2016 are presented in the table below:

**Table 2: Key programmes in HSS and RMNCAH operating in H4+ target provinces in the DRC**

| Project | Donor | Period | Kinshasa | Kongo Central | Kwango | Kwilu |
|---|---|---|---|---|---|---|
| Scaling up Nutrition Integrated Life-Saving Interventions Project (Vitamin A Supplementation) | Canada | 2013-2016 | ♦ | ♦ | | |
| UNAIDS programmes* | UNAIDS | 2013-2017 | ♦ | ♦ | ♦ | ♦ |
| Global Reproductive, Maternal, Newborn and Child Health Financing - RMNCH Fund | UNFPA | 2015-2016 | ♦ | ♦ | ♦ | ♦ |
| Enhancing SRH of Young People & Adolescent Girls and Women of Reproductive Age, | Sida | 2015-2020 | ♦ | ♦ | | |

[19] (MoH 2010 : 8)
[20] (MoH 2013a : 8)
[21] (GIBS 2015: 1). *Groupe Inter-Bailleur pour la Santé* (GIBS) is the health development partners' forum for coordinating their support to the health sector.

| | | | | | | |
|---|---|---|---|---|---|---|
| particularly the most vulnerable in Kinshasa | | | | | | |
| Composante Santé de la Reproduction Programme RDC-UNFPA 2013-2017 | UNFPA | 2013-2017 | ♦ | ♦ | ♦ | ♦ |
| Projet de Développement des Ressources Humaines en Santé | JICA | 2014-2018 | | ♦ | | |
| Projet de Prévention et de Contrôle du Paludisme dans la DPS du Kwilu | KOICA | 2013-2015 | | | | ♦ |
| Projet de Renforcement des Capacités sur les Soins de Santé de la Mère, du Nouveau-né et de l'Enfant dans la DPS Kwango | KOICA | 2014-2016 | | | ♦ | |
| Health Sector Rehabilitation Support Project (PARSS) – including results-based financing for RMNCAH | World Bank | 2010-2014 | ♦ | | ♦ | ♦ |
| Projet de Développement du Système de Santé (PDSS) | World Bank | 2015-2019 | | | ♦ | ♦ |
| New Funding Model grants | Global Fund | 2015-2017 | ♦ | ♦ | ♦ | ♦ |
| Projet d'appui au Système de Santé de Kinshasa | Canada | 2015-2017 | ♦ | | | |
| UNICEF funds** | UNICEF | 2013-2017 | ♦ | ♦ | ♦ | ♦ |
| Appui à l'Amélioration de la Santé des Populations des Zones de Santé des DPS | CTB and MEMISA | 2015-2016 | | ♦ | | ♦ |
| Projet d'équipement des structures sanitaires (PESS) | DRC Gov. | Ongoing | ♦ | ♦ | ♦ | ♦ |
| Formation en mangement du VIH dans la SRMNEA | USAID | n/a | | ♦ | | |
| Increase access, demand and utilisation of 13 essential products and improve child health and reproductive health interventions | RMNCH Trust Fund (Phase1) | 2013-2015 | ♦ | ♦ | ♦ | ♦ |
| Catalytic RMNCAH funds to improve the availability of family and delivery kits | RMNCH Trust Fund (Phase 2&3) | 2014-2016 | | | ♦ | ♦ |

** UNAIDS Unified Budget, Results, and Accountability Framework (UBRAF) 2014-2015; Global Programme to Enhance Reproductive Health Commodity Security 2013-2017; Thematic Trust Fund for Maternal Health 2013-2017; and Appui à la Réponse Nationale au VIH 2014-2015.*

*** UNICEF (Version2) and Survie de l'enfant*

*Source :* GIBS (2015). Mapping of health projects/programmes and H4+ Country Team (2015). H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+; RMNCH Trust Fund (2016). La revue du rapport annuel 2015. République Démocratique du Congo ; interview with WHO H4+ focal point.

The table illustrates that the three H4+ provinces received support from multiple funding sources. . It also indicates that the H4+ members also used funds from other sources to implement RMNCAH activities in the three H4+ target provinces.

In the three health zones visited by the evaluation team, the following partners have supported RMNCAH or general health systems strengthening during the implementation of the H4+ JCPS:

- **Nzele (Kinshasa):** PESS; UNICEF; UNFPA; WHO; PASSKIN (Canadian funds); Rotary Club Development; ICAP (Columbia University); World Vision International; Handicap International; The Diocesan Office of Medical Works (BDOM); MEMISA
- **Mosango (Bandundu):** PESS; UNICEF; UNFPA; WHO; MEMISA/IMT KWILU et DGD ; KOICA ; LUMOS ; JICA ; SANRU/Global Fund; MSV; Gavi the Vaccine Alliance; Action Damien; Begian Cooperation (CTB)
- **Mbanza-Ngungu (Bas Congo):** PESS; UNICEF; UNFPA; WHO; The Global Fund, AQUAL, DKT, BDOM.[22]

**The RMNCH Trust Fund:** In 2013 and 2014, UNICEF, UNFPA and WHO received two grants from the RMNCH Trust Fund to implement a joint programme, building on the lessons learned of the H4+ JPCS. Phase I grant aims to: *"Increase access, demand and utilisation of 13 essential products and improve child health and reproductive health interventions 2013-2015,"* (3.4 million US$). The phase 2 and 3 grants provide *"Catalytic RMNCAH funds to improve the availability of Family and Delivery Kits 2014-2016*" ($22.8 million).[23]

**The Health Facility Equipment Project (*Projet d'équipement des structures sanitaires)* (PESS):** The Government of the DRC funds a large-scale project that aims to improve the infrastructure and equipment in the health sector. It supports the renovation and construction of health facilities and provides equipment for 200 reference hospitals and 1000 health centres, and procures essential medicines.[24] PESS is implemented with logistical support from UNICEF.

While it has not been possible to obtain detailed information about the activities supported by theseprogrammes in the nine H4+ JPCS, the document review and key informants indicate that they were complementary to H4+ JPCS supported interventions. For example, CTB, KOIKA and JICA focused on general health systems strengthening, while Global Fund provides support for HIV and AIDS, malaria and tuberculosis, and Gavi for vaccines in H4+ target health zones. The H4+ JPCS filled an important gap in RMNCAH, for example through its support to essential commodities, EmONC and the family kit approach, which were not covered by other donors or programmes. The family kit approach was initially developed and piloted with H4+ JPCS funds, and then integrated into national policy and taken to scale with other funding sources (e.g. the RMNCH Trust Fund grants).

Neither the World Bank funded Health Sector Rehabilitation Support Project (PARSS) 2010-2014 (results-based financing), [25] DFID, nor the European Union intervened in any of the H4+ target health zones during 2011-2015.[26] The follow-on project to PARSS, Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) 2015-2019 (220 million USD), will cover RBF in Bandundu, including potentially some of the H4+ target health zones.[27]

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22 Source: Power point presentations given by the ECZ to the H4+ JPCS evaluation team, and follow-up interviews with the ECZ of Nzele, Mosango and Mbanza-Ngungu

23 (RMNCH Trust Fund 2016)

24 (H4+ Country Team 2015b)

25 (World Bank 2014a: 18)

26 Ibid.

27 Ibid.

## 2.4 Mechanisms and processes for coordinating action

### 2.4.1 National mechanisms for coordinating support to the health sector in the DRC

Key informants described a complex, interlocking set of committees and working groups for coordinating the health sector and RMNCAH interventions in the DRC:

- **The National Health Sector Coordinating Committee** (CNP-SS) is chaired by the Minister of Health. It convenes biannually and is responsible for setting policy and strategic direction in the health sector. It is a multi-sector forum with representation of other ministries, civil society and donors. The CNP-SS is not fully operational and is currently under reform.[28]
- **The Technical Coordination Committee** is the operational arm of the CNP-SS. It has several commissions that are responsible for the coordination of interventions in a specific sub-sector, including a **Commission for Service Delivery**, in which the MoH, H4+ partners and other development partners participate.
- **The national RMNCH Task Force** is a multi-stakeholder forum for coordinating RMNCAH partners and interventions. It is chaired by the Director of the Division for Family Health, who is also the H4+ coordinating arm of the MoH. There are also **provincial RMNCH task forces**. The national RMNCH Task Force will be integrated as a sub-group under the Commission for Service Delivery of the Technical Coordination Committee of the CNP-SS.
- **The *Groupe Inter-Bailleurs Santé* (GIPS)** is the platform for development partners for coordinating their support to the health sector and defining joint priorities. It has several sub working groups which by some stakeholders are seen as overlapping with the commissions of the CNP-SS.
- **A joint donor platform for coordinating results-based financing** interventions has been established between the World Bank, UNICEF, The Global Fund and GAVI. The partners have signed a memorandum of understanding and work closely together to harmonise their approaches, reduce fragmentation and duplication of support, and implement joint RMNCAH interventions aligned to the national RBF strategy and the MDG 4 and 5 Acceleration Framework.[29]

The relationship among these different committees is discussed in detail in section 4.3.

### 2.4.2 H4+ programme coordinating mechanisms and processes

The system for coordinated planning, supervision and review of the H4+ JPCS in the DRC has four main elements:

- Joint H4+coordinating meetings (MoH and H4+ members)
- Inter-agency H4+ coordinating meetings (H4+ members only)
  - Quarterly meetings of the heads of H4+ agencies meetings
  - Monthly meetings of the H4+ focal points
  - H4+ annual retreats
- Joint supervision and review missions to the nine health zones supported by H4+ (MoH and H4+ members)
- Quarterly provincial and health zone planning and review meetings with participation by the provincial health department (DPS), the health zone teams and some health facilities staff. These meetings occasionally feature participation by H4+ partners and non-governmental organisation (NGO) implementing partners.

[28] (MoH 2016b: 54-55)
[29] (World Bank 2014a: 10, 22, World Bank 2015a)

The H4+ coordinating mechanisms and their effectiveness have changed over time. In 2015, the MoH recommended the integration of the joint H4+ coordinating meetings into the national RMNCH Task Force. This evolution and its underlying causes are discussed in section 4.3.

## 2.5 The H4+ programme in the DRC

### 2.5.1 Programme expenditures

Programme expenditures under H4+ JPCS began gradually and reached their maximum levels in 2013-2015 (Table 3). These three years accounted for 80 percent of total expenditures in the five years of programme operation in the DRC (up to December 31, 2015). The programme began implementation in 2011 (although at a very low level of funding). According to H4+ members, this was possible because the H4+ partnership was already well established and operational in the DRC before the advent of the H4+ Canada grant. They also indicated that H4+ members pre-financed certain activities in preparation of the programme launch, including baseline studies, before the funds were actually disbursed from global to country level. The H4+ programme operated under a no-cost extension until 30 June 2016.

**Table 3: H4+ JPCS Expenditures by H4+ member in the DRC 2011-2015**

| US$ | 2011 | 2012 | 2013 | 2014 | 2015 | Total | % |
|---|---|---|---|---|---|---|---|
| UNFPA | 4,603 | 775,901 | 642,797 | 681,552 | 1,171,329 | 3,276,181 | 37% |
| UNICEF | 0 | 633,548 | 737,719 | 940,104 | 432,318 | 2,743,689 | 31% |
| WHO | 0 | 444,616 | 1,016,706 | 892,412 | 538,311 | 2,892,045 | 32% |
| TOTAL US$ | **4,603** | **1,854,065** | **2,397,222** | **2,514,067** | **2,141,958** | **8,907,312** | **100%** |

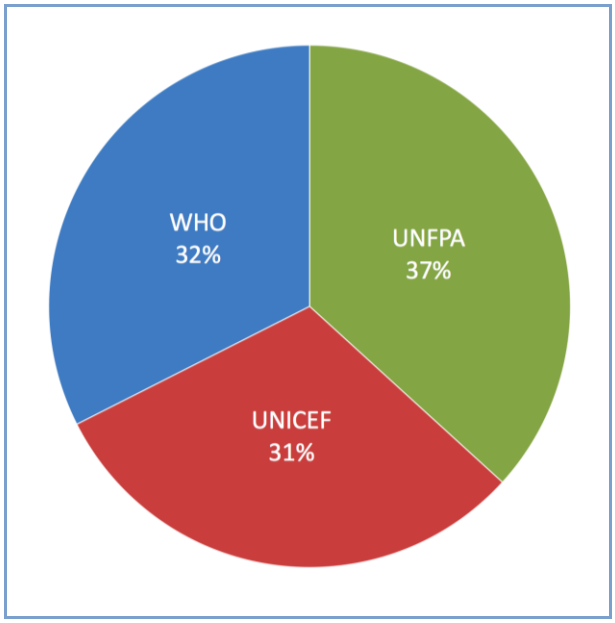
*Source*: UNFPA 2016

As is typical under the Canada Grant, only UNFPA, UNICEF and WHO received funding from the global level to implement H4+ JPCS activities in the DRC.[30] Table 3 and Figure 3 also illustrate that the funds were relatively equally allocated among the three H4+ members. In 2015, UNFPA decided to allocate US$ 150,000 of its H4+ JPCS funding to UN Women, as a local implementing partner, to strengthen community-based interventions in two out of nine HZs.[31] While WHO expenditures slowed down slightly in 2014 and 2015, as compared to previous years, UNFPA accelerated expenditures in 2015 (UNFPA expenditures increased by approximately 70 percent between 2014 and 2015).

[30] The DRC, (like Burkina Faso, Sierra Leone and Zambia) received financial H4+JPCS support only from the Canada Grant which was specifically targeted to WHO, UNICEF and UNFPA. A transfer of resources was made by UNFPA to UN Women within the operations of the H4+ JPCS in the DRC in order to UN Women to implement activities to address gender related barriers to access to RMNCAH services.

[31] Only US $90,000 of the US$150,000 was disbursed from UNFPA to UNWOMEN. This topic will be discussed in section 4.2.2 (assumption 2.5)

**Figure 3: Programme expenditures by H4+ members in the DRC (2012 – 2015)**




It is also worth examining the distribution of H4+ expenditures across the eight H4+ JPCS programme output areas over the period 2012 to 2015 (Table 4); and to link this analysis to the DRC H4+ JPCS theory of change (ToC) (Figure 4). The DRC ToC allocates the eight programme outputs into three streams: national leadership and management; health zone level supply of quality RMNCAH services (the supply side); and mobilising demand from users (the demand side).

Table 4 illustrates the actual H4+ JPCS expenditures by programme output over the period 2012 to 2015. Analysis of expenditure across the outputs illustrates that technology and communications;[32] human resources; information systems and M&E; and service delivery accounted for over half of the total expenditures (59 percent). These outputs are all situated within the central, *supply side* column of the ToC. Also notable is the modest investment in promoting demand, which accounted for just 11 percent of expenditures during the period.

**Table 4: H4+ JPCS Expenditures in US $ by Output Category (2012-2015)[33]**

| H4+ Output Categories | 2012 | 2013 | 2014 | 2015 | Total | % of Total |
|---|---|---|---|---|---|---|
| 1. Leadership and Governance | 100,120 | 143,833 | 329,862 | 281,039 | 854,854 | 10% |
| 2. Financing | 671,172 | 191,778 | 207,223 | 176,551 | 1,246,724 | 14% |
| 3. Technology and Communications | 567,344 | 551,361 | 454,747 | 387,439 | 1,960,891 | 22% |
| 4. Human Resources | 98,265 | 527,389 | 419,634 | 357,523 | 1,402,811 | 16% |
| 5. Information Systems and M&E | 74,163 | 215,750 | 517,925 | 441,266 | 1,249,104 | 14% |
| 6. Service Delivery | 88,995 | 383,556 | 63,219 | 53,862 | 589,632 | 7% |
| 7. Demand | 59,330 | 263,694 | 370,511 | 315,671 | 1,009,206 | 11% |
| 8. Communication and Advocacy | 194,677 | 119,861 | 150,947 | 128,605 | 594,090 | 6% |
| TOTAL US $ | 1,854,066 | 2,397,222 | 2,514,068 | 2,141,956 | 8,907,312 | 100% |

*Source*: UNFPA 2016

[32] Note that Technology and Communications include equipment, drugs and other procurement.

[33] *A note on Sources*: Data on the distribution of H4+ expenditures was coded by the H4+ coordinator in the DRC based on guidelines provided by the global H4+ coordinator at UNFPA headquarters, using source data provided by UNFPA in final annual expenditure reports to Canada.

In part, this reflects the low coverage and relatively late implementation of certain community-based interventions. The relatively small proportion of H4+ expenditures on activities aimed at engaging communities to increased demand raises the question of whether an appropriate balance has been found between improving the quality and availability of supply and creating demand for RMNCAH services, in particular with regard to adolescents and youth.

### 2.5.2 Programme content

The H4+ JPCS aimed to deliver a package of health systems strengthening RMNCAH interventions at health zone and facility levels, combined with policy advice and institutional capacity development at provincial and national levels. Key outputs are presented in the box below:

**Box 2: H4+ Interventions in the DRC 2012-2016**[34]

**At institutional level:**

- ***Technical support and policy advice*** to strengthen RMNCAH integrated policy and health care delivery, including the *CAO 4&5*, the draft reproductive health law, the national strategic plan for family planning, and the PNDS 2016-2020.
- ***Joint advocacy efforts*** leading to the government committing to increase the domestic budget for RMNCAH and create of a budget line for contraceptives. Provincial governments of Bandundu and Bas Congo created budget lines for RMNCAH.
- ***Revision of national RMNCAH norms and standards*** and distribution to all health zones supported by H4+ JPCS funding.
- ***Strengthening coordination of RMNCAH partners and interventions*** through technical support to the organization of national and provincial RMNCH Task Force meetings.
- ***Strengthening national capacity for midwifery and EmONC training*** through support to the revision of the pre-service training curricula for midwives, and development of a competency-based EmONC training module under the leadership of the Ministry of Higher Education and the MoH.
- ***Strengthening of accountability*** through the technical support to the development national MDSR system and national health accounts.

**At operational level**:[35]

- ***Strengthening human resources for RMNCAH*** through training of training of 40 trainers and 365 service providers in competency-based EmONC; 465 service providers in family planning; 86 service providers in management of RMNCH drugs; and 30 trainers and 120 service providers in prevention of mother to child transmission (PMTCT).
- ***Training and equipping community health workers*** (*relais communautaires*) to scale-up health promotion and community-based RMNCAH service delivery, including distribution of *family kits* and referrals to reduce "the three delays".[36]
- ***Provision of equipment and essential maternal and newborn drugs supplies and commodities*** to 15 general referral hospitals and 141 health centres; and distribution of six million condoms in the nine target health zones.
- ***Basic equipment and furniture of a maternity waiting home*** at the General Referral Hospital in Mosango, Bandundu Province.

[34] DRC H4+ Annual Narrative Work Plan 2015-2016

[35] The operational level refers to the provincial (DPS), health zone (ECZ) and health facility levels.

[36] The three delays: delay taking the decision to seek care, delay reaching appropriate care, delayed referral

- ***Provision of EmONC training equipment and materials*** (including mannequins) to several training institutes providing pre- and in-service training in midwifery and EmONC.
- ***Extension and strengthening of referral services*** through the provision of ambulances and motorbikes to extend and strengthen referral services and involvement of community health workers (CHWs) and families to recognise danger signs.
- ***Community mobilisation and demand creation*** through annual family planning campaigns; community radio shows and soap operas; CHW outreach work; celebration of International Day of the Midwife; and involvement of religious leaders, women's and youth clubs.
- ***Provision of youth-friendly sexual and reproductive health services*** and behaviour change communications (BCC) in youth centres and surrounding communities.
- ***Implementation of RBF*** in four health zones to improve the quality of services and the motivation of health facility staff.[37]
- ***Reduction of financial barriers to access*** through support to community-based health schemes and the introduction of flat-rate pricing (*tarification forfaitaire*).
- **Strengthening HMIS and M&E** through the revision and distribution of national data collection tools to health facilities and health zones; support to the organisation of quarterly and annual reviews at the HZ and provincial levels; and capacity development of MoH staff at central level.

**The H4+ members**

All six H4+ members are represented in the DRC and are active beyond their H4+ commitments. UNFPA coordinated the H4+ JPCS until the beginning of 2016, when the coordination role was handed over to the UNAIDS country office. In 2015, the World Food Programme (WFP) joined the H4+ partnership in the DRC, which has led to an increased focus on the importance of integrating nutrition with RMNCAH interventions. Through active participation in H4+ coordination meetings and joint advocacy efforts, WFP has played a pivotal role in bringing nutrition into the RMCNAH policy dialogue. The World Bank participates in the heads of agencies quarterly meetings, but does not play an active role in the coordination or delivery of the H4+ JPCS.

**H4+ JPCS implementing partners**

The H4+ JPCS programme is delivered through a range of implementing partners, including: the Ministry of Public Health, the Ministry of Gender, the Ministry of Higher Education, the National School of Public Health at the University of Kinshasa, the Higher Institute for Medical Techniques (ISTM) of Kinshasa, the Congolese Family Planning Association (ABEF), the Professional Association of Gynaecologist-Obstetricians (SCOGO) and National Union for Midwives. In addition, a number of NGOs and youth centres have been involved in the delivery of H4+ programme activities.

# 3 THEORY OF CHANGE FOR H4+ JPCS IN THE DRC

A detailed overview of the country-level theory of change (ToC) for the H4+ JPCS programme in The DRC is provided in Figure 3 (below). The ToC was tested and validated during the field missions and the analysis phase of the country case study.

The analysis presented in section 4 raises important concerns regarding the relative balance between the three main pillars of the ToC for H4+ in the DRC: in particular, the relative weakness of investments and supported activities intended to increase the capacity of communities to effectively demand quality care in RMNCAH.

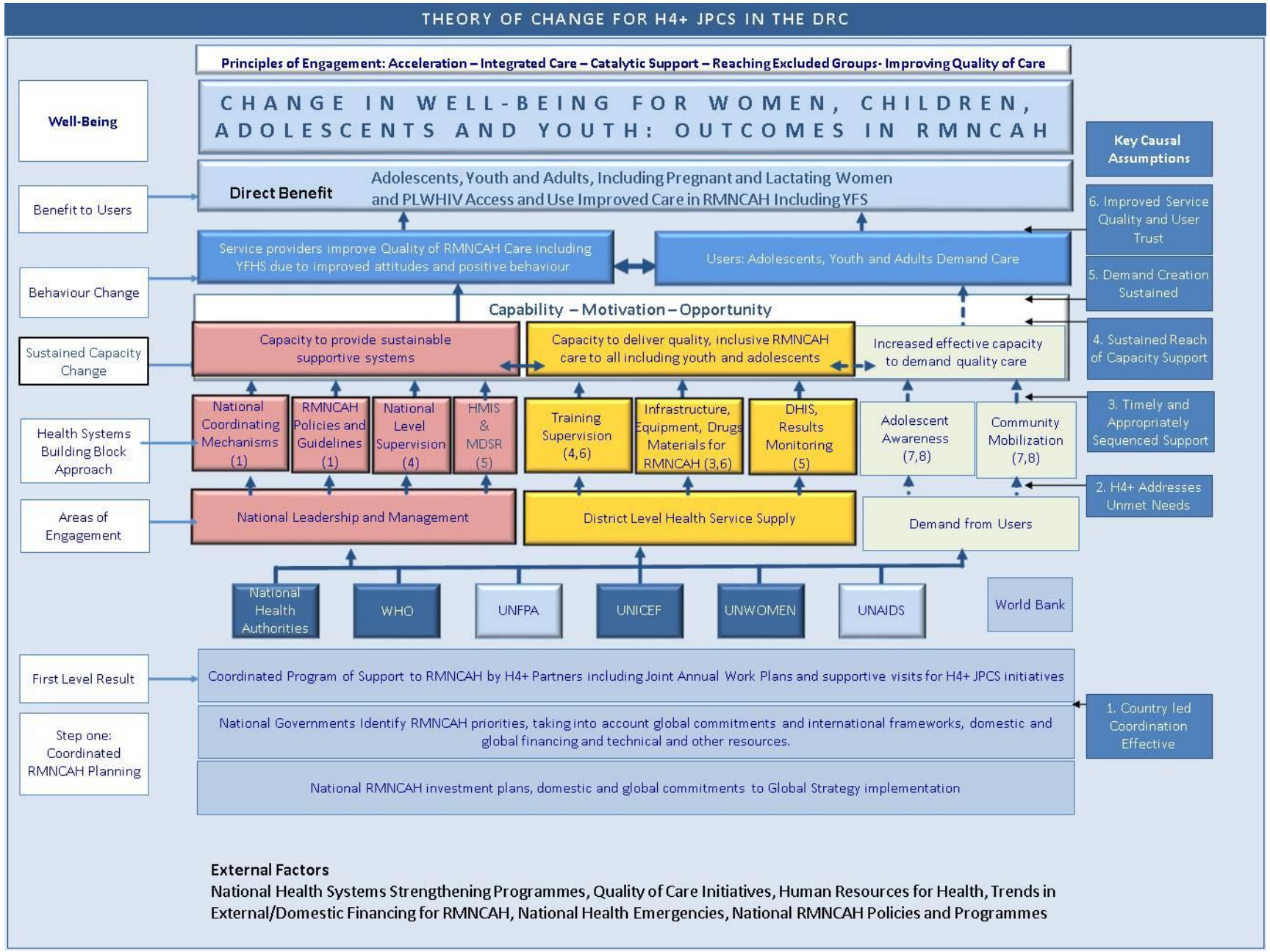
[37] The RBF activities described here were funded by H4+ JPCS.

This is represented graphically in Figure 3 in two different ways. First, the colour of the boxes representing H4+ JPCS investments in national leadership and management (filled in pink) and investments in district level health services supply (filled in yellow) are more intense than the colour of the other boxes. This has also been done for their contribution to immediate results (capacity strengthening at national and district level. In contrast, the colour of boxes representing investments in demand is light, reflecting the relative under-investment in these areas as in terms of both financial investment and the reach and duration of the supported activities. In addition, the three H4+ members who received funding from Canada (UNICEF, UNFPA and WHO) have been highlighted in a darker blue than the other agencies. The World Bank is farther to the right, as it was only minimally involved in coordination and implementation of the H4+ JPCS in the DRC.

In addition, the arrows indicating the direction of causality are solid for investments in national leadership and district level health service delivery and are, in contrast, dashed for investments in generating demand and engaging communities. This is not a direct criticism of the value of the investments in engaging communities and stimulating demand; rather it attempts to illustrate the risk that gains in community engagement may be both limited in scope and fleeting in duration due to factors illustrated in sections 4.1 and 4.2.

For detailed descriptions of the key causal assumptions numbered in the ToC figure, see Annex 6.

**Figure 4: Theory of Change for H4+ JPCS in DRC**



# 4 EVALUATION QUESTIONS AND FINDINGS

This chapter presents the findings of the DRC field country case study organised under the six main evaluation questions for the end line evaluation of the H4+ Joint Programme Canada and Sweden (H4+ JPCS) programme.[38]

All sections of the chapter follow the same structure, beginning with a summary box highlighting the main findings with regard to the evaluation question. This is followed by an analysis of the key causal assumptions identified in the evaluation inception report as they apply to each evaluation question.[39]

Under each evaluation question, the analysis is organised in two parts. In the first part, evaluation data is used to test the validity of the assumption, by answering the question: does the assumption hold and is the theoretical causal link evident? The second part of the analysis builds on this testing of causal assumptions to directly address the evaluation question.

By examining the validity of the causal assumptions informing the theory of change (ToC) as they relate to each evaluation question, the case study allows the evaluators to test the programme theory and to build a credible analysis of the H4+ contributions to key outcomes in DRC.

***Linking Evidence and Findings: The Evaluation Matrix***
The data and information supporting the evidence-based findings presented in this section are provided in detail in the evaluation matrix (Annex 1). The evaluation matrix is organised around the evaluation questions and assumptions.

## 4.1 Strengthening health systems

***Question One**: To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for reproductive maternal neonatal child and adolescent health (RMNCAH), especially by supporting the eight building blocks of health systems?*

### *Summary*

1. H4+ JPCS-supported interventions have addressed important unmet needs for health systems strengthening for RMNCAH through a consultative planning process, which was led by the MoH in the early years. The definition of needs and priorities was based on baseline surveys, national RMNCAH data, and additional studies supported by H4+ JPCS. Programme interventions address several of the health systems strengthening building blocks simultaneously, with a strong focus on developing human resources, governance and leadership, health financing and medicines and technology.
2. H4+ JPCS was designed to be complementary to other health programmes in the nine target HZs as it filled important gaps in RMNCAH which were not covered by these programmes H4+ JPCS supported investments thus augmented the effectiveness of these broader programmes of health systems support, including the government health facility equipment programme PESS, and CTB and JICA funded interventions. For example, the PESS programme supported the renovation and refurbishment of health facilitie, while H4+ JPCS provided RMNCAH specific training and commodities.

[38] In this country note, the term H4+ JPCS is consistently used to distinguish the Canada-funded programme from the wider H4+ partnership. This is particularly important to the DRC country case study, as the H4+ partnership implements several joint programmes with different funding sources.
[39] (UNFPA 2015: 35-49)

3. The evidence indicates that **H4+ JPCS has contributed to improvements in the availability** and to some extent the **quality of RMNCAH services in the nine target HZs**. However, there have also been issues with the duration, adequacy and sequencing of different inputs, such as RMNCAH training materials, equipment, power and water supply, essential drugs and post-training supervision. These shortfalls put the positive gains in quality and trust between service providers and community members at risk.
4. At national level, H4+ JPCS support to RMNCAH policies and strategies, the development of the midwife training programme and the EmONC training module, combined with capacity development of training institutes, are expected to have a lasting legacy. These approaches have already been replicated in other provinces beyond the H4+JPCS target HZs with other funding sources.
5. The evidence is mixed as to whether H4+ JPCS efforts to strengthen the health system for RMNCAH have caused an increase in the use of services. While the available HMIS data show limited progress on key output data, the health facility staff and community members provided a uniform picture of improved quality and utilisation of key RMNCAH services. However, there is indication that these gains are put at risk by the lack of coordination among partners at sub-national level, lack of sustained funding, and weak planning and sequencing of inputs.

### 4.1.1 Testing causal assumptions for health systems strengthening

***Assumption 1.1**: H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify **critical and unserved needs in the eight areas of health systems support for RMNCAH**. The needs in each of the eight areas are not fully met by other sources of support and, importantly, programme support can build on investments and activities underway with national and external sources of financing and support to accelerate action***.

*Unless otherwise noted, for evidence cited in relation to assumption 1.1 see Annex 1, Assumption 1.1*

The H4+ JPCS proposal was developed jointly by the Division for Family Health and Special Groups (D10) and the Department for Planning and Research (DEP) of the Ministry of Health (MoH) with the technical support of WHO, UNFPA, UNICEF and UNAIDS. Under the leadership of the MoH, the main programme priorities were defined through a consultative process involving joint field missions and planning workshops. The World Bank, WFP and UN Women did not participate in the development of the proposal.

The evidence indicates that the target provinces and districts were selected based on the following criteria:

- **Geographic accessibility to facilitate supervision and monitoring:** Key informants consistently pointed to geographic accessibility as the main selection criterion. Given the vast geographic size of DRC and the partially inaccessible areas, it was important to the H4+ team members that they could access the H4+ intervention zones with relative ease to conduct supervision.
- **Presence of H4+ members to foster complementarity and synergies:** Another criterion was the presence of at least two H4+ members in the selected health zone in order to facilitate collaboration and complementarity, and to ensure the sustainability of ongoing activities. For example in Nsele health zone, WHO and UNFPA already implemented a joint project.
- **Presence of other partners to create catalytic effects:** Health zones that already received support from other partners, in terms of equipment and capacity development, were selected so that H4+ support could complement existing activities.

- **Poor RMNCAH indicators:** Also, but less consistently, key informants mentioned that the health zones with poor RMNCAH indicators and the greatest needs in terms of health systems strengthening were selected.[40]

The National Health Development Plan (PNDS) 2011-2015, the demographic and health survey (DHS) 2007, the multiple indicator cluster survey (MICS) 2010 data, and a national emergency obstetric and newborn care (EmONC) baseline survey[41] were used to identify health system gaps and priorities in the three target provinces: *"This data enabled us to identify the characteristics, the priorities and the needs of each region. For example, the high maternal mortality rates in the Bas Congo region show a low quality of EmONC."*[42]

The process of needs identification and selection of health facilities and training institutes to be included in the H4+ JPCS was also supported by several studies and baseline surveys. These were often led by the MoH and the Ministry of Higher Education (School of Public Health) with support of the H4+ members. Examples include:

- A rapid EmONC assessment in H4+ JPCS targeted health zones to collect additional data for the H4+ JPCS baseline indicators (2012)
- A needs assessment of 45 Higher Institute for Medical Techniques (ISTM) (2011)
- A client satisfaction survey assessing the level of satisfaction with RMNCAH services among women of reproductive age (2013)
- A study assessing the availability of essential RMNCAH drugs and services and procurement and supply chain management (PSM) capacity in 63 HZs in eight provinces (2015).[43]

The ongoing process of identifying critical needs and develop appropriate responses was multi-dimensional, involving national, provincial and health zone levels. This question is discussed further in section 4.3.

The most critically important set of RMNCAH needs and responses identified in the original proposal and programme documents, and mentioned repeatedly in interviews, are:

- Strengthened leadership and coordination capacity for RMNCAH at national, provincial and health zone levels
- Improved capacity of training institutes to provide quality pre- and in-service training in specific areas of RMNCAH, especially midwifery, EmONC and family planning
- Increased number of qualified midwives at health facilities
- Improved quality of RMNCAH services through the revision of RMNCAH norms and standards; training and supervision of health providers; and provision of equipment, drugs and supplies
- Innovative health financing mechanisms including RBF (supply-side) and strategies to reduce financial barriers to EmONC (demand-side)
- Strengthened community involvement in health management through community health workers.

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[40] This is based on qualitative information. It has not been possible to compare key RMNCAH indicators in the nine health zones with other health zones, as the DHS only provide information for the provincial level, and the available HMIS data does not allow a reliable calculation of key outcomes.

[41] The national EmONC baseline survey assessed the availability and quality of RMNCAH services and interventions, covering 97% of all HZs and 89% of all health facilities (2012).

[42] (H4+ Country Team 2012e: 15)

[43] The references for these studies are included in the matrix under assumption 1.1.

The H4+ JPCS addressed these gaps through appropriate responses that were aligned to the PNDS 2011-2015 and the strategic interventions of the RMNCAH roadmap (CAO 4&5). Priority investments touched on most of the WHO health systems strengthening building blocks, with a particular focus on strengthening pre- and in-service RMNCAH training (*human resources for health*); strengthening the facility environment through provision of equipment and drugs (*medical products, vaccines and technologies*); strengthening management capacity at all levels (*leadership and governance*); and reducing financial barriers to access (*health financing*).

***Assumption 1.2**:* H4+ JPCS support to sub-national level funded activities capable of ***complementing other investments*** *and contributing to strengthening service delivery in RMNCAH*. The funded activities are *matched with support to health systems strengthening provided by other programmes and sources*.

*Unless otherwise noted, for evidence cited in relation to assumption 1.2 see Annex 1, Assumption 1.2*

There is a consensus among key stakeholders that the H4+ country team made significant efforts to design complementary interventions that could build on and strengthen other RMNCAH and health systems strengthening (HSS) investments in the three H4+ JPCS target provinces. The original JPCS proposal contains a mapping of other RMNCAH partners in the nine targeted health zones and outlines how H4+ JPCS will be complementary to those investments. A similar mapping is provided in the 2015-2016 workplan. In 2015, the H4+ members also participated in a broader mapping exercise of RMNCAH interventions in the DRC through the Development Partners' Health Forum (GIBS), which included the H4+ JPCS target zones.

These efforts to coordinate with other partners were most explicit at the national level. For example, H4+ JPCS interventions were regularly discussed and coordinated through the national health sector coordinating committee sub-commission for service delivery (CNP-SS) and the GIBS. Key informants also noted that CAO 4&5 provided a strong platform for aligning H4+ JPCS investments with government priorities and others RMNCAH programmes: "*It is important to link H4+ activities with other interventions carried out in the country. As part of the engagement process of the CAO 4&5 collaborative partners, a strategic analysis for the ongoing initiatives was conducted. This analysis revealed the gaps, and thus allowed a better positioning of the H4+ initiative within other funded initiatives (interventions).*"[44] A review of the CAO4&5 framework document confirms that a detailed situation and gap analysis had been undertaken, and that the strategies proposed in the CAO4&5 responded directly to the identified gaps and needs. H4+ JCPS activities in 2013 and onwards, as described in annual work plans and reports, were closely aligned with the strategies and interventions proposed in the CAO 4&5. For example, the family kit approach falls under one of the key strategies of the CAO 4&5. The Director of the Family Health Division of the MoH also stated that the process of developing and adopting the CAO 4&5 as the national policy framework and road map for RMNCAH had enabled them to better align RMNCAH partners to national priorities.

At the operational level, the evidence regarding improved coordination and complementary is mixed. On the positive side, H4+ members made efforts to coordinate support with other partners in the nine H4+ JPCS health zones, especially during the design and planning phases, to ensure complementarity among the different RMNCAH interventions: *"In the 9 targeted zones, H4+ interventions complement other interventions supported by Global Fund (supply in malaria and HIV medicines), GAVI (vaccines' supply) and the government (concerning mainly the activities of construction/ renovation; and provision of medical equipment)".*[45] For example, in Kenge health zone, H4+ JPCS and KOICA held consultative meetings to jointly identify RMNCAH gaps and plan activities. In Nsele, H4+ JPCS investments in capacity development are seen as complementary to

[44] (H4+ Canada 2015: 26)
[45] (H4+ Country Team 2015b: 3)

other partners' support to performance incentives, rehabilitation and construction.[46] Likewise, the health zone team in Mosango highlighted that H4+ JPCS activities were catalytic in the sense that they made the general health systems support provided by MEMISA, Japan and the Belgian Technical Cooperation more efficient as it added important inputs necessary for RMNCAH service delivery, which would otherwise not have been possible without H4+ JPCS funding. For example, in 2012 H4+ JPCS refurbished the maternity waiting home which had been built with funds from the Embassy of Japan in 2011.

Key informants also highlighted the complementary between the H4+ investments and the government health facility equipment project (PESS), which is implemented with logistical support from UNICEF. While PESS supported general construction, renovation and provision of a standard package of equipment (e.g. hospital beds), the H4+ JPCS complemented with RMNCAH specific equipment (e.g. delivery tables which had not been provided by PESS), drugs, and training courses, and thus helped improve the effectiveness of PESS investments. The fact that UNICEF was represented on the PESS planning committee facilitated the coordination of H4+ JPCS investments and PESS, including the joint selection of health centres and hospital to benefit from the support of both programmes. Some initial difficulties in distributing the equipment to health facilities were noted, although this was reportedly quickly solved.

H4+ JPCS funds were also complementary to the H4+ partners' other funding sources. For example, UNICEF and UNFPA used their own core funds to procure essential medicines, condoms and contraceptives, which were distributed to the H4+ JPCS-supported health zones. WHO supported integration of HIV in RMNCAH services with USAID funding, and RMNCH Trust Fund grants were used to increase demand and access to the thirteen essential RMNCAH drugs and to scale-up the delivery of *family kits*[47] to additional health zones. H4+ JPCS supported training of service providers in EmONC, family planning, IMNCI and management of RMNCAH drugs are seen as complementary to these other investments.

According to H4+ members, the fact that both the RMNCH Trust Fund grants and H4+ JPCS were managed jointly by UNFPA, UNICEF and WHO, facilitated the coordination of inputs. As stated by one H4+ country team member: *"Apart from the Canada funds, H4+ agencies also had funding from France Muskoka (implemented in Province Orientale) and from RMNCH Trust Funds implemented in Bandundu, Bas Congo, North Kivu, Katanga and Equateur provinces. These other funds came to complement and help scale up H4+ interventions to other provinces beyond the nine health zones funded by Canada."* There is strong evidence that the results produced by key H4+ JPCS interventions, including the competency based EmONC training course, the midwife training programme, and the family kit approach, have helped the government mobilise additional funds for their expansion to other provinces.

When initiatives supported by H4+ are designed and implemented not only to avoid duplicating or overlapping with other programmes, but also to enhance their effectiveness by adding missing (and complementary) elements, those elements, in turn, render other programmes more effective. In that sense, H4+ supported actions exhibit a catalytic as well as a complementary nature. At the same time, this leverage has made it somewhat more difficult to isolate the specific contribution made by the H4+ JPCS to end results. For example, WHO and UNFPA used both the RMNCH Trust Fund and H4+ JPCS funds to support the establishment of the maternal death surveillance and response system

[46] It should be noted here that the World Bank-funded health sector rehabilitation support project (PARSS) supported results-based financing (RBF) in Bandundu province, but did not target any of the H4+ JCPS-supported health zones(MoH 2013d: 6). The follow-on project, PDSS, will cover at least some of the H4+ JPCS HZs to sustain the RBF activities initiated with H4+ JPCS funds in Bandundu province.

[47] The *family kit* is explained under assumption 1.4.

(MDSR) and procure *family kits.* This should not, however, be seen as a weakness of the programme design, but rather as a methodological limitation (as described in the methodology section above)

However, there is also indication that the intentions to ensure complementarity were not fully put into practice and that coordination between H4+ JPCS and other partners was much less efficient during actual programme implementation, particularly with regard to the planning, sequencing and delivery of different inputs at the operational level. This puts into question whether the strong intentions of being complementary and thus increasing the effectiveness of other RMNCAH and health systems strengthening programmes (as described above), were put fully into practice at health zone and health facility level. These challenges in coordination will be discussed in detail under Assumption 1.4 and 2.5.

***Assumption 1.3:*** *RMNCAH managers and service providers trained with support from H4+ JPCS realise* ***intended gains in competence and skills****. These gains in skills and competencies are* ***tested and verified during and after training.***

*Unless otherwise noted, for evidence cited in relation to assumption 1.3 see Annex 1, Assumption 1.3*

The H4+ JPCS invested a significant share of its resources in capacity development of human resources through support to pre- and in-service trainings. Key interventions noted during interviews include:

- Support to the Ministry of Higher Education to establish a three-year midwives training programme at the higher institutes of medical training (ISTMs), with direct entrance after the bachelor degree[48]
- Development of a programme to upgrade nurses with a specialisation in midwifery (*'accoucheuses'*) to full midwives
- Development of a national EmONC competency-based training curricula using mannequins for in-service training of doctors, nurses and midwives[49]
- Training of trainers for the teachers at ISTMs and internship-supervisors at health facilities
- Establishment of national and provincial pools of EmONC trainers
- Provision of training equipment and materials to the ISTMs and the Faculty of Medicine of University of Kinshasa
- Production and distribution of the new midwife training curriculum and modules to 30 ISTMs
- Training of health facility staff and health zone teams in basic emergency maternal, obstetric and neonatal care (BEmONC) and EmONC, family planning, prevention of mother to child transmission (PTMCT), rational drug use and stock management, and blood transfusion.

Training reports and post-training supervision reports indicate that H4+ has supported efforts to assess the effectiveness of EmONC and family planning training courses. Pre- and post-tests were consistently included in all trainings to evaluate the participants' gains in knowledge and

[48] Prior to this revision of the midwife programme, it was necessary to have gone through the four-year nursing school and have two years of working experience before admittance to the midwife training.

[49] The MoH and the Ministry of Higher Education credit the NFPA H4+ coordinator's continuous support and advocacy efforts for the relatively fast development and adoption of the national 3-year midwife programme. H4+ JPCS funds were used to finance all activities related to the development of the programme, while other partners (such as ICAP) collaborated with the H4+ JCPS team and contributed technically.

competencies.[50] In 2012 and 2015, the Provincial Health Department (DPS) of Bandundu organised post-training supervision visits to observe the trainees practicing EmONC skills in the maternity wards and provide supportive supervision. However, consistent feedback from training institutes and health facility staff suggest that post-training supervision most often did not take place. They confirmed that the health zone teams conduct routine supervisions, but that these are based on a standard check-list and not specifically focused on EmONC.

Recognising the need to strengthen post-training follow-up and supervision, H4+ JCPS provided funds to the Provincial Health Departments and the regional pools of EmNC trainers in 2015 to organise supervision visits that focused specifically on EmONC. The available EmONC training and supervision reports are not uniformly positive. They often note both gains in skills and competence and some deficiencies. Some of the most important areas where gains in skills and competencies were noted in the supervision reports and confirmed by health providers include:

- Use of the partograph
- New caesarean techniques
- Active management of the third phase of labour, including management of post-partum haemorrhages
- Management of eclampsia, shock and neonatal infections
- Patient-centred antenatal consultations
- Improved attitudes towards women in labour.

Staff members at the visited health facilities and training centres felt that the EmONC training had improved their skills and competencies. They reported examples of how they had been able to save the lives of women after having been trained in EmONC. The training institutes stated that both the teachers and students were highly satisfied with the competency-based and practical training and noted improvement of skills of the students. Further, focus group discussions with a variety of community groups pointed to higher degrees of satisfaction with the quality of services and outcomes for women and children. While this represents self-reported perceptions of quality improvements, supervision and training reports provide additional sources of information with regard to observed quality imrovements.

The deficiencies, as reported those reports and observed during the evaluation field mission, are mostly related to incorrect use of the partograph (which was also mentioned as a positive gain, indicating that there is still room for improvement), newborn intensive care (using old practices), and lack of respect of the timing of antenatal visits.

To summarise, the evidence regarding skills improvement is mixed. While supervision reports point to some weaknesses and gaps, they also state that there have been significant improvement in skills and in quality of services as a result of the EmONC training, equipement and supplies. This positive view was confirmed both my health care providers and community members. There is sufficient evidence that H4+ JPCS clearly contributed to improve the availability and, to some extent, the quality of key RMNCAH services. These quality improvements should be seen in the light of the very low starting point: the 2012 EmONC survey revealed that EmONC services were practically non-existant in many health facilities across the country, and the quality improvemens as a result of H4+ JPCS support were therefore perceived as “signiciant improvement” as compared to “before” by both community members and health workers.

[50] The competencies verified during the training tests, internships and the post-supervision visits included: the ABCD scheme, maternal and neonatal intensive care, delivery assisted by vacuum extractor, retained placenta, umbilical cord prolapse, pre-eclampsia and eclampsia, and post-abortion care.

***Assumption 1.4:*** *Capacity development efforts in RMNCAH are supported with* ***well-sequenced supervision and required equipment, supplies and incentives*** *to allow service providers the ability, opportunity and motivation to improve service quality and access.*

*Unless otherwise noted, for evidence cited in relation to assumption 1.4 see Annex 1, Assumption 1.4*

In order to make use of the skills acquired or revived during training or through clinical mentoring, health facility staff need proper equipment, reasonable infrastructure, adequate essential medical supplies and supervision. They also need an incentive structure that keeps them in place and motivated to provide quality care. This section will analyse the appropriateness and sequencing of the required equipment, medicines and commodities.

The H4+ JPCS supplied 141 health facilities, 15 hospitals, and seven training institutes with equipment and materials, essential drugs and supplies for RMNCAH. The most critical medicines provided to health facilities on a regular basis were oxytocin, magnesium sulphate, and misoprostol. UNFPA supplied condoms and contraceptives with own core funding. Equipment and materials included delivery beds, midwife kits, caesarean kits, obstetric fistula kits, delivery boxes, and three ambulances (delivered to Mosango, Kenge, Bandundu and Nzanza health zones). Mannequins and other didactic material were given to higher training institutes. Within the framework of the CAO 4&5, H4+ JPCS also supported the introduction of the *family kit* approach with technical support from UNICEF, which includes: (1) distribution of ORS/Zinc, Paracetamol, and micronutrients to households to enable families to treat diarrhoea, fever, and malnutrition; (2) distribution of "delivery kits" to pregnant women; and (3) distribution of amoxicillin to health centres to treat children with pneumonia.[51] The family kit approach was initiated, developed and piloted with H4+ JPCS funds in 2013 and 2013. To ensure its adoption and scale-up at national level, the approach was integrated into the CAO 4&5 as a key recommended intervention to operationalise the strategies of the plan. This enabled the government and the H4+ partners to raise additional funds: The second and the third grant under the RMNCAH trust fund specifically focuses on scaling-up the family kit approach. The fact that the approach was included in the national RMNCAH road map (the CAO 4&5) and additional funds were raised will help ensure its institutional and financial sustainability beyond the H4+ JCPS.

Despite these significant investments, there is indication that important EmONC equipment, materials and drugs were either missing, inadequate or delayed. Based on interviews and observations at eleven health facilities visited by the evaluation team, it was found that 70 percent of the facilities had experienced frequent stockouts of essential drugs, including magnesium sulphate, newborn and ampicillin antibiotics, calcium gluconate, contraceptives (implants), and HIV test kits. The site visits also revealed that syringes for manual vacuum aspiration; protective clothing; colposcopies; suction cups; and aspirators were missing in nearly all facilities. Moreover, lack of electricity and running water was observed in several places. Only two out of three heath zones had an operational ambulance, and the motor-ambulance delivered by MEMISA (Belgian NGO) in Mosango was inappropriate for the difficult terrain which required fording rivers to reach certain areas. Until recently, the hospital in Mbanza-Ngungu charged patients a user fee for the ambulance due to lack of funds to pay for fuel for the ambulance delivered by H4+ JPCS. It was also observed that health facilities lacked capacity for maintenance of equipment which put the quality of services at risk (e.g. broken machines or delivery tables). EmONC training reports and interviews indicate that equipment and materials necessary for EmONC training were not delivered on time or in insufficient quantity, and that the recommended number of trainer-supervisors per practical session did not correspond to the national norms.

[51] See vocabulary of medical terms used in Annex 2

Document reviews and interviews consistently point to two main reasons for these sequencing issues: (1) lack of coordination of the timing of input provision among H4+ members and other partners supporting RMNCAH at the health zone level; and (2) a difficult enabling environment caused by structural health system challenges.

***1. Poor coordination of delivery of inputs to RMNCAH***

With regard to the problems in coordinating the delivery of inputs, one director of the provincial heath department noted that: *"The greatest challenge was to ensure the coordination of different [H4+ JCPS] interventions. Despite synergy in providing support, the inputs were not provided simultaneously by the different H4+ partners. There was a lag time between the training and the provision of materials and other supplies (…). There is a lack of good coordination at their [H4+ members] level.*" For example, in Mosango, the Global Fund principal recipient SANRU (NGO) delivered condoms although the health zone had already received a stock from UNFPA, which led to a surplus. The health zone team feel a pressure from the partners to receive whatever commodities they deliver. There is also indication of several issues in coordinating the delivery of equipment. For example, H4+ team members noted that the first provision of equipment in 2012 by H4+ JCPS was based on a "standardised UNICEF package", while important EmONC equipment and materials were missing. This was reportedly corrected in subsequent procurements by UNICEF and UNFPA. A review meeting in Bas Kongo Province in October 2012 confirms this tendency: *"Even if we have received the medicines and supplies, and they are available at the UNICEF stock in Matadi, some lots of medical supplies still have not been distributed by UNICEF. A harmonisation meeting among partners to agree to the modalities for developing a distribution plan revealed that the stock was incomplete (…). In the field, there is a crying need for delivery tables, baby and adult scales, and ultrasound equipment."*

***2. The weak enabling environment for health system performance***

The procurement and supply-chain management (PSM) system[52] in the DRC is extremely weak despite significant investments to strengthen its performance. It is based on a push rather than a pull system, and health zone teams and health facility staff lack basic PSM skills. A joint field mission undertaken by the World Bank, UNICEF and the Global Fund in 2014 indicates that there are significant overlaps and duplication in the provision of drugs and supplies and incentives (staff bonuses) at health facility level.

Another hindering contextual factor is the limited and poor state of many health facilities. Supervision reports, interviews with health providers, and observations made during the site visits indicate that some health facilities do not correspond to national norms, and have limited space to receive the increased number of women seeking services as a result of H4+ supported demand creation efforts.

Finally, the ongoing reform of the public health sector with the creation of 26 new provincial health departments (DPSs) in 2014 and 2015 has negatively affected the ability of newly created DPSs to manage and supervise health service delivery in their province and in the health zones. Some DPSs still lack human resources, infrastructure and equipment to function.

With regard to incentives, H4+ JPCS supported the introduction of RBF in Mosango, Kenge, Matadi and Nzanza HZs to provide financial incentives to the health zone teams, health facility staff and community health workers (CHWs) to improve RMNCAH service delivery. The RBF was implemented relatively late (2015), and only for a short period of time, and thus was not very well sequenced with the other inputs. This point will be discussed further under assumption 2.2.

[52] The national PSM system in the DRC is called *SNAME: Système National d'Approvisionnement en Médicaments Essentiel*

In summary, while care was taken in *planning and design* to ensure that H4+ JPCS was supporting inputs that were needed and complementary to investments by other programmes, in many cases this level of coordination did not extend to the timing and sequencing of the *delivery* of those inputs at the operational level.

Despite these significant challenges in provision and sequencing of different inputs, interviews with EmONC trainers, health zone teams, health facility staff and community members provided a uniform picture that the availability of drugs, equipment and materials has led to improved quality of EmonC training sessions and access to RMNCAH services. For the most part, interviewed health staff confirmed that equipment and supplies were provided by H4+ JPCS close enough to the training to avoid any major disruption of EmONC services. Training institutes and general referral hospitals highlighted that the new competency-based EmONC training course (using mannequins) had significantly improved the skills of students and interns as they were based on practice on mannequins rather than theoretical courses. Despite the poor state of many health facilities, site visits in Mosango and Mbanza-Ngungu provided examples of significant improvements in infrastructure when compared to their earlier reported state. These improvements came about as a result of the government PESS programme and other partners supporting efforts to renovate, refurbished and equipped many of the health facilities supported by H4+ JPCS.

***Assumption 1.5**: The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is **sufficient to produce a notable increase in the use of services and to overcome barriers to access which existed in the past**.*

*Unless otherwise noted, for evidence cited in relation to assumption 1.5 see Annex 1, Assumption 1.5*

A review of the available health management information system (HMIS) output data reported by the health zone teams and validated by the provincial health teams in the nine HZs supported by H4+ JPCS shows very mixed results with regard to increased usage, as shown in Table 5.

**Table 5: Output data on selected RMNCH services in the nine H4+ JPCS health zones (2011-2015)**

| Province | District | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| **Percentage of pregnant women who attend first antenatal consultation (CNP1)** | | | | | | |
| Kinshasa | Nsele | 94 | 72 | 129 | 93 | |
| | Mbinza Ozone | 69 | 59 | 69 | 60 | |
| | Mont Ngafula 2 | 87 | 61 | 61 | 90 | |
| Kongo Central | Matadi | 87 | 98 | 90 | 95 | 89 |
| | Nzanza | 47 | 54 | 55 | 68 | 49 |
| | Mbanza Ngungu | 112 | 102 | 112 | 114 | 109 |
| Bandundu | Kenge | 103 | 96 | 96 | 99 | 96 |
| | Mosango | 87 | 77 | 97 | 84 | 97 |
| | Bandundu | 111 | 82 | 93 | 72 | 82 |
| **Percentage of pregnant women who attend four antenatal consultations (CPN4)** | | | | | | |
| Kinshasa | Nsele | 33 | 52 | 25 | 62 | |
| | Mbinza Ozone | 15 | 30 | 18 | 23 | |
| | Mont Ngafula 2 | 21 | 39 | 17 | 46 | |
| Kongo Central | Matadi | 26 | 36 | 26 | 30 | 38 |
| | Nzanza | 27 | 25 | 30 | 42 | 37 |
| | Mbanza Ngungu | 75 | 56 | 21 | 37 | 41 |
| Bandundu | Kenge | | | | 26 | 32 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Mosango | | | | 25 | 40 |
| | Bandundu | | | | 35 | 29 |
| **Percentage of assisted deliveries** | | | | | | |
| Kinshasa | Nsele | 109 | 112 | 103 | 78 | |
| | Mbinza Ozone | 49 | 55 | 41 | 43 | |
| | Mont Ngafula 2 | 33 | 49 | 65 | 64 | |
| Kongo Central | Matadi | 89 | 106 | 84 | 86 | 91 |
| | Nzanza | 56 | 56 | 60 | 69 | 49 |
| | Mbanza Ngungu | 107 | 101 | 100 | 99 | 110 |
| Bandundu | Kenge | 71 | 36 | 63 | 75 | 91 |
| | Mosango | 94 | 84 | 98 | 83 | 90 |
| | Bandundu | 96 | 74 | 81 | 68 | 81 |
| **Number of caesareans** | | | | | | |
| Kinshasa | Nsele | 0 | 1 | | 1 | |
| | Mbinza Ozone | 6 | 0 | | 7 | |
| | Mont Ngafula 2 | 2 | 0 | | 1 | |
| Kongo Central | Matadi | 9 | 12 | 10 | 13 | 12 |
| | Nzanza | 8 | 8 | 9 | 7 | 7 |
| | Mbanza Ngungu | 6 | 7 | 5 | 6 | 6 |
| Bandundu | Kenge | 1 | 4 | 1 | 0 | 1 |
| | Mosango | 2 | 2 | 5 | 4 | 5 |
| | Bandundu | 4 | 6 | 4 | 4 | 5 |
| **Percentage of pregnant women attending postnatal consultation (CPoN3)** | | | | | | |
| Kinshasa | Nsele | 67 | 83 | 93 | 85 | |
| | Mbinza Ozone | 76 | 82 | 77 | 66 | |
| | Mont Ngafula 2 | 68 | 43 | 81 | 46 | |
| Kongo Central | Matadi | 37 | 40 | 49 | 55 | 56 |
| | Nzanza | 76 | 84 | 76 | 43 | 46 |
| | Mbanza Ngungu | 80 | 88 | 48 | 40 | 57 |
| Bandundu | Kenge | 84 | 63 | 63 | 41 | 73 |
| | Mosango | 82 | 98 | 51 | 74 | 63 |
| | Bandundu | 70 | 67 | 67 | 65 | 60 |
| **Percentage of pregnant women tested for HIV during antenatal consultations** | | | | | | |
| Kinshasa | Nsele | 31 | | 81 | 0 | |
| | Mbinza Ozone | 34 | | 42 | 0 | |
| | Mont Ngafula 2 | 13 | | 13 | 0 | |
| Kongo Central | Matadi | 41 | 60 | 43 | 54 | 54 |
| | Nzanza | 48 | 42 | 73 | 55 | 56 |
| | Mbanza Ngungu | 27 | 35 | 63 | 72 | 84 |
| Bandundu | Kenge | 100 | | | 2 | 0 |
| | Mosango | 23 | 0 | | 24 | 34 |
| | Bandundu | 13 | | | 23 | 38 |
| **Percentage of HIV positive pregnant women on ARV** | | | | | | |
| Kinshasa | Nsele | 100 | | 0 | 100 | |
| | Mbinza Ozone | 86 | | 79 | 21 | |
| | Mont Ngafula 2 | 100 | | 5 | 11 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Kongo Central | Matadi | 63 | 67 | 79 | 66 | 61 |
| | Nzanza | 48 | 100 | 59 | 51 | 59 |
| | Mbanza Ngungu | 78 | 82 | 40 | 50 | 100 |
| Bandundu | Kenge | 0 | | | 0 | |
| | Mosango | 4 | 4 | 2 | 0 | 2 |
| | Bandundu | 33 | | | 0 | |

*Source:* H4+ JPCS M&E framework 2011-2015
*Note:* The reason some numbers are above 100 per cent is that there is an issue with denominator in the DRC, as the last census is very outdated. Another reason is that, reportedly, many parients from neighbouring health zones seek services in H4+ health zones (H4+ member).

Overall, the progress towards key RMNCAH indicators has been limited, although some improvements can be seen in the attendance of four antenatal visits, and in the percentage of pregnant women who are tested for HIV during antenatal consultations. These positive trends are seen in over half of the targeted health zones. However, there has been a decline in the percentage of HIV positive pregnant women on ARV in three health zones; and the attendance of the first antenatal care and postnatal care visits has dropped significantly in eight out of nine health zones.

These numbers should be interpreted with caution and seen against the backdrop of the evidence collected in the health zones visited during the field mission. Health zone teams, service providers and community members provided a uniform picture hat H4+ JPCS support to improvements in the availability and quality of services and community involvement have contributed to increased use of RMNCAH services. In particular, community members highlighted the distribution of family kits (including vouchers and essential medicines for home-based IMCI care) by community health workers, improved referral system, and the availability qualified service providers as main factors leading to increased use of services (the perspective of health facility staff and community members is discussed under assumption 2.4 below).

### 4.1.2 Contributing to health systems strengthening for RMNCAH in the DRC

It is clear from the analysis of causal assumptions relating to evaluation question one that H4+ JPCS has been able to:

- Develop a common view, in consultation with key stakeholders, of the most critical needs for health systems strengthening for RMNCAH
- Design and plan interventions which aimed to complement existing programmes at national and health zone level with their own, substantial, sources of funding
- Provide support for the delivery of a comprehensive programme which contributed to improve the availability and quality of EmONC and other RMNCAH services.

Despite these positive developments, there are examples of poorly sequenced, coordinated or insufficient investments in service availability and quality improvements. These gaps and weaknesses in programme delivery may have reduced the potential gains in quality of services provided as a result of H4+ support, for example in instances when equipment, materials and drugs were not readily available or in sufficient quantities, or when trained staff were not regularly supervised or mentored to sustain the gains in skills and competencies. These issues could likely have been prevented by the H4+ country team through more careful planning, procurement and timing of the various inputs. At the same time, the enabling environment remains a major constraint to the development of better services. This is particularly true with regard to the fragmented PSM system, the uneven course of ongoing health sector reform, and poor infrastructure for electricity and water supply.

***Developing a common view of critical needs for health systems support***
There is clear evidence that the H4+JPCS responded to well documented needs for RMNCAH health systems support. The programmatic responses fell under all eight outputs of the H4+ JPCS, with priority given to human resources, governance and leadership, health financing, and medicines and technology. There is a broad consensus that the initial definition of needs and priorities took place through a consultative process led by the Division for Family Health (D10) and Department for Planning and Research (DEP) of the MoH with technical support from UNFPA, UNICEF, WHO and UNAIDS.

Development of the programme proposal was informed by existing health policies and strategies, national outcome data, and an EmONC baseline study. Several baseline and quantitative studies were also undertaken from 2011 to 2015 to ensure that H4+ JPCS programme interventions responded to real needs of the health zones and the communities they serve. The studies were primarily led by the MoH and the School of Public Health of University of Kinshasa, which helped build stronger awareness and ownership of the growing body of evidence about RMNCAH health system gaps and needs. These studies informed the development of the CAO 4&5 and other RMNCH programmes.

The fact that H4+ members had already established a working relationship to the advent of H4+ JPCS facilitated the development of a common view of the strategic direction for the H4+ JPCS. For example, they had already conducted joint field missions in 2009-2010 with the MoH, and developed a joint proposal (which was, however, not funded). There was already a national dialogue on RMNCAH needs in which H4+ partners took an active part. This facilitated a fast launch of the H4+ JPCS implementation in 2012.

***Catalytic interventions building on existing or planned interventions and sources of funding***
The H4+ JPCS interventions were designed to be catalytic by complementing the support provided by other RMNCAH programmes at national and health zone levels. The selection of H4+ JPCS target zones was based on the opportunity to build on existing or planned investments, particularly the government PESS programme and other funding streams of the H4+ members. For example, H4+ JPCS delivered additional RMNCAH equipment which was not provided under the “standard package” of the PESS, thus demonstrating flexibility in responding to local needs.

The catalytic nature of the JPCS was further strengthened in 2014 when UNICEF, UNFPA and WHO received additional funding from RMNCH Trust Fund to implement RMNCH activities that are complementary to the H4+ JPCS investments in the three target provinces. The H4+ team was thus able to leverage the investments made by the H4+ JPCS. Other interventions which have had catalytic effects at national level include the establishment of a MDSR system, the revision of the national miwife training programme which is gradually being integrated by all higher institutes for medical training (ISTM) nationwise, and the EmONC training curriculum used by other partners.

***Sufficient reach and duration to contribute to lasting change***
The H4+ programme has been delivered over a period of approximately four and a half years (2012-2016), although there is indication that some activities slowed significantly in 2015 (see section 2.4). Key approaches to strengthen national capacity to deliver quality RMNCAH services were developed and implemented already in 2012 and 2013. This provided a fairly long period for achieving results and contributing to health systems strengthening for RMNCAH. Significant investments were made in the development of national guidelines; capacity development of training institutes and health facility staff; and provision of RMNCAH equipment, drugs and supplies from 2012 and onwards.

These achievements helped improve the availability and access to RMNCAH services already in 2012-2013, as the number of health facilities that provided quality EmONC, integrated management of newborn and childhood illnesses (IMNCI) and family planning services in the nine H4+ health zones

increased as a result of training and equipment, materials and essential drugs for RMNCAH services. However, there were flaws in the design and delivery of the support and sequencing of different inputs.

***Demonstrating approaches that can have an effect beyond the H4+ JPCS health zones***
The question of how innovative approaches supported by H4+ JPCS have been taken to scale in the DRC is primarily discussed under assumption 4.4. This section focuses on how H4+ JCPCS in the DRC has made a contribution beyond the boundaries of the target health zones.

The contribution of H4+ JPCS to changes at national level was an explicit priority from the beginning of the programme. In particular, the development of national RMNCAH norms, protocols and training modules, combined with capacity development of training institutions to provide EmONC and midwifery training and the MDSR system, can be expected to have lasting legacy and positive effects on the health system for RMNCAH in DRC. The shift from a theoretical to a competency-based training methodology for EMoNC at the Faculty of Medicine and several ISTM and the creation of national and regional pools of trainers, are expected to be sustained beyond the H4+ JPCS. There are already several examples of the government and other partners using the national EmONC modules and pools of trainers to extend training sessions to other provinces. It is an example of how H4+ JPCS funds supported an intervention which could leverage additional funding sources for RMNCAH. Another example of an intervention applied at national level is the family kit approach which has been has been included in the national CAO 4&5.

In summary, the evidence reviewed suggests that the results of the H4+ JPCS health systems strengthening investments in DRC have been mixed. Stakeholders at all levels, from central to community level, confirmed that the H4+ support to the provision of training, equipment, drugs and commodities has improved the availability and quality of RHMCAH services at health facility and community level. The most significant contributions to health systems strengthening for RMNCAH consistently mentioned by key informants include: (1) the institutionalisation of EmONC training and a direct-entry midwife education programme at national and provincial levels; (2) the family kit approach (i.e. as a strategy to address health financing and access to live-saving commodities which was included in national policy after a pilot phase); (3) the subsidised flat-rate pricing system; and (4) the improved referral system at health zone level (see the following section for a more in-depth discussion of these approaches). However, there were several challenges in programme delivery, including timing, sequencing, duration and coverage of certain activities, questioning whether the improvements in RMNCAH service delivery achieved by H4+ JCPS can be sustained over time.

## 4.2 Expanded access to integrated care

***Question Two**: To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality?*

### *Summary*

1. H4+ JPCS supported several interventions that aim to remove financial and geographic barriers to access RMNCAH services among vulnerable populations. While there is strong evidence that the combination of family kits, subsidised flat-rate pricing for RMNCAH services, and investments in the referral system have improved access among vulnerable population in some areas, there were issues with coverage, duration and effectiveness of some interventions.
2. H4+ JPCS interventions were instrumental in increasing the availability of EmONC and Integrated Management of Newborn and Childhood Illnesses **(**IMNCI) services at health

facility and community level. However, the evidence with regard to quality improvements is mixed: service providers and users repeatedly noted that the quality of RMNCAH services has improved as a result of H4+ JPCS investments, while supervision reports and a review of output data provide a more mixed picture with regard to quality and increased use of services.

3. While H4+ JPCS has provided substantial and consistent support to strengthen the supply side of RMNCAH across the five years of implementation, most activities to promote demand were only implemented towards the end of the programme cycle. An important exception to this imbalance between supply and demand-side interventions is the family kit approach and involvement of community health workers in community-based IMNCI and the referral system.
4. H4+ JCPS did not have any unified strategy for targeting adolescents and youth with a comprehensive and evidence-based package of RMNCAH interventions, and thus missed an important opportunity to engage adolescents and youth at a large scale. Rather, H4+ members implemented one-off campaigns and activities, and there is no evidence that H4+ JPCS made efforts to build the capacity of youth leaders, youth associations and service providers to increase access to RMNCAH services.

### 4.2.1 Testing causal assumptions for expanding access to integrated care

***Assumption 2.1:*** *H4+ JPCS-supported initiatives are* ***targeted to increasing access for marginalised group members*** *(rural poor women, families in geographically isolated areas, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disabilities, indigenous people).*

*Unless otherwise noted, for evidence cited in relation to assumption 2.1 see Annex 1, Assumption 2.1*

The original H4+ JPCS proposal defines women and young girls as primary target group for H4+ JPCS. It also states that men and boys will be involved in the promotion of RMNCAH and prevention of GBV. However, the proposal did not contain any clear strategy for reaching the most vulnerable and marginalised population, including adolescents.

As described in section 4.1.1, the H4+ JPCS target health zones were primarily selected based on their accessibility and the opportunity to build on existing interventions. In addition, health zones high rates of maternal and newborn deaths and low availability and quality RMNCAH services were prioritised. In that sense, H4+JPCS targeted under-served areas and populations who have only limited access to quality services. It is worth noting that the factors contributing to vulnerability differ from one province to another. For example, in Mosango, a rural health zone in Bandundu Province, the isolated area of *Kinzamba 2* is difficult to access, as a river separates it from the rest of the health zone. In Mbanza-Ngungu, key informants repeatedly said that adolescent girls are at high risk for early pregnancy, with pregnancy rates on the rise, and in Mosango, adolescent do not have access to condoms before the age of eighteen.

H4+ JPCS supported the implementation of several studies to better understand the barriers to access for vulnerable populations. Examples are: a client satisfaction survey assessing the level of satisfaction with RMNCAH services among women (2013); a study identifying socio-cultural barriers to use of family planning services in the nine HZs (2013); and a study identifying lessons learned from existing community health insurances in Bas Kongo (2014). In addition to low availability of quality services, the studies highlight financial, geographic and cultural factors as key barriers to utilisation of RMNCAH services in the H4+ JPCS target health zones.

Based on this evidence, H4+ JPCS supported several interventions to address these barriers and improve access to RMNCAH services for vulnerable populations, including:

- A maternity waiting home in Mosango for women with high risk of obstetric complications
- Provision of ambulances to facilitate referrals to higher level care
- A subsidised flat-rate pricing strategy to reduce the cost of EmONC services for vulnerable populations
- Community health insurance plans to prevent catastrophic health expenditures[53]
- Support to women's cooperatives for income-generating activities
- Support for youth-friendly services.

Some of these strategies typically require several years to be developed, tested and scaled-up, including the flat-rate procing and mutual health insurances. WHO only provided support for the mutual health insurance for a short period of time, and the results in terms of improved access were minimal as the fund experienced several operational challenges. Contrary to this, the flat-rate pricing system in Mbanza Ngungu was relatively well tested and established at the time of the field mission and had clearly a positive impact on women's and children's access to RMNCAH services as financial barriers had been reduced. Other strategies, such as the maternity waiting home and the provision of ambulances to strengthen referral system had more immediate effects in reducing barriers to access.

Although the original proposal and 2011-2012 work plan identified youth as a specific vulnerable group in the DRC, this emphasis has not always been accompanied (especially during the early years of the programme) by adequate reach, significant duration and effective targeting of the support provided. For example, the 2012-2013 workplan did not contain any activities targeting youth, and the approaches proposed in the 2014-2015 workplan were only partially implemented. The most significant effort by the H4+ JPCS partners to target youth as a vulnerable group can be seen in the support provided to three youth centres to deliver youth-friendly sexual reproductive health (SRH) services: Bomoto and Coulibaly youth centres in Kinshasa, and a youth centre in Central Kongo Province. Interviews with implementing partners and a site visit to Coulibaly youth centre, provided evidence that H4+ JPCS support has improved access to STI treatment, rapid HIV tests and condoms for youth and adolescents living in the catchment area of these centres. The H4+ JPCS also supported mobile family planning and HIV testing campaigns in the surrounding communities. However, the support to these interventions came very late (2015), furthermore with weaknesses in the design and delivery of the approaches. For example, UNFPA support to the Coulibaly youth centre in Kinshasa was interrupted for several years, staff had never received training, and there were reported stockouts of drugs and commodities. Annual reports indicate that H4+ JPCS funded campaigns targeted youth, but there was little evidence that these have had any effects in the three health zones visited during the evaluation field visits. For example, UN Women supported activities to involve young men and boys in RMNCAH in Mosango. However, these activities were only implemented in the last year of the programme (2015), had limited duration and reach, and were unexpectedly disrupted before the workplan had been fully implemented due to lack of funds.

To summarise, there is strong evidence that the H4+JPCS missed an important opportunity to reach adolescent and youth on a large scale with key messages and comprehensive RMNCAH services tailored to their needs. This is particularly true for family planning and gender messages. Ministry of

[53] "Catastrohic health expenditures" is a term commonly used by the WHO in the area of health care finanicing and financial protection. The *"incidence of catastrophic and impoverishing health expenditures"* are used as indicators to *"monitor how well a health system is performing in terms of financial protection"* and *"are solely determined by the extent to which out-of-pocket payments absorb household's financial resources"*. WHO (2016). *Health financing for universal coverage. Out-of-pocket payments, user fees and catastrophic expenditure.* Retrived on January 4 2017 from: http://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

health officials, H4+ members, service providers and young people themselves consistently noted that H4+ did not specifically target adolescents and youth, as priority was almost always given to women and children.

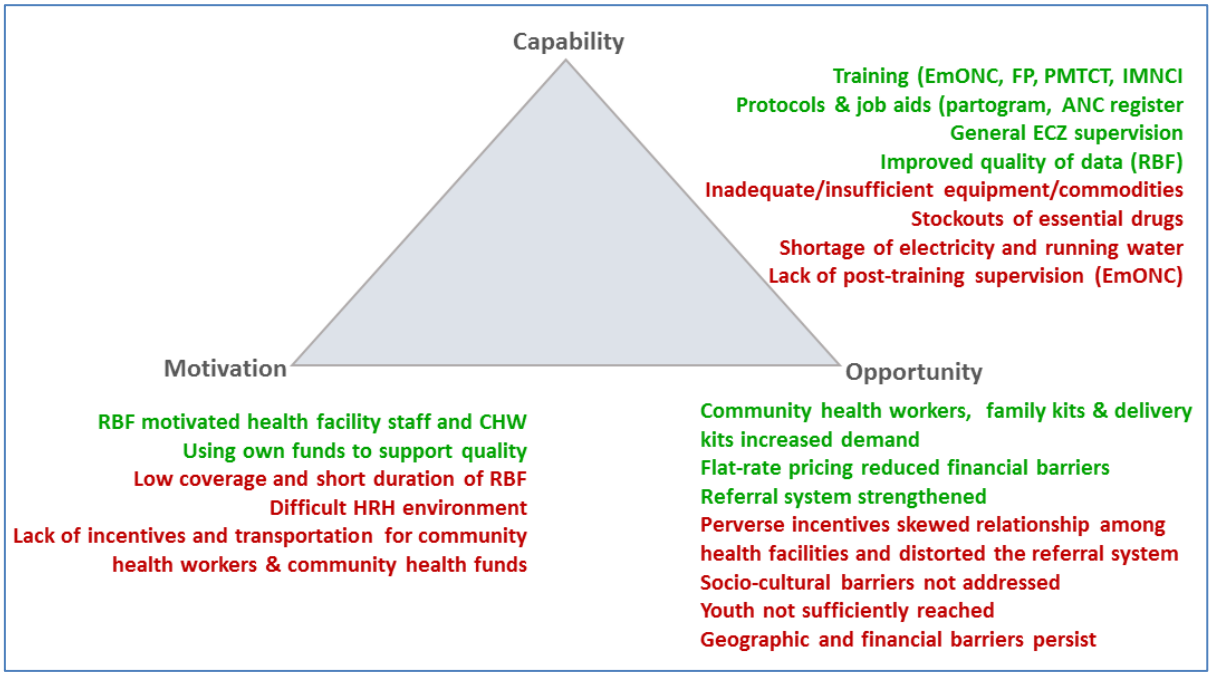
***Assumption 2.2:*** *H4+ JPCS* ***support to capacity development and to effective demand*** *by community members has* ***adequate reach*** *to effect access to quality services for marginalized groups. H4+ JPCS support addressed the three dimensions of* ***sustainable capacity improvement****:* ***capability, opportunity and motivation*** *for sustained provision of care.*

*Unless otherwise noted, for evidence cited in relation to assumption 2.2 see Annex 1, Assumption 2.2*

Overall, it is clear that the H4+ programme had a greater tilt towards the development of service delivery capacity, with the demand component coming mainly later in the programme cycle. Further, certain community interventions had limited coverage and reach, including support for boys' clubs, GBV and income generating activities in Mosango and Kenge (UN Women, 2015), youth-friendly centres (UNFPA, 2015), and results-based financing (WHO, 2014-2015).[54] However, it should be noted that interventions to strengthen community health workers involvement in promotion of RMNCAH and the distribution of family kits were launched already in 2012, and there is strong evidence that these activities contributed to raising demand and use of services.

Looking at the three points of the "capacity triangle" (capability, motivation and opportunity), figure 5 below highlights some of the positive influences achieved with support from H4+ JPCS (in green). The figure also identifies continued limitations or barriers (in red) which include limitations created by the enabling environment or the larger health system.

**Figure 5: The Capacity Triangle in the DRC**




***Capability***

H4+ JPCS provided significant support for capacity development in RMNCAH at institutional and operational levels. This included the development of the competency-based EmONC training module,

[54] Although RBF is considered a supply-side health financing approach, it is included here under demand creation activities, as RBF aims to improve the relationship and trust between health facilities and the community by improving the quality of services and user-friendliness.

the revision of the midwife training programme at the Institute for Higher Medical Techniques (ISTM), strengthening of training institutes, and trainings of health care providers. H4+ supported training of health providers focused on strengthening RMNCAH skills and competencies in a variety of areas, including basic and emergency EmONC, family planning, clinical and community IMNCI, PMTCT and rational drug use.

Health facility staff pointed out that the practice on mannequins during EmONC training helped them feel much more confident when they experienced an obstetric emergency situation in their work place. They gave several concrete examples of how they had reacted and treated the woman, and how this had saved her life or the life of her baby. The midwives highlighted the use of the partograph as an important aid which had helped them recognise the points at which they should refer a woman to the next level of care.

Although staff in the health facilities visited by the evaluation team were better skilled and had important tools to support their clinical work, the evidence points to several issues that put the gains in competencies at risk, and thus affect the ability of the health providers to deliver quality services. As described under assumption 1.4, important equipment and materials for EmONC were either not delivered, delayed or insufficient; there were reports of stockouts of essential medicines; and post-training supervision was not consistently integrated in the programming of H4+ JPCS. Lack of running water, electricity and solar panels further put the gains in quality of services at risk.

A major challenge is the low number of people trained and the frequent rotation of health facility staff. On average, only one provider per health facility was trained, and there are indications that competencies and skills were not always transferred to the rest of the team.

***Motivation***

As a supply-side health financing mechanism, H4+ JPCS supported the introduction of RBF in four out of nine H4+ target health zones. The activities were aligned with the national RBF strategy and implemented by the RBF division of the MoH with support from WHO. Although the original proposal included performance incentives as a key strategy to motivate staff, the planning process was only initiated late in 2013, and the actual purchase of services started in the last quarter of 2014.

RBF was introduced as a complementary strategy to other inputs at health facility level: *"We supported the health facilities that had already received equipment from the H4+ joint programme. (…) The material alone is not enough – you also have to motivate the staff, and that is why we targeted health facilities that had already received equipment."*[55] Low motivation of health workers due to poor working conditions and absence of salary payment is a major issue in DRC. H4+ JCPS therefore supported RBF in the HZs and health facilities that were not already covered by other programmes, providing performance-based bonuses or other types of salary top-ups. According to WHO, RBF was meant to complement the community health fund, which aims to increase demand by reducing financial barriers to access. As expressed by one H4+ member: *"The basic principle is that RBF will improve the quality of services at the health facilities, because we cannot ask women to join the mutual health insurance if there is no quality."*

The health zone team and health facility staff in Mosango stated that the RBF intervention has had a positive effect on their performance and on the quality of services. They indicate that RBF has helped the targeted health facilities improve the quality of data;[56] ensure more consistent use of the

[55] Interview with RBF Unit

[56] The quality of data is verified externally and is included in the calculation of the score and thus of the payment the health facility will receive.

partogram; and strengthen overall planning and management of health service delivery. A review of the evolution of quantity indicators confirm that the use of key RMNCH services increased in 2015.[57]

Despite these perceived positive results, key stakeholders at national and health zone level indicate that there were several flaws in the design and implementation of the RBF intervention. They mentioned the short implementation period of RBF (one year) as a risk to programme effectiveness amd sustainability, as the motivation of staff might decrease when the financial incentives stop. Moreover, H4+ JPCS did not have sufficient funds to comply with the national guidelines for cost per capita, and the WHO therefore negotiated a lower price with the RBF division of the MoH. It can be questioned whether it was the best use of the limited H4+ JPCS funds, as RBF require substantial investments over a longer period of time to yield positive results at health facility level.

On the positive side, the health zone team and the general referral hospital have continued the RBF programme with their own funds, using the *risk allowance*[58] funds to pay performance-based bonuses to staff. The new phase of the World Bank RBF programme is supposed to target some of the H4+ health zones, although it was not possible to obtain exact confirmation of which health zones and health facilities.

Health care staff reported that H4+ supported competency-based EmONC training had increased their intrinsic motivation to provide better quality services. For example, they expressed great satisfaction with the practice on mannequins, which has helped them improve the management of a number of situation, such as haemorrhages and caesarean sections.

In Mosango, the RBF intervention also provided performance incentives for community health workers. Based on the results achieved, community health workers received up to ten per cent of the total envelope paid to a health facility based on their achievements. However, H4+ JPCS has not sufficiently addressed the motivation factors, as community health workers consistently complained that they do not have sufficient means (transportation, tools, and financial incentives) to provide a quality service to the communities they serve.

***Opportunity***

H4+ JPCS supported several approaches to promote RMNCAH: reduced financial barriers and increased demand for services at community level, although with varying degrees of coverage and reach. Between 2012 and 2014, a total of 1,966 community health workers were trained in distribution of family kits and how to sensitise communities about family planning, home-based IMNCI and the danger signs and lifesaving actions for children and pregnant women. In addition to essential medicines, the family kit also includes vouchers that women can use to access services at a subsidised flat-rate (*tarif forfaitaire*). Subsidised services include: ante natal care (ANC) (USD 1.5) and pre-school consultations for free. Women also receive a *delivery kit* when they attend ANC at the health facility and voucher for assisted delivery (USD 7.5). They can only benefit from the subsidised price if they attend all four ANC visits. Similarly, a woman must be referred by a first line health centre in order to benefit from the subsidised price for caesarean sections (USD 50 instead of USD 150). Informants indicate this has helped strengthen the referral system in Mbanza-Ngungu. These flat-rate prices represent a significant reduction in the price women used to pay: "*If you have not benefited from the voucher in the family kit, it is more difficult to pay the cost of an assisted delivery.*" (Mother in Mbanza-Ngungu.)

At national level, the Department for Planning and Research with H4+ JPCS support from WHO undertook costing studies, provided support to the health zone teams, and negotiated the flat-rate

[57] Fifty per cent of the quantitative indicators are directly related the RMNCH.

[58] In the DRC, all health staff on MoH payroll are entitled to a monthly 'risk allowance' as a standard top-op to their basic salary.

prices with the national referral hospital. At HZ level, the approach was piloted in Mbanza-Ngungu with UNICEF support, while WHO supported the introduction of subsidised flat-rates in Mosango. The design of the approaches differed slightly, as UNICEF linked the flat-rate pricing to the *family kits*, while WHO aimed to create synergies with the community health fund. H4+ JPCS supported the introduction of the latter in Mosango and Kenge but the evidence of its effectiveness is mixed due to several operational and contextual challenges.[59]

Other activities supported by H4+ JPCS to increase demand for RMNCAH services, included several awareness campaigns on family planning and safe deliveries and the diffusion of a soap opera through three television channels and 84 community radios. While these activities are mentioned in reports, there is little available evidence of their overall effectiveness, and community members interviewed during the field visit did not recall these activities, with the exception of the national family planning campaign in 2014.

The 2015 decision by UNFPA to fund UN Women as an implementing partner represented an effort to address the relative weakness of demand side investments by H4+ JPCS. Specifically, UNFPA engaged UN Women to conduct community outreach to improve the enabling environment and increase demand for RMNCAH services in Mosango and Kenge. The activities included training and involvement of religious leaders to support the promotion of women's rights and the fight against gender-based sexual violence as well as support to boys' and men's clubs. Further, UN Women supported women's cooperatives to start up income-generating activities. The original purpose of this strategy was to reduce financial barriers of rural women to accessing RMNCAH services. The idea was that each member of the women's cooperative would use the additionally generated revenues to pay for enrolment in the community health fund in order to reduce the women's out-of-pocket expenditures on health care.However, this approach had unintended adverse effects, as described under Assumption 2.3, third paragraph, p. 36.

Despite these efforts to improve community engagement and demand generation, community health workers, youth clubs and implementing partners lack the basic means to provide quality services to the communities, such as training manuals, visual communication tools, and transportation to reach remote villages or conduct supervision. The community health workers in Mosango mentioned that they walk up to 15 km to attend the monthly meetings with the health zone team because they cannot afford to pay for a bus or taxi. After having been trained in community-based distribution (CBD) of contraceptives, CHW were supposed to start distributing contraceptives in the villages, but they never received the commodities or the CBD kit with basic materials and tools. Staff of the visited youth centre in Kinshasa and members of the youth clubs in Mosango also indicate they have never received any formal training in behaviour change communications, and lacked basic guidelines and tools to support messaging and outreach work.

The relatively late addition of many demand creation activities was compounded in its effect by weaknesses in the design and delivery of key interventions. In combination, these factors compromise the effectiveness of efforts to create demand, achieve sustainable behaviour change, and build trust between communities and health facilities. These challenges point to an imbalance in the capability, opportunity, motivation triangle, with a greater emphasis on the supply side than on comprehensive demand-creation among vulnerable groups. It raises the question of the sustainability of capacity development at health facility and community level beyond the H4+ JPCS.

[59] These factors include for example: insufficient capacity development and supportive supervision of the board members of the community health fund; low motivation of the board members due to lack of monetary and non-monetary incentives; and weak collaboration between the community health fund, the health zone team, and WHO and UNWOMEN at country office level. See second paragraph under Assumption 2.5, p. 38 for further details.

***Assumption 2.3:*** *H4+ JPCS support at national and sub-national level has been* ***sequenced*** *appropriately with support to RMNCAH from other sources. H4+ JPCS supported investments and inputs* ***do not conflict in timing or overlap*** *with those provided by other programmes. Further, H4+ JPCS support* ***combines with other programme inputs*** *to allow services to be scheduled and delivered in manners appropriate to reaching vulnerable group members and building trust between providers and users.*

*Unless otherwise noted, for evidence cited in relation to assumption 2.3 see Annex 1, Assumption 2.3*

As described under Assumption 1.2, the H4+ JPCS was designed to be complementary to other RMNCAH and health systems strengthening programmes at national and sub-national levels, namely the government PESS programme, the Global Fund grant, Gavi The Vaccine Alliance, H4+ members programmes, and the RMNCH Trust Fund grants.

Moreover, each participating H4+ member supported interventions based on its own distinct strengths, with clear delineations of responsibilities for programming as described in box 3. In some cases, where H4+ members have similar technical capacities, H4+ focal points indicated they coordinated and planed activities to avoid overlap and duplication. For example, both UNICEF and WHO supported activities to introduce flat-rate pricing for EmONC services, but piloted different approaches in two different health zones. Also, UNFPA and UNICEF both procured equipment and commodities for EmONC services, while WHO was responsible for delivering training equipment.

**Box 3: Assigned Roles of H4+ Members**

- **UNICEF** : Provision of essential medicines, material and equipment at household and health facility level; strengthening community involvement; scaling up PMCT; and paediatric HIV and treatment
- **WHO**: Support for the development of community health funds; results-based financing; purchase of training equipment for RMNCH; reproduction of RMNCH norms and guidelines
- **UNFPA**: Support to coordination and family planning ; capacity development in EmONC; strengthening human resources; and support for the M&E framework; additional EmONC materials; (and essential commodities with own funds)
- **UNAIDS**: Support to the coordination of HIV activities
- **UN Women**: Support to the integration of gender in H4+ JPCS programming
- **World Bank**: Health system financing
- **WFP**: Support to the integration of nutrition in H4+ JPCS programming

Ministry of Health technical staff credit H4+ JPCS for bringing together the UN agencies, drawing on their collective strengths. Previously, each agency would present its own programme and negotiate and plan activities individually with the MoH. With the advent of H4+ JPCS, the UN agencies started working in a holistic manner. According to H4+ members, this coordination had already been initiated with the H4+ partnership well before they received the funds from Canada. For example, UNFPA, UNICEF and WHO had developed a joint proposal for a RMNCAH programme in 50 HZs (which was however never funded). According to H4+ focal points, the added value of H4+ JPCS was the opportunity it gave the H4+ members to demonstrate what they could achieve together when implementing joint activities at provincial and HZ level. Both MoH and H4+ members repeatedly said that H4+ JPCS is just a funding source (although an important one), while the *H4+ approach* is much broader: *"a way of doing things."* Two H4+ members did mention, though, that there is still a tendency for each partner to "*present and defend their own interventions"* in national coordination

meetings and the development of joint workplans, rather than developing innovative and "*truly joint"* approaches.

As already noted, H4+JPCS interventions were also designed to complement investments made by other programmes supporting RMNCAH. However, issues with coordinating the timely delivery of inputs sometimes weakened the level of complementarity actually achieved. Probably more significant have been some of the problems which have arisen in the operational coordination and sequencing of investments in RMNCAH by H4+ partners themselves.

One important example occurred in Mosango, where UN Women and WHO-supported activities appear not to be well coordinated, which created unintended adverse effects in the communities. Specifically, UN Women H4+ JPCS investments aimed to create income-generating opportunities for poor women to enable them to pay for a membership of the community health fund supported by the WHO. However, only women who were already members of the community health fund were allowed to participate in the income generating activities. This created frustration among women in the community, as they said they could not afford a membership in the first place, and therefore felt automatically excluded from the income-generating activity. Furthermore, due to the insufficient equipment and materials for income generation donated by H4+ JPCS, women cooperatives had to refuse new members in order to "*avoid chaos*". These weaknesses in design and planning of the intervention combined with the lack of supportive supervision to the women's cooperative, created confusion and conflict in the community. Interviews provide strong evidence that communication and coordination between WHO, UN Women and the local actors were inefficient both at national and health zone level.

Another example concerns the lack of coordination and timing of the EmONC training sessions (UNFPA) and the procurement of equipment and materials necessary for EmONC services (UNICEF). It appears that the procurement was not well coordinated or planned, as UNICEF procured a standard package of equipment that did not correspond to the needs of EmONC services as defined by UNFPA supported training. As a consequence, important EmONC equipment and material was missing at the time when the service providers had been trained, and UNFPA found it necessary to order a complementary package.

Another example of unintended negative effects caused by the H4+ JPCS was found in Mbanza-Ngungu. The flat-rate pricing for obstetric emergency care was only introduced in the general referral hospital and primary health care centres, whereas referral health centres/hospitals at the intermediary level were left out.[60] This created a situation where the health centres had to refer all women with obstetric complications or emergencies to the general referral hospital, as this was the only hospital where the women could benefit from the reduced flat-rate price. This caused problems for pregnant women, as they had to travel longer distances, instead of being referred to the nearest referral heath centre or hospital. According to interviewed women, this caused delays in reaching the general referral hospital and accessing CEmONC services, as they first had to find money to pay for transportation. More importantly, the mismatch in incentives distorted the work and revenues of hospitals that were not part of the family kit approach and the subsidised flat-rate approach.This was observed in the maternity ward *La Cité de la Maternité* in Mbanza-Ngungu, which had experienced a significant drop in the number of deliveries and other RMNCAH services, and hence revenues, since

[60] In the DRC, there are four levels of health facilities at health zone level: health posts, health centres, referral health centres/hospitals, and typically one general referral hospital. When the referral health centres/hospitals were left out of the referral network for CEmONC, it meant that women had to travel longer distances, as the EmONC subsidised price was only offered at the general referral hospital. Prior to the introduction of the flat-rate pricing, pregnant women would be referred from the health centre to the nearest by referral health centre/hospital for cecarean sections, thus reducing the delay in obtaining lifesaving health care.

the introduction of the flat-rate pricing. The reason is that the maternity ward was not part of the flat-rate pricing intervention, and therefore, pregnant women living nearby who would normally be referred to the *Cité de la Maternité* in case of obstetric emergency, would now be referred to the general referral hospital instead. According to interviewed staff at the *Cité de la Maternité*, the drop in patients and revenues led to demotivation and abseentism among staff.[61]

***Assumption 2.4:*** *The combination of improved quality of services in RMNCAH,* ***increased trust and understanding between service providers and users****, and increased capability for service users to effectively demand care is sufficient to contribute to a notable increase in the use of services and* ***to overcome barriers to access*** *which existed in the past.*

*Unless otherwise noted, for evidence cited in relation to assumption 2.4 see Annex 1, Assumption 2.4*

*Note: This assumption was also addressed as assumption 1.5 with regard to health systems strengthening. The focus here (in relation to evaluation question two) is on the resulting improvements in access for the marginalised and overcoming barriers to their participation and draws primarily on qualitative evidence*.

There has been a positive shift in the communications and trust between the health facilities and the communities they serve. Support from H4+ JPCS is seen as contributing to an increased awareness of RMNCAH issues in the community and among health staff. This has contributed to: earlier detection of danger signs and referrals towards the health facilities; reducing the number of obstetric emergencies with fatal consequences; and a significant improvement in relations between the community and health facilities. The efforts of community health workers to promote RMNCAH messages and the distribution of the family kits, combined with improved capacity of health facilities to provide quality EmONC services, were repeatedly pointed out as the most significant contribution of H4+ JPCS to improved RMNCAH services.

Key informants recounted the same narrative of a "before" and "after" H4+ JPCS. While before, women were not able to recognise the danger signs and often arrived at the health centres "*too late,*" now, as a result of the sensitisation and support of community health workers, they understand the benefits of ANC visits and go to the health centres "*as soon as labour starts."* Several women and health facility staff stated that before, a woman in labour was "*treated badly"* by the midwives who said it was "*God's punishment*" if they were in pain. After H4+, there has been increased trust between facilities and communities because they have come to expect quality of care and attention. Interestingly, interviewed midwives and nurses did feel they had changed their attitude towards women in labour and understood that "*the women should not be in stress when she is giving birth"*. Community members trust that the service providers trained in EmONC provide better quality services and women feel they have gained important knowledge and skills related to exclusive breastfeeding, safe deliveries, family planning and hygiene. Focus group discussions with men in visited sites indicate that they were particularly satisfied with the family kits and the reduction of user fees on key RMNCAH services, as this has reduced the financial burden on the household, improved the health of their children, and improved safe deliveries.

There are, however, some persisting factors undermining the level of trust between community members and health service providers which, in turn, constitute continuing barriers to quality of care for marginalised group members. For example, interviewed community members noted some stockouts of essential medicines and implants (which are the preferred family planning method for

[61] It should be noted that the *Cité de la Maternité* had initially been selected as EmONC facility and the providers had been trained in EmONC service provision. There is thus no evident explanation as to why they were excluded from the flat-rate pricing approach.

women) in Mosango. They also point to the limited space of certain maternity wards to receive all women in labour. Community members also regret that the family kits and vouchers only cover selected RMNCAH services. Men, in particular, resented the fact that the family kit approach only target women and children below five, while they experience significant financial barriers in accessing services for themselves as well as for adolescent girls and boys. In most areas, H4+ JPCS did not support any activities to remove these barriers and increase access to youth-friendly RMNCAH services.

Focus group discussions with adolescents in Mosango and Mbanza-Ngungu indicate that H4+ JPCS-supported interventions have not effectively targeted or reached them. In both areas, they had little information on family planning methods and other RMNCAH topics, with the exception of HIV. In Mosango, cultural barriers and prejudices clearly prevent young girls from accessing condoms: they are charged a higher price for the condoms than their male peers, and health facility workers indicate that they only distribute condoms to adolescents above 18 years of age. The boys supported by UN Women in Mosango were able to recall some messages about *prevention of rape of young girls*, *HIV testing* and *safe deliveries*, but otherwise had very limited knowledge of gender equality, family planning methods, and GBV.

In summary, improvements in services and efforts at engaging the community have built trust between community members and health services staff. Yet barriers to access services for under-served communities persist, particularly for adolescents and youth who show significant knowledge gaps with regards to family planning, GBV and other RMNCAH topics.

***Assumption 2.5: Demand creation activities and investments have sufficient resources*** *and are sustained enough over time to contribute to enduring* ***positive changes in the level of trust*** *between service users and service providers in RMNCAH. Investments and activities aim to change service providers' attitude and behaviour towards users in an effort to build mutual trust.*
***Improvements in service quality and access are not disrupted*** *by failure to provide adequate facilities, equipment and supplies of crucial commodities in RMNCAH. H4+ JPCS support is not subject to disruptions, which can weaken trust and reverse hard won gains.*

*Unless otherwise noted, for evidence cited in relation to assumption 2.5 see Annex 1, Assumption 2.5*

H4+ JPCS investments have led to increased community engagement in RMNCH, quality improvements of services, and to positive changes in the level of trust between communities and health facilities. However, there are several indications these positive gains are at risk and might not be sustained beyond H4+ JPCS.

A main weakness of the H4+ JPCS support to demand creation were the low coverage and the short duration of certain activities, particularly the support to youth centres in Nsele and Matadi health zones, and efforts to combat GBV and support to income-generating activities in Mosango. Further, the community health fund has not received sufficient capacity development support to overcome certain difficulties related to the promotion and the management of the fund. At the time of the field visit, the community health fund was insolvent, i.e. it had no more cash left in their bank accont, and was unable to reimburse health facilities the costs they had incurred for treating patients that were members of the community health fund.

At Coulibaly youth centre, staff and volunteers expressed that there were many flaws in the support they received. The centre was created with support from UNFPA in 2007, but between 2011 and 2015, UNFPA did not provide any funds to sustain activities. In 2015, H4+ JPCS funded punctual activities and the supply of drugs and commodities, while little attention was given to capacity development, supportive supervision, and incentives to motivate staff and volunteers. The quantity of drugs was insufficient to meet the demand during HIV testing and family planning campaigns,

causing stockouts several times. The centre clearly needs a minimum of external support to be able to provide quality services. There is therefore a real risk that the positive gains in trust, quality and utilisation by young people are not sustainable beyond H4+ JPCS.

Three factors appear to have constrained the reach and duration of UN Women support. *Firstly*, UN Women-supported activities to engage men and boys in RMNCAH were implemented late the H4+ JPCS programme cycle, which did not allow the approaches to be developed and sustained over a longer period of time. This is particularly problematic for interventions that aim to change social norms and the enabling environment. *Secondly*, the approach had several weaknesses: there were little efforts to build the capacity of local authorities and youth associations to sustain the activities beyond H4+ JPCS. Further, the boys' and men's clubs lacked basic materials, incentives and transportation means to reach a larger number of youth with key messages.

*Third*, UN Women only received USD 90,000 of the USD 150,000 budgeted in the 2015-2016 workplan. This obviously disrupted the implementation of activities, which had a detrimental effect on the communities, particularly the members of the women's cooperatives who did not receive any support from the H4+ country team or the local authorities to solve the community conflicts. The truncated disbursement pattern also meant that some income-generating activities were never started because "*they missed the agricultural season"* due to lack of funds to pay for materials. Although several information sources were inquired, no one could provide a clear answer as to why UN Women never received the full committed amount.

Interviews with implementing partners, staff of provincial health departments, health zone teams and community health workers indicate that there have been significant disruptions, delays or reductions in the support they received from H4+ JPCS in 2015 and 2016. The examples given were mainly related to support to EmONC training and supervision activities, national and provincial RMNCAH coordination, and community interventions. Some implementing partners did not receive any support after the end of 2014; others confirmed that they had only received one quarterly disbursement in 2015, and none in 2016. Those receiving support from UNFPA were the most seriously affected.

A comparison of the approved 2015-2016 workplan and a UNFPA activity report for this period confirms that planned activities were either not implemented or only partially implemented in 2015 and 2016. This information is not matched by the H4+ final report of expenditures 2011-2015 which indicates that UNFPA expenditures increased by over 70 per cent between 2014 and 2015. Key informants suggested several reasons for this apparent mismatch between what implementing partners report and H4+ expenditure data indicates. The most important explanations include:

- **The reduction of H4+ JCPS implementing partners by UNFPA:** Between 2012 and 2014, UNFPA delivered its programmes (including H4+ JPCS) through several implementing partners at national, provincial and health zone level. In 2015, reportedly following a recommendation from the headquarters, UNFPA in the DRC decided to significantly reduce the number of implementing partners it supports. This meant that the Ministry of Health became the only implementing partner of the H4+ JPCS in 2015 for UNFPA, responsible for implementing nearly all activities in the 2015-2016 workplan, including those that were previously managed directly by the provincial health departments, training institutes, and NGOs as implementing partners. Howeever, there is a strong indication that the MoH was not able to properly manage the implementation of the H4+ JPCS activities in 2015, which is most likely the reason why key stakeholders at all levels have experienced a significant reduction in support (not only, but especially from UNFPA). This view is supported by an external audit which found that MoH was unable to justify all H4+ JPCS expenditures to the UNFPA country office in 2015. As the issue remains unresolved (as of August 2016), UNFPA can no longer disburse funds directly to the MoH, but has to directly pay suppliers for

material and services even though MoH continues to plan and coordinate the activities. According to key stakeholders, this has made the timely implementation of H4+ JPCS activities even more challenging.

- **Delays in funding disbursements from headquarters to country level:** H4+ members also noted that the H4+ JPCS joint annual workplan is only approved at global level in the second quarter each year, and that the first disbursement is typically made then, which means that implementing partners only receive funding in the third quarter. However, the fund disbursements were reportedly delayed in all years and can hence not explain why the implementation of activities apparently slowed dramatically in 2015 and 2016.
- **The on-going reform of the public health sector:** Finally, the recently created provincial health departments are not yet fully in place and operational, which has caused a general delay in the implementation of interventions funded by the government or development partners. H4+ members note this as a possible reason for the slow implementation of some H4+ JPCS activities.

### 4.2.2 Contributing to expanded access to integrated care

H4+ JPCS, working in complementary fashion with other programmes of support to RMNCAH, has made identifiable contributions to expanded access to integrated care in the DRC by:

- Strengthening the quality of care provided to under-served populations
- Expanding access to IMNCI services and safe deliveries for vulnerable women and children, especially by removing financial barriers to accessing those services
- Strengthening the integration of services across the RMNCAH continuum of care
- Helping to build trust between service providers and users.

***Strengthening the quality and appropriateness of care in RMNCAH provided to marginalised and excluded populations***

H4+ JPCS interventions were instrumental in increasing the availability and quality of EmONC and IMNCI services at health facility and community level. Health facility staff has been trained in EmONC, family planning and PMTCT, and facilities have been upgraded and equipped, leading the community to trust that quality services are available. H4+ JPCS was also successful in engaging community health workers in the promotion of safe deliveries and life-saving practices for newborns and children under five, primarily through capacity development and a continuous supply of family kits. The positive feedback from users and providers should be viewed against the backdrop provided by supervision reports and review of output data, giving a mixed picture with regard to quality and increased use of services. However, while challenges continue to exist with stockouts, transportation and supervision that are hard to address in a fragile health system, there is evidence that the combination of supply-side capacity development and community-based demand creation has increased access to RMNCAH services across the continuum of care.

***Expanding access for marginalised and excluded groups, especially adolescents, youth and the poorest women***

There is strong evidence that the family kit approach (including subsidised vouchers), in combination with the flat-rate price for ANC and EmONC services, have reduced financial barriers to access RMNCAH services. The maternity waiting home in Mosango and the provision of ambulances have reduced geographic barriers and improved timely referrals to higher level care for pregnant women with obstetric complications, living in rural areas. Further, family planning campaigns have been effective in raising awareness and demand and create new users.

However, there are examples of approaches to increasing access that had limited reach and duration, were ineffective, or counterproductive. These include the UN Women support to youth clubs and

women's cooperatives (short duration, design and implementation issues, and disruption of funds); the community health funds (insufficient capacity development and lack of supportive supervision); community-based distribution of contraceptives (lack of commodities); and youth activities (short duration and lack of capacity development).

Moreover, H4+ JPCS missed an important opportunity to reach adolescents and youth, as activities were limited in both reach and duration, particularly with regard to family planning, comprehensive sexuality education and condom (for young girls).

***Strengthening the integration of services across the RMNCAH continuum of care***
Mothers receive integrated services from ANC, HIV testing and counselling, PMTCT, and safe deliveries. Family planning has been integrated in the EmONC training module, and service providers integrate family planning counselling in ANC and Post Natal Care (PNC). However, a review of HMIS data indicates that the use of PNC is declining. Community health workers have helped increase access to a range of live-saving IMNCI interventions, primarily through the family kit approach, home-based visits, and extensive outreach work. There is less evidence of the integration of nutrition for pregnant women, although initiatives are underway with the active participation of WFP in the H6+ partnership.

***Developing trust between service providers and users of RMNCAH services and sustainability of investments***
H4+ JPCS investments have contributed to increased trust between service providers and users of RMNCAH services. H4+ JPCS supported capacity development and the provision of equipment, medicines and commodities to improve availability of key RMNCAH services, combined with extensive community-outreach work targeting families with family kits and adult women of reproductive age. Together, these inputs have made a difference in the quality of services. However, there is not a clear answer to the question of whether these improvements can be sustained. Given the abrupt ending of certain community activities (particularly those targeting youth and rural women) and lack of a clear plan for sustaining provider skills and competencies, equipment and supply of commodities and equipment, there is significant potential for losing the gains and for breaking trust with the community. The difficult operating environment and contextual factors outside the influence of H4+ JPCS do not make this task any easier.

## 4.3 Responsiveness to national needs and priorities

***Question three***: *To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level?*

### *Summary*

1. H4+ JPCS established efficient joint coordinating mechanisms at the beginning of the programme, which worked well in 2012-2014. However, in 2015, there was a breakdown of confidence and collaboration between the Department for Family Health (D10) and certain H4+ members, which has had a negative impact on the overall joint coordination of H4+ JPCS in 2015-2016.
2. The H4+ JPCS responded to well documented needs and health systems gaps for RMNCAH. H4+ members use existing MoH processes for continuously identifying needs at national and sub-national levels. These mechanisms worked well in the early years, but joint field missions and the participation of H4+ members in joint planning and review meetings have decreased since 2015. H4+ JPCS sometimes used a top down rather than a bottom up planning approach.

3. The joint platform for coordinating the work of H4+ JPCS members and implementing partners at national and sub-national levels did not function optimally from 2015 and onwards. Also, joint planning and coordination among seem to have been much less effective at the provinces, districts and health facilities than at national level throughout the programme lifecycle.
4. The Ministry of Health has actively participated in the planning and implementation of the programme, but issues of leadership and ownership have affected programme implementation. This should be seen in the light of broader contextual factors related to weak governance of the health sector.
5. There is little evidence that H4+ JCPS succeeded in strengthening capacity for RMNCAH coordination at national and sub-national level, although some support for the RMNCH Task Force and health zone planning meetings was provided.

### 4.3.1 Testing causal assumptions for responsiveness to national needs and priorities

***Assumption 3.1*** *H4+ partners supporting RMNCAH in JPCS countries have been able to establish* ***effective platforms for coordination and collaboration*** *among themselves and with other stakeholders using H4+ JPCS funds and with technical support from the global/regional H4+ teams.*

*Unless otherwise noted, for evidence cited in relation to assumption 3.1 see Annex 1, Assumption 3.1*

The joint coordination of the H4+ JPCS was established with the arrival of the H4+ JPCS coordinator (international UNFPA staff) in March 2012.[62] Before that point, there was already an effective inter-agency collaboration within the H4+ partnership which did not, however, systematically include the MoH. According to a MoH senior official, there was *"no specific H4+ coordination mechanism at the beginning of the programme in 2011*". From 2012 to 2014, the MoH convened monthly H4+ JPCS coordinating meetings. In addition, the H4+ partners held monthly inter-agency meetings, and the H4+ heads of agencies met on a bi-monthly basis to discuss strategic issues. Another important aspect of coordination were the joint field missions, which were more frequent in the early than in the later years of the programme.[63] Coordination of the programme evolved over time and in 2015, the MoH decided to integrate the joint H4+ JPCS meetings into the national RMNCAH Task Force.

The joint coordination worked well between 2012 and 2014. MoH senior officials noted that the most important benefit of the H4+ JPCS has been the learning experience of how collaboration and harmonisation can work: *"It has been a learning experience for the agencies and the government (…) we have learned to work together. That is the most significant result that H4+ has brought about."*

While this draws a positive picture of H4+ JPCS coordination, there is strong indication that there was a breakdown in confidence between the MoH and the agency responsible for H4+ coordination (UNFPA) in 2015, after which point the *joint* coordination of H4+ JPCS became much less effective. MoH senior officials felt that UNFPA did not collaborate sufficiently well with the Department for Family Health (responsible for the coordination of H4+ JPCS on the government side) from 2015 onwards. The main criticism is related to a perception that H4+ JPCS did not deliver on its promise to strengthen the capacity of the Division for Family Health to coordinate H4+ JPCS and other RMNCAH

[62] UNFPA hired an H4+ coordinator to lead the coordination of H4+ JPCS from the UN side. Whereas MoH said this person was meant to have his office at the MoH to build the capacity of PNDS to better coordinate RMNCH interventions, H4+ members indicate that his primary role was to coordinate H4+ members' internal coordination.

[63] The following mission reports are available: 2012 (four); 2013 (two); 2014 (three); 2015 (one – the joint mission of the H4+ Global Technical Team to the DRC).

programmes, and that H4+ members started "*implementing the programme on their own"*, and organised field visits and annual retreats without associating the Division for Family Health.

In response to this criticism, H4+ members explained that the annual retreats were internal, as they needed a forum to discuss and set joint strategic priorities among themselves before meeting with the government. However, it does appear that key elements of the H4+ JPCS annual work plans were defined at these meetings, and later presented, discussed and agreed upon with the MoH. H4+ members point to the weak leadership and capacity of the Division for Family to coordinate RMNCAH in general, as a possible reason for the disengagement of the government in joint coordination of H4+ JPCS from 2015 onwards.

According to MoH senior officials, the decision to integrate H4+ JPCS joint meetings into the RMNCH Task Force should be seen as an attempt to strengthen government leadership and ownership over H4+ JPCS, and to avoid overlapping coordination mechanisms. However, reportedly due to internal issues related to the health reform in DRC, the MoH did not convene any RMNCH Task Force meetings in 2015, which in effect meant that H4+ JPCS was not coordinated at this level for more than a year. This continued until the MoH convened a RMCNH Task Force meeting in March 2016, with support from WHO and Pathfinder. To keep programme implementation on track, the H4+ members continued to organise monthly inter-agency meetings. The MoH was occasionally invited them to participate in these internal meetings, if the H4+ members needed their input or approval for certain activities. Moreover, it appears that disagreements about resource allocation and lack of harmonisation of disbursement modalities among H4+ members were key sources of discontent for the Division for Family Health.

Document reviews confirm that key workplan activities related to strengthening the coordination of RMNCAH (specifically D10) were either not or not fully implemented in 2015 and 2016. H4+ members and MoH staff repeatedly stated that "*not all promises were kept"*. The available joint mission reports also indicate that only one joint supervision mission took place in 2015, i.e. the visit of the H4+ global technical team to DRC.

It should be noted that the challenges in collaboration seem to have concerned the relationship between the Division of Family Health and UNFPA in particular. According to UNFPA, the disagreement was primarily due to the fact that the Division of Family Health found UNFPA procedures too restrictive and rigid. Although these issues affected the overall coordination of the H4+ JPCS, there is also indication that H4+ JPCS continued to collaborate well with the MoH, but at a higher level (director of cabinet). Ministry of Health officials and H4+ members also noted that since the H4+ coordination role was handed over the UNAIDS, "*the page has been turned"* and the coordination of H4+ JPCS and H6+ is on a path of improvement.

Interviews with implementing partners consistently indicate that coordination has not been well established at their level and they were not invited to participate in joint meetings or joint supervision visits. Further, they noted that there is a lack of coordination among the H4+ members when viewed from the implementing partners' perspective: *"There have been too many problems with the coordination with H4+. The UN agencies know their different implementing partners, and they have not created a good coordination platform for bringing us together and inform us (…). There have been no meetings."* One key informant mention that it is the responsibility of the government, not the H4+ partners, to coordinate the implementing partners through its various coordinating committees.

An important exception to this viewpoint was the H4+ JPCS collaboration and coordination with the Higher Institute for Medical Techniques (ISTM) Kinshasa and the Faculty of Medicine of the University of Kinshasa, which were involved in the planning and implementation of H4+ JPCS supported EmONC and midwifery training programmes. H4+ JPCS was instrumental in creating a stronger relationship

and strengthening the coordination between MoH, Ministry of Higher Education, and other partners supporting capacity development in RMNCH.

A similar weakness in the coordination of H4+JPCS activities was observed at sub-national levels. The mechanisms for coordinating H4+ JPCS interventions at DPS and HZ level and their effectiveness will be discussed under assumption 3.3.

***Assumption 3.2**: Established platforms and processes for coordination of H4+ (and other RMNCAH initiatives) are **led by the national health authorities** and include as participants the H4+ partners, relevant government ministries and departments (including at the sub-national level) and key non-governmental stakeholders.*

*Unless otherwise noted, for evidence cited in relation to assumption 3.2 see Annex 1, Assumption 3.2*

Leadership, ownership and coordination of the H4+JPCS are highly complex issues which should be interpreted in the light of the broader context for coordinating RMNCAH in the DRC. Overall coordination and governance of the health sector is very weak in the DRC, and the national health sector coordinating committee (CNP-SS) and its sub-committees are not functioning optimally. Further, the provincial CNP-SS are directly affected by the ongoing reform and the creation of 26 new provincial health departments (DPSs). The DRC has embarked on an ambitious decentralisation process, which is also supported by development partners in the health sector through the health development partners' forum (GIBS) platform, of which H4+ agencies are also members. A key vision is to create provincial basket funds (*contrat unique)* and to strengthen the capacity of DPSs to manage and coordinate all health interventions in their area. In the area of RMNCAH, H4+ JPCS supported the decentralisation process by providing support for the regional RMNCH Task Force meetings, and selecting the DPSs as implementing partners for certain activities (until the end of 2014).

The H4+ JPCS was not *led* by the MoH throughout the programme cycle, although the Department of Planning and Research (DEP) and the Division for Family Health continuously *participated* in programme planning and supervision. According to H4+ members, the leadership and management capacity of the Division for Family Health is low. As a result, they felt they had to continue implementing the H4+ JPCS (with or without MoH leadership) as they are accountable to the donors. As one said: "*We cannot convene their meetings for them."* However, it raises the question of whether and to which extent H4+ members were effective in strengthening national capacity for coordinating RMNAH, which was an explicit goal under "governance and leadership", and included in the annual work plans.

Although the joint coordination of H4+ JPCS at the operational level was weakened in 2015, the Minister of Health and the director of cabinet displayed strong leadership in putting RMNCAH on the agenda, and in keeping the implementation of the RMCNH Trust Fund and the H4+ JPCS on track. For example, the Minister himself decided that the RMNCH Trust Fund would be directly coordinated and overseen at the level of the director of the cabinet. H4+ members confirm that RMNCH Trust Fund meetings were held on a monthly basis, with the participation of H4+ members. Issues related to the implementation of H4+ JPCS were also discussed at these meetings when needs arose. However, this also led to a fragmentation of RMNCAH coordinating mechanisms within the MoH.

***Assumption 3.3:** Programme work plans take account of, and respond to, **changes in national and sub-national needs and priorities in RMNCAH** as expressed in plans, programmes, policies and guidelines at national and sub-national level. H4+ partners consult and coordinate with stakeholders at both levels.*

*Unless otherwise noted, for evidence cited in relation to assumption 3.3 see Annex 1, Assumption 3.3*

H4+ JPCS clearly responded to well documented needs and was aligned to the priorities of the national health development plan (PNDS) 2011-2015 and the strategy for health system strengthening. From 2013 and onwards, most H4+ supported activities fell under the strategic direction of the CAO 4&5,[64] which was developed with technical assistance from the H4+ members. H4+ JPCS adapted to the overall framework and supported several strategies of the CAO 4&5, for example the family kit approach.

Interviews with H4+ members and MoH staff at national and sub-national levels indicate that the planning and coordination of H4+ JPCS investments is both a bottom up and a top down process. Normally, the health zones identify needs and priorities during annual and quarterly review and planning meetings. Based on these meetings, they develop and submit their workplan to the Provincial Health Department, which consolidates the workplans from several HZs and submits them to the MoH at central level. Health zones are informed in advance about what activities H4+ JPCS can fund in a given year, and plan their activities accordingly.

The evidence is mixed with regard to the effectiveness of this planning process and on H4+ JPCS responsiveness to needs at provincial, health zone and facility levels. On the one hand, H4+ JPCS responds to national and sub-national needs because it addresses root causes of maternal and child health, and supports the government in its implementation of the CAO 4&5. Also H4+ JCPS has occasionally provided financial and technical support for the health zone planning meetings. On the other hand, the participation of H4+ members and other partners in these meetings was not regular and not all H4+ partners informed the health zones in advance as regards the activities they would fund. This made health zone planning more difficult, and when they submitted their annual work plan to the DPS, they often did not receive timely feedback from the DPS or the H4+ partners regarding what activities would be funded. Instead, they would be informed several months later, when an activity would "*suddenly"* be funded.

The health zone team (ECZ) in Mbanza-Ngungu noted that in the early years of JPCS H4+, joint planning meetings with H4+ members were more frequent. The ECZ participated in provincial RMNCH Task Force meetings, but no meeting took place in 2015 and 2016, which has made planning and coordination of partners more difficult. One director of provincial health department (DPS) states that H4+ JCPS was planned and implemented in a top-down fashion, and that the DPS was not able to participate actively in any priority setting or planning. Additionally, the H4+ members who have a regional office are more likely to participate in the planning meetings than those without.

***Assumption 3.4****: Platforms and processes for coordination of* ***H4+ JPCS do not duplicate or overlap with other structures*** *for coordinating activities in RMNCAH. Further, they provide a strong RMNCAH focus to national and sub-national health sector coordinating platforms.*

*Unless otherwise noted, for evidence cited in relation to assumption 3.4 see Annex 1, Assumption 3.4*

H4+JPCS coordinating mechanisms did not duplicate or overlap with other coordinating committees; instead, they were, to some extent. integrated in these platforms. At the beginning, H4+ JPCS was coordinated through a sub-committee of the CNP-SS and, in 2012, established a separate coordinating mechanism. This worked well until 2015, when the MoH decided to integrate the joint H4+ JPCS meetings into the RMNCH Task Force. This would have allowed H4+ JPCS to be better integrated and coordinated with other RMNCAH programmes (if the RMNCH Task Force meetings had taken place). The risk of such integration is a loss in focus on H4+ JPCS interventions, as it becomes one among many programmes. Key stakeholders indicate that inter-agency meetings and

[64] In discussions with staff of the MoH and H4+ partners , it became clear that the CAO 4&5 was the most important guiding document used in programme planning and implementation from 2013 and onwards.

specific H4+ JPCS meetings with the government are necessary to ensure efficient coordination and planning of the programme. Looking forward, the RMNCH Task Force will be integrated as a sub-committee under the commission for service delivery of the CNP-SS, which represents an opportunity to further strengthen and consolidate RMNCAH coordination in the DRC.

### 4.3.2 Responding to national needs and priorities

H4+ JPCS in the DRC responded to well documented needs and gaps and was fully aligned to national RMNCAH and health systems strengthening priorities. Efficient coordination mechanisms were established at the beginning of the programme cycle, but the joint H4+ JPCS coordination between the Ministry of Health and certain H4+ members broke down in 2015, negatively affecting the overall coordination and implementation of the programme. H4+ JPCS responsiveness to provincial and health zone need has been overall effective, but there is evidence that lower levels in the "coordination chain" experienced more difficulties in communication, feedback mechanisms and coordination of implementing partners. It should be noted, though, that coordination of the health sector in the DRC is extremely challenging due to several contextual factors, inlucing multiple coordinating platforms and general communication and collaboration issues between the different levels of the health sector and MoH departments. This certainly influenced the possibility for H4+ JPCS to make a lasting change to improved RMNCAH coordination in DRC.

***Responding to emerging and evolving needs of national and sub-national health authorities***
Experience in the DRC indicates that the basic structures and processes of the H4+ JPCS programme are sufficiently flexible at country level to allow it to respond to the changing needs of the countries it serves. For example in 2013, H4+ members supported the development of the CAO 4&5 and subsequently adapted and aligned H4+ JPCS interventions to this national framework for RMNCAH. H4+ JPCS coordinating mechanisms were established in 2012 and served as an efficient platform for joint planning and review of H4+ JPCS interventions until the beginning of 2015.

In contrast, the evidence with regard to responsiveness to emerging and evolving needs at health zone level is mixed. On the one hand, H4+ members supported and participated actively in provincial and health zone planning process, which facilitated a joint understanding of H4+ JPCS strategic priorities and how the programme could best respond to needs identified at these levels. On the other hand, there have been several weaknesses in the relatively top-down planning process. The underlying causes of these difficulties in identifying and responding to needs at sub-national levels include:

- Communication between different levels of the MoH structures (HZ, DPS, MoH) was not functioning well
- Insufficient national capacity (and limited support from partners) to organise quarterly regional RMNCH Task Force meetings, which was intended to serve as a forum for joint planning with the participation of HZ, DPS and all development partners
- Irregular participation of H4+ members in HZ planning meetings and lack of timely feedback on the workplans.

***Placing countries at the centre of the programme and strengthening leadership and governance***
The initial design of H4+ JPCS in the DRC clearly defined the development of national leadership and governance capacity as a core pillar of the programme. The annual workplans contained activities aimed at strengthening national capacity to coordinate RMNCAH interventions. Furthermore, H4+ members (WHO, in particular) provided ongoing technical support to the Division for Family Health (D10) to organise the RMNCH Task Force meetings. However, despite continuous efforts to place the MoH at the centre of the programme, the D10 was not able to assume a real leadership role of the H4+ JPCS. This is one of the reasons why the Minister of Health decided to move RMNCAH coordination to a higher level in the MoH. While contextual factors, such as fragmentation of

coordinating mechanisms, weak internal communication mechanisms, and overall performance issues of the MoH, certainly influence the ability of the D10 to lead the programme, the need for capacity development and support to the RMNCAH Task Force was not fully met by the H4+ JPCS.

## 4.4 Innovative approaches to programming in RMNCAH

***Question Four**: To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilization and effective supervision, monitoring and accountability)?*


### *Summary*

1. The H4+ JPCS identified several effective RMNCAH practices that had the potential for significant effect in the DRC. Two key innovations have contributed to health systems strengthening for RMNCAH: strengthened capacity of health staff to provide EmONC services (through competency-based, in-service training) and improved access to essential mother and child drugs, IMNCI services and safe deliveries (through the family kit approach).
2. The H4+ members, in particular UNICEF, WHO and UNFPA, accessed regional and international sources for technical assistance in different areas, including competency-based EmONC training, family health kits and community health funds.
3. The programme made efforts to document and share the innovations with a broad audience in the DRC through various coordination meetings at national level, innovation specific reporting, and the H4+ template for documenting innovations. However, there was no explicit strategy for knowledge management. The programme did not apply a systematic approach to document the process and results of innovative practices when tested and taken to scale.
4. MoH has taken a leadership role in replicating and scaling up competency-based EmONC training and the family kit approach to other provinces. Additional funds have been mobilised from different donors to support the scale-up process, including KOICA, USAID, the French Muskoka Initiative and the RMNCH Trust Fund for a joint programme implemented by UNICEF, WHO and UNFPA.


### 4.4.1 A theory of change for innovation in the DRC

From the beginning, the H4+ initiative has emphasised the importance of innovation in country level efforts to catalyse and accelerate programming in RMNCAH. The H4+ working definition for innovation is "*any novel or newly packaged, scalable approach aimed at improving outcomes relevant to the continuum of maternal and newborn health care*".[65] The working definition does not provide criteria or guidance for what constitutes a systematic and deliberate process for testing, evaluating and scaling up an innovation. Ideally, this process would include the full cycle of innovation, as illustrated in Figure 6 below: from identification of an opportunity to experimentation, documentation.communication and adaption of results.

[65] H4+ Guidance for Documenting Innovative Approaches, November 2013

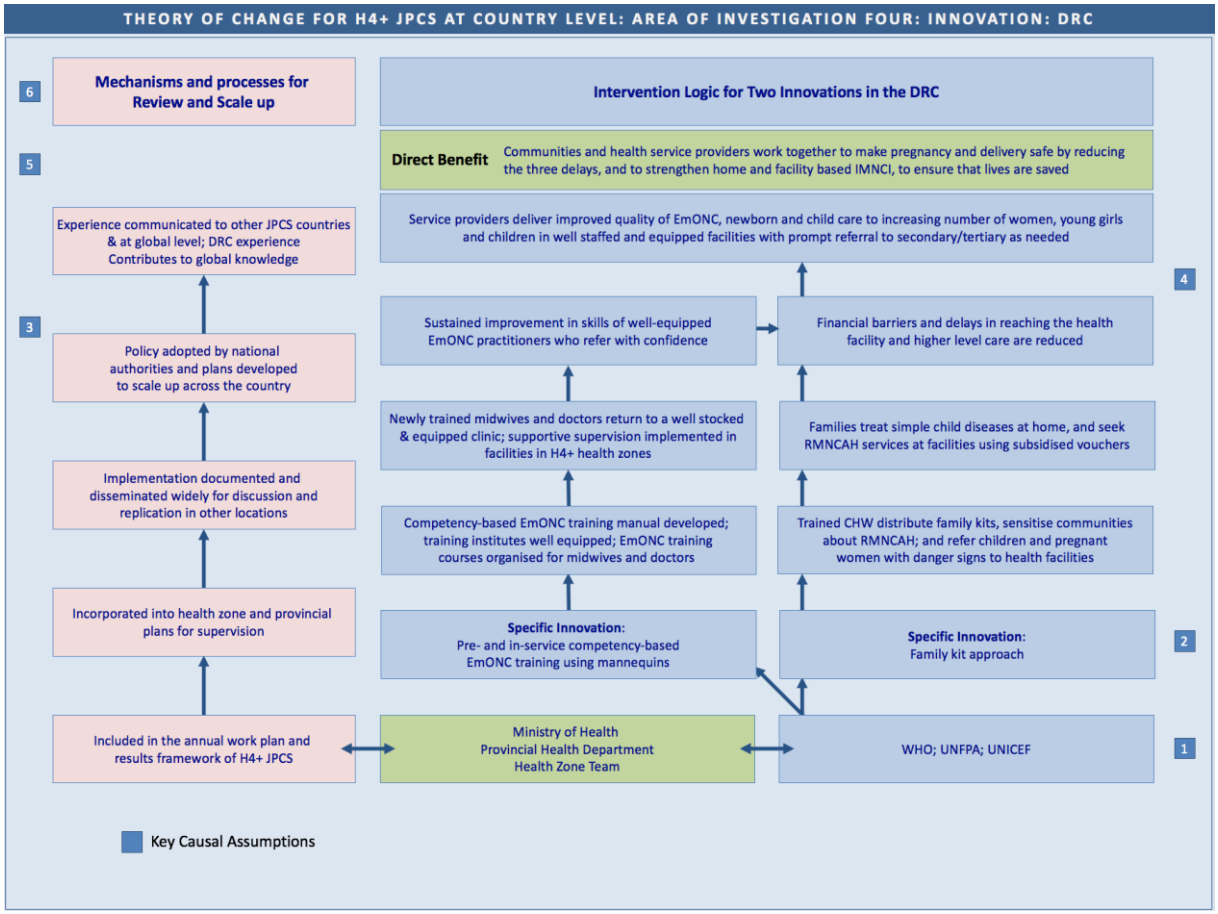
**Figure 6: The innovation to policy and scale up process**


The theory of change for innovation described in the inception report has been revised based on the DRC country case study using two examples:

1. **Competency-based EmONC training of service providers:** Based on experiences from other countries, H4+ JPCS supported the introduction of competency-based EmONC training in the DRC. It is seen as an innovation in the DRC, as it was the first time ever to introduce a competency-based training methodology using mannequins for EmONC training. H4+ JPCS funding enabled the Ministry of Higher Education in collaboration with the Ministry of Health to develop a training module based on international best practices, to pilot the approach in the nine H4+ JPCS target zones, and to train pools of national and provincial trainers to lay the foundation for a scale-up.
2. **Family kit approach and engagement of community health workers:** The family kit approach aims to improve home-based IMCNI and safe deliveries. Different kits are distributed, including a family kit to enable families to treat simple diarrhoea and fever; an ANC kit for pregnant women to stimulate demand and use of four ANC visits; and a delivery kit with essential supplies and commodities for safe deliveries. The kits also include vouchers for subsidised curative care, ANC and assisted deliveries in health facilities. The kits are distributed during the vaccination and ANC visits in order to stimulate demand and utilisation of key services, including coverage of vaccinations (Penta 3); preschool consultations for children above one year; and the fourth ANC visit for pregnant women. Promotion of RMNCAH and essential family practices by community health workers is an important component of the family kit approach.

The theory of change for innovation in the DRC is presented in Figure 7 below. The detailed causal assumptions for this ToC are stated and examined in detail in sub-section 4.4.3, and detailed descriptions of the key causal assumptions are provided in Annex 7.

**Figure 7: Theory of Change for Innovation in H4+ JPCS: DRC**




### 4.4.2 Testing causal assumptions for innovation

***Assumption 4.1:*** *H4+ JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+ JPCS, from practices in other H4+ JPCS countries or from the expertise and experience of key stakeholders at all levels.*

*Unless otherwise noted, for evidence cited in relation to assumption 4.1 see Annex 1, Assumption 4.1*

The MoH played a leadership role in selecting competency-based EmONC training using mannequins as an innovation to be developed and piloted under H4+ JPCS. The EmONC needs assessment conducted in 2012 revealed that less than one percentage of service providers working in maternity wards knew how to correctly manage obstetric complications. "*This observation was the reason behind the development of a new competency-based EmONC training curriculum by the National Reproductive Health Programme in 2013."* It was considered innovative because "*the training is based on the use of anatomic models (mannequins) to simulate real life complications. The use of mannequins helps to shorten the duration of training while allowing trainees to develop full competency in the management of each obstetric complication. A previous EmONC training which did not use mannequins was too long and trainees ended up not acquiring the competency required because they did not encounter enough obstetric complications during the training to allow them build the competency across all areas."*[66]

[66] (UNFPA nd)

The competency-based, in-service EmONC training module was developed based on an international best practice: *"Life Saving Emergency Obstetric and Newborn Care course"* developed by the Liverpool School of Tropical Medicine (LSTM) in collaboration with WHO and the Royal College of Obstetricians and Gynaecologists.

In the case of the family kit approach, UNICEF stated that this was an innovation developed in the DRC, which is now being promoted within UNICEF and extended to other countries in the region.

In addition to the widely recognised EmONC training and family kit approach, other examples of H4+ JPCS-supported innovations were identified:

- **Health financing initiatives:** The piloting of flat-rate pricing of key EmONC services is seen as an innovation in the DRC, as it has reduced financial barriers to access and strengthened the referral system in Mbanza-Ngungu and Mosango.
- **Maternity waiting homes:** This approach has reduced geographic barriers to access for women at risk of obstetric complications living in remote and rural areas in Mosango.
- **Maternal death reviews:** H4+ supported the establishment of the national maternal death surveillance and response system (MDSR), including MDSR committees at HZ, provincial and central level and the training of health zone teams in 39 HZs. Maternal deaths are now included in the list of notifiable diseases in the national disease surveillance system, and 211 out of 516 health zones notify maternal deaths on a weekly basis.
- **Local initiatives to reduce financial barriers to access:** In Mosango, a "caesarean solidarity fund" was created as a strategy to overcome financial barriers to emergency obstetric care. It built upon the principles of the community health fund. Many women enrolled in the solidarity fund because it was less expensive than a membership of the community health fund.

These practices were all new in the DRC and were therefore identified as "innovations". For example, H4+ members and senior MoH officials noted that the maternity waiting home in Mosango is the only one in the DRC to date, and the local initiatives in Mosango represent true innovations emerging from the field.

The original H4+ JPCS proposal identified a number of potential innovations, including competency-based pre-service and in-service training methodologies; performance based contracts to ensure motivation and retention of health personnel; the integration of PMTCT; and flat rate pricing for obstetric care. During actual implementation, only competency based training and flat-rate pricing were labelled as "innovation"; most likely because performance-based financing was not a novelty in the DRC; and because activities to strengthen the integration of PMTCT were limited in scope and duration.

***Assumption 4.2:*** *H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.*

*Unless otherwise noted, for evidence cited in relation to assumption 4.2 see Annex 1, Assumption 4.2*

The introduction of competency-based, in-service EmONC training using mannequins was led by the MoH and supported technically by UNFPA. The original proposal stated a need for technical assistance in introducing this type of EmONC in the DRC and the H4+ country team accessed regional and international expertise to develop the EmONC curriculum and training programmes. As early as 2007, national experts from the MoH and Ministry of Higher Education had participated in a regional

EmONC workshop in Burkina Faso prior to the advent of H4+ JPCS with the support of International Rescue Committee (IRC).

The H4+ members also resorted to technical expertise available in the DRC, including national experts, H4+ members with experience in both the noted innovations from other countries, and senior staff of the MoH and Ministry of Higher Education. They were instrumental in the piloting of these innovations in DRC.

For example, the national School of Public Health led the EmONC assessment with technical support from Colombia University (USA). Moreover, the H4+ JPCS-supported RBF intervention was implemented under the technical guidance and leadership of the national RBF unit of the MoH. A multidisciplinary group of medical doctors, professors and public health experts from the MoH, the Faculty of Medicine of the University of Kinshasa, and the Professional Association for Gynaecologist-Obstetrician was established to lead the introduction of competency-based EmONC training in the DRC. They were trained as trainers by an expert from Liverpool School of Tropical Medicine working with experts from the national maternal health programme of Madagascar.

The H4+ country team also made use of their respective regional and global sources of expertise in RMNCAH. For example, UNICEF was supported by headquarter (NYC) and its Dakar regional office in the development of the family kit approach. UNFPA staff members participated in a regional MDSR workshop organised jointly by the UNFPA East and Southern Regional Africa Office and WHO with technical support of University of Pretoria. Similarly, the WHO received support from their regional office to develop the community health fund.

H4+ members highlighted the joint review missions by the global technical team to the DRC as an opportunity for professional exchange and technical input. Documentation of one such mission to the DRC in 2015 covered all eight outputs of the programme and provided recommendations, including one on the documentation of best practices. H4+ members also noted that the inter-country review meetings have offered the opportunity for exchanges on technical aspects of innovation and the discussion of technical issues related to different RMNCAH interventions.

***Assumption 4.3:*** *H4+ partners and national health authorities agree on the importance of accurately and convincingly documenting the success or failure of supported innovations and put in place appropriate systems for monitoring and communicating the results of these experiments.*

*Unless otherwise noted, for evidence cited in relation to assumption 4.3 see Annex 1, Assumption 4.3*

In 2013, the H4+ global technical team produced a guideline for documenting innovations. It offers a template that includes: justification for the innovation, background or problem it is intended to address, strategy or intervention, results (quantitative and qualitative) and lessons learned.[67] UNFPA followed this guidance to document two innovations: the competency-based, in-service EmONC training of service providers and an approach to improve EmONC services developed by the association of midwives in Bandundu HZ. This partner also documented the MDSR approach, pre-service training of midwives, and the operationalisation of BEmoNC in July 2016, in response to a request from UNFPA headquartersin New York. UNICEF stated that they received support from the innovations team at headquarters to develop and document the family kit approach. However, there is no clear indication that the MoH or other partners participated in these documentation efforts.

Given the importance of communication and visibility for the programme, the H4+ JPCS team produced documents, including a flyer presenting the H4+ partnership and a human interest story for a global publication (together with Sierra Leone), and video documentaries on the family kit

[67] (H4+ 2013)

approach and the competency-based EmONC training. The videos have been shared through YouTube and H4+ member websites and are thus accessible to a larger audience outside DRC.

Despite these positive examples, the interviews with H4+ members and MoH officials at different levels indicate that there was no common understanding of a systematic approach to document the innovation process and the weaknesses and strengths of the pilot experiments.

MoH staff stated that innovations were well documented through reports and shared in H4+ JPCS and larger coordinating meetings, including for example the development partners' health forum, GIBS, and the RMNCH Task Force. The H4+ members provided a mixed picture with regard to the effectiveness of the programme in documenting innovations and of knowledge management in the broader sense. It was clearly a concern and a stated priority, but it was primarily seen as a need to share innovations with their headquarters and other countries, rather than as a knowledge management process instrumental to the RMNCAH in the DRC.

Some H4+ member staff recognised that they had not yet documented innovated approaches, but indicated that they planned to do so in the future for both the community health fund and the flat rate pricing approach for financing selected MNCH services. However, there was a broad consensus that the family health kits and competency-based EmONC training had been extensively shared with local audiences, development partners, H4+ donors and with other H4+ countries. The innovations were shared at local level through inter-health zone visits. Many other health zone teams came to visit Mosango and Mbanza-Ngungu HZ to learn from their experiences.

***Assumption 4.4:*** *National health authorities are willing and able to adopt proven innovations supported by H4+ JPCS and to* ***take them to scale****. They have access to required sources of financing (internal and external).*

*Unless otherwise noted, for evidence cited in relation to assumption 4.4 see Annex 1, Assumption 4.4*

The MoH has played a leadership role in promoting H4+ JPCS supported innovations at national level and extending the approaches to other provinces beyond the H4+ JPCS HZs. In 2013, the government included the family kit approach in the CAO 4&5 as a national strategy to increase access to life-saving essential medicines and IMNCI and safe delivery services. The family kit approach was piloted in Mbanza-Ngungu HZ with H4+ JPCS funds and extended to other HZs in 2014 with financial support from the governments of Canada and Sweden though the Management Sciences for Health programme (four HZs in Kasaï Occidental and Kasaï Oriental provinces), RMNCH Trust Fund (Bandundu and Equateur provinces), French Muskoka Initiative (Equateur province), and UNICEF core funds.

Support for competency-based EmONC training has also been institutionalised at the national level: *"H4+ supported the development of competency-based training guide for emergency obstetric and newborn care at the national level and this training guide is now being used by several implementing partners in other others where H4+ do not have interventions. This is a good example of catalytic effect of the Canada funding."* (H4+ country team member).

To support the scale-up of competency-based training, H4+ JPCS provided funds in 2015 for the establishment of a national and two provincial pools of EmONC trainers in Kinshasa, Bandundu and Bas Congo respectively. A total of 42 national and regional trainers were trained and provided with didactical materials. In 2015, trainers from these pools trained 180 service providers in BEmONC in Bandundu with funds from KOICA (two health zones) and UNICEF (six health zones). Other development partners, including for example USAID and Pathfinder, are also using the EmONC training curriculum and the pools of trainers to extend capacity development in EmONC to other

provinces. Pools of trainers were also established in Katanga, North Kivu, South Kivu and Equateur provinces with funds from other partners.

The midwife curriculum was officially adopted by a ministerial decree and midwifery was recognised as a separate professional category by the committee for human resources for health of the MoH. H4+ JPCS also supported the development of a national curriculum to upgrade nurse-midwives to midwives. The programme supported the extension beyond the H4+ JPCS target health zones through:

(i) The integration of the new midwife curriculum in 38 training institutes (ISTM) that previously trained nurse-midwives
(ii) Provision of equipment and trainings to 12 ISTM
(iii) Training of 154 teachers in competency-based teaching methodologies
(iv) Technical and financial support to strengthen technical capacities of internship-mentors and clinical teachers.
(v) In 2016 and 2017, the H6 partnership plans to provide equipment to another eight training institute and train another 146 teachers and 105 internship-mentors and clinical teachers. Challenges for further extension are identified as: low quantity and quality of teachers in the ISTM, insufficient funds to scale-up nationally, and the double '*tutuelle'* of the MoH and the MoHE.

Several organisations, including UNICEF, UNFPA, the World Bank, Gavi and the Global Fund, have established a joint collaboration platform to facilitate harmonisation and coordination of their approaches. The family kit approach is a key component of this partnership and will be complemented by funding from multiple sources to support the extension of a comprehensive package of RMNCAH services in several provinces of the DRC.

Further examples of the catalytic effect of H4+ JPCS supported innovations are the support to develop national RMNCAH norms and guidelines, the MDSR system, and the national strategy and operational manual for developing community participation in the DRC based on the experiences with the family kit approach. Key informants identified these as catalytic because they enable other partners to build on the first, innovative experiences supported by funds from H4+ JPCS.

### 4.4.3 Contributing to innovation for RMNCAH in DRC

***Recognising potentially effective innovations in RMNCAH***

The H4+ JPCS country team identified several effective practices that have the potential to contribute to significant effects in the DRC. Two key innovations clearly contributed to strengthening the health system for RMNCAH: the family kit approach and the competency-based EmONC training. The identification of these and other innovations was a joint effort by the MoH and H4+ members. The process of selecting innovations was based on international best practices and the H4+ members tapped into regional and global sources for technical expertise in specific areas, including EmONC training, the family kit approach, MDRS and community health funds.

***Information on the success or failure of innovations gathered and made accessible to decision makers***

While innovation in programming was clearly a priority for the government and the H4+ JPCS country team, there was no formal process for systematically documenting evidence of the successes and failures of innovative practices. It was rather done in an informal way and shared with other partners in the DRC and abroad through regular reporting, coordination meetings, inter-country workshops and promotional material (brochures and videos). Only UNFPA documented two innovative practices using the standard template for documenting innovations provided by the H4+ global team. There is no clear evidence that the MoH participated in this documentation exercise. Although the process of innovation was not continuously and systematically documented, the government and H4+JPCS

members made a significant effort to share lessons learned and tools with other partners at national level.

While innovation was highlighted as a priority aspect of the joint programme at its inception, it appears that the routine and intensive acts of programme coordination take precedence over investing in the implementation of the full cycle of programme innovation. Apart from exchanges at meeting, there has been little efforts dedicated to knowledge management within and across programmes.

***Replication of innovations across health zones and at national level***
H4+ JPCS had access to the necessary resources and platforms for supporting the development of the family kit approach and the competency-based EmONC training modules, as well as the revision of the midwife training programme. H4+ JPCS funds were catalytic in the sense that they allowed for these innovations to be piloted in a few HZ and then extended to several HZ in other provinces. The joint advocacy efforts by the government and H4+ members to obtain additional funds from the RMNCH Trust Fund certainly helped scale up these innovations.

## 4.5 Division of labour

***Question Five***: *To what extent has the H4+ JPCS enabled partners to arrive **at a division of labour which optimises their individual advantages** and collective strengths in support of country needs and global priorities?*

### *Summary*

- The H4+ country team in DRC was able to establish an effective platform for coordinating H4+ JPCS interventions, which has allowed them achieve an effective joint review and planning process. Implementing partners were not part of the coordination efforts which led to weaker coordination of activities in the field.
- H4+JPCS made best use of the individual strengths of the H4+ members. This was particularly noticeable with the midwifery and EmONC training (UNFPA), the family kit approach (UNICEF), and GBV activities (UN Women). However, this was limited by the absence of a clear division of roles and responsibilities among the H4+ members with regard to activities targeting adolescents, and the lack of efforts to harmonise messages or approaches for this vulnerable group.
- The World Bank was not engaged at all in H4+ JPCS planning and implementation at the technical level. The RBF activities funded by H4+ JPCS were managed directly by WHO, although they could clearly have benefited from the technical expertise of the World Bank staff. This suggests that only those agencies, who received H4+ JPCS funds to implement activities, became actively engaged in providing technical assistance to the MoH.
- The H4+ JPCS led to more collaborative programming among H4+ members at national level. However, this efficient collaboration and division of labour did not extent to HZ and health facility level. Rather, there were several issues in coordinating the delivery of key inputs, particularly with regard to EmONC equipment and material, and certain community-based activities.

### 4.5.1 Testing causal assumptions for the division of labour

***Assumption 5.1**: H4+ teams at country level in collaboration with key stakeholders have **established forums for coordinating programme action and the division of labour** for H4+ JPCS financed and supported activities in particular and in RMNCH generally.*

*Unless otherwise noted, for evidence cited in relation to assumption 5.1 see Annex 1, Assumption 5.1*

As noted in section 4.3 in relation to evaluation question three, the mechanisms for joint coordination of the H4+ JPCS was established early in the programme cycle and worked well until the end of 2014. The decision to hire a full-time staff to assume the role as H4+ coordinator helped strengthen the joint planning and coordination of programme activities. While coordination with the MoH became less robust in 2015, H4+ members continued to organise monthly inter-agency technical meetings and bimonthly heads of agency meetings, which enabled the programme to continue implementation.

Within the context of the broader H4+ partnership, in particular UNICEF, UNPFA and WHO had already established efficient internal coordinating mechanisms prior to the advent of H4+ JCPS. H4+ members repeatedly noted that the H4+ JCPS helped them boost the coordination of their activities. While they were already working together and met regularly to coordinate activities before 2011, it was not until H4+ JPCS funds came that they were able to *"demonstrate what results improved coordination could produce in the HZs"*. They highlight the monthly technical meetings of the H4+focal points, the bimonthly head of agency strategic meetings, and the annual inter-agency retreats as very effective platforms for coordinating their inputs and avoiding overlap.

***Assumption 5.2**: The assigning of activities and investments in support of H4+ JPCS programme goals in participating countries is based on both **the distinct capacities and advantages of each H4+ JPCS agency** in that country and the national and sub-national context for support to RMNCAH.*

*Unless otherwise noted, for evidence cited in relation to assumption 5.2 see Annex 1, Assumption 5.2*

The assignment of roles and responsibilities among H4+ JPCS members was generally consistent with their distinct capacities and comparative advantages, although some overlaps can be noted, as table 6 below illustrates. While UNICEF, UNFPA and WHO had begun coordinating their input already prior to 2011, UN Women and UNAIDS joined in 2013, and WFP in 2015. UNESCO recently asked to become a member of H6, but their participation is not yet effective. Although the World Bank did not participate actively in the implementation of H4+ JPCS at a technical level, they coordinated inputs at the head of agency meetings. Expanding the H4+ membership to include the WFP in 2015, allowed WFP to contribute its expertise and, thereby helped the H4+ members to give more attention to nutrition than was previously done.

The roles of each H4+ member in the DRC are outlined here based on four different sources: interviews with H4+ country team members, the 2014-2015 and 2015-2016 workplans, and the mapping of RMNCAH work by UN agencies.[68] Table 6 provides an overview of areas of work of each partner. It does not inlcude the World Bank, UNAIDS and WFP, as these agencies did not receive H4+JCPS funds and were not assigned a specific role in annual H4+ JPCS work plans. The areas marked in red are activities supported by two different H4+ members, with no clear distinction between the two, leading to potential overlaps.

[68] (H4+ agencies nd)

**Table 6: H4+ members and their roles and contributions in the H4+ JPCS, DRC programme (2014-2016)**

| H4+ Agencies | Areas of Work |
|---|---|
| UNFPA | • H4+ Coordinator until February 2016<br>• Support to national RMNCAH coordination platforms, including RMNCH Task Force at provincial and national levels; the secretariat of the H4+ JPCS coordination at the MoH (D10); and health zone board meetings (WHO)<br>• Midwifery policy and advocacy and support; revision of midwife training programme and a curriculum to upgrade nurse-midwives to midwives; training of internship-mentors<br>• Strengthening BEmONC and CEmONC training of service providers, including training manuals and supervision<br>• Procurement of mannequins, equipment and didactical materials for pre-service training of midwifes at the Higher Institutes for Medical Techniques (ISTM) (WHO)<br>• Youth-friendly SRH services and family planning/HIV campaigns targeting youth (UNICEF)<br>• Mass media campaign to raise awareness and advocate for RMNCH/FP, including PMTC<br>• Produce educational materials to support community involvement in RMNCAH<br>• Establish strategic partnerships with religious leaders for RMNCAH (UN Women)<br>• Ensure supervision and quality assurance of training institutes for EmONC and family planning training (WHO) |
| UNICEF | • Provision of equipment, medicines and commodities for RMNCAH<br>• Improve access to community and clinical IMNCI and safe deliveries through the family kit approach and support to communiath health workers to promotion of RMNCAH<br>• Support to early diagnostic of children exposed to HIV, strengthening the referral system<br>• Strengthening M&E for RMNCAH<br>• Support the involvement of men in ANC and PNC Support for a youth consultations in Kinshasa and Bas Kongo (UNFPA)<br>• Flat-rate pricing of obstetric care services in Mbanza-Ngungu (WHO) |
| WHO | • Support to national health sector coordination (CNP-SS) and the RMNCH Task Force at national level (UNFPA)<br>• Establishment of community health funds<br>• Introduction of results-based financing in four HZs<br>• Support the establishment of national health accounts<br>• Creation of a national MDSR system including establishment of national, provincial and HZ MDSR committees (H4+)<br>• Ensure supervision and quality assurance of training institutes for PMTCT training (UNFPA)<br>• Flat-rate pricing of obstetric care services in Mosango (UNICEF)<br>• Procurement of didactical materials for in-service EmONC training in Mosango, Matadi and Kinshasa (UNFPA) |
| UN Women | • Provide opportunities for income-generating activities for women cooperatives to stimulate demand for community health funds<br>• Support to young boys' and men's clubs to promote RMNCAH and girl's and women's reproductive rights<br>• Involve religious and local leaders in HIV and GBV prevention (UNFPA) |

| | |
|---|---|
| UNAIDS | • Provide technical support to MoH/ National AIDS Control Program for development and implementation of PMTCT plan and monitoringSupport capacities building of the civil society and promotion of PMTCT at community level<br>• H4+ oordinator as of February2016 |

The table illustrates that in some areas, there was a clear division of labour between the three agencies. This particularly concerns: capacity development in EmONC and midwifery (UNFPA); health financing strategies, including community health funds, RBF and national health accounts (WHO); approaches to strengthen PTMCT, IMCNI and community involvement in RMNCH promotion through the family kit approach (UNICEF); and integration of GBV prevention in programming (UN Women). However, some examples of potential overlaps or similar activities can be noted:

- **Equipment and materials for EmONC training:** Both WHO and UNFPA were involved in the procurement of didactical materials for EmONC. WHO provided materials to strengthen in-service training, while UNFPA delivered materials to ISTM for pre-service midwifery training. However, there is little evidence of how or if this was coordinated between the two H4+ members, and it is likely that this was the sources of gaps in procuring the appropriate materials for the EmONC trainings (as discussed under assumption 1.4). UNICEF also provided equipment to health facilities which was not sufficient to deliver EmONC services.
- **Post-supervision of EmONC training:** The 2015-2016 workplan indicates that WHO is responsible for supervising and ensuring the quality of teacher training at the ISTM, while UNFPA is responsible for post-training supervision of service providers. Although this is a clear division of tasks (i.e. supervision at different levels), it would have been more efficient to have the H4+ partner providing the training (UNFPA) assuring supervision at all levels of the training chain, from the ISTM and national cadre of trainers to the health facility level.
- **Engaging men and religious leaders in RMNCAH:** Both UNICEF and UN Women target men and religious leaders. While this might not create an overlap if they use different strategies and intervene in different zones, there is no indication of how these approaches were discussed and coordinated, or if there was any sharing of lessons learned.
- **Activities targeting youth:** UNFPA is clearly responsible for the integration of youth-friendly services. UNFPA, UN Women and UNICEF have all conducted communication activities targeting youth with different messages. Again, this might notcreate overlaps, but there is no evidence that the H4+ JPCS developed a common vision and strategy for targeting adolescents and youth with a comprehensive package of services across the continuum of RMNCAH care.
- **Community involvement:** UNFPA and UNICEF both implement activities to engage communities in the promotion of RMNCAH, with each agency focusing on various topics. While no direct overlaps were observed in the field, there is no clear evidence of how these activities were coordinated. The workplan often lists several agencies as 'responsible agency/implementing partner', which makes it difficult to understand who does what and where. An example of this is activity *'6.2.1.1. Organise training sessions of 160 community health workers in community-based distribution of contraceptives'* (2013-2014 annual workplan), which states that UNFPA, WHO, UNICEF, DPS, and ABEF are all involved in funding/implementing this activity.
- **Flat-rate pricing approach:** WHO supported this in Mosango and linked it to the community health fund and RBF initiatives, while UNICEF provided technical assistance to introduce flat-rate pricing in Mbanza-Ngungu in relation to the family kit approach and activities to strengthen referral. There is thus no overlap between the two approaches, but it is unclear why two different H4+ partners would support the same type of activity in two different HZs.

It is also questionable if the role played by the WHO in introducing RBF in four H4+ JPCS health zones can be plausibly linked to its advantages in support of RMNCAH. It is clear that the World Bank RBF programme (PARSS) did not overlap with H4+ JCPS support for RBF, as PARSS did not intervene in the nine H4+JPCS target zones. However, given the expertise and the leadership of the World Bank in piloting RBF in DRC and building the capacity of MoH for its scale-up, it seems strange that the World Bank did not play an active role in supporting the implementation of RBF under the H4+ JCPS. There is no clear evidence that WHO provided any technical assistance to the RBF division of the MoH (implementing partner for the RBF); rather, the MoH staff had to explain certain national guidelines and principles to WHO.

***Assumption 5.3**: H4+ JPCS agencies have used structures and processes established for programme coordination at country level to **rationalise their support to RMNCAH and to avoid or eliminate duplication and overlap** in support. This trend is reinforced by increasing levels of coordination contributing to improved operational effectiveness and strengthened advocacy.*

*Unless otherwise noted, for evidence cited in relation to assumption 5.3 see Annex 1, Assumption 5.3*

Although, in some instances, H4+ members implemented similar activities (as described in the previous section), the evaluators did not identify any specific areas of overlap or duplication of efforts on the part of the H4+ members at provincial and HZ levels. As mentioned above, the main issue was rather related to: inefficient joint planning of procurement (EmONC equipment and didactical materials), sequencing of certain inputs, and lack of coordination of inputs at HZ level. MoH senior officials noted that there had been an improvement of inter-agency coordination vis-à-vis the MoH, which did not exist before H4+ JPCS: "*Before, we [MoH] worked bilaterally with each agency. Sometimes, you would find WHO and UNFPA doing the same thing in the same place, there were overlaps (…) Activities are now better coordinated [among H4+ agencies]".* They drew a picture of a 'before' and 'after' the H4+ JPCS: Before, each agency operated independently, now, the H4+ members speak with the same voice. H4+ members and MoH staff believe that the improved coordination will be sustained beyond H4+ JPCS because *"it is a state of mind that has changed, and it will continue. The [collaborative] approach has been adopted, but will require a minimum of resources to be sustained".* The MoH also noted more consistent messages and joint advocacy efforts as a positive outcome of the H4+ JPCS.

Despite these positive trends, there was a major overlap in support to the national RMCNH Task Force at the national level. Both the WHO and UNFPA provided support to the Division for Family Health and Special Groups (D10) to strengthen RMCNAH coordination. While it is not included in the annual workplans, WHO supported the secretariat of the RMCNH Task Force to organise meetings. At the same time, that role was also assigned to UNFPA, and the H4+ coordinator (UNFPA staff) aimed to support the D10 in coordinating RMNCAH interventions. Having two different H4+ members providing support to the RMNCH Task Force, yet with different approaches and rules for budgeting and disbursements created confusion among MoH officials. For example, while one agency is flexible and pays per diem for participants, another woud not do, hence triggering some sort of 'competition' between the agencies according to key informants.

### 4.5.2 Achieving an effective division of labour

While the H4+ country team established efficient mechanisms for inter-agency joint planning and review, and assignment of roles and responsibilities, there is no strong evidence that the H4+JPCS contributed to a more efficient division of labour. Some key areas were clearly divided among the three H4+JPCS members based on their distinct capacities and advantages, such as UNFPA taking the technical lead on midwifery, EmONC training and family planning; UNICEF on PMTCT and IMNCI; and WHO on health financing and national health sector coordination. However, several areas seem not to be well coordinated, such as support for provision of EmONC equipment to training institutes

(UNFPA and WHO) and health facilities (UNICEF and UNFPA), and support to national coordination of RMNCAH (WHO and UNFPA).

***A robust platform and system for coordinating support***

The H4+ JPCS country team was able to achieve an effective system and process for coordinating H4+ JCPS interventions at the beginning of the programme. While the MoH leadership and engagement in the joint coordination was weakened in 2015, the H4+ members continued to organise regular technical and heads of agency meetings to coordinate their respective work, and agree on common advocacy objectives and strategies. Although the workplans sometimes lack clarity with regard to the division of roles and responsibilities, there is no evidence that H4+ partners were duplicating or overlapping the services they provided at provincial and HZ levels. Where similar services were provided by two different H4+ partners, they occurred in different geographic locations, e.g. UNICEF supporting flat-rate pricing in Mbanza-Ngungu, and WHO in Mosango; or campaigns targeting youth implemented in different areas.

H4+ members and MoH officials at national level repeatedly stated that H4+ JPCS funds enabled them to boost the already existing platform for coordination and to demonstrate tangible results, i.e. integrated services along the continuum of care, at HZ, health facility and community levels. At provincial and HZ level, no direct overlaps were observed, yet there is no strong indication of H4+ members' joint planning efforts at sub-national levels. Moreover, there was no coordination among NGO implementing partners.

***Making best use of the strengths of H4+ partners***

H4+JPCS making best use of the individual strengths of the H4+ members was particularly noticeable in the support by UNFPA to midwifery and EmONC training, the family kit approach introduced by UNICEF, and UN Women focusing on GBV and women's sexual and reproductive rights. All three agencies target adolescents and youth as part of their core mandate and programming, but there was no clear division of roles and responsibilities with regard to the youth activities funded by H4+ JPCS. The evidence indicates that UNICEF, UNFPA and UN Women supported different one-off activities in different locations, such as for example a campaign targeting youth with HIV messages, but without harmonising messages or strategies to reach the youth. This points to significant weakness in the design and programming of interventions, caused by a lack of vision for a comprehensive and evidence-based package of adolescent and youth RMNCAH services and education.

The World Bank was not engaged at all in H4+ JPCS planning and implementation at the technical level. The RBF activities supported by the programme could clearly have benefited from the technical expertise of the World Bank staff, and there is no evident explanation as to why WHO and not the World Bank was chosen as the technical partner for RBF. This suggests that only those agencies, who receive funds to implement activities through partners, are actively engaged in providing technical assistance and expertise to the MoH and others involved in programme delivery.

***Do coordination efforts result in collaborative programming of activities which is more effective than separate initiatives?***

The H4+ JPCS led to more collaborative programming among H4+ members, primarily at national level. The inter-agency annual retreats and monthly technical meetings served as an important forum to discuss and agree to a division of labour between the agencies and to plan and review activities together. However, there is no strong evidence that the improved collaboration and coordination at national level led to more effective and comprehensive programme delivery at HZ and health facility level. Rather, there were several issues in coordinating key inputs, particularly with regard to necessary equipment and material for quality EmONC services and certain community-based activities. These include UN Women support to cooperatives linked to WHO supported community health funds, and lack of provision of contraceptives to CHW workers trained in community-based

distribution of contraceptives. There is no clear evidence that UNFPA and UNICEF coordinated their specific support to community health workers at the health zone level; however, there are also no examples of direct overlap.

## 4.6 Value added for advancing the Global Strategy

***Question Six*:** *To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's and Children's Health (the Global Strategy) and the "Every Woman Every Child" movement?*

### *Summary*

1. The H4+ JPCS has allowed H4+ partners to significantly increase the volume of their policy and advocacy work for RMNCAH in the DRC. The most significant results include: (1) support to the development of national RMNCAH strategies (including the CAO 4&5), standards and guidelines; and (2) advocacy efforts leading to high level government commitment to RMNCAH and the mobilisation of additional government and external funds to extend H4+ JPCS supported innovations beyond the nine target health zones.
2. The inter-agency platform for coordinating joint support to the RMNCAH agenda in the DRC **is likely to continue beyond the H4+ JPCS. The reasons are that the H4+ partnership was relatively well established in the DRC before the advent of the H4+ JCPS, and that it serves as a broader platform for coordinating RMNCH interventions funded by different donors. The H4+ members and the government clearly see H4+ JPCS as just one funding source among others, which will come to an end, while the H4+ partnership is believed to be sustained beyond the H4+ JPCS**.
3. The H4+ JPCS contributed to improved availability and quality of key RMNCAH services and resulted in improved trust between service providers and community members. H4+ JPCS has also helped improve policies and practices in RMNCAH at national level and in other provinces, particularly with regard to EmONC training and the family kit approach within the framework of the CAO 4&5.
4. There is currently a lack of trust and efficient coordination between the H4+ members and certain departments and programmes of the MoH, which should be seen within the overall context of weak governance and leadership, and the multiplication and fragmentation of coordinating platforms in the DRC.

### 4.6.1 Testing causal assumptions for value added

***Assumption 6.1****: The establishment of H4+ JPCS in 2011 and its expansion in 2012 helped* ***strengthen the rationale for and extent of policy support for coordinated action in RMNCAH*** *at national and sub-national level by the H4+ agencies*.

*Unless otherwise noted, for evidence cited in relation to assumption 6.1 see Annex 1, Assumption 6.1*

H4+ JPCS contributed significantly to improving the policy, strategies and guidelines for RMNCAH in the DRC. H4+ members provided policy advice and technical input to a number of policies and strategies leading to an improvement policy framework for RMNCAH in DRC. These include:

- The national health development plan 2016-2020 (2016)
- The CAO 4&5 (2013)
- The national family planning strategic plan 2014-2020 (2014)

- National policy and guideline for integrated treatment of acute malnutrition of pregnant women and children
- Global Financing Facility (GFF) H4+ members participated in the development of the investment case to the GFF (2016)
- HIV and AIDS investment case for a generation without AIDS in DRC (2014)
- HIV and AIDS National Strategic Plan 2014-2017 (2014)

In 2012, H4+ JPCS contributed to the development of RMNCAH norms and standards, including specific volumes for: (1) BEmONC; (2) CEmONC; (3) basic and emergency care of newborns; (4) child health services; (5) health services adapted to adolescents and youth; (6) family planning services; (7) care and treatment for survivors of sexual violence; and (8) community based interventions for maternal, newborn and child health. In 2015, H4+ JPCS contributed to the update of the 2012 edition of the RMNCAH norms and standards, the revision of the partograph, and the development of norms and guidelines for utilisation of a wide range of medicines and commodities used in RMNCAH. Several guides, job aids and data collection tools for RMNCAH services were also developed. In addition, annual reports indicate that H4+ JCPS supported the distribution of these updated norms and guidelines. Observation at eleven health facilities during the field visit found that 82 percent of the facilities had received the updated norms and guidelines, training manuals and job aids. However, not all health providers were aware of the existence of the training modules developed with H4+ support (EmONC, family planning and PMTCT). Service providers consistently highlighted the partograph and the ANC registers as useful tools for improving the quality of services in RMNCAH developed with support from H4+.

In 2012, the advocacy efforts by H4+ members led to the signature of a ministerial decree to establish the midwife education programme as a separate professional category. H4+ JPCS provided support for the development of (1) the three years direct-entry midwife programme (curriculum development for a more concentrated and detailed programme); (2) a programme to upgrade nurses to midwives; and (3) the national EmONC training module.

Further examples of H4+ JPCS policy work include:

- UNICEF support to the family kit approach and community involvement in RMNCAH informed not only the CAO 4&5, but also the development of a national strategy to develop community involvement in health
- WHO policy advice to establish national health accounts to improve accountability in the health sector
- UNFPA support to establish a MDSR system, including development and distribution of tools to HZs and health facilities.

In summary, the H4+ JPCS funds enabled the H4+ members to support a considerable body of policy work in RMNCAH, and this work was refined in operational RMNCAH guidelines and procedures. H4+ JPCS provided support to the distribution of these standards and protocols. With funding from the RHMNCH Trust Fund, H4+ members currently supported the MoH in a large-scale diffusion of and guidelines to provinces and health zones beyond the H4+ JPCS intervention zones.

***Assumption 6.2***: *By providing targeted funding for global activities (and funding the coordinating office) H4+ JPCS programme funding* ***facilitated the development of knowledge products and joint, coordinated advocacy in RMNCAH by H4+ agencies*** *which would not have otherwise been undertaken*.

*Unless otherwise noted, for evidence cited in relation to assumption 6.2 see Annex 1, Assumption 6.2*

It is neither practical nor desirable to assess the level of output of knowledge products developed at the global level by the H4+ partners when conducting a country case study. However, it is worthwhile considering which H4+ global knowledge products may have been of most direct use in the policy and advocacy activities when viewed from a country perspective. In June 2016, the global coordinator for H4+ JPCS produced a listing by year and agency of the global knowledge products funded by H4+ through its global workplan. The products with the clearest **potential** linkages to policy work undertaken by the H4+ programme in the DRC include:

- Toolkit for RMNCAH strategic planning, implementation, monitoring and review (WHO, 2012)
- An RMNCAH policy compendium developed (WHO 2013)
- Technical guidelines for maternal death surveillance and response (WHO 2013)
- MDSR implementation monitoring tool drafted (WHO 2014)
- Final version of rapid assessment of RMNCH Interventions and Commodities (UNICEF 2013)
- Development of the list of essential life-saving commodities/equipment for MCH/family planning by the UN Commission on Life Saving Commodities with H4+ input (UNICEF 2013)
- Feasibility of indicators of quality of care for MNCH care in facilities tested in DRC, Chad, Tanzania, Zambia and Zimbabwe (WHO 2015)
- Midwifery Services Framework developed and community health workers RMNCH training guidelines (UNFPA 2014)
- RMNCH training guidelines developed. A mapping of existing training tools for CHWs in SRH/MNH (UNFPA 2013)
- Core competencies for adolescent health and development for health care providers in primary care settings published (UNFPA 2015)
- Template for documenting innovations (UNFPA 2015)
- Zero Discrimination in Health Care and Putting Human Rights on Fast Track (UN Women 2014)
- Policy briefs and advocacy material on rights and equality for SRHR and RMNCAH – one global and two regional (UN Women, 2015)
- Use of amoxicillin for treatment of pneumonia (WHO 2015)
- Development and release of the State of the World's Midwives Yearly report in June 2014 (WHO 2014).

It is difficult to know which of these products might have been produced at global level in the absence of the H4+ JPCS. What they do demonstrate is that H4+ partners have been active at global level in producing policy inputs, guidelines and advocacy tools that can support action at country level. More importantly, they are relevant to the policy inputs and guidelines which have been supported by H4+ in the DRC as listed in relation to assumption 6.1 above.

As described under assumption 4.1., H4+ members received technical input, used guidelines and participated in regional training workshops to support advocacy efforts and RMNCAH work in the DRC. They specifically mentioned their use of the various RMNACH training guidelines and the participation in regional workshops on EmONC and MDSR.

***Assumption 6.3***: *H4+ partners, assisted by programme funding, were able to be more effective in* ***advocating for commitments to Global Strategy principles and priorities*** *than they would have been without programme support. Their communications and advocacy work was made more consistent through collaboration on common products.*

*Unless otherwise noted, for evidence cited in relation to assumption 6.3 see Annex 1, Assumption 6.3*

In the DRC, the H4+ partnership has been able to articulate a coherent set of policy priorities consistent with the Global Strategy principles. H4+ country team members suggest this is partly a result of their experience working together to implement a comprehensive programme funded by Canada. Ministry of Health officials and H4+ members repeatedly highlighted the important role of H4+ JPCS funds in boosting inter-agency collaboration and joint advocacy efforts to raise additional funds for RMNCAH. H4+ members noted that the experience of working together on a joint programme helped them agree on joint priorities and be more effective in delivering key messages to the MoH and other development partners. For example, in 2015, they decided to advocate and provide joint support to the MoH to integrate RMNCAH as a key priority in the PNDS 2011-2016. Recently, the H6 partnership decided they will work together to influence the government to use a large donation from the Chinese government to improve RMNCAH. During the annual inter-agency retreat in January 2016, the H4+ members identified four strategic objectives, including the continuing effort to support the government in RMNCAH policy and strategy development, as well as mobilising funds by preparing the investment case for the Global Financing Facility.
The H4+ members also brought a stronger RMNCAH focus into larger health sector coordination platforms, particularly the donors' forum for health (GIBS). Together, H4+ partners were able to communicate a set of key messages more effectively, encouraging other partners to align their investments to the CAO 4&5. As one H4+ member states, *"The H4+ enabled the agencies to influence other development partners, through the GIBS, to become engaged in RMNCAH.*
"*H4+ JPCS allowed us to have one joint position from which we could influence partner platforms, such as the GIBS, the donors. It allowed us to have one unique goal, and to know which joint priorities we defend when we are in front of the development partners. That priority is the health of mothers and children and the fight against different forms of morbidity and mortality."* The stronger focus on RMNCAH in GIBS meeting was facilitated by the fact that UNICEF was the lead agencies for the GIBS in 2014 and 2015, as this strengthened the ability of the H4+ members to influence other donors/ partners. The H4+ members also influence other partners and the government through the technical committees of the National Health Sector Coordinating Committee (CNP-SS).

The H4+ partnership has enabled the H4+ agencies to be more efficient in their advocacy efforts, which has led to the mobilisation of additional resources for RMNCAH, such as for example the RMNCH Trust Fund grants. In that sense, the H4+ JCPS had catalytic effects at a broader, national level. Achievements resulting from the improved, increased joint advocacy efforts of H4+ partners include:

- Parliamentarians were sensitised to allocate more resources for maternal health at the provincial level.
- H4+ JPCS provided technical support to the MoH for the development of the CAO 4&5 to accelerate progress towards MDGs 4 and 5 (USD 15 million was mobilised by the government to finance this roadmap).
- H4+ JPCS communication and advocacy efforts helped the MoH align other partner support with this national framework.
- H4+ JPCS advocacy resulted in government commitments of USD 300,000 for contraceptives and USD 66 million for medical equipment beyond programme areas to strengthen the health system in 2013 (i.e. the PESS project).
- Two provincial governments committed to create a special budget line for RMNCAH.
- A joint mission by H4+ members from headquarters and representatives of Canada and USAID in 2014 led to the mobilisation of RMNCH Trust Funds for scaling up access to 13 essential mother, newborn and child medicines.

- Advocacy efforts to reposition family planning led to the creation of a national Task Force for the Demographic Dividend at the Office of the Prime Minister which defines family planning as one of its key strategies. H4+ JPCS supported the development of the national family planning strategy 2016-2020.
- H4+ JPCS supported the development of the Reproductive Health Law, including the strengthening of family planning. H4+ has also been involved in the advocacy for the adoption of the law, which has been presented to the parliament and is under review by the constitutional court.
- A stronger focus on RMNCAH was integrated into the PNDS 2016-2020.
- Advocacy efforts with the Ministry of Higher Education resulted in the establishment of a three-year, direct-entry Midwives Education Programme.
- H4+ JCPS support to strengthening in-service EmONC trainings, and the effective communication of results achieved under H4+ JCPS, helped mobilise other partners to fund EmONC training in other provinces and health zones.

H4+ members and MoH officials consistently highlighted how H4+ JPCS boosted inter-agency work on joint advocacy priorities. There is clear evidence that participating collectively in the H4+ JPCS helped the partners become more coherent and effective in their policy engagement and advocacy work, and that this helped the government mobilise additional funds for RMNCAH with other partners.

***Assumption 6.4***: *Where H4+ JPCS has contributed to improvements in service quality and access for RMNCAH, these have in turn made a* ***contribution to positive outcomes in RMNCAH*** *including the targeted operational outcomes of the Global Strategy and "Every Woman Every Child".*

*Unless otherwise noted, for evidence cited in relation to assumption 6.4 see Annex 1, Assumption 6.4*

The H4+ programme has contributed significantly to increase the availability, and to some extent also the quality of RMNCAH services in the nine health zones supported by the H4+ JPCS (see Section 4.2). Improvements in RMNCAH policies and practices have extended beyond the nine targeted HZs and reached the the national level, other provinces and HZs. Concrete examples of how H4+ JPCS-supported interventions were taken to national scale are provided in section 4.4. Moreover, the H4+ JPCS has brought the H4+ members closer together around a joint agenda and joint advocacy efforts, which has contributed significantly to an increased focus on the RMNCAH priorities in the DRC, as defined in the Global Strategy and the Every Women Every Child movement, and to the mobilisation of additional funds for RMNCAH.

While the data presented in section 4.1 (assumption 1.5) provides a mixed picture of the progress against key RMNCAH output indicators, national level outcome data suggest that there have been improvements in maternal and child health outcomes.

### 4.6.2 The value added of H4+ JPCS

The H4+ JPCS in DRC was able to develop and implement a programme that strengthened RMNCAH policies, strategies and institutions at national level, while addressing key barriers and improving access to RMNCAH services at the operational level. Importantly, the programme was complementary and catalytic in support of other programmes, including the government PESS, the Global Fund, Gavi, Belgian Technical Cooperation, and the H4+ members' own funds. These programmes focused on general support for health systems strengthening, HIV, malaria and TB medicines (The Global Fund), and vaccination of children (Gavi). The H4+ JPCS, on the other hand, provided important inputs to capacity development of service providers in RMNCAH and to EmONC specific equipment, medicines and commodities not provided by these other programmes.

The contribution to policy and advocacy work, mobilisation of additional government and donor resources for RMNCAH, together with key interventions to improve the availability and quality of RMNCAH services at health facility and community level, represent the most important element of value added of the H4+ JPCS programme in DRC.

***More extensive and coherent policy and advocacy engagement at country level***
The availability of H4+ JPCS funding, combined with agreed priorities between the MoH and the H4+ members for policy and advocacy work in RMNCAH, allowed the programme implementing partners to intensify their level of involvement in policy engagement and advocacy. The most significant results include the alignment of partners to the CAO 4&5, high level government commitment to family planning, and the mobilisation of additional funds to improve the availability of essential RMNCH medicines and extend H4+ JPCS supported innovations (competency-based EmONC training and the family kit approach) to other provinces and health zones. Finally, the approach to policy work and advocacy used by H4+ partners was clearly more coherent and efficient than before the H4+ JPCS. The resulting products were used well beyond the boundaries of the nine targeted H4+ JPCS districts.

***Contributing to outcomes in RMNCAH at national, provincial and HZ level***
Sections 4.1 and 4.2 document the contribution made by H4+ to strengthening health systems and improving access to integrated care in the nine target HZs. The H4+ JPCS-support resulted in improved trust between service providers and community members, although some of these gains are at risk if the interventions are disrupted or defunded after a short period of time. The combination of trainings, equipment, medicines and community involvement in RMNCH and the family kit approach has improved access to services significantly. This HZ level effect does not mark the limits of the H4+ contribution to results in RMNCAH. H4+ has helped to improve policies and practices in RMNCAH at national level and in other provinces, particularly with regard to EmONC training and the family kit approach within the framework of the CAO 4&5.

However, it is not possible to estimate the extent of the contribution made by H4+ to national, provincial and HZ level improvements in outcomes in RMNCAH. This is methodologically particularly difficult as the H4+ members implemented similar activities with their own funds or resources provided by the RMNCAH Trust Fund in the same provinces.

***Informing H6 support to RMNCAH after the close of H4+***
There is strong evidence that the inter-agency platform for coordinating joint support to the RMNCAH agenda in the DRC will continue to last beyond the H4+ JPCS. H4+ members continue to meet frequently and organise retreats during which the future of H6 is discussed, for example during the H4+/H6 annual retreat in January 2016. It is clear that H4+ members and the government saw H4+ JPCS as one funding source among others, yet an important one that helped accelerate the implementation of the CAO 4&5 and test important innovations. Besides, rather than being limited to one donor funded programme, the H4+ partnership is understood in a much broader sense in the DRC.

It is this broader vision and platform that will help ensure the sustainability of the inter-agency collaboration and some of the gains produced with H4+ JPCS funds. However, the most urgent issue to address in the post-H4+ era is the lack of trust and efficient coordination between the H4+ members and certain departments and programmes of the MoH, which should be seen within the overall context of weak governance and leadership, and the multiplication and fragmentation of coordinating platforms in the DRC.

# 5 CONCLUSIONS

This chapter presents the conclusions and implications of the field country case study of DRC. The conclusions presented here are directly based on the findings provided in section 4. They are drawn from the answers to the six evaluation questions and directly address all six areas of enquiry of the End Line Evaluation of the H4+ JPCS.

## 5.1 Conclusions

1. The H4+ partners were able to establish an efficient process for planning and coordinating the programme in the DRC, especially at the national level. In the early years, they were also able to engage with the Ministry of Health (MoH) in developing the H4+ JPCS and to ensure it addressed systematically identified gaps in reproductive maternal neonatal child and adolescent health (MNCAH) coverage and that it was aligned with national priorities.

2. Over time however, the level of MoH leadership and engagement in the processes and structures for planning and coordination of H4+ JPCS initiatives in the DRC significantly diminished. The H4+ partners continued to use the established structures and processes to ensure that their own work was coordinated at national level and aligned with expressed national priorities, but this was done without regular participation from and leadership by the MoH (or any other government representatives). To some extent this can be attributed to capacity issues within the MoH. The significant question that remains concerns whether or not the H4+ partners could have made greater efforts to engage with and support leadership by the MoH and whether or not these efforts would have had a reasonable chance of success.

3. While early national engagement and ongoing efforts at coordinating the work of the H4+ partners led to alignment of H4+ JCPS interventions to national priorities and complementarity with other RMNCAH and health systems strengthening programmes, these coordination efforts did not extend sufficiently to the provincial and health zone level. In particular, they did not incorporate implementing partner participation at sub-national level where there were significant ongoing challenges to coordination.

4. There are some significant elements of success in H4+ support to health systems strengthening for RMNCAH in the DRC, with clear linkages from the national to the health zone level. In particular, the support provided to the family kit approach to include elements of integrated management of newborn and childhood illnesses (IMNCI) with other aspects of RMNCAH, represent an important contribution to the health systems in the targeted health zones and at the national level. Similarly, the H4+ contribution to competency-based, in-service training for emergency obstetric and newborn care (EmONC) has had important effects at the national, provincial and health zone level. H4+ JPCS-support to provision of essential medicines and commodities has also contributed to health system strengthening at sub-national level.

5. Unfortunately, progress has been significantly impeded by bad sequencing and delayed delivery of important inputs financed by the programme. This resulted from either issues in internal coordination of support among the H4+ partners, or lack of coordination with other programmes. It is however important to recall that the context in the DRC is marred by extremely limited capacity in, for example, EmONC services, effective procurement and supply chain management (PSM), as well as management of human resources for health. In this context, and despite its own limitations in local coordination and delays in delivery, H4+JPCS was able to contribute to the improving quality of RMNCAH services, especially but not exclusively in the targeted health zones.

6. The 2015 decision by the UNFPA country office to consolidate its support among a very small number of implementing partners in the DRC (including funding from H4+ JPCS and other programmes) led to the abrupt termination of partnerships with a number of H4+ JPCS implementing partners. These implementing partners were active at national, provincial and health zone levels and had a reasonable expectation of continued support based on their performance. This made it difficult for them to maintain the level of trust they had established in the communities they served. Furthermore, the choice by UNFPA to concentrate its H4+ JPCS financing in the DRC on a single implementing partner – the Ministry of Health – contributed to a marked reduction of activities at provincial and district level. It does not appear that this was compensated by an increased level of activities implemented at national level.

7. In the DRC, the H4+ JPCS programme had important positive results in improved access by youth and adolescents to RMNCAH services, mainly through its support to a small number of youth friendly centres, although these had quite limited geographical reach. It is however noteworthy that the programme lacked a vision and a coherent strategy for addressing the needs of youth and adolescents and thus, missed a significant opportunity to engage effectively with youth and to address the very significant barriers to access critical products and services in RMNCAH, especially for young women and girls.

8. In the DRC, H4+ JPCS was particularly effective in identifying and supporting two very important innovations in RMNCAH: the use of the family kits for IMNCI and maternal, newborn and child health (MNCH) services provided by community health workers, and the introduction of competency-based pre- and in-service training for EmONC. These innovative approaches were followed closely and scaled up to the national level by the MoH. They were also shared with other development partners in the DRC and with H4+ JPCS country teams in other countries. Unfortunately, the innovations supported by H4+ JPCS in the DRC have not been systematically documented nor have they been processed through an explicit knowledge management strategy which the programme lacks.

9. The investments and activities of H4+ JPCS focusing on community engagement and demand creation were limited in scope and duration. Hence, they reflected a significant imbalance between supply and demand side interventions supported by the programme.

10. H4+partners made considerable efforts to establish a clear division of work. While roles and responsibilities were generally assigned based on the distinct competencies of each H4+ member, this did not entirely prevent potential overlaps and inefficient collaboration. These were most clearly noted with regard to the strengthening of the RMNCH Task Force, which was supported by both WHO and UNFPA; the attempt to link the UN Women supported income generating activities with the community health fund supported by WHO; and the RBF intervention, which was led by WHO, with very limited involvement of the World Bank.

11. Overall, the value added of the H4+ programme in the DRC rests in the national level policy work and outstanding joint advocacy efforts which, in turn, have contributed to a stronger focus on and government engagement in RMNCAH with the mobilisation of additional funds. There is a strong vision for H4+ in the DRC where partners established a strong collaborative platform before the beginning of the H4+ JPCS, and where the three most active partners (UNICEF, UNFPA and WHO) had already implemented several programmes jointly. The active participation of UNWomen, UNAIDS and WFP (who joined the partnership at a later stage) has also contributed to the successes of the H4+JPCS in the DRC.

## 5.2 Implications for the H6 partnership

This section identifies some implications for the ongoing evolution of the H6 partnership arising from the field country case study of H4+ JPCS in the DRC. The points raised here apply to the partnership as a whole and to any funded programmes it may be responsible for in the future. They do not require or call on actions from the H6 team in the DRC. Recommendations will be presented in the final report of the end line evaluation of H4+JPCS.

1 H6 should systematically emphasise the need for country-led processes for coordination regardless of the fact that interventions result from dedicated and earmarked funds (as in the H4+ JPCS), or consist in advocacy with national governments on the use of additional national resources for RMNCAH.

2 H4+ partners have made considerable efforts to strengthen national mechanisms for health sector coordination, including the health sector coordinating committee (CNP-SS) and the RMNCH Task Force. Yet there is an urgent need to intensify technical assistance to the MoH to consolidate the multiple (at times, overlapping) coordinating platforms. It is important to harmonise the approach of the H6 partners support to the RMNCH Trust Fund at national and provincial levels, as it integrates further into the CNP-SS at both levels. This requires the harmonisation of technical input as well as financial procedures among H6 partners. The H6 should also address the need for capacity development of key actors in the MoH so they can lead these coordinating mechanisms.

3 There is an urgent need to improve communication and coordinating mechanisms at provincial and health zone level – both between H6 partners and with other RMNCAH partners. More regular and consistent participation of H4+ partners in provincial and health zone planning and review meetings is an important step towards improved joint planning and coordination of inputs for RMNCAH at these levels. Particular attention should be given to the appropriateness, timing and sequencing of inputs. This will also help improve the responsiveness to local needs as expressed by provincial health departments and health zone teams.

4 H6 should develop a unified vision and a clear operational strategy for the delivery of a comprehensive package of RMNCAH services adapted to the needs of adolescents and youth. Particular emphasis should be given to linking demand and supply side activities, combined in-school and out-of-school approaches, and current gaps in skills and knowledge (such as family planning, child marriages, early pregnancies and gender relations). A clear division of labour between H6 partners will be important to ensure that the full package of services is delivered, including: youth-friendly services; comprehensive sexuality education in schools; social marketing of RMNCAH products; multi-media campaigns; approaches reaching the most vulnerable youth; and income-generating activities.

5 Experience in the DRC has shown the importance of reaching an appropriate balance between funding to support improvements in the supply of services in RMNCAH and supporting interventions to mobilise demand in the communities being served. Long-term funding for demand-creating activities seem particularly important to sustain demand, to contribute to sustainable behaviour change, and to influence the enabling environment for RMNCAH service delivery and utilisation.

6 Wherever initiatives like the H4+ JPCS are involved in funding and programming resources for RMNCAH in a defined time frame, it is critical to build links between ongoing programmes and larger, more durable initiatives to support the health sector as part of a clear exit strategy. Only then can the modest resources available to H6 partners have a lasting impact on service quality, access and community mobilisation.

# 6 ANNEXES

## ANNEX 1 EVALUATION MATRIX

**Area of Investigation: Strengthening Health Systems**

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| **Question One: To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for RMNCAH, especially by supporting the eight building blocks of health systems?[69]**<br>**a. To what extent has regional and global technical support from H4+ helped enable country teams and national health authorities to identify opportunities, develop innovative approaches and design technically sound initiatives to strengthen health systems for RMNCAH?**<br>**b. To what extent have H4+ JPCS programmes at country level supported health systems strengthening interventions which are catalytic and have the potential to build on existing or planned interventions with international or national sources of funding?**<br>**c. Are H4+ JPCS supported investments sufficient in reach and duration to contribute to lasting changes in capacity for service providers which can sustain behavioural change?**<br>**d. Are H4+ JPCS supported investments at sub-national level (especially in high burden districts) capable of demonstrating approaches to health service strengthening which can be taken to scale at sub-national and national levels?** | | |
| **Assumption 1.1**<br>*H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify **critical and unserved needs in the eight areas of health systems support for RMNCAH.** The needs in each of the eight areas are not fully met by other sources of support and, importantly, **programme support can build on investments and activities underway** with national and external sources of finance and support to accelerate action.* | | |
| | **Information/data** | **Information sources** |
| 1 | **Based on a H4 joint mission in 2009, the H4+ JPCS proposal included** a basic intervention package and key priorities aimed to rapidly scale up the coverage of services to reduce the number of unwanted pregnancies and ensure save deliveries were identified. | *« Pour une accélération d'atteinte des OMD 4 et 5 en RDC. Soutien interagence (H4+) au plan d'accélération de la réduction de la mortalité maternelle et néonatale dans trois provinces sur fonds Canadien »* (hereafter |

[69] While the term 'health systems strengthening' applies to the entire health system rather than a specific sub-element, the inception phase has shown that almost always, H4+JPCC support to national health systems is aimed very specifically at strengthening national systems for planning, prioritizing, budgeting, delivering and assessing services in RMNCAH. For that reason, the evaluation will focus mainly on health systems strengthening for RMNCAH. It will not, however, ignore broader support to national health systems wherever that becomes evident.

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| | | referred to as "DRC H4+ JPCS proposal"), p. 3 |
| 2 | • A joint mission to Bandundu and Kinshasa prior to the proposal development identified problems, challenges and needs including in the selected health zones (HZ). Those areas had very poor indicators.<br>• A rapid emergency obstetric and newborn care (EmONC) assessment revealed issues with coverage, as certain health zones had never had EmONC. It also identified needs in equipment and capacity development. The rapid assessment covered all nine health zones, and informed the selection of health facilities. | Interview, senior official in MoH in Kinshasa |
| 3 | The H4+ joint programme proposal was developed by the Division for Family Health (D10) of the Ministry of Health (MoH) and the H4+ agencies. A national consultant was hired to assist with the proposal writing. The division of labour was agreed upon according to the specific attributes and mandate of each agency. A rapid baseline EmONC survey was conducted in the three target provinces to identify needs. | Interview, senior official in MoH in Kinshasa |
| 4 | The original H4+ JPCS proposal was developed under the leadership of the Division for Family Health of the MoH with the technical support of WHO, UNFPA, UNICEF and UNAIDS. The World Bank, WFP and UN Women did not participate. | Interview H4+ coordinator (UNFPA) |
| 5 | The original proposal was developed jointly by the Ministry of Health and the H4+ agencies and the main priorities were identified during an off-side planning workshop in Matadi. *« Cet atelier a été sous le leadership du gouvernement notamment la D10 qui avait délégué deux de ses représentants. Y avait également le PNSR et la DEP ."* | DRC H4+ JPCS: *proposal* (H4+ Canada 2010b: 11). (Email with H4+ coordinator 20 Sep 2016) |
| 6 | The proposal was developed in 2011 by the D10 and the Division for Planning and Studies (DEP) with technical assistance from the H4+ agencies: *"Quand le projet a été établi, les agencies ont appuyé D10 et la DEP."* | Interview, H4+ country team member |
| 7 | Meeting minutes indicate that the H4+ partners and the government held joint planning meetings in 2010 to prepare the start-up of the H4+ JPCS. | H4+ country team (2010): *Réunion sur la préparation du plan de travail pour l'implantation du SONU dans les 3 provinces*, 28 Avril 2010 (H4+ Country Team 2010) |

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| 8 | The **selection of the nine health zones** (HZs) took place in dialogue with the government. The districts were chosen based on the presence of the UN agencies (at least two agencies should be present in the HZ), to facilitate collaboration and continuation of activities. For example in Nsele, WHO and UNFPA already had a joint project. Another criterion was to intervene in HZ that already received other support in terms of equipment and capacity development of staff, i.e. to complement what already existed. Prior to the H4+ programme, the UN agencies had already written a joint proposal (mother and newborn health) to cover 50 health zones, but it was never financed. When they received H4+ Canada funds, H4+ members chose nine out of the 50 health zones. | Interview, H4+ country team member |
| 9 | A **selection criterion** was that at least two H4+ agencies should already be present and conducting RMNCH activities in the HZ, as it was believed this would facilitate the coordination among the agencies. | Interview, H4+ coordinator |
| 10 | "*We* [MoH] *selected the HZ that had already received UNFPA and WHO support, with the idea of complementing the activities that had already been implemented by these agencies."* | Interview, senior official in MoH in Kinshasa |
| 11 | *« La sélection des différents districts ou zones de santé H4+, ont été superposable aux zones de santé qui sont appuyées par une autre agence de nation unie ou partenaire, et l'appui serait complémentaire aux appuis existants. »* | Interview, implementing partner (NGO) |
| 12 | *"The H4+ project was designed to complement and build on RMNCAH investments already made by the H4+ agencies in the context of the H4+ partnership approach in the nine HZ."* | DRC H4+ JPCS: *proposal* (H4+ Canada 2010b: 6) |
| 13 | *« L'identification des besoins et la définition des priorités étaient réalisées sur base des données statistique du pays en rapport avec la mortalité infantile et maternelle élevées de la sous-région voir la source est (l'EDS MICS) articulé et PNDS 2011-2015 et 2016-2020) »* | Interview, implementing partner (NGO) |
| 14 | The H4+ intervention areas were primarily selected based on the ability of the MoH at central level to access, coordinate and supervise these areas. Furthermore, within the three target provinces, the health zones with the weakest health infrastructure and service delivery were selected. | Interview, H4+ country team member |
| 15 | The choice of HZs was based on the HZs with the most needs, i.e. the highest rates of morbidity and mortality. | Interview, senior official in MoH in Kinshasa |
| 16 | The following data sources were used to identify gaps and needs and to establish the baseline indicators: Demographic Health Survey (DHS) 2007; MICS 2010, EmONC baseline survey; rapid assessment of EmONC services; and HMIS data: *« Ces données nous ont permis d'identifier les spécificités et priorités/besoins de chaque province. Par exemple, le taux de l'létalité maternelle est* | H4+ Country Team (2012). Annual Progress Report 2012, (H4+ Country Team 2012a : 15) |

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| | *très élevé dans la province de Bas Congo, ce qui suggère que la qualité des SONU est très loin d'être optimal. »* | |
| 17 | Within the Bas Congo province (now Kongo Central), the health zones with the poorest RMNCAH indicators were selected. | Interview, provincial health director |
| 18 | H4+ Heads of agencies discussed strategies to ensure the catalytic nature of the H4+ Canada funds and complementarity with other partners: *« Les aspects de convergence des interventions en termes de complémentarité : amener les fonds catalytique là où il y a déjà appuis d'autres partenaires. »* | Minutes of H4+ heads of agencies coordinating meeting |
| 19 | The priorities of the H4+ programme were chosen based on the National Health Development Plan (PNDS) 2011-2015 which had just been developed, and were thus perfectly aligned to the priorities of the government. | Interview, H4+ country team member |
| 20 | The proposal was developed based on priorities defined in the PNDS and on different studies, including the MICS and DHS 2007. | Interview, H4+ country team member |
| 21 | *« L'identification des besoins et la définition des priorités étaient réalisées sur base des données statistique du pays en rapport avec la mortalité infantile et maternelle élevées de la sous-région voir la source est (l'EDS MICS) articulé et PNDS 2011-2015 et 2016-2020). »* | Interview, implementing partner (NGO) |
| 22 | • The DRC H4+ JPCS proposal identifies the **main causes and unserved needs of maternal and neonatal deaths** to be: (i) insufficient health personnel qualified in essential obstetric and neonatal services; (ii) weak supply of quality obstetric and neonatal services; (iii) weak integration of PMTCT in maternal and child health services; (iv) financial and socio-cultural barriers that prevent women, newborns and children accessing available services; and (v) weak community participation in solving health problems and managing health services.<br>• Challenges such as **weak coordination of RMNCAH partners** and interventions and challenges related to Health Management Information Systems (HMIS), Monitoring and Evaluation (M&E) and documentation are indicated as main priorities to be addressed.<br>• A rapid **EmONC baseline survey** conducted prior to the proposal development identified unserved needs which allowed the H4+ agencies to expand the minimum package of interventions offered in nine target HZ was referred to in the proposal | DRC H4+ JPCS: *proposal* (H4+ Canada 2010b: 6-7) |

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| | • The proposal identifies the low quantity and quality as well as inequitable distribution of **human resources** as a factor influencing the supply of RMNCH services. There is a lack of nurses and midwives (nurses A1, A2, A3/midwives) at health centre and reference health centre level. | |
| 23 | A number of **(baseline) studies** were conducted at the beginning and during the implementation of the H4+ to identify critical needs, gaps and barriers to access, and to inform programme design and ongoing adjustments, including:<br>1) A study to identify socio-cultural barriers to use of family planning services in the 9 HZs<br>2) A client satisfaction study to assess the level of satisfaction with RMNCH services among women of reproductive age<br>3) A national study to assess the availability of RMNCH services (including family planning) and to map existing RMNCH interventions, covering 97% of all HZ and 89% of all health facilities in DRC<br>4) A sub-national survey on the availability and quality of EmONC services in the three target provinces (Kinshasa, Bandundu, and Bas Congo) was conducted by the National School of Public Health of the University of Kinshasa with technical support from Colombia University in USA (Enquete de Besoin en Soinds Obstétricaux et Néonatal d'Urgence (ESONU) 2012)" (p. 10). To complement this information and collect additional data for the baseline indicators, a rapid assessment of EmONC services was conducted also in 2012 (p. 15)<br>5) In 2015, a study to evaluate the level of availability of essential reproductive maternal neonatal child health (RMNCH) drugs and services, procurement and supply management capacity at all levels, and update the sanitary map of each HZ supported by UNFPA. The study covered 63 health zones in 8 provinces, including the 3 provinces covered by H4+ JPCS<br>6) A result based financing (RBF) baseline study to inform the introduction of RBF in the H4+ health zones conducted in 2013<br>7) In 2014, a feasibility study to document lessons learned of existing community health insurances in Bas Kongo<br>8) Baseline studies evaluating the level of knowledge and skills of health workers in EmONC.<br>9) Population Media Centre conducted a baseline study to identify barriers to improved RMNCAH. | 1) MoH (2013). *Etude des facteurs socio-anthropologiques limitant l' utilisation des services de planification familiale dans 9 zones de sante des provinces de Kinshasa, Bas-Congo et Bandundu* (MoH 2013b)<br>2) MoH (2013). *Etude sur la satisfaction des utilisateurs/clients des services de santé de la mère, du nouveau-né et de l'enfant y compris la planification familiale dans les provinces de Kinshasa, Bas Congo et Bandundu, août 2013* (MoH 2013c)<br>3) MoH (2012). *Cartographie des interventions et intervenants de la sante de la mère, du nouveau ne et de l'enfant y compris la planification familiale en RD Congo.* (MoH 2012a)<br>4) H4+ Country Team (2012). Annual Progress Report 2012 (H4+ Country Team 2012e: 10, 15)<br>5) MoH (2015). *Évaluation des indicateurs pour le Suivi du Programme de Sécurisation des Produits de Santé de la Reproduction en RDC.* (MoH 2015a: 25)<br>6) DRC H+4 Annual Report 2013 (H4+ Canada 2014a: 5)<br>7) DRC H4+ Annual Report 2014 (H4+ Canada 2015: 12) |

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| | | 8) Interview Prof Lokoma et Prof Mboloko, Universite de Kinshasa; interview with ISTM Kinshasa<br>9) Interview with Population Media Centre |
| 24 | *« Le quatrième jour a porté essentiellement sur les travaux en groupes consistant à remplir le canevas d'identification des structures devant être renforcées pour offrir le SONU de base ou complet dans les avant-midis tandis que les après-midis la plage a fait focus sur la restitution des travaux des différents groupes. Cet exercice a permis d'identifier les formations sanitaires pouvant offrir SONUB et le SONUC.* | UNFPA (2013). *Rapport de mission de restitution de l'enquête SONU et d'élaboration du PAO SONU dans la ville de Matadi du 12 au 17 novembre 2013*<br>(UNFPA 2013: 4) |
| 25 | • « *Une enquête viabilité des Instituts d'enseignement médical supérieur a été organisée conjointement par le MINESU et le JICA et a montré une faiblesse de la formation du personnel de santé. Pendant la célébration de la première journée des Sages-femmes (5/05/2011), le Mémorandum de l'Association des Accoucheuses du Congo a révélé l'Insuffisance en nombre et en qualité de formation de la sage-femme*. »<br>• « *Un état des lieux des ISTM a été organisé en novembre 2011 conjointement par le ministère de l'enseignement supérieur et universitaire (MINESU) et l'UNFPA. Tous les 45 ISTM de la RDC qui organisent la filière accoucheuse ont été visités. Les constats faits a la suite de cet état des lieux des ISTM, peuvent se résumer comme suite :*<br>- *Les programmes des cours n'étaient pas adaptés au standard international de l'AISEM ;*<br>- *Les programmes des cours étaient plus théoriques que pratiques ;*<br>- *Les enseignants étaient sous-qualifiés ;*<br>- *Les matériels didactiques faisaient défaut pour une bonne formation ;*<br>- *L'orientation accoucheuse n'était qu'une orientation dans la section sciences infirmières.* » | Interview, Member of the Faculty of Medicine, University of Kinshasa |
| 26 | *"H4+ JPCS interventions are **aligned to MoH priorities**, as they are developed based on the MDG 4&5 Acceleration Framework. All new RMNCAH projects are now aligned to the Acceleration Framework."* | Interview, senior official in MoH in Kinshasa |
| 27 | • The **MDG 4&5 Acceleration framework (CAO 4&5)** refers to five major health system gaps which affect access to reproductive maternal neonatal child and adolescent health (RMNCAH) services: « *(i) La faible disponibilité des médicaments y compris les contraceptifs et intrants essentiels spécifiques liée essentiellement à la problématique de la chaine d'approvisionnement et de* | • MoH (2013). *CAO 4&5* (MoH 2013a: 6, 9-10) |

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| | *gestion ; (ii) Une insuffisance des ressources humaines qualifiées et inégalement réparties ; (iii) La faible qualité des soins ; (iv) la faible capacité de gestion des zones de santé le ; (v) La faible accessibilité géographique et financière aux services de santé.* » In response to these gaps, the CAO 4&5 outlines six strategic approaches to achieve the MDG 4 and 5 :<br>- *« Stratégie 1 : Couverture universelle des soins ciblant les populations vulnérables (femmes enceintes et enfants de moins de 5 ans) /approche Kits familiaux/coupon.*<br>- *Stratégie 2 : Appui à la continuité des soins au niveau périphérique y compris aux structures de référence*<br>- *Stratégie 3: Amélioration de la gouvernance et gestion des zones de santé*<br>- *Stratégie 4 : Renforcement des ressources humaines*<br>- *Stratégie 5 : Communication pour le développement*<br>- *Stratégie 6 : Engagement communautaire. »*<br>• *The activities proposed in the annual work plans (2013-2016) are directly aligned to the CAO 4&5 national priorities.* | • DRC H4+ annual work plans 2013-2014 and 2015-2016 (H4+ Canada 2012, H4+ Canada 2014b) |
| 28 | The DRC H4+ JPCS intervention logic, M&E framework and annual work plans address the needs and health systems gaps identified in the project proposal and the baseline studies. The interventions address the **HSS building blocks as defined by WHO**:<br>- The original proposal states: development of human resources through pre-service and in-service training in RMNCAH including FP (*Human Workforce*); strengthening the facility environment through provision of equipment and drugs (*Medical Products, Vaccines and Technologies*); strengthening planning, implementation and M&E capacity at all levels (*Leadership and Governance)*; promote financing mechanisms that reduce financial barriers to EmONC services, including performance-based financing (PBF) and mutual health schemes (*Health Financing*); strengthening the integration of FM and HIV services (*Service Delivery*); strengthening community involvement through CHW and community-based organisations (CBOs) (*Service Delivery*) (p. 17 ff.)<br>- The M&E framework (as presented in the 2013-2014 annual work plan) identifies 17 specific outputs (*résultats attendus*) that fall under the eight H4+ JPCS. | • DRC H4+ JPCS annual work plans 2011-2012, 2013-2014, 2014-2015 and 2015-2016 (H4+ Canada 2010a, H4+ Canada 2012, H4+ Canada 2013, H4+ Canada 2014b)<br>• DRC H4+ JPCS proposal (H4+ Canada 2010b: 17ff)<br>• DRC H4+ JPCS annual work plan 2013-2014<br>(H4+ Canada 2012) |
| **Assumption 1.2** | | |

*H4+ JPCS support to sub-national levels funds activities* ***capable of complementing other investments and contributing to strengthening service delivery in RMNCAH****. The funded activities are* ***appropriately sequenced*** *and matched with support to health systems strengthening provided by other programmes and sources.*

<table>
<tr><th colspan="2">Information/data</th><th>Information sources</th></tr>
<tr><td>29</td><td>The original proposal contains a mapping other RMNCAH investments in DRC, including programmes supported by UNFPA, WHO, UNICEF UNAIDS, World Bank, USAID, PEPFAR, GAVI, and GIZ. The map provides general information of which areas each partner covers, but no details. None of the listed partners support EmONC or other RMNCAH trainings. NGOs and other implementing partners are not presented here.</td><td>DRC H4+ JPCS proposal (H4+ Canada 2010b: 13-14)</td></tr>
<tr><td>30</td><td>The narrative 2015-2016 work plan provides an updated overview of other partners' investments in RMNCAH in support of the implementation of the RMNCAH road map (CAO 4&5) : « Le financement du CAO 4&5 est assure par le Gouvernement et les bailleurs de fonds en complémentarité et en synergie des appuis pour une extension coordonnée et cohérente de la couverture des interventions prioritaires. Dans le cadre du Projet d'Equipement des Structures Sanitaires (PESS), le gouvernement de la DR Congo assure la rénovation et construction des établissements sanitaires, équipe 200 Hôpitaux Généraux de Référence et 1000 centres de santé et achète les médicaments essentiels. Les grands partenaires financiers pour la santé maternelle et infantile sont les suivants (Table 1).
Table 1. Grands partenaires financiers en RD Congo
<table>
<tr><th>Interventions</th><th>Gouvernement, RDC</th><th>DFID</th><th>USAID</th><th>GAVI</th><th>Fonds Mondial</th><th>H4+</th></tr>
<tr><td>Approvisionnement en intrants</td><td>√</td><td>√</td><td>√</td><td>√</td><td>√</td><td>√</td></tr>
<tr><td>Mobilisation communautaire</td><td></td><td>√</td><td>√</td><td></td><td></td><td>√</td></tr>
<tr><td>Financement basé sur la performance</td><td></td><td>√</td><td></td><td>√</td><td></td><td>√</td></tr>
<tr><td>Monitorage amélioré pour 'action</td><td></td><td></td><td></td><td></td><td></td><td>√</td></tr>
</table></td><td>H4+ Country Team (2015). H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+. République Démocratique du Congo (H4+ Country Team 2015b: 2)</td></tr>
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|---|---|---|
| | <table><tr><td>*Surveillance active intégrée des décès*</td><td></td><td></td><td></td><td></td><td></td><td>√</td></tr><tr><td>*Mutuelles de santé*</td><td></td><td></td><td></td><td></td><td></td><td>√</td></tr><tr><td>*Appui à la coordination*</td><td>√</td><td>√</td><td>√</td><td></td><td>√</td><td>√</td></tr></table> *« Dans les neufs zones de santés ciblés, les interventions du H4+ sont complémentaires avec les interventions du Fonds Mondial (approvisionnement en médicaments du paludisme et VIH), du GAVI (approvisionnement en vaccins) et du Gouvernement (essentiellement la construction/rénovation et l'équipement médicaux). Les autres partenaires financiers interviennent dans d'autres zones de santé. En 2015, la Banque Mondiale va étendre le projet sur financement basé sur les résultats (FBR) dans les zones de santé du plan conjoint H4+ Canada. Afin d'éviter le chevauchement, les activités du FBR menées par le H4+ seront laissées à la Banque Mondiale à partir du 2015 pour focaliser sur les autres gaps qui existent dans ces zones de santé. »* | |
| 31 | • The **PESS (construction, renovation and equipment of health facilities) is a government project** developed by the DEP with support of UNICEF. PESS rehabilitates and provides a package of basic equipment to health facilities.<br>• In the context of H4+, the PESS provided a standard package of equipment to health facilities in the nine- health zones based on the baseline EmONC assessment. It *"did not take into consideration which equipment already existed"*, but provided a *"complete package"* according to the government's approach. | Interview, senior official in MoH in Kinshasa |
| 32 | When the PESS provided a standard package of equipment to the H4+ health zones, H4+ partners had to "reorient" the equipment delivered by H4+ to other structures. H4+ JPCS equipment was complementary to the equipment provided by PESS. H4+ played an important role in identifying the structures that needed rehabilitation, as WHO/H4+ was part of the technical committee that planned the PESS. | Interview, H4+ country team member |
| 33 | *« Sur fond propre, UNFPA a approvisionné 48 établissements de santé en kits de réparation des fistules et en équipements, et 74 établissements de santé en préservatifs et contraceptifs selon les détails dans le tableau ci-dessous (Table 2). »* | DRC H4+ Annual Report 2014 (H4+ Canada 2015: 14) |
| 34 | *« Quelques activités complémentaires telles que l'approvisionnement en contraceptif qui rentrent dans le cadre de ce plan seront financées avec les fonds propres des agences (UNFPA, UNICEF, OMS, ONUSIDA). »* | DRC H4+ JPCS annual work plan 2014-2015 (H4+ Canada 2013: 1) |

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| 35 | *"Apart from the Canada funds, H4+ agencies also had funding from France Muskoka (implemented in Province Orientale) and from RMNCH Trust Funds implemented in Bandundu and Equateur provinces. These other funds came to complement and help scale up H4+ interventions to other provinces beyond the 9 health zones funded by Canada."* | Email with former H4+ coordinator prior to the field mission, 4 August 2016 |
| 36 | *« Nous avons aussi reçu le fond de MOSKOKA France, Canada et autres, et on a fait voir les liens avec les autres projets au pays cela était important »* | Interview, H4+ country team member |
| 37 | UNICEF, UNFPA and WHO received two grants from the RMNCH Trust Fund to implement a joint RMNCH programme:<br>• Phase 1 grant: *« Augmenter l'accès, la demande et l'utilisation des 13 produits d'importance vitale et d'améliorer la santé des enfants et des interventions de santé reproductive »*, $3.4 million, October 2013-December 2015<br>• Phase 2 & 3 grant : *« Fonds catalytiques de la SMNEA pour améliorer la disponibilité des intrants PCIME et accouchement (Delivery kits) », $22.8 million, Septembre 2014-Juillet 2016 »* | RMNCH Trust Fund (2016). La revue du rapport annuel 2015. République Démocratique du Congo. (RMNCH Trust Fund 2016) |
| 38 | The H4+ approach enabled the agencies to work together and put resources together. It was also **catalytic** in the sense that the agencies also mobilized their own funds for RMNCAH in addition to the H4+ Canada funds. The partners coordinate their work through the CNP-SS commissions, for example UNICEF, UNFPA and USAID for commodities. | Interview, senior official in MoH in Kinshasa |
| 39 | *« Quelques leçons apprises lors de la mise en œuvre sont: Il est indispensable de faire le lien entre les activités du H4+ et les autres initiatives du pays. Une analyse stratégique des initiatives en cours dans le cadre du processus d'engagement des partenaires au CAO 4&5 a permis de ressortir les gaps et mieux positionner l'Initiative H4+ au seine des autres initiatives de financement en RDC. »* | DRC H4+ Annual Report 2014 (H4+ Canada 2015: 26) |
| 40 | *« Dans le cadre de la lutte contre la mortalité maternelle, l'UNFPA appuie la zone de santé de Mosango dans la province de Bandundu (…) ; en 2011, il a financé la construction d'une maternité d'attente pour l'amélioration de l'accessibilité des femmes enceintes aux soins obstétricaux et néonatals d'urgence de qualité avec le financement de l'Ambassade du Japon. Les travaux ont été exécutés par l'UNOPS et la maison a été équipée en Juillet dernier avec les fonds de l'ACDI [(H4+ JPCS] pour une valeur d'environ 29 000 dollars. »* | UNFPA (2012). Rapport de mission sur l'inauguration de maternité d'attente de Mosango du 05 Octobre 2012 au 07 Octobre 2012. (UNFPA 2012: 1) |
| 41 | *« En plus, ce projet a attiré d'autres bailleurs qui ont décidé d'investir dans la SMNE. Des réunions de concertation avec la coopération Sud-Coréenne (Korean International Cooperation Agency, KOICA), ont permis d'identifier des gaps en SMNE dans les zones de santé de Kenge à Bandundu. Ces gaps ont* | DRC H4+ Annual Report 2013 (H4+ Canada 2014a: 20) |

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| | *été pris en compte dans le projet qui sera financé par KOICA et qui va couvrir 14 zones de santé dans le district sanitaire de Kwango dans le Bandundu. »* | |
| 42 | *« Les prestataires de Bandundu, Kenge et Mosango soit 60 prestataires ont été formés en gestion des commodités de santé de reproduction. Dans le cadre du Projet mis en place pour équiper les structures de santé (PESS- un projet géré avec l'appui de l'Unicef), 10 membres des Equipes Cadre de la Zone de santé de Bandundu et de Kenge ont été formés en gestion des médicaments. »* | DRC H4+ *Annual Report* 2014. (H4+ Canada 2015: 14) |
| 43 | The national RBF manual (version 2013) includes a list of HZ covered by the national RBF programme with different funding sources. The World Bank supported RBF project PARSS targeted 14 HZ in Bandundu Province and 6 HZ in Kinshasa Province from 2011-2015, but did not include any of the H4+ JPCS health zones. | *Manuel des procédures pour la mise en œuvre de la Stratégie du Financement Basé sur les Résultats - FBR Version- Octobre 2013.* Ministère de la santé , République Démocratique du Congo. (MoH 2013d: 6) |
| 44 | In the context of H4+ JPCS, WHO collaborates closely with Pathfinder to strengthen the national RMNCH Task Force and provide support for the development of national RMNCH norms and guidelines. The coordination is stronger at national than operational level: *« **Nous collaborons beaucoup plus en termes de partage d'informations sur les besoins en appui au niveau central et pas au niveau opérationnel.** Il y a eu une certaine coordination des interventions pour éviter les doublons en orientant les partenaires ou en renforçant les interventions qui existent dans certains appuis comme la revue nationale (ESMN) qui est sur la table. Nous avons de manière collaborative appuyé le ministère pour l'élaboration des termes de référence et même la mobilisation des ressources dans un cadre multipartenaires pour appuyer le ministère dans ce processus. Il y a eu des partenaires mobilisés pour prendre en charge certaines parties du budget. »* | Interview RMNCAH partner (USAID implementing partner) |
| 45 | The 2014-2015 work plans include an activity to provide technical and financial support to MoH (D5, D10, DEP) to conduct a mapping of all RMNCH interventions and present it to the Health Partner's Forum (GIBS). | DRC H4+ JPCS: *annual work plan 2014-2015.* (H4+ Canada 2013: 4) |
| 46 | A mapping of all RMNCH programmes was prepared by the development partners' health forum (*Groupe Inter-Bailleurs Santé, GIBS*). It specifies the period, annual budget by programme, and target provinces of RMNCH programmes. Donors include: USAID, Global Affairs Canada, UNAIDS, UNFPA, Swedish International Development Cooperation Agency (Sida), JICA, KOIKA, World Bank, Expertise France, Coopération Bèlgue (CTB), DFID, The Global Fund, MAECD Canada, Bill and Melinda Gates Foundation (BMGF), UNICEF, DDC/Coopération Suisse, and GAVI. | Development partners' health forum (2015): *GIBS dataset 5.11.2015* (mapping of RMNCH interventions), unpublished. (Development Partners' Health Forum 2015) |

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| 47 | **Coordination and complementarity at sub-national level:** In Mosango, the health zone team presented a mapping of all partners and interventions, which illustrated that H4+ JPCS activities were particularly complementary to general support provided by MEMISA and Belgian Cooperation (CTB) primary health care and HSS projects. | Mosango health zone team (2016): Power Point presentation to H4+ JPCS evaluation team on 15 August 2016, slide 4-6. (Mosango Health Zone Team 2016) |
| 48 | **Coordination and complementarity at sub-national level:** *« Il y a eu flexibilité et complémentarité dans la planification de H4+ avec les autres partenaires : le paiement de la prime de performance a été offert aux membres des ECZS et aux formations sanitaires (FOSA) par les autres partenaires comme Rotary, PASSKIN, et non le PBF avec l'OMS. Il y a eu aussi des réhabilitations qui ont été réalisée par d'autres partenaires en fonction de notre plan d'action opérationnel (PAO). Les investissements H4+ étaient complémentaires à ces activités et intrants »* | Interview, health zone team (Nsele), 10 August 2016 |
| 49 | **Coordination and complementarity at sub-national level:**<br>• *« Les réunions de concertation des partenaires étaient tenues pour assurer la coordination des interventions sous la responsabilité de la DPS en raison de deux fois par an. Mais elles s'étaient tenues d'une manière irrégulière. La ZS de Nsele a eu comme partenaires qui appuient son PAO : (i) La coopération canadienne à travers le projet PASSKIN, (ii) Rotary Club développement, (iii) Handicape internationale, (iv) vision mondiale, (v) fonds mondial, (vi) ICAP, (vii) UNFPA, (viii) UNICEF. »*<br>• *« Il y eu complémentarité des interventions entre les partenaires grâce à une bonne coordination(…). La réhabilitation des maternités de trios 3 FOSA a été réalisée en complémentarité avec les autres appuis. (…) La bonne synergie des interventions avec les partenaires UNICEF, UNFPA, PASSKIN, RCFD, Word Vision, Handicape international, BDOM, OMS a induit une disponibilité de l'offre de service SMNE et des résultats escomptés avec et une augmentation de la fréquentation des services »* | Interview, health zone team (Nsele), 10 August 2016 |
| 50 | • A part l'UNFPA, les autres partenaires ont appuyé suffisamment l'ISTM [Higher Inistitute of Medical Techniques] in Kinshasa, notamment l'ICAP-NEPI qui a appuyée financièrement la ré-visitation du programme de sciences infirmières hospitalières. La ré-visitation et la validation du programme de l'enseignement, administration en soins infirmiers (EASI) ont été aussi appuyées par le JICA.<br>• L'ICAP-NEPI a aussi équipé la salle technique en matériels didactiques, en ouvrages et en matériels informatiques, afin ils sont aussi entrain de monter une clinique de simulation dans le domaine de | Interview, implementing partner (ISTM Kinshasha) |

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| | formation des infirmières et des sages-femmes. A l'ISTM, deux programmes sont organisées selon l'approche basée sur les compétences (sage-femme et soins généraux).<br>• Des réunions conjointes des groupes de travail ont été organisées entre l'ISTM, la faculté de médecine, le MINESU, le MINISANTE, l'UNFPA, l'ICAP et le JICA. C'étaient des réunions mensuelles de coordination qui continuent encore jusqu'à présent. La coordination de ces réunions était assurée par l'ICAP. Ce partenariat se poursuit avec l'ICAP et l'UNFPA.<br>• L'ISTM participe régulièrement à des réunions organisées par le MINISANTE et en particulier les réunions organisées par la D10 [Division for Family Health]. L'ISTM participe même a la revue annuelle organisée par le ministère de la coopération. | |
| 51 | • The joint and collaborative development of the EmONC trainings and midwives programme has helped strengthen the relationship and technical collaboration between the MoH and Ministry of Higher Education (MoHE). ISTM often participates in meetings convened by the MoH, in particular D10. They also participate in the annual review meetings organised by the Ministry of Cooperation | Interview, implementing partner (ISTM Kinshasha) |
| 52 | For evidence of the **lack of coordination in Mosango health zone (SANRU/Global Fund and H4+ JPCS),** please refer to the matrix for question one, assumption 1.4., line 101 | Interview, health facility staff (Mosango) |
| 53 | For evidence of the **catalytic nature of H4+ JPCS support to RMNCAH and scale-up efforts** please refer to the matrix for question two, assumption 4.4. (all lines) | |
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| **Assumption 1.3**<br>*RMNCAH managers and service providers trained with support from H4+ JPCS realise intended gains in competence and skills. These gains in skills and competencies are tested and verified during and after training.* | | |
| | **Information/data** | **Information sources** |
| 54 | **Human Resource achievements as presented at Douala Inter-Country Meeting 2015:**<br>*"Initial Training*<br>- *MoH Human Resources Commission validated a Ministerial Degree creating a professional cadre called Midwives in MoH*<br>- *Direct entry to the Midwifery Training programme from high school* | Canada / H4+ Collaboration (2015). *Accelerating Progress in Maternal & Child Health.* Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 21) |

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| | - *Revised Midwifery Curriculum according to ICM standard*<br>- *Midwifery Tutors trained in 11 schools;*<br>- *Equipment: 11 midwifery schools, 2 medical schools.*<br>*In-service training*<br>- *New competency-based Emergency Obstetric & Newborn Care (EmONC) curriculum & 3 training centres set up*<br>- *Training: EmONC, Newborn Care, FP, HIV management, health commodity management, PMTCT, M&E etc.*<br>*Signature indicators*<br>- *Providers trained in EmONC (total = 686): 11%(2012), 40%(2013), 50%(2014)*<br>- *Health extension workers trained: 136 in 2012, 410 in 2013, 1420 in 2014*<br>- *All the targeted 11 Midwifery Schools are using the new curriculum"* | |
| 55 | The H4+ joint programme contributed significantly to **capacity development through support to training institutes, training of trainers (ToT) and trainings of service providers, and through the provision of training materials and equipment:**<br>In 2012:<br>• *"1. Training modules reflecting new EmONC methodologies were developed.*<br>• *2. Three training sites were identified and training materials for EmOC and FP, including models and other basic equipment, were purchased.*<br>• *3. One hundred sixty (160) providers participated in training sessions on EmONC and FP conducted for the three districts of Bas-Congo (81) and Kinshasa (79).*<br>• *4. Forty-three (43) healthcare providers received capacity strengthening in the provision of FP services in the districts of Bandundu.*<br>• *5. The technical capacity of pre-service training institutions was strengthened through: (1) provision of training equipment (including mannequins for technical training at the Higher Medical Technology Institute of Kinshasa); and (2) revision of training curricula of midwifery by the mentioned Institute.*<br>• *6. In order to increase the number of competent, practicing midwives, advocacy by the H4+ led to the agreement for training of midwives of level A1 (3 years training) with direct entrance after the* | H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| | *bachelor degree, without going through the training of nurses (4 years) and also without two years of experience.*<br>• *7. Awareness-raising took place in conjunction with celebration of the International Day of the Midwife. This included: (a) sensitization on lifesaving during pregnancy, and FP; and (b) a week of free ANC consultation services performed by midwives in the communes of Kinshasa."*<br><u>In 2013:</u><br>• *"1. Seven health care training institutions received support from H4+ Canada.*<br>• *2. At the national level, 21 EmONC instructors were trained.*<br>• *3. Eighty service providers were trained in EmONC.*<br>• *4. Fifty service providers were trained in Family Planning.*<br>• *5. Fifty patient peer educators were trained.*<br>• *6. Sixty trainers and coaches in midwifery received instruction in the new competency-based methodology*<br>• *7. Training modules for HIV management. Midwife training institutions received manikins."*<br><u>In 2014:</u><br>• *"1. Strengthened the capacities of two midwifery schools through the supply of technical equipment and mannequins and the training of tutors.*<br>*2. Supported the set-up of two training centers on EmONC and FP with didactic material and training of tutors, leading to 75 health providers trained in EmONC (modules developed by H4+ and used by the MoH and other partners throughout the country); 60 members of health district teams and 120 health providers trained in integration of HIV in RMNCH; 267 providers trained in FP; 60 providers trained in management of reproductive health medicines."*<br><u>In 2015:</u><br>• *"1. 2 higher Institute of medical technology of Kisantu and Kimpese received teaching materials to improve the quality of basic training of midwife.*<br>*2. 15 teachers and coaches of course have been strengthened on pedagogical techniques in the use of educational materials.*<br>*3. 20 trainers (teachers) trained in obstetric and neonatal emergencies (SONU) care, this course was given to teachers of the ISTM finally that they incorporate it as early as in the training base of wise - woman to have well qualified midwives.*<br>*4. Strengthening capacity of the beneficiaries in SONU on offer. 50 service providers (doctors,* | |

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| | *nurses and midwives) in the area of health of Bandundu and Mbanza Ngungu have benefited of training in obstetric and neonatal emergency according to the new approach to care*<br>*5. At the central level 26 trainers have been trained and the provinces of Bandundu and Bas Congo (Kongo central) each has a pool consisting of 16 trainer care obstetric and neonatal of emergencies (SONU).*<br>*6. this year different pools formed 180 providers in SONU Bandundu in 8 areas of health, whose Boko (25) and Frank (25) with funding from KOICA, and Kingandu (25), Mosango (25), Koshibanda (25), Popokabaka (25), Ipamu (25) and Wamba Luadi (25) within the framework for acceleration of the objectives of Millennium Development (Goals MDGs) 4 and 5 with the UNICEF funding.*<br>*7. structures of 9 areas of health providers have benefited from follow-up training in their workplace. Thus, a team of 4 formateurs-tuteurs and supervisors all selected in the pools of trainers were followed for 12 days providers in their place of work in each area of health.*<br>*8. formation of 105 providers in provision of the PF allowed improving an increased coverage of area of health in FP service offering.*<br>*9. 25 providers have been trained in rational use of medicines including the health of the mother and child.*<br>*10. a technical and financial support was provided to the Government side in the organization and holding of the training of the Ministry of health on the use of the Tier-Net software to monitor the elimination of new paediatric infections HIV and congenital Syphilis by 2030."* | |
| 56 | Based on the results of an assessment ISTM, H4+ JPCS supported the revision and upgrading of the **midwives programme** to create a direct-entry 3-year programme. The new programme was developed by teachers from the ISTM, Faculty of Medicine of University of Kinshasa, and staff of the PNSR/MoH. | Interview, implementing partner (ISTM-Kinshasa) |
| 57 | H4+ JPCS supported to following **midwifery and EmONC training activities**:<br>- A new competency-based EmONC training module was developed<br>- 4 professors and 3 specialist doctors of the Faculty of Medicine of the University of Kinshasa were trained as "national trainers" in the new EmONC training module by specialists from Oxford University (1) and Madagascar (2).<br>- They conducted the training of doctors in Mosango, HZ Health Teams, midwives and health managers (administration). | Interview, Member of the Faculty of Medicine, University of Kinshasa |

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| | - The Faculty of Medicine has integrated a 10-day EmONC training course into the medicine programme: « *Selon les professeurs, les étudiants étaient très satisfaits à la suite de cette formation qui est très pratique avec l'usage des mannequins. Les cibles ayant bénéficié sont au total 650 étudiants en médecine et 22 médecins internes pour la spécialisation.* »<br>- Les autres partenaires qui appuient les SONU (JICA) et la synergie pour H4+ (OMS, UNFPA). La JICA a appuyé de l'enquête sur la viabilité des institutions de formation. | |
| 58 | The **new 3-year midwife training curriculum** included the following competencies : *« Cependant, la famille de situation « soins généraux de base » a été ajouté pour servir à la transversalité de capacités techniques : (1) Soins généraux de base (SGB) ; (2) Soins Obstétricaux Essentiels (SOE) ; (3) Soins Obstétricaux et Néo-natals d'Urgence (SONU) ; (4) Soins Essentiels et d'Urgence au Nouveau-né : Nouveau-né Normal (SENN) et Nouveau-né Malade (SENM) ; (5) Soins de l'Enfant ; (6) Consultation pré-scolaire (CPS), (7) Prise en Charge Intégrée de maladies de l'Enfant (PCIME) ; (7) Soins de Santé Adaptés aux Adolescents et Jeunes (SSAAJ) ; (8) Planification familiale ; (9) Soins aux Victimes/survivants de Violence Sexuelle (SVVS/SVS) : (10) Soins à la Mère, au Nouveau-né, et à l'Enfant à base Communautaire (SMNE/C) »* | MoH (2012). *Minesurs Référentiels Sage-Femme RDC - UNFPA* 2013. (MoH 2012b: 20) |
| 59 | The **ISTM-Kinshasa was selected by UNFPA as implementing partner** to implement the following activities:<br>- Establishment of the direct-entry 3-year midwife programme<br>- Creation of a programme to upgrade nurses and nurse-midwives ('accoucheuses') to full midwives<br>- Provision of equipment and didactical materials to six ISTM (Kinshasa, Lubumbashi, Bandundu, Kenge, Bukavu et Kimpese), including mannequins, equipment for the technical room, information and communication technologies materials and office equipment<br>- Traning of trainers at the ISTM in Kinshasa, Lubumbashi and Bukavu in 2013; and Kikwit, Kisantu, Kimpese et Nyakunde in 2014<br>- Reproduction and distribution of the new midwife training curriculum to 30 ISTM<br>- Organisation of a series of training workshops to strengthen the skills of internship-supervisors at health facilities ('encadreurs de stage') with the teachers of the ISTM in Kinshasa, Lubumbashi, Kimpese, Kenge, Bandundu and Nyakunde. | • Interview, Member of the Faculty of Medicine, University of Kinshasa<br>• Interview, implementing partner ( ISTM-Kinshasa) |

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| 60 | Les **défis pour ces formations en SONU** organisées par le MINISANTE sont : le manque de chronogramme précis de formation entraînant ainsi des dérangements des programmes des bénéficiaires ; Certains formateurs n'étaient pas qualifiés (des personnes qui n'étaient pas obstétriciens), équipes des personnes formées avaient de profils différents (on avait parfois affaire aux administratifs). | Interview, implementing partner (ISTM-Kinshasa) |
| 61 | The **CFDBT training institute was selected as implementing partner** to provide EmONC and FP trainings for service providers in the H4+ JPCS target health zones and beyond:<br>• *« Le CFDBT est un centre de formation en SONU, en PF et en soins après avortement. Ce centre a vu le jour grâce une collaboration entre l'Hôpital Roi Baudouin et l'IRC. Ce centre a servi pour la formation des prestataires du centre hospitalier qui l'abrite et par la suite ce centre a offert et continue à offrir son expertise pour la formation des prestataires de tout le pays (RDC) grâce à l'appui des différents partenaires (formation en SONU, en PF et en soins après avortement). »*<br>• *« Centre de Formation Boubacar Touré, les universités, les instituts supérieurs de techniques médicales et la société congolaise de gynéco-obstétrique (SOCOGO) (…) Il s'agissait au départ d'une formation en SONU de 5 semaines, par la suite durée de cette formation a été revue à 3 semaines. A la suite de cette formation, le centre hospitalier Roi Baudoin a été retenu comme centre de formation. Avec l'appui de l'UNFPA, la durée a été réduite en une semaine dans le cadre de H4+, avec une autre méthodologie de travail, une formation pratique axée sur les compétences.»* | Interview, implementing partner (CFDBT training institute) |
| 62 | • Chaque formation organisée par le CFDBT est suivie d'un stage pratique qui se fait au niveau de trois centres hospitaliers (…). Il y a lieu de retenir que les formations organisées par le CFDBT a comme un impact sur les prestataires en terme de : (1) Acquisition des nouvelles connaissances et amélioration des compétences ; (2) Pratique sur le mannequin en plus de l'enseignement des cours théoriques.<br>• Deux types de formation sont organisés au niveau du CFDBT : la formation des formateurs et celle des prestataires. Les principaux bénéficiaires de ces formations étaient ceux des zones de santé de Mosango, Kenge, Bandundu ville, Matadi, Mbanza Ngungu.<br>• **Le suivi et évaluation des formations restent un défi majeur.** Bien que le plan de suivi et d'évaluation soit inscrit dans le PTA de 2014, l'activité n'a pas été réalisée ; A l'exception des formations organisées a l'ISTM-Kinshasa, le chef de section chargé de l'enseignement qui assure le suivi et évaluation des enseignants qui ont été formées. | Interview, implementing partner (CFDBT training institute) |

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| 63 | *« La **formation en SONU basée sur les compétences en utilisant les mannequins** a réduit la durée de formation SONU de 14 jours à 5 jours. L'utilisation des mannequins permet l'acquisition rapide des compétences.»* | H4+ Country Team (2015*). H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+.* (H4+ Country Team 2015b: 8) |
| 64 | *« Ce financement (H4+) nous a donné l'accès à l'élaboration des modules de formation. Par exemple, dans le cas de SONU, on a eu des ateliers à Mbanza-Ngungu pour participer à l'élaboration des modules. L'association était fortement représentée ».* | Interview, implementing partner (NGO) |
| 65 | Health zone teams regularly conduct **supervision visits in health facilities**, although these do not focus specifically on EmONC services: *« 80% des points de prestation de service ont connu des visites de supervision récentes qui sont généralement mensuelle ou trimestrielle et au cours desquelles sont revues les directives, les pratiques cliniques, les ruptures de stock, la qualité des données et la formation du personnel. »* | MoH (2015). *Évaluation des indicateurs pour le Suivi du Programme de Sécurisation des Produits de Santé de la Reproduction en République Démocratique du Congo.* (MoH 2015a: 21) |
| 66 | *« Il n'avait pas de suivi particulier après la formation SONU, mais les encadreurs des equipes cadre du zone de santé descendent, et font un accompagnement de façon cadre global. »* | DPS Kongo Central |
| 67 | *« On a une supervision intégré, un superviseur qui passe doit voir l'aspect global et palpe chaque activité. Et au moins chaque mois, nous sommes superviser. »* | Interview, MULUMA health centre staff, Mosango |
| 68 | *« Le suivi et évaluation des formations restent un défi majeur. Bien que le plan de suivi et d'évaluation soit inscrit dans le PTA de 2014, l'activité n'a pas été réalisée ; A l'exception des formations organisées a l'ISTM-Kinshasa, le chef de section chargé de l'enseignement qui assure le suivi et évaluation des enseignants qui ont été formées. »* | Interview, implementing partner ( ISTM-Kinshasa) |
| 69 | • Toutes les structures ont bénéficiés de la formation en SONU, à moyenne de deux personnes par centre, mais la mobilité du personnel a fait que nous puissions trouver à moyenne une personne formée par structure appuyée.<br>• Les infirmiers titulaires et les accoucheuses ont plus bénéficiés de plusieurs formations, entre autres en SONU B, PTME, PF, PCIME que les infirmiers et les médecins, qui viennent en second plan. Les équipes cades des zones de santé (ECZ) sont de moins en moins touchées par les formations, ce qui rend la supervision et le suivi post formation fastidieux. Les autres infirmiers et les nouvellement recrutés ont assez de lacunes sur l'utilisation des partogramme et | EHG consultants/evaluator team (2016). Summary of the evaluation team's health facility check lists |

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| | ordinogramme ce qui fait croire entre autre que la restitution organisé par les pairs avait connue assez des lacunes.<br>• Le mécanisme d'assurance qualité couramment utilisé est la supervision par les ECZ ; rarement les audits internes /externes, la retro information positive et le monitorage amélioré pour action. Bien que la supervision soit le mécanisme d'assurance qualité le plus utilisé, elle a été irrégulière beaucoup plus à au centre NSELE qu'à l'Ouest. | |
| 70 | *« Le prépositionnement à Mosango du matériels des formations SONU de toute la province était une opportunité pour nous (ceci permet de former localement aussi des élèves de l'ITM option accoucheuse) »* | Interview, health zone team (Mosango) |
| 71 | A 2012 training report of a 3-week EmONC training of health facility workers in Nzanza HZ indicate that pre-test, mid-term test, and post-test were conducted. The results show significant improvements over the 3-week period. Nearly all participants had reached above 95% composite score. At pre-test, the composite score varied between 33% and 75%, and at mid-term between 70% and 100% | Centre de Formation Dr Boubacar Touré (2012). *Rapport de formation en SONU de la zone de santé de Nzanza à Matadi du 02 au 22 octobre 2012.* (Centre de Formation Dr Boubacar Touré 2012: 13-14) |
| 72 | A 2015 training report from the EmONC training of regional trainers in Bandundu indicate that a theoretical and practical pre-test was organized (there is no indication of post-test). The practical pre-test *"a concerné les compétences suivantes : schéma ABCD, réanimation néonatales, accouchement assisté par ventouse, rétention placentaire, pré-éclampsie sévère-éclampsie, AMIU et procidence du cordon »* | MoH (2014) *Rapport de l'atelier de formation des formateurs provinciaux de la Province du Bandundu en SONU pour les ZS sante de Bandundu, Kenge et Mosango du 20 au 27 octobre 2014* |
| 73 | Le renforcement de capacité a été réalisé pour les prestataires de soins, les relais communautaires et les leaders religieux et chefs coutumiers en PF, PTME en SONU B. Cependant le **suivi post formation** n'a pas été effectué. | Interview, health zone team (Nsele) |
| 74 | • *« La séance a continuée par le prétest suivi de l'évaluation pratique des différentes compétences (retenues par les facilitateurs (approche ABC, réanimation maternelle et cardio-respiratoire, réanimation du nouveau-né, procidence du cordon, rétention placéntaire, prise en charge de la pré-éclampsie et de l'éclampsie, soins après avortement (AMIU). »* (p. 6)<br>• *« Tous les participants ont réussi au post-test pratique, tandis qu'aucun d'eux n'avait validé une seule compétence au pré- test. La cote la plus élevée au post test est de 73% et la cote la plus basse est de 58,6% Néanmoins, certains participants doivent être encadrés pour bien intégrer les nouvelles techniques apprises. Toutes les compétences étaient moins connues au pré-test "* (p.27) | MoH (2015). *Rapport de l'atelier de formation des prestataires de la Zone de Sante de Bandundu en SONU, Août 2015.* (MoH 2014: 6, 27) |

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| 75 | The **results of the pre- and post test of a FP training** show the following gains:<br>- Highest score: Pre-test: 83% / post-test 97% (14% increase)<br>- Lowest score: Pre-test: 26% / post-test 50% (24% increase)<br>- Number of participants with acceptable FP knowledge level e.g. 50%): Pre-test: 24% / post-test 92% (68% increase) | MoH (2015). *Rapport de l'atelier de formation des prestataires de la zone de sante de Mosango en planification familiale selon la nouvelle approche du 30 Août au 10 Septembre 2015.* Province de Bandundu, Ministère de la santé publique. (MoH 2015f) |
| 76 | The **results of the pre- and post test of a training in drug management** showed the following results:<br>- The highest score: Pre-test:8% / post-test 19% (11% increase)<br>- The lowest score: Pre-test: 2% / post-test 16% (14% increase) | MoH (2015). *Rapport narratif de la formation des prestataires de la zone de sante rurale d'IDIOFA en gestion des commodites. Du 26 au 30 Août 2015 AU BCZ IDIOFA (Province de Bandundu*). (MoH 2015g: 10) |
| 77 | • In 2015, 50 health facility staff from KWILU and KWANGO provinces (former Bandundu) were trained in EmONC. The DPS conducted post-training supervision with UNFPA support.<br>• The 2015 EmONC trainings in Kwilu allowed the DPS to increase the number of health facilities offering BEmONC services from 4 to 8 health facilities, and CEmONC from 1 to 3<br>• *"Cette activités [supervision post-formation] à permit d'améliorer la qualité de l'offre de service qui est un élément clé pour la réduction de la mortalité maternelle dans la zone Kenge. Cette activité a également contribué à l'accroissement de la couverture de la zone à l'offre de SONU, car les nombres de structures offrant le SONU de qualité s'est vu augmenté. »* | • MoH (2015). *Rapport d'activité, 4 ème PROGRAMME D'ASSISTANCE UNFPA, juillet - septembre 2015, DIVISION PROVINCIALE DU KWANGO* (Excel sheet). (MoH 2015d)<br>• MoH (2015). *Rapport d'activité, 4 ème PROGRAMME D'ASSISTANCE UNFPA, juillet - septembre 2015, DIVISION PROVINCIALE DU KWILU* (Excel sheet). (MoH 2015e) |
| 78 | In 2015, the DPS Bandundu organized a 3-week **post-training supervision mission** to supervise the staff trained in EmONC in all health areas of Mosango and Bandundu health zones. The supervision report documents that there are some improvements in skills and competences, but also several weaknesses:<br>- Strengths *« Points forts: Présence du personnel formé; Existence de quelques matériels et médicaments de la salle d'accouchement ; Existence de certains prestataires qui ont maîtrisé les nouvelles pratiques et compétences SONU ; Suivi du travail d'accouchement à l'aide du partogramme, existence des registres d'accouchement »* | MoH (2015). *Rapport narratif de la mission de suivi post formation SONU dans les zones de sante de Bandundu et Mosango du 10 au 25 septembre 2015. Province du Bandundu, Programme National de Santé de la Reproduction, Ministère de la Santé Publique.* (MoH 2015h: 17-18) |

<table>
<tr><td></td><td>- Weaknesses; « CPN: CPN traditionnelle ; insuffisance en personnel formé et utilisation des outils ne répondant pas aux normes, mauvais remplissage des fiches et registres ; Rupture intempestive en intrants ; Insuffisance en matériel de CPN ; CPoN : Ignorance des éléments de surveillance de la CPoN; Faible couverture. Accouch. Assistées : Insuffisance en personnel formé ; Insuffisance en matériel et médicaments ; Partogramme mal rempli et de mauvaise qualité; Registre mal tenu et ne répond pas aux normes »</td><td></td></tr>
<tr><td>79</td><td>• « Tous les participants ont appris, avec un gain allant de 4 à près de 30%. Ci-après VALEURS EXTREMES DES COTES (en %)
<table>
<tr><th></th><th>% Pré test Théorique</th><th>% Post test Théorique</th><th>Gain %</th></tr>
<tr><td>Minimum</td><td>13</td><td>22</td><td>9</td></tr>
<tr><td>Maximum</td><td>61,5</td><td>79</td><td>17,5</td></tr>
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• « Onze participants, soit 55% , ont obtenu une cote ≥70% dans une compétence. Tous ont eu 50% et plus dans au moins 2 compétences tandis que 13 participants sur 20 ont maîtrisé 4 compétences ou plus sur les 8 ayant fait l'objet de la formation. (…) Huit participants seulement ont satisfait à la fois au post test et dans au moins 2 compétences ! Il a été constaté la satisfaction dans la pratique sans performance concomitante en connaissances théorique ; cette contradiction peut s'expliquer par les difficultés de maîtrise de la langue française ! Les formateurs ayant souvent été contraints à utiliser les langues vernaculaires lors des démonstrations en stations! »</td><td>Ministry of Higher Education (2015). Formation des formateurs en SONU pour l'ISTM Kinshasa filière sage-femmes, Kola du 01 au 07 juillet 2015, ISTM de Kinshasa, Ministère De l'enseignement Supérieur, Universitaire et de la Recherche Scientifique, République Démocratique Du Congo. (MHE 2015: 14-16)</td></tr>
<tr><td>80</td><td>« La principale difficulté notée dans le cadre de la mise en œuvre de l'initiative H4+ est le manque de suivi des formations, c'est ça le point faible que nous avons déploré. L'explication a été donnée sur tout le processus qui comprend l'organisation des séances de formation qui devraient être accompagnées des missions de suivi après formation. Les missions de suivi planifiées initialement n'ont pas été réalisées pour des raisons financières. Les missions de suivi des formations sont importantes car elles permettent d'identifier et corriger certaines lacunes (…) Lorsque les missions de suivi ne sont pas organisées après les séances de formations, les nouvelles connaissances passent vite dans l'oubli et la pérennisation des acquis risque d'en pâtir. »</td><td>Interview, implementing partner (CFDBT training institute)</td></tr>
<tr><td>81</td><td>• Toutes les FOSA visités lors de la mission d'évaluation ont bénéficié de l'appui en renforcement de capacité respectivement en SONU B et C, et chaque structure sanitaire a été équipements et en médicaments nécessaire pour l'offre de service SMNE</td><td>Summary of the evaluation team's health facility check lists</td></tr>
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| | • Il y a eu des lacunes constaté à la ZS de MOSANGO, à la ZS de MBAZANGUNGU et À la ZS de DE NSELE. En rapport avec le SONU B, il y a eu des lacunes dans le remplissage des partogramme, surtout la partie en rapport avec le la surveillance de la femme pendant la grossesse la phase de lantane, la surveillance de BCF et de dilatation. Dans 3 structures sur 11 visité, il y avait aussi des lacunes en rapport avec la formation en SONU B et C (HGR de MBANZA NGUNU, AS de NGUNGU et LOMA). Autres prestataires non formés à CS MULUMA et KUMBI, KITAMBO ne maitrisaient pas les différentes aspects de la formation en PF, et SONU.<br>• Les infirmiers titulaires et les accoucheuses ont plus bénéficiés de plusieurs formations, entre autres en SONU B, PTME, PF, PCIME que les infirmiers et les médecins, qui viennent en second plan. Les ECZS sont de moins en moins touchés par les formations, ce qui rend la supervision et le suivi post formation fastidieux.<br>• Les autres infirmiers et les nouvellement recrutés ont assez de lacunes sur l'utilisation des partogramme et ordinogramme ce qui fait croire entre autre que la restitution organisé par les pairs avait connue assez des lacunes. | |
| 82 | In 2015, H4+ *"Strengthened the capacities of two **midwifery schools** through the supply of technical equipment and mannequins and the training of tutors. (…) Supported the set-up of two training centers on EmONC and FP with didactic material and training of tutors" (…) Health facility staff in nine health areas nine have benefited from follow-up training in their workplace. Thus, a team of four trainer-tutors and supervisors, all selected in the pools of trainers, were followed for 12 days providers in their place of work in each area of health."* | H4+ Global Technical Team (2016). DRC 2011-2015 *Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 83 | The regional training of trainers in EmONC organized in Bandundu in 2014 included a mentoring approach. At the end of each day "mentor-participant-meetings" were organised. | MoH (2014) Rapport de l'atelier de formation des formateurs provinciaux de la Province du Bandundu en soins obstétricaux et néonatals d'urgences (SONU) pour les zones de sante de Bandundu, Kenge et Mosango du 20 au 27 octobre 2014. |
| 84 | Some of the most important **areas where gains in skills and competencies** were noted by health facility staff and EmONC trainers and the evalution team during the field visit include:<br>• Integrated management of neonatal and child illnesses (IMNCI) | • MoH (2015). Rapport narratif de la mission de suivi post formation SONU dans les zones de sante de Bandundu et Mosango du 10 au 25 septembre 2015. Province du Bandundu.(MoH 2015h) |

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| | • Active management of the third phase of labour, including management of post-partum haemorrhages<br>• Management of eclampsia, chock and neonatal infections<br>• Patient-centred antenatal consultations<br>• Improved attitudes towards women in labour | • Summary of the evaluation team's health facility check lists<br>• Interview with Faculty of Medicine and ISTM of University of Kinshasa |
| 85 | **Perceived achievements and improvement of quality of EmONC training at the ISTM and Faculty of Medicine:**<br>• Les anciens programmes étaient plus théoriques, mais les nouveaux programmes sont plus pratiques, centrés sur l'étudiant et répondent aux exigences de la reforme LMD (licence-Mater et Doctorat).<br>• Les résultats des étudiants sont plus performants et le nombre d'étudiants est réduit dans cette filière de sages-femmes (au maximum 100 étudiants sont inscrits alors que dans la section accoucheuse, plus de 100 étudiants étaient inscrits).<br>• Les compétences des étudiants sont acquises en salle techniques (en manipulant les mannequins) avant d'aller en stage.<br>• Degré élevé de satisfaction des prestataires (évaluations par les encadreurs ensemble avec les enseignants qui les accompagnent) est dans les maternités qui accueillent les stagiaires. | Interview, implementing partner (ISTM-Kinshasa) |
| 86 | • For evidence of **health worker perceptions about improved quality of care**, please refer to the matrix for question two, assumption 2.2, lines 44-52 | |
| 87 | • For evidence of the **increased use of services,** please refer to the matrix for question one, assumption 1.5, all lines | |
| **Assumption 1.4**<br>*Capacity development efforts in RMNCAH are supported with well-sequenced supervision and required equipment, supplies and incentives to allow service providers the ability, opportunity and motivation to improve service quality and access.* | | |
| **Information/data** | | **Information sources** |

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| 88 | • The following **equipment, supplies, drugs and materials were procured** and distributed to improve access to quality RMNCH services in the 9 HZ:<br>• In 2012: *"(1) Forty-five (45) health facilities in the nine implementation districts were supplied with contraceptives, equipment and materials for childbirth and EmONC, and essential drugs. (2) Eleven (11) pharmacy assistants were trained in CHANNEL software package/programme for rigorous logistics management. (3) Orders were placed for solar devices for blood banks and for lighting of operating theatres for deliveries."*<br>• In 2013: *"Fifteen general referral hospitals and 141 maternity clinics in the programme areas received equipment and materials."*<br>• In 2014: *"Provided instruments and materials for emergency obstetric care in 45 BEmONC and three CEmONC sites; supplied 74 health centres with mixed contraceptive methods and 48 health centres with obstetric fistula kits, and regularly supplied 141 health centres with delivery kits and essential medicine for mother."*<br>*"Provided instruments and materials for newborn care in 45 BEmONC and three CEmONC sites; supplied 74 health centres with mixed contraceptive methods and 48 health centres with obstetric fistula kits, and regularly supplied 141 health centres with delivery kits and essential medicine for child."*<br>• In 2015: *"(1) 800,000 doses of oxytocin, 600,000 doses of sulphate of magnesia and 154.300 plate of 4 tablets of misoprostol has been given countries to improve the provision of obstetric and neonatal emergency care services.(2) 1600 kit 100 rapid tests for syphilis: Alere determined Syphilis RTD and 23,500 Vial benzathine penicillin to handle cases of neonatal syphilis; 1600 kits of 25 tests rapid malaria Bio SD line Malaria Pfpan and 41,000 kits rapid tests of HIV to fight against malaria and HIV;(3) the structures were equipped with 18 additional equipment midwife kits, 80 caesareans kits, 888 boxes delivery, 106 boxes for repair of the perineum and cervical uterine and 3 maternity hospitals equipped with bed of postpartum hospitalization. (4) areas of health of Kenge, Bandundu and Nzanza have 3 Ambulances to ensure real time references and improve support in time of obstetric complications.(5) the MEKHERIS Kinshasa was supplied through the lot awarded by UNFPA to SEN MEKHERIS: 474 000 male condoms and 72 000 female condoms.(6) 170 health centres in 30 health zones supported provinces Kinshasa, Bandundu and Bas Congo and Ecuador) have been supplied with contraceptives"* | The H4+ Global Technical Team (2016*). DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| 89 | • *« Les fonds canadiens ont financé principalement – dans le cadre de la responsabilité de l'Unicef, et dans les zones de santé H4+ i) les activités de dynamique communautaire, une stratégie mise en place pour créer la demande des services en renforçant le lien entre les structures et communautés ; ii) les médicaments essentiels pour la santé maternelle ; et iii) les kits familiaux à partir de 2014 début de la mise en œuvre de la Stratégie Kits familiaux pour pallier le goulot liés à la disponibilité des médicaments essentiels (diarrhée, fièvre, malnutrition et kits accouchement) au niveau de ménages et centre de santé (antibiotiques contre la pneumonie). »* (20 Sep)<br>• *« En guise d'exemple, en 2014, quinze (15) hôpitaux et 141 centres de santé dans les 9 zones de santé appuyées par H4+ ont été approvisionnés régulièrement en médicaments essentiels et en kits familiaux pour les mères et les enfants »* (20 Sep)<br>• *« Pour la RDC, "Kits Familiaux" comprend:*<br>- *SRO/Zinc, Paracetamol, Micronutriments (disponibilisés auprès des ménages)*<br>- *Kit accouchement (remis à la femme enceinte)*<br>- *Amoxicilline (disponibilisé au niveau centre de sante) »* (23 Sep) | Email H4+ country team member 20 and 23 Sep 2016 |
| 90 | • Le H4 + a appuyé l'hôpital général de référence depuis 2013<br>- Une dotation en équipements médicaux et matériels médicaux au niveau de la maternité et outils de la collecte des données,<br>- Ambulance et réhabilitation / equipment pour la maison d'attente<br>- Au total 7 prestataires ont bénéficiés de renforcement des capacités en SONUC+B au sein de l' HGR de MOSANGO, y compris des prestataires (Infirmiers, Médecins(3), Anesthésiste et médecin directeur) de 2011 2015 à ce jour | Interview general referral hospital team (Mosango) |
| 91 | The partograph was distributed to several health facilities to support the surveillance of deliveries | DRC H4+ *Annual Report 2015.* (H4+ Canada 2016: 12) |
| 92 | A review meeting in the Bas Kongo Province in October 2012 indicates that essential RMNCH equipment and essential medicines were insufficient or incomplete, although 75 health workers had already been trained in EmONC. It also indicates a delay in distribution by UNICEF:<br>- *Quoi que les médicaments et matériels déjà acquis et disponibles au dépôt de l'UNICEF Matadi Lot de matériels médicaux et quelques molécules (solutés) non encore distribué par l'Unicef* | Compte Rendu de la Reunion d'Evauation de la Mise en Œuvre des Activite de l'Initiative H4+ du 27/10/2012 dans la Salle de Reunion de la Division Provinciale de la Santé du Bas-Congo a Matadi (H4+ Country Team 2012d: 1-2) |

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| | - *Il ressort qu'une réunion d'harmonisation avec les partenaires sur les modalités d'élaboration du plan de distribution tenu et que le Stock est incomplet, pour se faire on envisage l'achat d'un lot complet de MEG SMNE*<br>- *Pour ce qui de l'équipement et autres consommables, que les MCZ rapportent les listes de ce qui est disponible (penser aussi aux zones à problèmes : NsonaMpangu, Luozi, Kitona, Ngidinga, Kuimba et Sona Bata)*<br>- *Sur terrain, il y a un besoin criant en tables d'accouchement, balances pèse-bébé et balances adultes avec toise ainsi que des échographes.* | |
| 93 | Two inter-agency meeting in January 2014 and June 2014 discussed challenges related to delays in disbursements of funds and/or equipment, drugs and materials which had been revealed by a headquarters joint mission:<br>- *Les ECZ reçoivent le fond d'appui à la supervision en retard (3ème trimestre) et un seul trimestre par an.*<br>- *Les structures ont reçu les commodités, mais n'ont été formés en gestion de commodités*<br>- *Les prestataires ont été formé en SONU au nombre de 25 pas zone de santé et cela demeure insuffisant*<br>- *Les matériels didactiques octroyés à la zone de santé de Mosango pour le centre de formation de puis novembre sont jusqu'à ce jour non utilisé et entreposés dans le dépôt pharmaceutique par manque de locaux*<br>- *Les zones de santé sont en rupture de contraceptif depuis plus d'une année*<br>*<u>ISTM Kenge</u>*<br>- *La salle technique a été équipée, mais certains matériels ne fonctionnent pas par manque d'énergie*<br>*<u>Mutuelle Kenge et Mosango</u>*<br>- *Le fond des mutuelles se garde en dehors des banques sans beaucoup de sécurité.*<br>- *Le model de mutuelles mise en place n'ont pas bénéficié d'assez d'expertise de la gestion financière. Ce model éprouve encore certaines difficultés. P.ex la mutuelle de Mosango n'est pas en mesure de payer son gestionnaire et fonctionne avec un déficit financière d'environ 35%.*<br>*<u>Financement Basé sur le résultat.</u>*<br>- *L'activité a connu beaucoup de retard. A moins de deux ans de la fin du projet, les structures n'ont toujours pas touché les primes de performance* | • H4+ country team: Compte rendu de la réunion H4+ 13/01/2014. (H4+ Country Team 2012b: 1-2)<br>• H4+ country team : Compte rendu de la réunion H4+ 17/06/2014. (H4+ Country Team 2012c) |

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| | - *La visibilité des bailleurs pas suffisamment assurée* | |
| 94 | *« Les formations y en a mais les structure y a encore beaucoup de chose à faire là-dessus. Il y a des équipements et matériels utilisés pendant les formations SONU mais qui n'existent pas dans les structures appuyées, c'est le défi le plus important. »* | Interview, Provincial Health Department (Kinshasa) |
| 95 | **Système d'information sanitaire** :<br>Chaque FOSA visitée dispose des outils nécessaires pour la collectes des informations sanitaires et sont tenus à jours. (…) Les registres de soins curatifs ne sont pas en version imprimés dans la plupart des FOSA visitées. Le remplissage de partogramme est beaucoup mieux à l'Est (MUSANGO) qu'à l'Ouest, beaucoup moins au centre NSELE. Les revues des décès maternelles ne sont pas documentées dans les centres, car tous les cas sont référés à la structure supérieure du deuxième échelon. Les registres de références et contres références sont mieux tenues à l'Est qu'au centre et tenues.<br>**Disponibilité de documents de protocoles à jour, politiques, guides, manuels de formation et de matériel d'IEC :**<br>Nous notons que 82 pourcents des FOSA disposent des guides, normes et protocoles à jour, guides, manuels et de matériel d'IEC. Certains parmi de ces protocoles et guides n'ont pas été vulgarisés, et les modules de formation et de matériel en rapport avec la SMNE sont mieux connus par les uns que par les autres. La structure du centre Nsele en disposait moins que les autres structures visitées.<br>**Infrastructure physique et environnement :**<br>Les salles d'opérations contigües à des salles d'accouchements ont été aménagés aux seins des hôpitaux et CSR et un CSR a une salle d'accouchement éloignée de la salle d'opération cas (constaté à l'Ouest). Par ailleur certaines CS possèdent des locaux qui jouent double rôles en tant que salle d accouchement et de travail, soit salle de la CPNr et salle de travail, ceci est plus prononcé des structures ou la capacité d'accueil est limité . Certains CS manquent d'espaces pour la réhydratation orale.<br>Le problème d'accessibilité en eau potable et électricité demeure cristal, les structures de la ZS de MOSANGO recourent à l'énergie solaire et à des groupes électrogènes, mais cela demande une logistique supplémentaire car la fourniture d'énergie est réglée sur demande est beaucoup plus orientée vers la conservation des vaccins (réfrigérateurs des vaccins et médicaments) soient fournies par moment . Au centre et à l'Ouest , malgré la présence de la société nationale d'électricité , les | EHG consultants/evaluation team (2016): Summary of the evaluation team's health facility check lists |

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| | structures sont obligées d' acquérir des groupes électrogènes et panneau solaires car il y des coupure et délestage fréquente .<br>Concernant l'ambulance deux ZS sur trois visitées disposent d'une ambulance fonctionnelle qui rends d'énormes services, le système de référence est mieux fonctionnel dans les deux ZS que celle de Nsele.<br>**Inventaire des médicaments, consommables et équipements**<br>80 pourcents des équipements adéquats à l'offre de service SMNE sont disponibles dans les FOSA visitées, cependant un nombre important manque partout notamment la boite (de composition) - Aspiration Manuelle Intra-Utérine A.M.I.U., les habits de protection (lunettes +bonnet +tablier), le colposcope, ventouse nouvelle version, l'aspirateur manuel ou électrique.<br>Certains équipement manquent par structure, il s'agit de couveuse, lampe gynécologique, lits gynécologique, nombre infusant des boites d'accouchement, Machine Doppler pour le rythme cardiaque fœtal, Sac et masque pour la réanimation de bébé, Kit de test de syphilis, Kit de dilatation et de curettage, Lampe gynécologique existe mais non fonctionnel et Incubateur pour nouveau-né<br>Concernant les médicaments consommables, 70 pourcent de FOSA connaissent la rupture de stock de médicament pour l'offre de service SMNE comme, le gluconate de calcium, le sulfate de magnésium, les antibiotiques nouveau-né et ampicilline, les contraceptifs couramment demandés par la population tel que les implants, dépôts provera, et certains réactifs pour le dépistages VIH , voir même les ARV. Neuf pourcent (1/11) ne dispose aucun médicament pour l'offre, pour cette structure les patients et parturientes vont se procurer les médicaments en dehors de la structure. | |
| 96 | • *« Le centre de santé réfère les cas de complication à l'hôpital à temps. On appelle l'**ambulance** du bureau central mais quand tu n'as pas les moyens, l'ambulance traine à venir, mais en ce qui concerne les infirmiers, ils nous réfèrent à temps. Il faut payer le carburant pour l'ambulance, et ça dépend de la distance. »*<br>• *« Il y a de fois, on n'a pas des moyens, y a pas d'ambulance, l'infirmier n'a pas de crédit, où vous-même n'avez pas de crédit pour appeler, l'ambulance peut être occupée. La distance pose un problème. »*<br>• *« Exemple : moi-même j'avais eu un problème, je devais accoucher mais il n'y avait pas de transport et je n'avais pas d'argent et les médecins n'étaient pas là. S'il y avait des moyens on pouvait m'amener rapidement. Il a fallu attendre mon mari. (…) on est arrivé au centre de santé à 23 heures et à l'hôpital à 1 heures du matin. »* | Interview women Mbanza Ngungu Femmes (CS Ngungu, next to Cité de la Maternité) |

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| | • *« Il peut se faire que vous n'ayez pas de crédit, le numéro de l'ambulance ne passe pas, ou même que le réseau est perturbé. »* | |
| 97 | *« L'utilisation de l'ambulance est aussi facilité par les rélais communautaires (RECO), qui identifie les signes de danger chez la parturiente lors de la visite à domicile.Le RECO va appeler l'ambulance qui va venir secourir le malade ou le patient ou parturiente. La famille de la patiente va contribuer à l'achat du carburant avec l'AKF, sa contribution est minime de l'ordre de 10 à 15 litres pour les grandes distances et de 5 à 10 litres pour les courtes distances. L'HGR n'achète pas du carburant de l'ambulance par manque des moyens. »* | Interview, health zone team in Mbanza-Ngungu |
| 98 | UNICEF provided the general referral hospital with funds to purchase fuel for the ambulance in 2016 | Interview Mbanza-Ngungu general referral hospital |
| 99 | La dotation de l'ambulance n'a pas été réalisée. Les activités de la référence et contre référence n'ont pas bien fonctionnées dans la ZS par manque des outils et d'ambulance | Interview, health zone team (Nsele) |
| 100 | *« Il y eu (…) une bonne coordination, sauf le cas de la dotation des certains équipements des FOSA appuyées par H4+, où une inégalité de la répartition a été vraiment remarqué, la flexibilité des autres partenaires est venu combler le manque dans d'autres structures. »* | Interview, health zone team (Nsele), 10 August 2016 |
| 101 | *« Par ailleurs,* ***une faible coordination des interventions en rapport avec la dotation des médicaments a été remarquée****, nous avons remarqué un chevauchement des dotations des médicaments (préservatifs et autres lots des médicaments avec les dates de péremptions proches ) entre le fonds mondial /SANRU et les même intrants que l' UNFPA avait déjà livré , il y a un faible filtre des interventions au niveau de la DPS et* ***la non prise en compte des réels besoins de la ZS. Une pression forte reçue de la part des intervenants /partenaires dans la ZS et HGR de Mosango lors de la dotation des intrants qui ne répondent pas à nos besoins »*** | Interview, health facility staff (Mosango) |
| 102 | **Sequencing of trainings and medicines** has been good (no delay), but there have been some delays of equipment due to logistic and distribution issues (among others delivery tables) | Interview, H4+ country team member |
| 103 | *« Le kit de réanimation manque sur le terrain. Tout équipement en SONU manque. C'est une réalité. La sage-femme est formée mais par manque de matériel, elle ne sait quoi faire par manque d'équipement approprié. »* | Interview, implementing partner (NGO) |
| 104 | *« Le grand défi était par rapport à la coordination des interventions. Bien que l'appui était en synergie, mais cet appui n'arrivait pas au même moment entre les différents partenaires [H4+]. Entre la formation et la dotation matérielle, il y a eu un temps mort même en dotation en intrants, c'est de* | Interview, Provincial Health Department (Bas Kongo) |

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| | *façon séquentielle. (…) il faut éviter ce temps mort entre les différences fréquences. Pas une bonne coordination à leur niveau. »* | |
| 105 | For evidence of the **findings from post-training supervision in Bandundu in 2015** please refer to the matrix for question one, assumption 1.3, line 78 | |
| 106 | Mosango health zone team reveals **several issues with sequencing and quantity of inputs** :<br>• *Faible couverture de la Zone en PTME (suite au faible approvisionnement en test de dépistage et appui à la supervision )*<br>• *Difficultés dans l'évacuation des dystocies référés (axe Kinzamba 2, moto ambulance non adaptée au réalité du terrain et actuellement en panne)*<br>• *Maternité faiblement équipées en kit d'énergie*<br>• *Faible taux de pénétration à la mutuelle de santé (faible pouvoir d'achat )*<br>• *L'ETME faiblement intégrée*<br>• *Pesanteur culturel: Utilisation des ocytociques traditionnelles, Mariage précoces ,Rejet de la PF surtout les injections et les pilules ( préfèrent les implants)*<br>• *Ignorance des signes de danger.*<br>• *Quasi-inexistence de service de santé de reproduction pour adolescent et jeunes*<br>• *Difficultés de communication (Recos)*<br>• *Formateur en SONU muté*<br>*<u>Recommandations:</u>*<br>• *Capitalisation/mutualisation des experiences de Mosango vers l'exterieur et vice-versa*<br>• *Approvisionner régulièrement les FOSA en intrants SR*<br>• *Doter la mutuelle de santé de Mosango (MUSAMOS ) en subside nécessaire pour le fonctionnement et la sensibilisation*<br>• *Renforcer le système d'évacuation des urgences obstétricales et pédiatriques par la dotation d'une ambulance 4x4 pour l'axe Kinzamba*<br>• *Construire une maternité à Kinzamba 2 pour améliorer l'accès, car pas de SONU-C dans cette zone juqu'à maintenant* | Health zone team Mosango power point presentation given to evaluation team 15 August 2016 |
| 107 | **Defis à surmonter :**<br>• Pas d'ambulance pour la référence et la contre référence surtout pour les accouchées et les césarisées | Interview, health zone team (Nsele) |

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| | • Insuffisance de supervisions conjointes BCZS, PNSR et partenaires H4+<br>• Certains équipements et certains normes et directives qui devraient être doté après la formation SONU, PF ne sont jamais été dotés | |
| 108 | H4+ team members indicate that the first provision of equipment in 2012 was based on a **'standardized UNICEF package'** which was primarily focused on newborn and child health, while important equipment and materials for maternal health were missing. This was corrected in subsequent procurements by UNICEF and UNFPA, but caused some delay in the provision of adequate EmONC materials to health facilities. | Interview H4+ country team members |
| 109 | - PNSR « borrowed » some of mannequins and did not give them back<br>- The material and equipment for EmONC training are insufficient : «*Il faut fournir suffisamment de matériel, mannequin, production des vidéos qui peuvent appuyer la formation, vidéos téléchargées par les enseignants de la faculté de médecine et remise à l'UNFPA* ». | Interview with Members of the Faculty of Medicine, University of Kinshasa |
| 110 | **Family planning post-training supervision** in Kenge and Mosango indicate weaknesses:<br>• <u>Mosango :</u><br>- *« Pas de débriefing des autres membres de l'ECZ par ceux qui ont récemment été formés en PF*<br>- *La mauvaise utilisation des outils de collecte.*<br>- *Insuffisance en outils de collecte des données (, registres PF, d'accouchement, registres de CPN,ect)*<br>- *Manque de rapport systématique des audits de décès maternels et des résultats*<br>- *Pas suffisamment de nouvelles acceptantes*<br>- *Les activités communautaires ont diminué d'intensité*<br>- *Insuffisance en contraceptifs*<br>- *Mauvaise tenue de certains outils de collecte : partogramme, registre PF, CPN…*<br>- *faible proportion de nouvelles acceptantes*<br>- *surstockage en contraceptifs et intrants PF »*<br>• <u>Kenge :</u> | MoH (2015). *Rapport narratif de la mission de supervision PF dans les zones de sante de Bandundu, Kenge, Mosango, Idiofa, Kikwit Nord, Kikwit Sud et Boko. Province du Bandundu,* Programme National de Santé de la Reproduction, Ministère de la Santé Publique (MoH 2015i: 1-11)e |

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| | - *« Beaucoup de lacunes dans la gestion des médicaments en dépit des formations en gestion des médicaments reçues (pas de frigo pour la conservation des médicaments, mauvaise utilisation des fiches de stocks, manque d'un plan de distribution des médicaments SR,)*<br>- *MCZ non formé en PF, SONU et CPNr*<br>- *Faible utilisation des services*<br>- *Mauvaise gestion des médicaments autres intrants SR »* | |
| 111 | • In 2015, **important equipment and supplies were missing** during the practical module (internship) of a FP training in Bandundu HZ :<br>- *« <u>Sur le plan Matériel et Intrants</u> : Pas de COC; Insuffisance en tests de grossesse ; Pas de registres de PF dans les structures ;*<br>- *<u>Sur le plan technique</u> : Non respect de certaines étapes des précautions universelles et dans l'application des méthodes contraceptives le premier jour du terrain (préparation de matériels ; désinfection du site, instillation de l'anesthésie locale et exécution de la technique d'insertion du Jadelle et DIU) ; Difficultés dans le counseling spécifique avec les clientes*<br>- *<u>Problèmes rencontr</u>és : insuffisance en intrants ; Pas des moyens pour atteindre les femmes des autres aires de santé Pendant le stage »*<br>- *<u>« Points faibles :</u> Rupture en intrants surtout le Jadelle ; Deux sites de stage retenus sur place (alors qu'il est recommandé « Un encadreur de stage pour 6 participants, rendant souple le travail des facilitateurs et aide à bien suivre les participants »* | MoH (2015). *Rapport de l'atelier de formation des prestataires de la zone de sante de Mosango en planification familiale selon la nouvelle approche du 30 Août au 10 Septembre 2015.* Province de Bandundu, Ministère de la santé publique, République Démocratique du Congo. p. 31 ; p. 3-4. (MoH 2015f: 3-4, 31) |
| 112 | • *« A la fin du déballage et montage du matériel, l'équipe de la facilitation s'est rendu compte de **l'absence de quelques matériels et consommables critiques**, notamment : les ampoules de Kétamine, le sulfate de Magnésium, les thermomètres, mètre-ruban. (…)*<br>• *On a également noté qu'il n'y avait qu'une seule ventouse KIWI disponible, marteau à reflexes. Il manquait aussi le modèle anatomique pour l'accouchement en cas de dystocie des épaules les démarches et courses supplémentaires ont permis de combler le vide sauf pour le mannequin de dystocie des épaules ! »*<br>- *« La durée allouée à la formation jugée courte par les participants (6 jours).*<br>- *Le profil de participants qui a montré que la majorité n'ont jamais travaillé en salle d'accouchement et ne maîtrisent pas le français d'où les difficultés d'assimilation.* | Formation des formateurs en SONU pour l'ISTM Kinshasa filière sage-femmes, Kola du 01 au 07 juillet 2015, ISTM de Kinshasa, Ministère De l'enseignement Supérieur, Universitaire et de la Recherche Scientifique, République Démocratique Du Congo. (MHE 2015: 9) |

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| | - ***Manque de certains matériels, médicaments et modèles anatomiques***<br>- *Les formateurs de l'ISTM ont besoin de plus de pratique clinique, et d'un accompagnement afin de s'aguerrir et donner les futures formations de SONU de manière autonome »* | |
| 113 | The 2013 annual report indicates a delay in the procurement for EmONC trainings: *« **Retard dans la livraison des équipements, des mannequins et des médicaments commandés**. Afin de réduire ce retard, un suivi rapproché des commandes a été adopté. »* | DRC H4+ Annual Report 2013, p. 21 |
| 114 | H4+ challenge**:** *« Il faut respecter de l'approvisionnement en médicaments »* | Interview, senior official MoH in Kinshasa |
| 115 | *« **Un autre grand défi est l'état délabré des infrastructures sanitaires** qui demandent une réhabilitation pour une offre de services de qualité. Les agences font le plaidoyer auprès du Gouvernement et d'autres bailleurs de fonds pour réhabiliter ces formations sanitaires. Le Gouvernement pour la première fois a alloué l'argent pour la construction et réhabilitation de 1320 centres de santé et 198 hôpitaux généraux de référence."* | DRC H4+country team (2014). DRC H4+ Annual Report 2013. (H4+ Canada 2015: 21) |
| 116 | **Influence of health reform on H4+ JPCS implementation :** *« En 2015, Le programme conjoint H4+ a été mis en oeuvre dans un contexte de la reforme sanitaire avec le passage de 11 provinces à 26 provinces. **Certaines Divisions Provinciales de Santé (DPS) créées n'avaient pas des capacités nécessaires pour leur fonctionnement.** La majorité des infrastructures sanitaires étaient dans un état de délabrement avancé qui demandaient leur réhabilitation pour une offre un minimum de services de qualité. »* | DRC H4+country team (2016). DRC H4+ JPCS Annual Report 2015. (H4+ Canada 2016: 5) |
| 117 | **Influence of health reform on H4+ JPCS implementation :** *« Le processus de recrutement des cadres des futures Divisions Provinciales de Santé (DPS) par le Ministère de la santé au courant du 1er trimestre 2014 avait **ralenti l'élan de l'engagement de ces derniers quant à la mise en œuvre et le suivi des activités sur terrain.** »* | DRC H4+country team (2015). DRC H4+ Annual Report 2014. (H4+ Canada 2015: 27) |
| 118 | **Influence of health reform on H4+ JPCS implementation:** *"Contextual factors: <u>Facilitating</u>: Leadership at the operational in some health zones like the Nsele HZ in Kinshasa really facilitated the implementation. <u>Hindering</u>: ongoing health reforms that started in 2015 to increase the number of Provincial Divisions of Health in the country from 11 to 26 slowed the implementation as many staff changed function and **some newly created DPS are not yet functional because of lack of infrastructure and human resources.**"* | Email with H4+ coordinator, 3 August 2016 |
| 119 | **Contextual factors – poor PSM system:** The PSM system is highly fragmented and dysfunctional, and that there are multiple parallel circuits for distribution of drugs. Development partners distribute | Association Régionale d'Approvisionnement en Médicaments Essentiels (ASRAMRES) |

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| | drugs through a push-strategy to the CDR (Centre de Depot Regional); essential medicines often expire due to overstock: *« Péremptions des MEGs des CDRs dans les CDRs et (ceux des partenaires périment dans les ZS) »* | (2015). *Problématique de la disponibilité des médicaments dans les CDR présentation à la réunion du GIBS,* Kinshasa, 15 janvier 2015 (power point présentation). (ASRAMRES 2015) |
| 120 | **Contextual factors – poor PSM system:** *« Le fonctionnement du SNAME n'est pas encore optimal et le médicament connait toujours des problèmes de disponibilité, d'accessibilité, de qualité et d'utilisation rationnelle affaiblissant le fonctionnement du système de santé. (…) un bon nombre des produits pharmaceutiques sont du circuit hors SNAME à cause de la faible pénétration de ce système national dans l'organisation sanitaire du pays.»* | MoH (2016). *PNDS 2016-2020*, p. 41-42. (MoH 2016b: 41-42) |
| 121 | **Contextual factors – poor PSM system:** *« Dans le cadre de l'harmonisation des interventions, l'Unicef, le fonds mondial et la Banque Mondiale autour du Ministère de la santé publique se sont penchés depuis le mois de février 2014 à identifier les opportunités d'harmonisation des interventions pour plus d'efficacité en appui au gouvernement dans ses efforts de la mise en oeuvre du cadre d'accélération de la réduction de la mortalité des mères et des enfants (CAO 4&5). (…) En effet, les visites de terrain conjointes organisées avec l'UNICEF, le FM et le Ministère de la santé dans plusieurs provinces démontrent qu'il y a des zones hyper-appuyées aux côtés desquelles existent d'autres zones de santé moins appuyées et pour lesquelles, les populations ont des besoins de santé criants. Cette situation est tributaire du manque de dialogue entre les partenaires qui fait qu'on se retrouve le plus souvent concentrer dans les mêmes zones de santé, donnant de fois les mêmes ressources, ce qui entraine l'inefficience et la gaspillage des moyens pour la population. »* | World Bank (2015). *Termes de référence de l'atelier de concertation sur les modalités opérationnelles d'harmonisation des mécanismes de financement dans le cadre des interventions de l'UNICEF - de la Banque Mondiale- du Fonds Mondial en République Démocratique du Congo, février 2015.* (World Bank 2015b: 1-2) |
| **Assumption 1.5** *The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services and to overcome barriers to access which existed in the past.* | | |
| | Information/data | **Information sources** |
| 122 | Please see table in report for RMNCAH output data (derived from the updated H4+ JPCS M&E framework 2011-2015 provided by the H4+ coordinator in DRC) | H4+ coordinator in DRC (2016). *Usage data from H4+ JPCS health zones.* September 2016, Excel sheet. (H4+ Coordinator in DRC 2016) |

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| 123 | *« Les principaux indicateurs sur **l'offre et utilisation des services et soins de santé maternelle et néonatale dans les provinces d'interventions H4+ et Muskoka sont supérieurs à la moyenne nationale**. Dans les provinces de Kinshasa, Bas Congo et Bandundu, l'accroissement de l'intégration de l'offre de service de la planification familiale a fait passer de 9 à 26 zones de santé avec PF intégrée dans le Paquet Minimum d'Activité (PMA) en 2014. Le nombre de formations sanitaires offrant la PF est passé de 51 en 2012 à 244 en 2014*. » | DRC H4+country team (2015). *DRC H4+ Annual Report 2014.* (H4+ Canada 2016: 18) |
| 124 | **H4+ JPCS contributed to a 3 weeks long media campaign and free offer of FP services across 44 clinics within 16 provinces, including** health zones of Kinshasa, Bandundu (and Kikwit Idiofa) and Bas Congo (Boma), which produced the following results: *"**19,220 new acceptors** (74%) were recruited for modern contraceptive methods, either an acceptance rate of 74%, 60% for Jadelle, 44% for DMPA and 13% for the pills. Girls aged 15-20 years have joined Noristerat 81% for and 32% for the pills; while Jadelle was used at 47% by the age of 20 to 35 years."*<br>*"The campaigns on family planning in the provinces of Kinshasa, Bandundu and Bas Congo helped to recruit large numbers of new acceptors this year."* | DRC H4+ Country Team (2014). *2014 H4+ Country Communications Results.* (H4+ Country Team 2014a: 1-2) |
| 125 | In 2015, H4+ joint programme contributed to achieving **1,045,752 new users of family planning** methods in DRC. | DRC H4+country team (2016). *H4+ Annual Report 2015* (H4+ Canada 2016) |
| 126 | **Il y a eu une bonne augmentation de fréquentation des services de soins disponible (SMNE) suite à l'amélioration du plateau technique, de la capacité d'accueil de la maternité et au renforcement des capacités des prestataires en SONUC, PTME, PF** induisant :<br>• Amélioration de la performance des prestations de soins par les prestataires et une meilleure prise en charge des parturientes **a induit une augmentation de la fréquentation des services de la maternité , réduire le taux de mortalité maternelle et infantile, l'augmentation de l'utilisation de la CPN4 et le taux d'occupation de lits,** le renforcement de l'équipe de garde des prestataires pendant la garde la nuit qui avant était qu'un seul prestataire, (i) Un aménagement adéquat de la salle d'opération contigüe à la salle d'accouchement facilitant un bon déplacement des parturientes à césariser urgemment de la salle d'accouchement vers le bloc opératoire et vis – versa, (ii) le remplissage correcte et à jour des outils de travail bref dossier du malade (partogramme , fiche de la CPN , CPoN) facilitant la prise des décision à temps, (iii) **une réduction sensible des infections post opératoire suite à la bonne maitrise des pratiques apprises lors de la formation en SONU C,** (iv) en rapport avec l'anesthésie, la maitrise de la rachi anesthésie après la | Interview general referral hospital team, Mosango |

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| | formation en SONUC (v) pour la césarienne nous avons appris la nouvelle méthode qui nous fait gagner le temps de l'intervention chirurgicale.<br>• Une bonne tenue des dossiers médical, l'équipe s'approprient des bonnes pratiques des exigences de la PBF, une espèces de contrôle dans le groupe, l'équipe plus méticuleux et a enclenché des bonnes pratiques et a développé des bons réflexes en rapport avec l' accueil, la prise en charge des parturientes.<br>• Améliorer le management hospitalier du médecin et une meilleure gestion, une bonne surveillance et un contrôle interne et le collectif est bien renforcé, et un aspect compétitif entre les services au sein de l' HGR. | |
| 127 | *« Dans les zones où H4+ a agit, ça a vraiment **rapidement amélioré les indicateurs de la mère et des enfant**s surtout à Mbanza-Ngungu. A Mbanza-Ngungu, il y a eu aussi un autre élément qui a influencé : l'UNICEF était déjà là avec l'approche PAO dans le cadre de la réduction des objectifs 4 et 5 ».* | Interview, Provincial Health Department (Kongo Central) |
| 128 | Ces différents appuis (formations, équipements, médications, et supervision) eu à produire des résultats **ayant influencé les indicateurs SMNE positivement et améliorer la fréquentation des services de santé,** la disponibilité de l'offre de services. | Interview, health zone team (Nsele) |
| 129 | In 2015, **419 youth were treated for sexually transmitted infactions** by the Youth Centre Bomoto in Kinshasa | DRC H4+country team (2016). *H4+ JPCS Annual Report 2015.* (H4+ Canada 2016: 13) |
| 130 | In 2015, H4+ supported the The National Union of Midwives (*Union nationale des accoucheuses et accoucheurs (UNAAC))* were provided with bicycles, 2 motorbikes and IT equipment, which enabled them to promote FP services at communit level in Bandundu town and Kikwit, which created **400 new users of FP methods** | DRC H4+country team (2016). *H4+JPCS Annual Report 20.* (H4+ Canada 2016: 14) |
| 131 | *« Le nombre des **nouvelles acceptantes de la PF dans les provinces da Bas Congo, Bandundu et Kinshasa a augmenté** de façons progressive entre 2011 et 2014. Ceci a contribué à l'augmentation de la prévalence contraceptive avec les résultats ci-après : Kinshasa de 14% à 19 % ; Bas Congo de 4% à 17% et Bandundu de 3% à 8% (EDS 2007, EDS 2013) »* | DRC H4+country team (2015). *H4+ Annual Report 2014.* (H4+ Canada 2015: 20) |

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| 132 | *« En effet, depuis 2008, le centre Loma Etat, a reçu l'appui de UNFPA, en termes d'équipements (table d'accouchement, boîte d'accouchement, kit de réanimation,….) et la réhabilitation de la structure avec l'agrandissement de la partie de la maternité qui a permis au centre de passer d'une moyenne de 10 accouchements mensuels à 30. »* | DRC H4+country team (2015). H4+ *Annual Report* 2014. (H4+ Canada 2015: 15) |
| 133 | « **Amélioration de référence** à travers la construction d'une maison d'attente : La maison d'attente de maternité construit par le H4+ à l'Hôpital Général de Reference de Mosango accueille en moyen 15 femmes par mois avec grossesses à haut risque. Leur référence dans cette structure a permis une meilleure prise en charge dans le délai. En 2014, la maison d'attente de maternité de Mosango a accueilli 122 femmes avec grossesses détectées à haut risque. Leur référence dans cette structure a permis une meilleure prise en charge» | DRC H4+country team (2015). H4*+ Annual Report* 2014. (H4+ Canada 2015: 18-19) |
| 134 | *« La **maison d'attente** a été équipée en Décembre 2012. Raison pour la quelle ils disent qu'elle a commencé a fonctionné en 2013. Mais déjà en Decembre 2012 on y avait enregistré quelques cas (…) en fin 2014, ils étaient déjà à 122 femmes+ le 144 de 2015+ le 17 de 2016. »* | Interview, H4+ coordinator |

**Area of Investigation 2: Expanded Access**

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| **Question Two: To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality?**<br>a. **How have H4+ interventions contributed to strengthening the quality and appropriateness of care in RMNCAH provided to marginalised and excluded (encompassing skills and attitudes of staff, availability of equipment and supplies and timing of services)?**<br>b. **To what extent have H4+ JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women?**<br>c. **How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care?**<br>d. **To what extent do H4+ JPCS investments and activities (alone or in conjunction with other programmes of support) contribute to developing trust between service providers and users of RMNCAH services and are these efforts sustained?** | | |
| **Assumption 2.1**<br>*H4+ JPCS supported initiatives are targeted to increasing access for marginalised group members (rural poor women, families in **geographically isolated areas**, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disabilities, indigenous people).* | | |
| | **Information/data** | **Information sources** |
| 1 | For evidence of the **criteria for selection of H4+ JPCS target health zones**, please refer to the matrix for question one, assumption 1.1., lines 8-17 | |
| 2 | The original proposal identifies women and young girls as the primary target group, and men and boys as a secondary target group as part of an explicit strategy to address gender inequalities and gender-based violence (GBV) affecting RMNCAH. Women and youth groups that defend the right of women and girls are briefly mentioned, but there is no information as to how these groups will be addressed.<br>While the proposal presents a vision for involving men and boys in RMNCAH, and young girls in general, there is no specific strategy for targeting the most vulnerable and marginalized adolescents. | DRC H4+ JPCS proposal, p. 14-15 |
| 3 | Activities targeting adolescents and youth were not included in the revised 2011-2012 and the 2012-2013 annual work plans, only from 2014 and onwards:<br>• The 2011-2012 draft work plan included in the original proposal contains an activity to *"integrate/strengthen the supply of reproductive health services to adolescents and youth in* | • DRC H4+ JPCS proposal (H4+ Canada 2010b: 18)<br>• DRC H4+ JPCS annual work plans 2011-2012, 2013-2014, 2014-2015 (p. 7), and |

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| | *health facilities in the target HZ"* and an indicator related to contraceptive prevalence rate among youth.<br>• However, the final approved 2011-2012 and 2013-2014 work plans do not include *any* activities specifically addressing adolescents and youth.<br>• Work plans for 2014/15 and 2015/16 did incorporate specific results indicators relating to adolescent and youth participation. | 2015-2016 (p. 3-4). (H4+ Canada 2010a, H4+ Canada 2012, H4+ Canada 2013: 7, H4+ Canada 2014b: 3-4) |
| 4 | *« Le groupe d'âge auquel le programme s'intéresse est constitué des femmes en l'âge de procréer, les femmes enceintes, les enfants moins de cinq ans, et les PVV.* ***Les adolescents et autres jeunes et personnes de troisième âge ne sont pas ciblés*** *»* | Interview, implementing partner (NGO) |
| 5 | *« Les groupes vulnérables comme* ***les jeunes filles et garçons ne sont pas pris en compte par le programme*** *»* | Interview community health workers, Kasayi, Mosango |
| 6 | *«* ***Les jeunes adolescents ne sont pas vraiment appuyés****, sauf pour les filles qui sont devenues mère et vont bénéficier de l'approche Kit Familial (AKF) »* | Interview health zone team, Mbanza-Nngungu |
| 7 | • *« Outres la cible définie pour le PTME,* ***aucune activité n'a ciblé les jeunes et adolescents, ni les autres PVV.*** *Cependant quelques initiatives ont été planifiées avec le programme PNSA et UNFPA pour la santé des adolescents, entre autres les espaces de convivialités à intégrer dans huit FOSA pour les jeunes adolescents,* ***mais la mise en œuvre n'a pas eu lieu****. »*<br>• *« Ici la cible est bien déterminée par le programme, en dehors de la PF à base communautaire, la formation des ADBC,* ***très peu d'activités ont touché les plus vulnérables et adolescents d'une manière spécifique****»* | Interview, health zone team (Nsele) |
| 8 | *« Les jeunes filles sont vulnérables puisque à risque de mariage précoce / grossesse. L'exercice de planification des interventions pour ce groupe n'a pas été bien défini avec le programme H4+. Seulement quelques initiatives VIH/PF avec ONU FEMME dans l'encadrement des jeunes filles et garçons »* | Interview general referral hospital team (Mosango) |
| 9 | In Mbanza Nungu HZ, a family planning campaign targeted the general population, including youth. The campaigns allowed women to use a contraceptive method of their choice for free (during the campaign). But it seems that *"the messages did not reach youth very well, as they do not have a good understanding".* | Interview, provincial health department (Kongo Central) |
| 10 | *« Le programme national de la santé des adolescents n'était pas appuyé par H4+ ni associé à la planification, mais nous avions des informations de l'existence de la plateforme »* | Interview, senior official in MoH in Kinshasa |

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| 11 | H4+ JPCS supported the *"Organization of the meetings of awareness among young people in the areas of health supported helped to increase demand for condoms and believe that this will significantly reduce the proportion of STIs HIV and unwanted pregnancies among young people because respectively 3,000, 2130 and 4,000 young people have been sensitized in the ZS of Bandundu, Mosango and Kenge.* | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet)<br>(H4+ Global Technical Team 2016b) |
| 12 | Youth are primarily targeted with HIV messages (not comprehensive SRHR): *« Le mois de décembre a été mis à profit pour sensibiliser les jeunes et adolescents sur le VIH/Sida à travers les différentes chaines radio-télévisées nationale et provinciales en français, Kikongo, Tshiluba, Swahili et lingala ».* | DRC H4+ Annual Report 2014, p. 24 |
| 13 | H4+ JPCS supported three youth centres to deliver youth-friendly SRH services (Bomoto and Coulibaly in Kinshasa and Centre des Jeunes (CJ) in Central Kongo). Services include STI treatment, rapid HIV testing and distribution of condoms. In 2015, the H4+ JPCS programme provided funds for renovation of Bomoton and Coulibaly, and Etonga health centre in Nsele HZ in Kinshasa. | DRC H4+ JPCS Annual Report 2015, p. 13<br>(H4+ Canada 2016: 13) |
| 14 | **Strategies to reach the most vulnerable and marginalised:**<br>• In 2012: *"1. Access for pregnant women to quality obstetric, neonatal and emergency care was improved in the hard-to-reach district of Mosango in Bandundu province (480 km and a seven hour drive from Kinshasa), through the refurbishment of a maternity facility."*<br>• In 2014: *"2. Built a maternity waiting home that hosted 122 pregnant women with high risk of complications in 2014"* | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 15 | **Strategies to reach the most vulnerable and marginalised:** The mutual health schemes aimed to improve access for the most vulnerable populations, women in particular. But implementation has been difficult, as the government does not allow free services, which limits access to health care. To overcome this challenge, WHO negotiated the price as low as possible with the health facilities, i.e. the flat-rate approach *('tarification forfaitaire')*. | Interview, H4+ country team member |
| 16 | • The H4+ JPCS prioritised health facilities with the poorest supply of quality services, and provided them with 'Delivery Kits' and equipment. It is a question of equity: « la notion d'équité : on va d'abord là où il y a des besoins les plus importants."<br>• Another strategy to reach the most vulnerable has been the flat-rate pricing (« tarification forfaitaire") to minimize the [catastrophic] spending of households. It has helped the health facilities increase their revenues, which has been a motivating factor for the health personnel, as they have also fained from this. However, some of them also complain about increased work load. | Interview, H4+ country team member |

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| 17 | • The original proposal states that it will introduce a flat rate for key obstetric services (‘*forfait obstetric*’) to reduce the financial barriers and create demand poor women and children for RMNCAH services. | DRC H4+ country team (2011). *DRC H4+ JPCS proposal.* (H4+ Canada 2010b: 16) |
| 18 | The subsidized flat-rate approach was not implemented in Nsele health zone: *« Il serait souhaitable de mettre en place l’ambulance et* ***le tarif préférentiel des parturientes*** *pour éliminer le goulot d’étranglement de l’accessibilité aux soins SMNE .”* | Interview, health zone team (Nsele) |
| 19 | • In 2012, *“Committees for the support of health mutual funds were set up; the committee is functional in the province of Bandundu and a feasibility study is underway. 2. A survey was conducted on community’s perception about health mutual. 3. Four (4) facilitators and 14 operators of health mutual at the provincial level were provided training. The operators conducted a feasibility study that helped identify the pathways taken by patients during an illness.”*<br>• In 2013, *“An awareness-raising campaign resulted in a large number of households taking out social health insurance in Bandundu. The authorities pledged support to the provincial branch of The Mutual Health Care Fund of Bandundu, launched with 1,012 beneficiaries. In Kenge, the Mutual Health Care Fund was improved and now has 3,654 beneficiaries compared to 2,800 in 2012. In Mosango the fund, focused on pregnant women, has 7,852 beneficiaries.”*<br>• In 2014, H4+ partners *“strengthened the management capacities of health insurances (‘mutuelles de sante’) reaching 3,654 beneficiaries, including 1,240 women and 1,458 children”.* | The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet) |
| 20 | In 2015, H4+ supported: “*the empowerment of women to reduce financial barriers and facilitate access to the SRMNE. Four women's cooperatives have been created and strengthened with the support of two mutuelles de santé of Mosango and Kenge sensitisers, the approach of the project was presented to communities in the 36 health areas.”* | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 21 | The construction and equipment of a maternity waiting home in Mosango for pregnant women who live far away from the general referral hospital is seen as an innovation. Pregnant women, especially those with previous history of obstetrical complications, are admitted to the maternity ward. | Interview general referral hospital team (Mosango) |
| 22 | In 2015, “To improve the references in the best time and support in times of obstetric complications 3 Ambulances were presented to the Ministry of health for use in Kenge, Bandundu and Nzanza areas.” | H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| 23 | In Mosango, the Kinzamba 2 area is isolated as it is divided by a river and the terrain is difficult to access. The existing ambulances and the motor-ambulance delivered by MEMISA (Belgian NGO) are not adapted to the dififcult terrain which makes timely referrals difficult. The health zone team recommends « *Renforcer le système d'évacuation des urgences obstétricales et pédiatriques par la dotation d'une ambulance 4x4 pour l'axe Kinzamba »; and « Construire une maternité à Kinzamba 2 pour améliorer l'accès, car pas de SONU-C dans cette zone juqu'à maintenant »* | Health zone team Mosango power point presentation, 15 August 2016. (Mosango Health Zone Team 2016) |
| 24 | **H4+ JPCS support to Coulibaly youth centre in Kinshasa:**<br>• *« Le centre a bénéficié du financement de UNFPA en 2009, 2010 et 2011. De 2011 à 2015, le centre n'était plus financé par l'UNFPA. Le centre ne bénéficiait pas de certaines commodités comme les préservatifs venant de l'UNFPA. La raison était que le centre n'était plus dans le PTA en ce temps. (…) Nous n'avions pas eu de financement du tout, d'aucun partenaire (…) Il y a eu diminution des activités à cause de manque des financements. Il y a eu relâchement du personnel médical qui ne bénéficiait plus de leur prime, ils sont partis. Même les jeunes après avoir terminé leurs études universitaires, ils sont partis pour trouver d'autres emplois ailleurs. Un moment pénible pour nous qui gérons le centre »*<br>• *« Les activités actuelles ont bénéficié de l'appui à partir de novembre 2015 au sein du centre des jeunes quasiment à 60 %. Ces activités étaient la campagne de sensibilisation couplée à l'offre des services aux jeunes. Dans le cadre de H4+, UNFPA nous a doté en commodités pour survenir aux besoins des jeunes pour la prise en charge des IST et pour le test de VIH donc le dépistage volontaire. »*<br>• *« nous avons une rupture de stock par exemple les intrants, les commodités, pour offrir les services. Il arrive qu'on manque le « Determine » [HIV rapid test] et un jeune quitte sa chambre pour venir et il trouve qu'il n'y a rien, cela n'est bien. La rupture de stock nous fait défaut et si nous n'avons pas des moyens, nous ne serons sur terrain pour mener des campagnes (…) Le désir est là mais le manque des moyens fait défaut. Pour le moment, nous sommes en rupture de stock. »*<br>• *« Les défis est que nous n'avons pas senti l'appui de H4+ chez nous, étant donné que nous avons trop à faire, mais pas assez bénéficié. Par rapport à nos besoins, nous n'avons pas senti. »*<br>• The staff of the centre did not receive any training or capacity development (except training of 20 peer educators in June 2015,the last month of the H4+ JPCS) | Interview, staff at Coulibaly Youth Centre |

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| 25 | In Mosango, the health zone team reports that sexual and reproductive health services for adolescents are *"quasi inexistent"*, and they experience issues with the referrals/evacuation of women with labour dystocia from the isolated area of Kinzamba 2. | Health zone team Mosango power point presentation, 15 August 2016. (Mosango Health Zone Team 2016) |
| 26 | For evidence of the **UN Women supported activities in Mosango**, please refer to the matrix for question two, assumption 2.3., lines 81-85, and the matrix for question five, assumption 5.2., line 16-17 | |
| **Assumption 2.2**<br>*H4+ JPCS support to **capacity development, and to effective demand by community members has adequate reach** to effect access to quality services for marginalized groups. H4+ JPCS support addresses the three dimensions of sustainable capacity improvement: **capability, opportunity and motivation** for sustained provision of quality care.* | | |
| | **Information/data** | **Information sources** |
| 27 | For evidence of **H4+ JPCS supported capacity development activities,** please refer to the matrix for question one, assumption 1.3. | |
| 28 | For evidence of challenges related to **issues with coordination, sequencing and timing of inputs**, refer to the matrix for question one, Assumption 1.4., lines 92-114 | |
| 29 | For evidence of the **Coulibaly youth centre**, please refer to the matrix for question two, Assumption 2.1, line 24. | |
| 30 | **H4+ JPCS support to RMNCAH in Mosango HZ :**<br>• *« Renforcement des capacités des prestataires*<br>- *58 prestataires formés en SONU (1 pers. en moyenne formée/FOSA)*<br>- *25 prestataires formés en CPNr /PTME (7 FOSA)*<br>- *16 prestataires formés en PCIME (seuls les IT)*<br>- *25 prestataires formes en PF (7 FOSA)*<br>- *16 CS avec personnel formés en SONU, CPNr/PTME, PCIME, PF (1 pers. Formée en moyenne)*<br>• *Approvisionnement en MEG, autres intrants et équipement*<br>- *Approvisionnement en intrants pour PF (rupture en implant actuellement)*<br>- *Approvisionnement en équipement*<br>- *16 Kits maternité pour CS* | Health zone team Mosango power point presentation, 15 August 2016<br>(Mosango Health Zone Team 2016) |

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| | - *15 Lits d'accouchement pour les maternités*<br>• *Financement de la santé*<br>• *Existence d'une mutuelle de santé*<br>• *Tarification forfaitaire subsidiée mise en place dans toutes les structures (CAO 4 et 5)*<br>• *FBR était appliqué dans 5 CS, l'HGR et BCZ (OMS) (Fin 2015) »* | |
| 31 | **H4+ JPCS support to RMNCAH in Nsele HZ :**<br>• *le renforcement des compétences des ressources humaines en SONU en PTME, en PF (80 prestataires sont formés en SONU, 120 en PF, 60 en gestion des commodités SR, 40 en CPN r, 4 PEC victimes, 2 en réparation de fistules)*<br>• *l'approvisionnement en commodités, la dotation en matériels et équipements, la sensibilisation sur les différentes thématiques,*<br>• *la réhabilitation et l'appui à la supervision.*<br>• *« Ces différents appuis ont eu à produire des résultats ayant influencé les indicateurs SMNE positivement et amélioré la fréquentation des services de santé, la disponibilité de l'offre de services. »* | • Interview, health zone team (Nsele)<br>• Health zone team Nsele power point presentation, 10 August 2016. (Nsele Health Zone Team 2016) |
| 32 | **H4+ JPCS support to RMNCAH in Mbanza-Ngungu HZ :**<br>• *Formations: planification familiale, PCIME (clinique et communautaire), SONU, PTME, PCIMA, Gestion des médicaments*<br>• *Equipement et médicaments: Médicaments essentiels, contraceptifs, équipements, kits familiaux, dotation d'une ambulance médicalisée /PESS*<br>• *Financement de la santé : Financement basé sur les performances, tarification forfaitaire, mutuelle de la santé* | Health zone team Mbanza Ngungu power point presentation, 18 August 2016. (Mbanza Ngu Health Zone Team 2016) |
| 33 | **Community outreach activities**<br><u>In 2012:</u><br>• Awareness campaigns on danger signs and lifesaving actions for pregnant women, and on family planning, were organized in the nine districts with support from H4+ JPCS<br><u>In 2013:</u><br>• Social mobilization campaign at community level to increase demand for family planning services and institutional delivery; training of300 religious leaders in RMNCAH. | H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| | <u>In 2014:</u><br>• Blood donation campaign initiated under the leadership of the First Lady; campaign to increase demand for FP (in 44 health facilities, radio messages, churches, boards on roads, etc.).<br><u>In 2015:</u><br>• Awareness campaigns for young people to increase the demand for especially condoms and provide messages on STIs HIV and unwanted pregnancies in Bandundu, Mosango and Kenge (Bandundu province): National union of midwives and midwife (UNAAC) of the DRC organised awareness campaigns to promote contraceptive methods in Bandundu and Kikwit towns; VCT testing campaigns in Kinshasa.<br>• In Mosango and Kenge health zones: Support to four women cooperatives to empower women to reduce financial barriers and facilitate access to the SRMNE, with linkages to community health funds; 100 chiefs and community leaders are committed to improve maternal and infant health, promote women's rights, and fight against the gender-based violence; Sensitisation of young men on women's rights as most of the types of gender-based violence through a 16-days campaign; establishment of 72 clubs of men and boys towards women's rights either 2 clubs in each area of health have implemented. | |
| 34 | • 12 functional community networks for RMNCH (religious and traditional leaders, women associations, youth networks) were supported to mobilise the community and create demand.<br>• 1830 health extension workers trained<br>• Home visits, health talks, referrals and provision of services (FP).<br>• 300 religious and traditional leaders trained to promote RMNCH<br>• Population Media Center covering 84 community radios and 3 TV stations | Canada / H4+ Collaboration (2015). *Accelerating Progress in Maternal & Child Health.* Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 28) |
| 35 | **Training of Community Health Workers (CHW)**<br>• In 2012, “One hundred twenty (120) community-based agents were trained on distribution of contraceptives in the targeted districts”<br>• In 2013, “410 community health care providers were trained, compared to 136 in 2012, and 138 were training in Family Planning and Maternal and Newborn Health“<br>• There are no CHW activities reported in the table for 2014-2015 | The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements,* internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| 36 | *« Les relais communautaires formés en communication SMNE en 2013 continuent à sensibiliser les communautés sur l'utilisation des services - visites à domicile, causeries éducatives, etc. En 2014, 1420 relais communautaires (dont 424 femmes) ont été formés sur la communication pour la santé de maternelle, du nouveau-né et de l'enfant et les autres pratiques familiales essentielles. En plus, 203 cellules d'animation communautaire et 12 Comités du Développement Sanitaire (CODESA) ont été redynamisés. »* | DRC H4+ country team (2015). *H4+ Annual Report 2014.* (H4+ Canada 2015: 22) |
| 37 | Community-based organizations (OAC) have been strengthened and have implemented demand creating activities. Other activities include peer education and sensitizations by community health workers (*relais communautaires*). The topics they promote include CPN, vaccination, hygiene etc. | Interview, H4+ country team member |
| 38 | • The Family Kit is distributed by CHW to families with pregnant women and children below five. It contains essential drugs, including ORS/Zinc, Paracetamol, and Micronutrients to treat diarrhea, fever and malnutrition. The Family Kit also includes vouchers that women can use to access services at a fixed/subsidised flat-rate price ('tarif forfaitaire'), including ANC services (US$ 1,5), assisted delivery (US$ 7,5) and pre-school consultations for free. This represents a significant reduction in the price they used to pay: « *si tu n'as pas bénéficié du kit familial pour l'accouchement, le coût est plus difficile."*<br>• CHW conducted "an important number" home-based visits to distribute the kits and inform the families about key RMNCH themes, including: IMCNI, ANC, PMCT, nutrition for pregnant women, and exclusive breastfeeding. The sensitisations took place in 2013 and again recently according to the women. According to community members (women), this has lead to an increase in use of ANC consultation, and it is estimated that 60 per cent of all women follow the four visits now. The CHW first counted the families and then distributed the Family Kits. | FGD with mothers in HGR DE MBANZA NSONA NKULU |
| 39 | *« En 2014 les ménages et centre de santé ont été approvisionnés régulièrement en médicaments essentiels et 45,553 kits familiaux pour accouchement (ménage et centre de santé) ont été rendu disponible pour couvrir 80 % des femmes enceintes et des nouveau-nés attendus. Des kits PICME communautaires ont été rendus disponibles dans les sites communautaires dans 2 zones de santé (Mbanza Ngungu et Kenge). »* | DRC H4+country team (2015). H4+ Annual Report 2014. (H4+ Canada 2015: 13) |
| 40 | *« Distribution de Kits familiaux comprenant des médicaments et intrants essentiels nécessaires pour la prise en charge des grossesses et accouchements ainsi que les maladies tueuses d'enfants de moins de 5 ans (CPN, Accouchement, Soins Essentiels Nouveau-Né, Maladies tueuses). Cette distribution se fera lors de la phase de dénombrement, au cours des séances de CPN et CPS ».* | MoH (2013). CAO 4&5. ](MoH 2013a: 11) |

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| 41 | **« La démotivation des ADBC** (*community based distribution agents*) et RECO (*communith health workers*) conduit à la perte des acquis de la communauté en rapport aux bonnes habitudes de la planification familiale lors des campagnes sensibilisation.Cette perte d'acquis serait dûe au manque en intrants, rupture de stock des intrants. **(…)** en plus [les ADBC/RECO] sont restés sans activités [après avoir eté formés] et ceci va induire la perte de la confiance de la communauté auprès des ADBC. **La faible réalisation** des supervisions des relais communautaires par les infirmiers titulaires en rapport avec les ADBC [constitue une risque supplémentaire] ; les supervisions ne se réalisent plus régulièrement. | Interview, health zone team Mbanza-Ngungu |
| 42 | **La démotivation des ADBC :**<br>• Les membres de relais communautaires (RECO) de KASAY ont des difficultés majeures en rapport avec l'accessibilité aux soins de santé pour leur propre famille, ils continuent à payer alors qu'ils offrent des services énormes à la structure.<br>• Il y a des très longues distances à parcourir pour les RECO, certains marchent 15 KM à pied pour arriver à des réunions mensuelles au bureau central de la zone de santé (BCZS). Le RECO quitte son travail pour faire le bénévolat, et cela démotive quand il n'y a pas de moyens de transport.<br>• Les RECO ont été formés en planification familiale et distribution à base communautaire, mais n'ont jamais reçu les contraceptifs pour distribution. | Community health workers, Kasayi, Mosango |
| 43 | *« Il y a moins de retard maintenant qu'avant dans les références, car il y a l'ambulance et la sensibilisation. On travaille en partenariat avec la communauté, les mamans sont sensibilisés, en cas de signes de danger, les mamans viennent directement au centre de santé. Dans le temps, il y avait de retard d'arrivée aux structures de santé (…) actuellement les mamans qui viennent en CPN connaissent déjà les signes généraux de danger chez une femme enceinte. Lorsqu'elle trouve ne fusque qu'un signe, elle est dirigée directement a un CS. (…) On a des affiches murales qui représentent tous les signes de danger chez une femme enceinte. Et dès qu'elle trouve même un seul signe, qu'elle se dirige à un CS. »* | Intervi]ew, LOME health centre staff, Mbanza-Ngungu |
| 44 | *«« La formation [SONU] nous a aidé à connaitre des autres choses qu'on ne connaissait pas avant ; on applique cela maintenant (…). Auparavant, il y avait plusieurs cas de décès maternel, de mort nés frais. Juste après la formation, il y a eu amélioration de la qualité de service. (…) il y a plusieurs preuves. La prise en charge se fait à temps, quand un cas n'est pas de notre niveau ont réfère à temps. Avant, on n'avait pas l'information, on tâtonné, et c'est pourquoi on avait souvent beaucoup* | FGD Muluma health centre, Mosango |

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| | *de morts maternels et des morts nés [dans notre centre de santé]. Mais après la formation, on a appris à reconnaitre les signes de danger et donc à référer plus tôt. (…)* | |
| 45 | *« Grace à la formation SONU, j'ai amélioré mes compétences, le taux d'accouchement assisté a augmenté, le taux d'adhésion au planning familial a augmenté mais on est en rupture de stock, on ne sait pas satisfaire les demandes. »* | Interview MULUMA health center staff, Mosango |
| 46 | *« La communauté apprécie d'abord l'initiative SONU parce qu'avec des difficultés qui se vivent aujourd'hui, avoir beaucoup d'enfants ça pose des problèmes. Il y a certaines mamans qui réclament beaucoup les implants (qui sont vraiment préférés ici). Et même la participation au CPN a diminué le retard dans la référence des cas des complications. »* | Interview MULUMA health center staff, Mosango |
| 47 | *"Before the training, every school thought a different way of reading and filling in the partogram. With the EmONC training, we learned how to use the partogram correctly."* | Interview, Kassai health centre staff, Mosango |
| 48 | • *« Il y a eu des changements après la formation, du point de vu technique, car la zone de santé connaissait beaucoup de décès maternels mais après la formation le taux de mortalité maternel a baissé. (…) En termes de fréquentation du centre de santé, nous avons maintenant 30 accouchement, au lieu de18, et en général nous avons 400 à 500 cas par mois.*<br>• *« La population est vraiment satisfaite car, auparavant, quand les mamans venaient elles devaient apporter des gants, seringue …etc mais maintenant elles n'apportent rien car ils ont un kit complet d'accouchement. De plus, il y aussi une baisse des frais d'accouchement : avant les mamans payaient 18 000 FC, maintenant elles payent 7 000 FC et les enfants paye 1000 FC pour les soins. »*<br>• *« Il y a des changements [positifs], puisque avant, le parthogramme avait seulement une seule partie, mais maintenant, le parthogramme a quatre parties, à savoir : l'identité du malade, suivie de la femme et de l'enfant, suivie de la femme pendant la phase active, et les soins essentiels de l'enfant et de la femme. Donc, nous faisons les choses (…)de façon beaucoup plus ordonnée [et détaillée], il y a un plan [le partogramme] maintenant »."*<br>• *« Avec les connaissances que nous avons maintenant, dès que nous détectons les signes du danger, nous faisons appel directement à l'ambulance pour évacuer le malade vers l'hôpital général pour la prise en charge à un coût bas. »* | Interview KUMBI health center staff, Mbanza-Ngungu |
| 49 | • *« En terme de prise en charge, il y a une réduction sensible du taux de mortalité maternelle et neonatale parce que dans le temps on n'avait pas de ballon d'ambu, on utilisait des poires, or le* | Interview MULUMA health center staff, Mosango |

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| | *poire n'a pas la capacité d'evacuer les mucus, mais avec des ballons d'ambu [il s'agit du ballon-masque est un outil de ventilation.. Ambu est le nom de la compagnie l'ayant commercialisé en premier], la ventilation est rapide. Ca réduit le taux des morts nés et des complications liées a l'accouchement. Avec l'appui de l'UNICEF, il y a amélioration de la référence en cas de problèmes.»*<br>• *« Dans le temps, on regroupait les femmes au CPN, on avait une date fixée pour regrouper toutes les femmes mais actuellement, la femme vient au temps et au moment voulu a la CPN. On repond aux besoins au moment ou le besoin se presente, parce que la CPN est individuelle. Et la frequentation est accrue, parce que la femme vient et ne traine pas a l'attente comme avant (…) Dans le temps, on avait 20 à 25 CPN par mois mais actuellement on peut aller jusqu'à 45 femmes. »*<br>• *« la participation au CPN a diminuée le retard dans la référence des cas des complications (…) le mécanisme de feedback fonctionne, le relais communautaire nous donne les informations de la communauté. »*<br>• *« J'ai amélioré mes compétences, le taux d'accouchement assisté a augmenté, le taux d'adhésion au planning familial a augmenté mais on est en rupture de stock, on ne sait pas satisfaire les demandes. »* | |
| 50 | *« La formation en SONU C (CEmONC) des prestataires au niveau de la maternité a amélioré la prestation de service, notamment la nouvelle technique pour la césarienne qui nous fait gagner énormément de temps, et la faible utilisation des antibiotique après l'intervention, l'usage de la rachianesthésie pour la césarienne ».* | Interview general referral hospital team Mosango |
| 51 | The DEP with support from WHO undertook costing studies, provided support to the ECZ, and negotiated the flat-rate prices with the general referral hospital. | • Interview, H4+ country team member<br>• Interview, health zone team (Mbanza-Ngungu) |
| 52 | • *« La planification de la tarification forfaitaire a été appuyée par l'OMS à Mosango, et à Mbanza-Ngungu le financement était assuré par l'UNICEF. L'approche de Mosango est différente de Mbanza-Ngungu mais avec les mêmes acteurs. Lla différence provient du fait que, à Mosango, l'approche utilisée était que la mutuelle soit comme une porte d'entrée , nous réfléchit comment prendre tarif accessible pour les mutualistes , discuter les tarifs pour les gens qui sont dans la mutuelle ne soient pas trop facturés. Ppar ailleurs à Mbanza-Ngungu l'approche utilisée état le kit familiaux. »* | Interview, H4+ country team member |

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| | • *« Concernant les mutuelle à Mosango, il y a eu quelque problèmes dans la gestion, oui quand il y a des gens dans un bureau , il s' attendent à avoir de l' emploi car la rémunération ne vient pas , il y a un désintéressement , c'est avec les un grand nombres des adhérents que cela va pouvoir générer les fond et le PBF devrait aussi financer le PBF, les mutuelle ne va pas bien fonctionner car les gens sont trop pauvre. »* | |
| 53 | The women can only benefit from the subsidized price if they attend all four ANC visits. A woman has to be referred by a first line health center in order to benefit from the subsidised price for cesareans, which is fixed at US$ 50 instead of US$ 150. This has helped strengthen the referral system in Mbansa-Ngungu. | Interview, health zone team (Mbanza-Ngungu) |
| 54 | At least 5 health facilities in each of the 9 HZ integrate PMTCT services. All structures have received the revised RMNCAH norms and standards, which also contribute to strengthening of service integration. | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 13) |
| 55 | In DRC (…) a media campaign on PMTCT was launched on radio, television and in print. | H4+ Global Technical Team (2014). Canada Annual Narrative Progress Report 2013. H4+ Canada Initiative. Accelerating Progress In Maternal And Newborn Health Reporting period: 1 January 2013-31 December 2013. June 2014. (H4+ Global Technical Team 2014a: 11) |
| 56 | *"In DRC, a social mobilisation campaign was carried out to increase demand for FP services and for delivery in a health facility. The plan to promote men's involvement was carried out with the help of 300 trained traditional and religious leaders."* | H4+ Global Technical Team (2014). *Canada Annual Narrative Progress Report 2013. H4+ Canada Initiative. Accelerating Progress In Maternal And Newborn Health Reporting period: 1 January 2013-31 December 2013. June 2014.* (H4+ Global Technical Team 2014a: 11) |
| 57 | Population Media Fund (implementing partner) produced a radio soap opera on key RMNCH topics in three different languages (French, Lingala and Kiswahili). The French version was broadcast on the national radio station OKAPI from February 2014 to March 2013, the Lingala version from September 2015 to August 2016, and the Kiswahili is still underway. They use action reseach to identify key | Interview, implementing partner (NGO) |

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| | barriesr snd design messages. The use of real actors aas role models and theatre techniques helps create an "affective relationship" between the audience and the actors. They use role models. | |
| 58 | **Demand-creation for family planning:**<br>• *« (i) la campagne nationale multimedia sur l'offre de la planification familliale ; (ii) Intégration de l'offre de service de la Planification Familiale dans les services de la formation sanitaire. Un accent particulier a également mis sur les adolescents et jeunes ; (iii) un partenariat diversifié avec les ONGs, les privés, les organisations de confessions religieuses ont également largement contribué à l'extension de l'offre de la planification familiale. Le couplage des activités communautaires tant pour l'offre par les agent de la distribution de contraceptifs à base communautaires, que pour la création de la demande à travers les sensibilisation et orientation vers les formations sanitaires ; (iv) Les contraceptifs, les intrants VIH ont renforcé l'offre de de service PF »* | DRC H4+ country team (2016).*DRC H4+ Annual Report 2015.* (H4+ Canada 2016: 13) |
| 59 | In 2015, H4+ supported the The National Union of Midwives (Union nationale des accoucheuses et accoucheurs (UNAAC)) we provided them with bicycles, 2 motorbikes and IT equipment, which enabled them to promote FP services at communit level in Bandundu town and Kikwit, which created 400 new users of FP methods. | DRC H4+ country team (2016). *DRC H4+JPCS Annual Report 2015.* (H4+ Canada 2016: 14) |
| 60 | H4+ JPCS contributed to a 3 weeks long media campaign and free offer of FP services across 44 clinics within 16 provinces, including health zones of Kinshasa, Bandundu (and Kikwit Idiofa) and Bas Congo (Boma). | DRC H4+ Country Team (2014. *2014 H4+ Country Communications Results.* (H4+ Country Team 2014a: 1) |
| 61 | *« Grace au partenariat avec la Radio Okapi et les stations de télévisions (RTNC, Digital TV, Numerica TV …), plus de 10 émissions radio-télévisées ont été réalisées sur la problématique de la santé maternelle et infantile. Dans le cadre de l'appui aux médias, les spots en rapport avec l'utilisation des services de Consultation Prénatale (CPN) et accouchement ont été diffusées à Bandundu, Kenge et Mosango afin d'accroître la demande. Lors des journées commémoratives d'évènements mondiaux, en général des émissions ciblées ont été diffusées. »* | DRC H4+ country team (2016). *DRC H4+JPCS Annual Report 2015.* (H4+ Canada 2016: 24) |
| 62 | The original proposal identified the following measures to increase motivation of health personnel: performance-based payment (p. 22), improvement of their working conditions and training to improve their competencies (p. 29) | DRC H4+ country team (2011). *DRC H4+ JPCS proposal*<br>(H4+ Canada 2010b: 22, 29) |
| 63 | • The 2011-2012 work plan includes activities to introduce performance-based payment as a strategy to introduce financial incentives to increase **motivation** among community health workers and health personnel; | • DRC H4+ country team (2011). *H4+ JPCS annual work plan 2011-2012.* (H4+ Canada 2010a: 9-11) |

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| | • The 2013-2014 work plan contains the exact same activities to introduce PBF in health facilities (indicating that the activities were not implemented in 2011-2011), but no longer contains any activities to provide financial incentive to CHW. | • DRC H4+ country team (2013). *DRC H4+ JPCS annual work plan 2013-2014.* (H4+ Canada 2012: 3) |
| 64 | • In 2013, the H4+ partners planned a RBF programme: *"A Result-Based Financing (RBF) study led to the development of a plan to implement RBF in each health zone (i.e., financial support based on each health facility meeting agreed-upon indicator targets). The implementers (60 regulators, 72 service providers and 175 community members) were trained and the implementation of RBF is planned for 2014;"*<br>• In 2014, H4+ partners *"Supported the criteria, interventions and operational plan for performance-based financing (PBF) and co-financed the set-up of PBF in the health zone of one province."* | The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 65 | • *« Le processus d'implémentation de l'approche FBR dans les quatre zones de santé de Kenge et Mosango dans le Bandundu et Matadi et Nzanza dans le Bas- Congo a été mené à ce jour selon les étapes suivantes:*<br>- *Mener une analyse situationnelle de base sur terrain au cours de laquelle les données de base des toutes les interventions n'ont été disponibles ni dans les CS ni au BCZS;*<br>- *Organiser un atelier de planification des activités avec les zones de santé ;*<br>- *Organiser la formation des acteurs de mise en œuvre : BCZS, HGR, CS et ASLO ;*<br>- *Organiser un atelier de contractualisation.*<br>• *Le projet a démarré effectivement avec un retard, soit le 1er octobre 2014. »* | MoH (2016). *Rapport d'accompagnement des structures contractantes dans le processus de vérification des prestations des Zones de santé de Mosango, Kenge, Matadi et Nzanza, avec l'appui H4+. Cellule Technique de Financement Basé sur les Résultats.* Ministère de la Santé Publique, Février 2016. (MoH 2016c: 3) |
| 66 | • The RBF unit works with the H4+ through WHO. Based on a baseline study conducted in the 9 H4+ HZ at the end of 2013, three pilot HZ were selected for the PBF intervention (Matadi, Kenge, Mosango). At the beginning of 2014, service providers were trained. A contractualisation workshop was held in August 2014 with the aim of negotiating annual targets and costs by health facility. The targets/indicators are aligned with the national priorities. The health facilities and members of the community participated in this workshop. Purchase of services started in the last quarter of 2014. The DPS play the role as regulators.<br>• Sequencing, complementarity, and catalyticness :<br>- The PBF unit used the EmONC baseline survey to identify needs and select health facilities to be included in the RBF programme; | Interview, senior official in MoH in Kinshasa |

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| | - *"We supported the health facilities that had already received equipment from the H4+ joint programme. It was a continuation of what PNSR had already done. The material alone is not enough – you also have to motivate the staff, and that is why we targeted health facilities that had already received equipment."*<br>• Challenges:<br>- The intervention does not cover all health areas in a health zone (for example, only five Health Areas, one hospital and the Central Office of the health zone (*Bureau Central de la Zone de Santé*)<br>- The fact that only some health facilities were included in the PBF programme has created jealousy between health workers. It also caused many patients to use the PBF health facilities (instead of the nearest health facility) because the prices are lower (PBF creates an incentive to lower the prices to stimulate demand and attract more clients) [in other words, health facilities not included in the PBF programme have lost clients]<br>- Budget constraints – WHO pays only 1.3 USD per capita whereas the national guidelines recommend 3 USD per capita.<br>- The PBF unit said to WHO up front that one year for 4 health zones is too short a period.<br>• At the first quarterly community verification exercise, it was found that some health facilities had maintained the high prices, and the waiting lines were long. The PBF unit provided feedback to those facilities, and at 2nd and 3rd verification exercises, they had improved (60% satisfaction at the 2nd community verification). | |
| 67 | • La mise en œuvre du mécanisme de PBF au sein de l'HGR de MOSENGO, dont la source de financement était le H4+ /OMS, était une innovation. Ensuite l'appropriation du mécanisme et son application avec les fonds générés par l'HGR lui-même et la mise en peuvre de l'approche CAO 4-5.<br>• *« Il y a eu des innovations dans la planification, la gestion en ce sens : la mise en œuvre du PBF a contribué à l'amélioration de notre planification des activités, à la bonne gestion de l'HGR de MOSANGO et acquérir des bonnes pratiques. »* | Interview general referral hospital team Mosango |
| 68 | *« Il y a eu la mise en place de PBF septembre 2014 à septembre 2015 et suivi de la mise en place de CAO 4 et 5. »* | Interview general referral hospital team Mosango |

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| 69 | *"PBF and mutual health insurance: There have been many studies and preparatory steps, but we have not seen any tangible effects yet."* | Interview, senior official in MoH in Kinshasa |
| 70 | • A challenge is that the process of establishing a PBF programme is quite long:<br>- The actual implementation (i.e. purchase of services) started only in 2014-2015<br>- The PBF unit manages the funds<br>• The World Bank will cover some HZ (but not all) in the Bandundu province with the new PDSS (RBF) programme. | Interview, H4+ country team member |
| 71 | • The RBF external verification exercises has indicated that that there is an increase in quantity and quality indicators<br>• The client satisfaction survey conducted at community level indicate that the community has been satisfied with the quality of services – as the facilities had the basic equipment, material and staff trained in EmONC<br>• When a health facility has more than 3 days of stock outs during a period, it loses money (the performance bonus is not paid). This creates an incentive to buy drugs and supplies locally<br>• The approach has created a certain discipline in the health facilities<br>• The health staff motivation increases – when the providers are supervised and receive technical support by the DPS/EQZS they are more motivated and satisfied. | Interview, senior official in MoH in Kinshasa |
| 72 | • WHO supported health insurance to reduce financial barriers- and at the same time PBF to improve quality – in other words, a combined supply-demand side approach: *« Nous sommes partis du principe que le BPF va améliorer la qualité de soins et nous ne pouvons pas demander aux femmes de cotiser si elles ne trouvent pas la qualité, donc pour nous le PBF c'était pour la qualité de soins aux niveaux des structures. »*<br>• It was decided to support PBF in health zones with no other support to "salary top ups" to health workers. For example, Kinshasa and Mbanza Ngungu already had funds for "prime".<br>• Coordination of WHO supported RBF with other initiatives : *« En effet la ZS de MBANZA-NGUNGU, la planification était identique à celle de MOSANGO, sauf qu'au moment où nous allions commencer la mise en oeuvre du projet,* ***un autre projet de l'AKF allait commencer avec la même approche des MUTUELLEs et achat de performance,*** *c'est ainsi qu'avec H4 + ne devrait plus faire la même chose pour éviter le dédoublement. Il y a eu la même approche qui était financé par RMNCH Trust Fund, l'AKF est financé par RMNCH est venu s'ajouter pour éviter le dédoublement. Une réflexion approfondie va être menée pour éviter la verticalité. »* | Interview, H4+ country team member |

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| 73 | Positive effects of RBF : « *[Le préstataire est] plus précis et méticuleux dans la tenue des dossiers du malade (Partogramme, Fiche de CPN, fiche de référence) pour être à jour dans la tenue des dossiers et dans la documentation. L'équipe s'est approprié des connaissances acquises pendant la formation, il y une espèce de contrôle dans l'équipe ; et l'équipe a enclenché des bonnes pratiques»* | Interview, health zone team (Nsele) |
| 74 | 10 percent of the PBF enveloppe (i.e. the performance payment) that the district health team receives from the PBF programme is paid to community health workers engaged in RMNCAH service delivery (the remaining 90 percent is paid to staff of district health teams and the health facilities. Thecommunity health workers confirm that they have received the money and that the payment schedule was respected. | Community health workers, Kasayi, Mosango |
| **Assumption 2.3**<br>***H4+ JPCS support at national and sub-national level has been sequen****ced appropriately with support to RMNCAH from other sources. H4+ JPCS supported investments and inputs do not conflict in timing or overlap with those provided by other programmes. Further, H4+ JPCS support combines with other programme inputs to allow services to be scheduled and delivered in manners appropriate to reaching vulnerable group members and building trust between providers and users.* | | |
| | **Information/data** | **Information sources** |
| 75 | *« **Les interventions ont été conjointement développées en tenant compte des avantages comparatifs des agences et organisations de l'Initiative H4+.** Ainsi dans leur complémentarité, les agences et organisations de l'initiative ont appuyé le système de santé, comme décrit ci-après : (i) UNICEF : Approvisionnement en médicaments essentiels, matériels et équipements au niveau des ménages et des centres de santé ; renforcement de la dynamique communautaire ; mise à l'échelle des activités de la Prévention de Transmission Mère-Enfant du VIH (PTME) et de la prise en charge pédiatrique du VIH. (ii) OMS : appui au développement des mutuelles de santé ; financement basé sur la performance ; achat des équipements de formation pour la Santé de la Mère, du Nouveau-né et de l'Enfant (SMNE) ; reproduction des normes et directives de la SMNEA. (iii) UNFPA : appui à la coordination, la planification familiale ; développement des Soins Obstétricaux et Néonatals d'Urgence (SONU), développement des ressources humaines ; et l'appui au cadre de suivi et évaluation. (iv) UNAIDS : appui à la coordination des activités de la Prévention du VIH. (v) ONU Femmes : appui à l'intégration de l'égalité du genre dans la programmation. (vi) Banque Mondiale :* | DRC H4+ *Annual Report 2015.* (H4+ Canada 2016: 19) |

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| | *financement du système de santé. (vii) WFP : appui à l'intégration de la nutrition dans la programmation. »* | |
| 76 | *Synergie avec d'autres partenaires ; le KOICA a octroyé les bourses d'études aux 22 étudiants de la filière sage-femme de l'ISTM Kenge.* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 26) |
| 77 | En plus, ce projet a attiré d'autres bailleurs qui ont décidé d'investir dans la SMNE. Des réunions de concertation avec la coopération Sud-Coréenne(Korean International Cooperation Agency, KOICA), ont permis d'identifier des gaps en SMNE dans les zones de santé de Kenge à Bandundu. Ces gaps ont été pris en compte dans le projet qui sera financé par KOICA et qui va couvrir 14 zones de santé dans le district sanitaire de Kwango dans le Bandundu. | DRC H4+ Annual Report 2013. (H4+ Canada 2014a: 20) |
| 78 | *"Dans le cadre de partenariat avec le Fonds mondial et SANRU, 47 520 000 préservatifs masculin ont été distribués dans les zones de santé des provinces, Kongo central, Kwilu et Kwango ».* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 13) |
| 79 | UNFPA purchased additional EmONC equipment to complement the standard kit that had been provided by UNICEF. | Interview, H4+ country team member |
| 80 | • UNWOMEN was selected as local implementing partner of UNFPA to conduct GBV and community-outreach activities, which were integrated in the 2015-2016 joint work plan. It was a country-level agreement. Of the 150.000 USD, 8% indirect costs were taken by UNWOMEN headquarters.<br>• UNWOMEN received one disbursement (90,000 USD) in 2015 which they justified at the end of the year. Early 2016, UNWOMEN requested a new fund transfer, but never received a second disbursement. Neither UNFPA nor UNWOMEN country offices could give any reasons why the second disbursement was not made. UNWOMEN Representative a.i. was not informed that UNWOMEN had never received the second disbursement. The former UNFPA H4+ coordinator, who handed over to a colleague in February 2016, indicated it might be because UNWOMEN never submitted a work plan to UNFPA based on which the second disbursement could be made. "Maybe it was an administrative misunderstanding that caused the delay" (UNWOMEN not being aware that they were supposed to develop a work plan). However, this information was not confirmed by other sources. The current UNFPA H4+ coordinator and other UNFPA senior staff were not able to give any reasons as to why the second disbursement was not made.<br>• *« Le transfert de fonds s'était fait entre le siège de l'UNFPA et celui de ONU Femmes mais les accords ont été signés localement par les deux Représentantes (…) Nous n'avons pas reçu une* | Interviews, H4+ country team members] |

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| | *réponse à la correspondance envoyée à l'UNFPA pour solliciter le reste de fonds. Nous ne savons pas la raison pour laquelle l'UNFPA ne nous a pas donné le reste de fonds. »* | |
| 81 | • *« Sur terrain il y a eu une incompréhension au niveau de la communauté qui n'ont pas bien compris donc la relation entre la mutuelle de santé [appuyé par OMS ] et l'autonomisation de la femme [appuyé par UNWOMEN ]. Les femmes de KITAMBO disent que l'accès aux activités génératrices de revenues AGR est limité à certaines femmes, [car] il faut [d'abord] être membre de la mutuelle pour pouvoir participer à l'ARG. Cela a crée des conflits entre les femmes au sein de la communauté. »*<br>• *« [La confusion et ces conflits entre les femmes ne sont pas du à ] un manque de la compréhension de la part communauté, mais le fait de combiner les deux approches. »*<br>• Au niveau de la mutuelle, il n y a pas eu une bonne collaboration entre les membres des ECZ , les mutuelle et la personne de l'ONUFEMME. Les membres du bureau de la mutuelle] dit que s'il était impliqué aux activités de L'ONUFEMME, il aurait trouvé une bonne solution pour encadrer et amener la communauté à adhérer à la mutuelle. | • Interview women KITAMBO<br>• Interview executive board of community health fund |
| 82 | • ONUFEMME est venue à Mosango après pour compléter les activités en rapport avec l'autonomisation de la femme. Le bureau pays de l'OMS à Kinshasa n'a jamais su qu'il y a eu une incompréhension sur terrain entre la mutuelle de santé et l'intervention de l'ONUFEMME. Un représentant de l'OMS pense que l'OMS et l'ONUEFEMME n'ont pas eu de réflexion profonde au départ pour bien développer l'approche conjointe, clarifier le lien entre les activités de l'autonomisation de la femme de la mutuelle, et préparer les mutualistes à Mosango de la présence des interventions de ONUFEMME. | Interview, H4+ country team member |
| 83 | • UNFPA allocated 150.000 USD of its approved budget to UN Women as a local implementing partner to conduct community-based activities, including GBV, HIV and IGA, based on its distinct expertise in these areas. It was based on a local decision and agreement between the two country offices (CO) and funds were thus to be disbursed by UNFPA CO to UN Women CO.<br>• However, only 90.000 USD of 150.000 USD were disbursed and there is no clear evidence of the reason. This had a negative impact at community level, as it caused certain activities in the approved work plan not to be implemented. | • H4+ country team members<br>• H4+ Global Technical Team Member |
| 84 | • As a consequence of the fact that the second disbursement was never made from UNFPA to UN Women, the planned agricultural income-generating activities were never implemented, as the | Interview, H4+ country team member |

season started in March/April, and the women never received the necessary equipment/seeds to start the activities. Some equipment had already been given in January.

- *« Une seule activité (planifiée) n'a pas été réalisée mais les autres ont été entamées mais pas achevées. Il s'agit surtout des activités génératrices de revenu qui devaient consommer un budget important et qui devaient consolider l'action qui a été menée dans les deux zones de santé de Kenge et Mosango. Voici dans ce tableau, les activités partiellement réalisées et celle qui n'a pas été réalisée. »*

| ***Activités partiellement réalisées*** | ***Activité non réalisée*** |
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| *Appuyer les organisations des femmes en âge de procréer en coopératives et activités génératrices de revenus en lien avec les mutuelles* | *Renforcer les compétences des sages-femmes, des Relais communautaires et des associations à base communautaire sur les droits des femmes y compris les droits reproductifs* |
| *Appuyer la mise en place et le fonctionnement des clubs des hommes et des garçons favorables à la promotion des droits des femmes y compris les droits reproductifs* | |
| *Organiser la sensibilisation de la population sur les barrières culturelles d'accès des femmes à des soins de qualité* | |
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**Assumption 2.4**

*The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability for service users to effectively demand care is sufficient to contribute to a notable* ***increase in the use of services and to overcome barriers*** *to access which existed in the past.*

| | **Information/data** | **Information sources** |
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| 85 | For evidence of the **increased use of services,** please refer to the matrix for question one, assumption 1.5, all lines | |
| 86 | *«Les* ***formations basées sur les compétences*** *ont permis d'améliorer l'offre des services en matière des SONU et de la planification familiale. »* | DRC H4+ *Annual Report 2014.* (H4+ Canada 2015: 26) |

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| 87 | Témoignage sur amélioration de qualité des soins : Dr Fidel NZIMBALANGA, Médecin Chef de Zone de Kenge : *« Depuis le début de l'année 2014 jusqu'à ce début Juin, nous n'avons enregistré qu'un seul décès maternel en intra hospitalier, alors que l'année passée, pour la même période, nous en étions déjà à 11. Ceci est dû au fait que les prestataires ont été formés en SONU et les structures médicales ont été équipées ».* | DRC H4+country team (2015). *H4+ Annual Report 2014.* (H4+ Canada 2015: 6) |
| 88 | • *« Il y a un changement positif, parce qu'il y a diminution de décès chez les enfants et chez les mamans. Ça nous a beaucoup aidé et surtout grâce aux kits familiaux donnés gratuitement enfin de donner le soin à la maison avant d'aller à l'hôpital. (…) Il y a un changement réel pour les maladies qui touchent les enfants 4. (…) et aussi il y a des kits qu'on donne avant l'accouchement ».*<br>• *« Il y a aussi diminution du coût à payer dans le centre de santé, ce qui donne la possibilité à tout le monde d'accéder aux soins de santé (…). Les gens ont une facilité pour le moment d'aller avec toute quiétude dans le centre de santé avec ou sans argent afin de trouver une solution à leurs maladies ou préoccupations »*<br>• *« Moi j'ai beaucoup plus remarqué la sensibilisation par le relais communautaire dans des zones de santé et celle-ci se fait de porte en porte»*<br>• *« Auparavant, il y avait une barrière entre la communauté et le centre de santé, le relais est venu remettre en liaison la relation entre le centre et la communauté. »* | FGD, community health workers (RECO), Mbanza-Ngungu |
| 89 | • *« L'intégration à l'AKF est progressive, l'AKF a commencé d'abord au niveau du premier échelon (CS puis au deuxième échelon) la maternité de la cité est du deuxième échelon à ce stade l'AKF est à 100 pourcent au CS mais au niveau des CSR pas encore. »* | Interview, health zone team (Mbanza-Ngungu) |
| 90 | • The women confirm that they have acquired new knowledge and skills, particularly related to exclusive breastfeeding, HIV, FP and hygiene. One testifies that she practiced exclusive breastfeeding with her second child (but not with the first) because she now understood the importance.<br>• The women state that there has been a 'significant improvement with regard to the quality of services and the way they are received and treated by the health facility staff'. However, they have noted some stock-outs of essential drugs. Also, they point to the limited space of certain maternity wards to receive all women. In some, men and women are mixed in the same room. Other challenges include: | Women DE MBANZA NSONA NKULU |

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| | • The Family Kit and flat-rate approach only subsidize certain services. If your child has other health problems (such as anemia), you pay a high price, for example in the case of referrals to the General Referral Hospital<br>• Certain women refuse to receive the Family Kit due to ignorance and cultural barriers. | |
| 91 | • Le programme H4+ a contribué efficacement à l'accélérer le progrès en RSS et résultat SRMNE de cette manière :<br>• (i) Améliorer la qualité de la prise en charge des enfants et femmes enceintes à travers le renforcement des capacités des prestataires en SONUB et C, PF , PTME créant la confiance entre les prestataires et la communauté ;<br>• (ii) Supervisions régulières du BCZS vers les FOSA ont contribué à améliorer la qualité de soins | Interview, health zone team (Nsele) |
| 92 | • *« Le changement est là, surtout quand je vais dans les ZS dont les structures sanitaires appuyées, le changement est remarquable surtout en termes d'amélioration de la qualité des services et d'amélioration des indicateurs. »* | Interview, Provincial Health Department (Kinhsasa) |
| 93 | • *« La rupture de stock des intrants spécifiques de la PF, quand les Relais communautaires ont créé la demande dans la communauté, par la sensibilisation et la formation des ADBC qui, pour l'instant sont insuffisants ne couvrent pas tous les besoins. Les Aires de santé orientent les nouvelles adhérentes au CS, mais les CS manquent aussi d'intrants (produits PF et réactifs pour le dépistage volontaires en VIH) ceci démotive la communauté. Nous avons été formés en distribution à base communautaire (DBC), mais jusqu'à maintenant, nous n'avons pas reçu de contraceptifs pour distribution, ni le « bag » pour les agents DBC »* | Communith health worker, Kasay, Mosango |
| 94 | • In Mbanza-Ngungu, CHW were trained in FP and community-based distribution (CBD) of contraceptives several times (2011/2012, 2012/2013, and recently in 2016. UNFPA provided a stock of contraceptives for CBD in 2012, and several activitise were organized : *« Pour accroitre l'utilisation de service et la fréquentation de services de PF plusieurs mécanismes ont été mis en place, entre autre l'organisation des campagnes ou la distribution est gratuite. Mais en routine les services et les intrants sont payants exemple lors de la CPN et ce service payant est au niveau des CS où les intrants sont disponibles».*<br>• CHW were trained in CBD again in in 2016, but they have not received the commodities: *"la formation a eu lieu en 2016 mais les intrants ne sont pas encore disponibles pour les ADBC* | Interview, health zone team (Mbanza-Ngungu) |

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| | *provenant des relais communautaires, malgré les promesses formulées après la formation. Par ailleurs, nous notons que les intrants au niveau des CS sont disponibles. »* | |
| 95 | In 2015, "*To improve the references in the best time and support in times of obstetric complications 3 Ambulances presented to the Ministry of health for health of Kenge and Bandundu Nzanza areas."* | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 96 | A community health worker in Mosango states that the community have not been well informed about women's rights, including sexual and reproductive rights. | Communith health worker, Kasay, Mosango |
| 97 | • A community health worker in Mosango notes that *community participation* in RMNCAH has been revitalised under H4+ JPCS, through stronger engagement of traditional and local leaders, the community health workers and other community participation platforms. The community health workers have been trained on RMNCAH and the trust between trust between the service providers and the communities has been strengthened.<br>• *« Les rélais communautaires ont créé la demande dans la communauté, les services sont plus fréquentés, et les prestataires ont beaucoup amélioré leurs prestations. ,Les visites familiaux sont régulièrement organisées, [et] les RECO continuent à sensibiliser la communauté à fréquenter les services de soins . [Les femmes (…) utilisent maintenant les services parce que la qualité a été améliorée, [à travers une meilleur] accueil, des prestataires formés, des équipements disponibles. »* | Communith health worker, Kasay, Mosango |
| 98 | • *« avec l' arrivée du programme H4+ , il y a eu des améliorations en rapport avec l' accès et la qualité, surtout avec la survenu de PBF et CAO 4-5 , la formation en SONU , PTME, PF , PCIME. Nous avons remarqué une nette amélioration de soins surtout pour la qualité d' accueil, il y a eu a aussi une amélioration pour la qualité de la prise en charge et nous avons accès à l' ambulance ».* | RECO Kasay, Mosango |
| 99 | • « *La prise en charge de la femme au CS était vraiment indésirable [d'une mauvaise qualité] avant, mais maintenant il faut l'avouer, l'accueil s'est amélioré, la qualité des prestations est à un bon niveau à partir de 2015, jusqu' à présent le CS a amélioré ses prestations car il y a eu la réhabilitation du CS avec amélioration de la capacité d'accueil, les équipements et renforcement des capacités du personnel . Les ADBC à travers les RECO, continuent à nous informer sur la PF, sur l'approche kit familial, lors de sensibilisation. »* | Girls in LOMA (Mbanza Ngungu |

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| | • *« Au début quand une jeune fille a une grossesse, elle était l'objet de stigmatisation au niveau du quartier, de la famille et du CS, aujourd'hui nous sommes bien accueillies par les prestataires qui nous prodiguent des conseils et l'AKF nous aide à mieux prendre en charge nos enfants.»* | |
| 100 | Young girls in Loma express that there has been a reduction in maternal mortality in their neighbourhood since H4+ trained CHW and provided Family Kits: *"Un autre changement constaté par le groupe est la réduction de la mortalité maternelle."* | FGD girls Loma, Mbanza-Ngugu |
| 101 | **Boys' and girls' knowledge about family planning methods:**<br>Concernant la PF, très peu d'entre-eux connaissent plus de quatre nouvelles méthodes à savoir implants, pilules, colliers de cycles, le plus utilisé est le préservatif, mais trois à quatre jeunes filles ont démontré qu'elles avaient une meilleure connaissance sur l'utilisation des nouvelles méthodes PF. La moitié du groupe ne maitrisent que les préservatifs et une ont connaissance limitée des implants. Une autre source d'information serait l'éducation à la vie cours de l'école, quelques témoignages ont été recueillis. | FGD girls Loma, Mbanza-Ngugu |
| 102 | **Boys' perceptions about appropriate age for condom use :**<br>• *« pour moi il faut qu'on le donne à l'âge de 12 ans parce qu'il y a des enfants qui utilisent les préservatifs mais ils ne comprennent pas ce qu'ils font. »*<br>• *« pour moi il faut l'âge de 18 ans parce qu'à cet âge on comprend quelque notion de la vie et avant 18 ans il faut laisser la tâche aux parents pour l'éducation. »*<br>• *« Il y a aussi des filles qui disent que les préservatifs détruisent leurs sexes lors des rapport sexuels et refusent le port des préservatifs. »* | FGD boys Loma, Mbanza-Ngugu |
| 103 | • *« Avant lorsque les jeunes se rendaient aux centres de santé, il y avait des difficultés, il fallait attendre longtemps. Mais actuellement, nous les jeunes, nous reçevons des soins plus rapidement que les années antérieures (il ya amélioration). »*<br>• *« Avant on ne nous donnait pas de préservatifs aux CS, pour le moment on donne les préservatifs gratuitement et sans problèmes et on donne aussi les conseils. »*<br>• *« Nous sommes informés par sensibilisation communautaire des jeunes par des relais communautaires qui passent sur les avenues pour distribuer les preservatifs, et ils nous demande d'aller aux centres de santé et a l'hopital pour recevoir des preservatifs et des conseils sur* | FGD boys Loma, Mbanza-Ngugu |

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| | *l'utilisation de ces preservatifs. Ces relais communautaires passent egalement dans des écoles pour les seances de sensibilisation.*<br>• *Nous sommes informés aussi par nos professeurs à l'école pour éviter les grossesses et les infections. »* | |
| 104 | **The challenges experienced by young boys:**<br>• La barrière financière demeure malgré l'approche de kit familial qui ne prend en charge que les femmes enceintes et les enfants de moins de cinq ans, car les autres tranches d'âges sont délaissées à leur propre sort par manque d'argent.<br>• Les participants n'ont aucune connaissance sur le planning familial, connaissent aucune méthode, et ils affirment que les activités sont plus orientés vers le VIH.<br>• La moitié du groupe affirme que le groupe de jeune garçon n'ayant pas de moyens pour se faire soigner, et manque de moyens de transport bref l'inaccessibilité aux soins par manque d'argent,<br>• Le groupe déclare que les garçons souffrent de plusieurs maladies comme le Paludisme, la rougeole, les IST Gonococcie surtout, sont exposés au VIH,<br>• Ils affirment qu'ils ont peur de se faire dépister CDV et de faire soigner quand ils sont malades alors ils recourent à des automédications<br>• Ils sont mal accueillis au niveau de CS, ne reçoivent aucune information sur le PF<br>• Il n'existe aucune structure de confidentialité pour les jeunes<br>• Nombreux soufrent de la malnutrition soit chronique ou aigue | FGD boys, Tumikya, Mosango |
| 105 | In Mosango, young boys report that the hospital distributes free condoms to youth, but only to those above 18 years of age. They refuse to hand-out condoms to those below 18, who therefore seek condoms at the market and the pharmacy. But here, boys pay 50 congolese francs, whereas girls pay 100 congolese francs. The boys find that unfair. They say that they are well received at the health centre, if they have a sexually transmitted infection, and that the health providers tell them to use condoms and respect the girls. | FGD boys, Mosango |
| 106 | • ONUFEMME a appuyé le club SIDA de Mosango et donné des ballons de foot aux jeunes garçons pour les amener à se distraire et à sensibiliser d'autres jeunes sur le VIH, la santé maternelle et d'autres thèmes. Les jeunes garçons apprécient cet appui, mais les ballons ne sont pas en nombre suffisant, et s'abiment très rapidement. Ils ont reçu aussi des t-shirts avec des messages sur la santé maternelle et la prévention des violences sexuelles. | FGD boys, Mosango |

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| | • Il y a un manque de formations et d'équipement pour les activités des jeunes. Il y a une maison des jeunes juste à côté del'hopital général de référence de Mosango, mais la salle est vide, les jeunes n'y viennent pas à cause de manque de jeux, de meubles, et d'équipments.<br>• Un volontaire de ONUFEMME les a sensibilisés et encadrés, mais ils n'ont recu aucune formation formelle en pair éducation ou sur la santé sexuelle et reprouctive des jeunes, ni de matériel pour la sensibilisation de leurs pairs.<br>• Ils recommendent qu'il faudrait *« encadrer les jeunes, initier les microprojets, doter un post téléviseur le CD-rom, appareil de sonorisation et des films ou projections, chaises, groupe électrogène comme source d'énergie, comme cela a été réalisé en 2013 avec le Fonds Mondial dans le cadre de la prévention contre le SIDA, avec des films en rapport aux violences sexuelles.*<br>• . Les jeunes hommes pensent que le nombre de moulins pour les activités génératrices de revenus était trop petit et qu'il faut doter assez des moulins dans tous les 13 aires de santé pour éviter les effets pervers, comme par exemple des conflits entre les femmes .<br>• Les garçons affirment que leurs activités étaient beaucoup plus focalisées sur le VIH, mais avec l'appui ONUFEMME ils ont pu intégrer d'autres thèmes sur les mariages et grossesses précoces, la violence sexuelle et l'adhésion à la mutuelle. Par contre, ils n'ont presque aucune notion sur le genre et l'égalité entre homme et femme.<br>• Les garçons disent que les membres de la communauté ont des meilleures connaissances sur les méfaits des violences sexuelles et les signes de danger d'une femme enceinte, ainsi qu'une réduction de la délinquance juveniles, car les jeunes sont occupés par le foot maintenant. | |
| 107 | • L'utilisation de l'ambulance est aussi facilité par les RECO qui identifie les signes de danger chez la parturiente lors de la visite à domicile, le RECO va solliciter l'ambulance ou appeler l'ambulance qui va venir secourir le malade ou le patient ou parturiente , la famille de la patiente va contribuer à l' achat du carburant avec l'AKF , sa contribution est minime de l'ordre de 10 à 15 litres pour les grandes distances et de 5 à 10 litres pour les courtes distances<br>• L'HGR n'achète pas du carburant de l'ambulance par manque des moyens. | Interview, health zone team (Mbanza-Ngungu) |
| 108 | • When the flat-rate pricing approach was introduced in the HZ, it only targeted the general referral hospital and primary health care centres, whereas the 'referral health centres' and hospitals at the intermediary level were left out. This created a situation where the health centres that were included in the Family Kit/flat-rate approach were obliged to refer all women with obstetric | Interview with staff at Cité de la Maternité (referral maternity ward) |

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| | complications or emergencies to the general referral hospital, as this was the only hospital where the women could benefit from the reduced flat-rate price, for example for caesareans.<br>• Before, the maternity ward 'La Cité de la Maternité' was highly frequented by women before, but after the introduction of the flat-rate for caesareans and other EmONC services at the general referral hospital, the number of patients, and thus also the revenues, decreased by nearly 50 per cent, causing demotivation and absenteeism among the staff.<br>• La Cité de la Maternité had been selected as a EmONC site, and providers had received EmONC training supported by H4+ JPCS through UNFPA, but were now unable to deliver the services. | |
| 109 | • The fact that only thee general referral hospital in Mbanza-Ngungu was included in the "flat-rate approach" caused problems for women, as they had to travel longer distances, instead of being referred to the nearest referral heath centre or hospital. Focus group discussions with women in Mbanza-Ngungu provided examples of women who were referred, but delayed in reaching the general referral hospital, as they first had to find money to pay for the transportation.<br>• Women living just next to Cité de la Maternité deplored that they could not receive the reduced price for CEmONC services at the Cité de la Maternité, but had to be referred to the general referral hospital. | Interview with women near the Cité de la Maternité (referral maternity ward) |
| 110 | The lack of motivation of CHW (health extension workers as volunteers) is a challenge | Canada / H4+ Collaboration (2015): *Accelerating Progress in Maternal & Child Health*. Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 31) |
| 111 | **Overcoming financial barriers**<br>• In 2012*, "Committees for the support of health mutual funds set up; the committee is functional in the province of Bandundu and a feasibility study is underway. 2. A survey was conducted on community's perception about health mutual. 3. Four (4) facilitators and 14 operators of health mutual at the provincial level were provided training. The operators conducted a feasibility study that helped identify the pathways taken by patients during an illness."*<br>• In 2013*, "An awareness-raising campaign resulted in a large number of households taking out social health insurance in Bandundu. The authorities pledged support to the provincial branch of The Mutual Health Care Fund of Bandundu, launched with 1,012 beneficiaries. In Kenge, the* | The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| | *Mutual Health Care Fund was improved and now has 3,654 beneficiaries compared to 2,800 in 2012. In Mosango the fund, focused on pregnant women, has 7,852 beneficiaries."* | |
| 112 | 2013 : *"La campagne de sensibilisation pour obtenir une adhésion massive des ménages aux mutuelles de santé a été réalisée dans la province de Bandundu. La Mutuelle de Santé de Bandundu à son démarrage a un effectif de 1012 bénéficiaires (356 hommes, 458 femmes et 198 enfants). La mutuelle de Kenge après redynamisation ½a amélioré sa performance et compte actuellement 3654 bénéficiaires (956 hommes, 1240 femmes et 1458 enfants) contre 2800 bénéficiaires en 2012."* | DRC H4+ Annual report 2013. (H4+ Canada 2014a: 5) |
| 113 | Before, the traditional birth attendants and midwives often treated the women badly (involving violences), but UN Women did not work specifically with them due to insufficient funds. | Interview, H4+ country team member |
| 114 | **Client perceptions about quality:**<br>• ***« Perception des bénéficiaires de services :*** *(…) Concernant les aspects techniques, 60 à 94% sont satisfaits des services reçus. Néanmoins,* ***38% des patients ne sont pas informés de la marche à suivre en cas de complications.*** *74 à 90% sont satisfaits des aspects organisationnels comprenant la confidentialité, la propreté de l'établissement, l'attente de services et le temps consacré aux clients. Du point de vue relationnel, au moins 90% des bénéficiaires déclarent ne pas avoir été forcés d'accepter une méthode contraceptive. En ce qui concerne les résultats de services de la PF, plus de 90% sont satisfaits de services reçus et sont prêts à revenir ou à recommander d'autres bénéficiaires. Dans 51,4% de cas, le service de la PF était payant et le coût moyen des actes y relatifs variait de 2000 à 3000 Fc (2 à 3 $ US). Les sources de financement provenaient généralement du client lui-même, du conjoint, ou autres sources.»* (p. 22)<br>• *« dans l'ensemble, 91,5% des clients sont satisfaits du temps qui leur a été consacré, 91,8% sont satisfaits de la confidentialité dont ils ont bénéficié dans la salle d'examen, seuls 26,7% jugent la durée d'attente trop longue. (…) en ce qui concerne les aspects relationnels les opinions sont également satisfaisantes dans toutes les provinces. 97,7% des clients déclarent avoir été traités avec courtoisie et respect, et 96,7% sont satisfaits de l'attitude globale de prestataires à leur égard. Il n'y a que 10.7% des clients qui disent avoir été forcés d'accepter une méthode de planification par les prestataires. »* (p. 152-153)<br>• *« leur perception en ce qui concerne les aspects techniques, peut être jugée bonne (80%). Néanmoins, seulement deux tiers déclarent avoir été informés des complications éventuelles de la méthode utilisée. Ceci peut favoriser les rumeurs qui souvent entravent l'acceptation des méthodes »* (p. 167-168) | MoH (2015). *Évaluation des indicateurs pour le Suivi du Programme de Sécurisation des Produits de Santé de la Reproduction en République Démocratique du Congo. Rapport 2015.* (MoH 2015a : 22, 152-153, 167-168) |

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| 115 | Accoucheuse de formation et responsable de la Maternité (…) Pour elle, la majorité de cas de décès maternels ou infantiles enregistrés dans la zone de santé étaient dûs aux références tardives. Les villages sont très éloignés des centres de santé et la population est pauvre. De plus, le mauvais état des routes et le manque de moyen de transport adéquat, ne permettent pas aux femmes prêtes à donner naissance, d'arriver à temps à l'hôpital. Mais depuis qu'elle a été construite, la maternité d'attente, a sensiblement résolu cette difficulté ; les femmes qui ont des antécédents obstétricaux lourds sont référés à temps et sont suivis sur place jusqu'à leur accouchement. Ainsi des vies des femmes et des nouveau-nés ont été sauvées. | DRC H4+ Annual Report 2013. (H4+ Canada 2014a: 17) |
| 116 | *Also reported under 1.5. « Amélioration de référence à travers la construction d'une maison d'attente : La maison d'attente de maternité construit par le H4+ à l'Hôpital Général de Reference de Mosango accueille en moyen 15 femmes par mois avec grossesses à haut risque. Leur référence dans cette structure a permis une meilleure prise en charge dans le délai. En 2014, la maison d'attente de maternité de Mosango a accueilli 122 femmes avec grossesses détectées à haut risque. Leur référence dans cette structure a permis une meilleure prise en charge»* | *DRC H4+ Annual Report 2014.* (H4+ Canada 2015: 18-19) |
| 117 | *Also reported under 2.4.* The maternity waiting home in Mosango was refurbished and equipped in December 2012. The number of pregnant women who stayed in the maternity waiting home was 122 in 2013-2014, 144 in 2015 and 17 in 2016. | Email exchange with H4+ country team member |
| 118 | H4+ JPCS supported several activities at community level to stimulate demand in Mosango, including: capacity development of community health workers on how to engage the community in RMNCH, community sensitisation activities; home-based visits; training of community-based distribution agents (ADBC) for contraceptives; the creation of a community solidarty fund to help mothers pay for the ambulance; and informing the community about the availability of RMNCAH services at the health centres and the general referral hospital. The improvement of service quality has created greater trust between the community memers and the health workers at the general referral hospital | Interview general referral hospital team (Mosango) |
| 119 | **Infirmière titulaire du centre de santé Loma Etat dans la zone de santé de Mbanza Ngungu en Province du Bas-Congo :**<br>• *« Pour elle, La formation SONU reçue en 2012, a changé sa façon d'agir surtout devant des cas compliqués. Avant pour réanimer les nouveaux-nés, nous appliquions de l'alcool, soit on donnait des fessés, au bébé. Mais aujourd'hui, grâce à la formation SONU, nous avons appris que les éléments clés de réanimation de nouveaux nés sont l'oxygène et la lutte contre l'hypothermie.* | *DRC H4+ Annual Report 2014.* (H4+ Canada 2015: 15) |

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| | *Tout cela a été rendu possible par les équipements des réanimations (tables chauffantes, ballon d'ambu,…) octroyés à notre centre de santé à travers le projet H4+. (…) La formation acquise, Abetty ne l'a pas gardée pour elle seule. Elle profite des heures libres de service pour restituer à ses collègues les acquis de la formation.* | |
| 120 | **Témoignage sur l'amélioration de qualité de soins à travers le renforcement de capacités des prestataires :**<br>• *Silas NGOMBE EMPWE, Infirmier Titulaire de Centre de santé Kassai dans la zone de santé de Mosango : « la formation en Soins Obstétricaux et néonatals d'urgence m'a permis de sauver les vies de 6 femmes cette année. Toutes étaient référées à retard après avoir perdu beaucoup de sang. Avant, je ne savais pas comment m'y prendre et j'ai paniqué devant de cas pareils et je perdais beaucoup de temps à poser des gestes inadéquats qui augmentaient les risques de mourir pour ces patientes. Mais j'ai procédé au bilan initial comme apprit dans la formation SONU, ce qui m'a permis à moi et mon équipe d'évaluer l'état de choc, de réanimer, de stabiliser avant d'appeler l'ambulance pour une référence à toute sécurité. J'ai pris le temps de restituer la formation à toute mon équipe selon un plan qui consistait à passer une complication par semaine. Donc même à mon absence, mon équipe s'en sort sans trop de difficulté»*<br>• *Témoignage sur la réduction du nombre des décès maternels intra-hospitaliers*<br>• *Dr Fidel NZIMBALANGA, Médecin Chef de Zone de Kenge : « Depuis le début de l'année 2014 jusqu'à ce début Juin, nous n'avons enregistré qu'un seul décès maternel en intra hospitalier, alors que l'année passée, pour la même période, nous étions déjà à 11. Ceci est dû au fait que les prestataires ont été formés en SONU et les structures médicales ont été équipées. »* | *DRC H4+ Annual Report 2014.* (H4+ Canada 2015: 20) |
| **Assumption 2.5**<br>*Demand creation activities and investments have sufficient resources and are sustained enough over time to contribute to enduring positive changes in the level of trust between service users and service providers in RMNCAH. Investments and activities aim to change service providers' attitude and behaviour toward users in an effort to build mutual trust. Improvements in service quality and access are not disrupted by failure to provide adequate facilities, equipment and supplies of crucial commodities in RMNCAH. H4+ JPCS support is not subject to disruptions, which can weaken trust and reverse hard won gains.* | | |
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| 121 | • *« Vers la fin de l'année 2014 , il y a eu un relâchement dans la tenue des réunions de coordination entre les parties prenantes gouvernement et les agences , le sous financement des PTA du PNRS, la non production du bulletin SRMNE, faible réalisation des missions conjointes sur terrain »*<br>• *« Par contre l'agence UNPFA (le programme habituel) a appuyé notre programme de la santé des adolescents la production des bulletins sur la santé des adolescents, mais après nous avons constaté une réduction de l'appui de notre PTA sous l'UNFPA. »* | *Interview, senior official in MoH in Kinshasa* |
| 122 | • *« [Il faut] éviter les retards dans le décaissement des fonds : Nous sommes du Ministère de l'Education Supérieur où le calendrier académique doit être respecté ; Lorsque une activité est planifiée au début de l'année (en octobre) et les fonds arrivent en retard au mois de juin presque vers la fin de l'année. C'est serait mieux de respecter les procédures de décaissement »*<br>• *« En 2015, il n'y a pas eu de financement ni pour les formations, ni pour le suivi et évaluation car l'ISTM n'a pas signé de PTA directement avec l'UNFPA. Le PTA général a été signé par le gouvernement et les agences de Nations Unies, on ne sait pas affirmer si les fonds ont été disponibles pour les activités. »*<br>• *« La fin du financement a affecté le programme car certaines formations ont été planifiées en 2015 dans certains ISTM comme Matadi, Gbadolite et Kisangani. Le MINESU a même préparé le personnel de ces ISTM qui attendaient l'équipe de l'ISTM-Kinshasa. Suite au manque de financement, cette activité n'a pas été réalisée. Les seules activités organisées en 2015 sont les deux ateliers de formations en SONU avec le financement direct de l'UNFPA. L'ISTM est toujours en contact avec l'UNFPA et la D10 du MINISANTE qui demandent à l'ISTM de patienter. A part les deux partenaires (ICAP et l'UNFPA), aucun autre partenaire n'a appuyé les formations en SONU organisées par l'ISTM. »* | Interview, implementing partner (ISTM Kinshasa) |
| 123 | *Les ECZ reçoivent le fond d'appui à la supervision en retard (3ème trimestre) et un seul trimestre par an.* | Compte rendu de la réunion H4+ 13/01/2014, 1-2 |
| 124 | *« Le financement a baissé ces derniers temps, surtout ces 2 dernières années. Il y a des activités qui étaient prévues depuis 2014, mais jusqu'aujourd'hui cela n'est pas encore réalisé. Les fonds ont sensiblement baissé. Les fonds font défaut. On remarque même la lourdeur de la procédure. »* | Interview, implementing partner (NGO) |

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| 125 | *The coverage and reach of RBF is limited. For example, H4+ JPCS supported RBF intervention does not cover all health areas in a HZ (for example, only 5 Health Areas, 1 hospital and the Central Office of the HZ (Bureau Central de la Zone de Santé).This is a challenge.* | Interview, senior official in MoH in Kinshasa |
| 126 | *Delayed disbursements from global to country level : « Retard dans le décaissement des fonds a entrainé un retard dans la mise en œuvre. Afin de réduire ce retard, nous avons préfinancé certaines activités. »* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 27) |
| 127 | Conflicting agendas and postponement of meetings are the main challenges. Another challenge was that the work plans are well elaborated but the disbursements of funds often late, which delays implementation of important activities. | Interview, H4+ country team member |
| 128 | • *In 2014, WHO country office received funds from headquarters with significant delay. UNFPA had received funds by 17 June, but not yet disbursed funds to implementing partners:*<br>  • ***UNFPA :*** *a déjà reçu les fonds et les commandes ont été passée pour toute activité procurement. Les fonds pour les partenaires de mise en œuvre en voie de déblocage*<br>  • ***OMS :*** *Les fonds ne sont pas encore arrivés dans le compte de l'OMS, néanmoins une mission de prospection a été effectuée avant la formation de formateurs.*<br>• ***UNICEF :*** *Les fonds ne sont pas encore arrivés dans le compte de l'UNICEF.* | Compte rendu de la réunion H4+ 17/06/2014 |
| 129 | "Le 30. Avril. 2015 (…) UNFPA a reçu déjà 60% du fonds canadien pour cette année, tandis que UNICEF et OMS pas encore." | Compte Rendu de la Reunion des Points Focaux d'Agentes de l'Initiative H4+, le 30 Avril 2015 (H4+ Agencies 2015b: 2) |
| 130 | • *The DRC country team received less credit of USD 146,811.63 in 2016 as a result of a mistaken transfer entry by the central Finance Unit (which credited the funds to Sierra Leone).*" Staff members indicate that this might be one of the reasons why UNWOMEN did not receive the remaining balance of the 150.000 USD. The mistake was not discovered until questions were raised by the evaluation team after the field mission to DRC in September 2016. According to the Global Technical Team staff member, the DRC country office had not informed the HQ that they had received less funds than budgeted for.<br>• The UNFPA country office say they did not receive all funds (compared to budget), but when they asked headquarters in November 2015, they were told that there were no more funds available and everything had been disbursed. | Interviews, Global Technical Team and H4+ country team in the DRC |
| 131 | • Health providers state that there is an insufficient numbers of staff trained in EmONC : « *Malgré ma volonté de transférer les compétences, je reste la seule en qui tout le monde à confiance.* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 15) |

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| | *C'est aussi l'une des raisons pour lesquelles, le service ne soit pas couvert 24h/24. S'il y a des cas des complications, l'équipe fait toujours appel à mon appui même pendant mes jours de repos et Dieu merci, grâce à ma formation très peu de complications obstétriques sont fatales. Je souhaite que le projet H4+ forme d'avantage des prestataires pour lutter efficacement contre la mortalité maternelle à Mbanza-Ngungu ».* | |
| 132 | • *« En rapport avec les sages-femmes bénéficiaires de nos formations (SONU), c'est le besoin en formation qui demeure. C'est-à-dire qu'il y a beaucoup de thèmes à aborder pour être formées mais les occasions ne sont pas trop fréquentes. Ce sont les formations un peu isolées, ponctuelles. On trouve que les besoins en formation persistent dans le renforcement de leurs capacités. Même si ces formations sont organisées, on n'arrive pas à atteindre tous les 4 coins seulement on est dans la ville province de Kinshasa. On est limité par l'appui des partenaires et des moyens. Le nombre est insuffisant, donc le besoin en formation demeure. »*<br>• *« Le H4+ a créé la demande. C'est un apport apporté mais par rapport à la grandeur de la ville (de Kinshasa), l'appui H4+ JCPS est une goutte à l'océan. Avec l'offre que nous avions faite ici et si nous sommes dans un pays comme le Gabon, toute la population gabonaise est de 4 millions d'habitants, par rapport à la ville de Kinshasa dont la population est 8 à 10 millions d'habitants, c'est comme une goutte dans l'océan. »* | Interview, implementing partner (NGO) |
| 133 | For evidence of the **Coulibaly youth centre**, please refer to the matrix for question two, Assumption 2.1, line 24. | |
| 134 | **Sustainability:** *« En RDC, les agences H4+ prévoit de tenir une retraite avec l'appui d'un expert international pour renforcer le leadership de cette approche et surtout d'élaborer un plan annuel de travail 2016 et définir les sources de financement autre que le fond Canadien. A cette occasion des mécanismes efficaces seront mis en place pour mobilisation de ressources pour renforcer l'approche H4+ (…)* | DRC H4+ JPCS Annual Report 2015. (H4+ Canada 2016: 2) |
| 135 | **Sustainability:** UN Women will not support activities in the two health zones beyond the H4+ Canada funds, as other UN Women programmes are primarily implemented in other provinces. | Interview, H4+ country team member (UN Women) |
| 136 | **Sustainability:**<br>• The PBF unit explained to WHO that one year for 4 health zones is too short a period. | Interview, senior official in MoH in Kinshasa |

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| | • Ensuring sustainability is challenging, as it is still not clear whether PBF will continue to be funded by other partners in the 4 HZ. The PBF Unit announced the end of financing to WHO but still has not received a response.<br>• "We will go back to zero if there is no longer funding, as the motivation will suffer"<br>• It is possible that the World Bank PDSS project will continue to fund PBF in Kenge and Mosango (but not the two other H4+ HZ). The training of provincial trainers for the new PDSS project will take place early September, and the activities will start in October. | |
| 137 | **Sustainability was considered already in 2014 (as reported in the 2013 annual report), and strategies to ensure sustainability include:**<br>• The Reproductive Health Law, including articles on Family Planning, will set the stage for improvements in FP programming as well as EmONC. This means that the government is once again responsible for ensuring access to quality health care for mothers and babies.<br>• The National Reproductive Health Programme includes modules that are being used to train EmONC providers, including in OJT.<br>• The availability of appropriate training modules and management tools as part of Mutual Health Insurance plans will ensure the standardization of this approach.<br>• The national RH and HIV programmes contain guides and training modules in HIV management that will improve the integration of HIV services in RH.<br>• The revision of the midwife training curriculum will produce sustainable improvements in the basic training of midwives and will be applicable to all basic training institutions.<br>• The maternity waiting facility that was repaired in Mosango provides improved access for all members of the community.<br>• The strengthening of national capacity as a result of H4+ evaluations is a benefit that will outlast the H4+ Canada programme. | H4+ Global Technical Team (2014). Canada Annual Narrative Progress Report 2013. H4+ Canada Initiative. June 2014. (H4+ Global Technical Team 2014a: 63) |
| 138 | • What will last when the programme ends: H4+ agencies, make sure that when new funding for RMNCAH is in the pipeline, it is targeted to the 9 health districts. For | Interview, H4+ country team member ( |

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| | example, the new /GFF-WB project and the MOU between UNICEF, WB, Global Fund will provide support to the 3 H4+ health zones in Bandundu. In Central Kongo, UNICEF will provide family kits. The RMNCH Trust Fund will also support the 9 health zones. | |
| 139 | RMNCH Trust Fund ends December 2016 | Interview, H4+ country team member |
| 140 | When H4+ JPCS funds end: Bandundu will be covered by PDSS (World Bank RBF), and certain health zones will be covered by UNICEF's own funds. Funds to sustain activities in Kongo Central have not yet been guaranteed. In Kinshsasa, Canadian funds CCSD – will support the continuation of activities | Interview, senior official in MoH in Kinshasa |

**Area of Investigation 3: Responsiveness to National Needs**

| **Question Three: To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level?**<br>**a. Is the basic structure of the H4+ JPCS (decision making structures, management processes, approval mechanisms, disbursement rules and procedures) able to respond to evolving and changing contexts and situations in a timely and appropriate manner? Does the structure place countries at the centre of the programme?**<br>**b. As the programme has evolved over time, has it become more flexible in responding to changing contexts and events, for example the Ebola Viral Diseases or to changing national plans and priorities?** | | |
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| **Assumption 3.1:**<br>*H4+ partners supporting RMNCAH in JPCS countries have been able to establish effective platforms for coordination and collaboration* ***among themselves and with other stakeholders*** *(including work plans, activities and investments, and results monitoring frameworks and systems) using H4+ JPCS funds and with technical support from the global/regional H4+ teams.* | | |
| | **Information/data** | **Information sources** |
| 1 | The system for coordinated planning, supervision and review of the H4+ JPCS in DRC has four main elements:<br>• Joint H4+coordinating meetings (MoH and H4+ members)<br>• Inter-agency H4+ coordinating meetings (H4+ members only)<br>  ○ Quarterly meetings of the heads of H4+ agencies meetings<br>  ○ Monthly meetings of the H4+ focal points<br>  ○ H4+ annual retreats<br>• Joint supervision and review missions to the nine health zones supported by H4+ (MoH and H4+ members) | • Interview, H4+ country team member<br>• Interview, senior official in MoH in Kinshasa |
| 2 | • The number of joint supervision missions decreased in 2015 and 2016<br>  - 2012: 4 joint missions<br>  - 2013: 2<br>  - 2014: 3 | ALL SUPERVISION REPORTS – see bibliography |

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| | - 2015: 1 (the H4+ Global Technical Team visiting DRC) | |
| 3 | In April 2012, an inter-agency meeting recommended to « Organiser un rencontre avec la partie nationale pour valider le plan de coordination ». | H4+ meeting minutes: *PV de la réunion H4+ du 27 avril 2012.* (H4+ Agencies 2012b) |
| 4 | MoH senior officials note that there have been less joint field missions in 2015 and 2016 than previous years. | Interview, senior official in MoH in Kinshasa |
| 5 | • H4+ coordination became active as of 2012, including regular meetings with active participation of H4+ members and government<br>• Coordination meetings:<br>- In 2012-2014, internal inter-agency meetings and meetings with MoH and H4+ agencies were organized on a monthly basis<br>- In 2015, the two H4+ meetings were merged into one single meeting, as the MoH wanted to reduce the number of meetings. MoH hence established one single RMNCH Task Force meeting with all PTF, including the H4+.<br>- The inter-agency meetings continue to take place, and the MoH is invited, but only participates once in a while<br>- In addition, the Representatives meet every two months<br>• Only UNICEF, WHO and UNFPA received funds, but UNFPA decided to give a small budget to UNWOMEN to implement GBV and IGA in Mosango. WFP joined in 2015.<br>• The World Bank participation:<br>- In 2013-2014, World Bank participated both technically and strategically in meetings<br>- In 2015, there were no longer any technical staff who could ensure participations, as she left for New York<br>- The current staff (Michel Muvudi) is alone and does not have sufficient time to participate | Interview, H4+ country team member |
| 6 | **The evolution of H4+ JPCS coordination between 2011-2016**:<br>• *"From 2011 to January 2016, UNFPA was the lead agency for H4+, but early 2016, this coordination role was handed over to UNAIDS.*<br>• *From 2012 to 2014, there were monthly coordination meetings at the technical level convened by the UN lead agency and monthly coordinating meetings between the MoH and H4+ agencies convened by the MoH. From 2015, the two types of technical meetings were fused into one monthly technical meeting in which both the H4+ agencies and MoH participate.* | Email with H4+ country team member, 4 August 2016 |

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| | • *The strategic meetings between H4+ heads of agencies are organized every two months.*<br>• *There were 4 agencies in 2012 (WHO, UNICEF, UNFPA, UNAIDS) participating in H4+ meetings in 2011-2012. In 2013 after advocating strongly for H4+ membership, the World Bank and UN Women started participating in the meetings. World Food Programme joined the H4+ team in 2015 expanding the membership"* | |
| 7 | **Direction10 views on coordination – set-up and strengths:**<br>• At the beginning of the programme (2011), there was no H4+ coordination mechanism. The H4+ work was coordinated through the Commission for Health Services of the National Health Sector Coordinating Committee (*Comité National de Pilotage du Secteur de la Santé, CPP-SS*).<br>• When the H4+ coordinator arrived in March 2012, a joint coordination mechanism was established between MoH and theH4+ agencies, which worked well in 2012-2013.<br>• *"It has been a learning experience ('école d'apprentissage') for the agencies and the government to work together. That is the most important result".*<br>• *"We have learned to work together, that is the most significant result that H4+ has brought about. Before, we worked bilaterally with each agency. Sometimes, you would find WHO and UNFPA doing the same thing in the same place, there were overlaps"*<br>• *"Activities are better coordinated [among H4+ agencies]. That is the most important; not that they present themselves as H4+"* | Interview, senior official in MoH in Kinshasa |
| 8 | **DEP (MoH) views on coordination - strengths:**<br>• Before, each agency operated independently: *"Chacun faisait de son coté".* Now, the partners (H4+ agencies) speak with the same voice.<br>• The improved coordination will be sustained because: *"it is a state of mind that has changed, and it will continue. The (collaborative) approach has been adopted"*. But a minimum of (financial) resources will be necessary to sustain the collaboration (i.e. support for meetings, joint visits etc.) *"la pérennité demande un minimum de resources".* | Interview, senior official in MoH in Kinshasa |
| 9 | In 2015, UNFPA supported joint supervision visits with the D10 and PNSR Mosango, Kenge (field visits in the DRC), Douala (inter-agency meeting) | *DRC UNFPA Activity Report 2011-2016* (Excel sheet) (UNFPA 2016b) |
| 10 | • The original proposal stated that the H4+ JPCS will be coordinated by the Division for Family Health of the MoH with the technical support of the H4+ agencies, which operate under the leadership of | DRC H4+ proposal. (H4+ Canada 2010b: 11-12) |

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| | the UN Resident Coordinator in DRC. Further, the existing coordinating structures should be used as platforms for H4+ joint programme coordination, including the National Health Sector Coordinating Committee *(Comité National de Pilotage du Secteur de la Santé, CNP-SS)*, the Provincial CNP-SS,the Board of Directors and the Management Board of the HZ<br>• At national level, the RMNCH Task Force, which is a sub-commission of the Service Delivery Commission of the CNP-SS, was identified as the ideal platform for consultation and M&E of the H4+ JPCS, while it was recognized that it needs to be strengthened to play this role well. | |
| 11 | • « Pour le PNSR, le programme avait bénéficié d'un assistant technique [H4+coordinator, UNFPA staff] qui avait aussi le mandat de la coordination de H4+ et de la coordination des réunions des Agences et Bailleurs. »<br>• *« Au début de programme, Les réunions de coordinations des activités étaient régulièrement tenues, le suivi et l'évaluation des activités étaient bien organisés (…) nous remarquons que durant les deux dernière années les réunions ne se tiennent plus régulièrement.»*<br>• Il y a eu quelques faiblesses au niveau de tenues réunions de coordination, car au début tout allaient bien, mais vers la fin de l'année 2014, *« il y a eu un relâchement dans la tenues des réunions de coordination entre les parties pérennantes gouvernement et les agences, le sous financement des PTA du PNRS, la non production du bulletin, faible réalisation des missions conjointes sur terrain.»*<br>• *« Les défis à surmonter ? Que les agences H4+ jouent leur rôle d'accompagnement et non comme des ONGs d'exécution. Le coordinateur de H4+ devrait vraiment aider le gouvernement à jouer son rôle de leadership. Aussi, la faible motivation de la partie gouvernementale serait un facteur de relâchement dans la tenue des réunions de coordination entre les Agences et Gouvernement. »* | Interview, senior official in MoH in Kinshasa |
| 12 | 2012-2014: When the UNFPA H4+ coordinator came to DRC in March 2012, UNFPA and the Family Health Direction of the MoH (Direction 10, D10) agreed that there would be two types of coordination meetings: It was the H4+ coordinator's mandate to convene inter-agency coordination meetings, while the MoH would convene the larger MoH and H4+ agencies meeting. This coordination worked well from 2012-2014. | Interview, H4+ country team member |
| 13 | Les agences H4 + tiennent des réunions internes mensuelles auxquelles le PAM est une partie prenante entant que agence de Nation Unie. Par ailleurs la tenue des réunions de coordination de H4 + des agences et le gouvernement est organisée à un rythme irrégulier. | Interview, H4+ country team member |

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| 14 | On the government side, The H4+ Canada programme is coordinated by the Directorate 10 at the MoH. The MoH also leads the RMNCH Task Force. UNFPA has led the coordination on behalf of the H4+ partnership. The H4+ agencies holds monthly internal meetings, while coordination meetings with the H4+ agencies and the government take place bi-monthly. | Interview, H4+ country team member (UNICEF) |
| 15 | • Another reason for the "broken" relationship between the H4+ coordinator (UNFPA) and the Director of Family Health in 2015 is that the H4+ 2015-2016 work plan had foreseen to strengthen the coordination of the Family Health Direction (i.e. vehicle, internet etc.) but that never happened.<br>• The UNFPA H4+ coordinator made efforts to ask the WHO, UNICEF and UNFPA if they could support the coordination (not with H4+ Canada funds, but with other funding sources), which led to UNICEF giving the Family Health Division a vehicle. | • Interview, senior official in MoH in Kinshasa<br>• Interview, H4+ country team member |
| 16 | « La faible coordination des réunions entre agences et le gouvernement demeure un défis parce que [par conséquence,] le suivi et l'évaluation des activités ne sont pas réalisés. » | Interview, H4+ country team member |
| 17 | • The first two years the coordination worked well, but the last two years (since beginning of 2015), no H4+ joint mission has taken place. The DEP did participate in a field mission with UNICEF in May 2016, however, this was not with H4+JPCS funding<br>• Main challenges: Lack of (joint) supervision visits in the field. There was a discussion whether it is necessary for the central level to supervise the health zones, as the DPS should assume this work. DEP submitted request for funds for supervision visits to H4+ but was never funded. Maybe it was an issue of disbursement, according to the DEP.<br>• Recommendation: The agencies should not conduct supervision visits without informing the government. | Interview, senior official in MoH in Kinshasa |
| 18 | According to a key stakeholder, in 2013-2014, the government was engaged in the planning of H4+ JPCS activities at health zone level and in the organisation of RMNCH task foce meetings. But since 2015, government involvement has diminished and joint coordination with the government has become less functional. Joint meetings are not held regularly and there is no consultation, When the health zones submit their annual work plans to th H4+ partners, they do not always receive timely feedback as to which activities in the work plan H4+ JPCS can fund (except from UNICEF). Sometimes, the health districts receive the information in the middle of the year that a certain activity will be funded by H4+ JCPS and take place the following month. | Interview, H4+ country team member |

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| 19 | Selon un membre de l'équipe paus H4+, en 2015, il y a eu de moins en moins d'activités de coordination conjointe du programme H4+ JPCS. Cela est attribuable à la réforme de la Direction Provinciale de la Santé, car il y avait les nouvelles équipes au niveau des DPS, et cela a perturbé le fonctionnement des DPS. Selon lui, c'est d'abord cette réforme a induit un ralentissement dans la mise en œuvre du H4+ JPCS. Normalement, le Ministère de la Santé au niveau central, provincial et de zone de santé soumet des requêtes à l'OMS pour obtenir le financement. Mais durant cette reforme, ce sont plutôt les agences H4+ qui ont fourni un effort en rappelant au gouvernement de rédiger des requetés pour le financement des activités H4+ . La responsabilité revient au Gouvernement, cependant la reforme a beaucoup perturbée fonctionnement, (…) | Interview, H4+ country team member |
| 20 | « La coordination des intervenants constitue un deuxième défi et mérite d'être améliorée pour plus des résultats, ceci entre les agences et la partie gouvernementale dans la mise en œuvre. » | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 27) |
| 21 | Une planification conjointe est effectuée avant le début de l'année avec la participation active de toutes les agences (UNFPA, OMS, UNICEF, ONUSIDA) et du Ministère de la santé publique. Toutes les agences sont impliquées dans le suivi et l'évaluation du projet. Le suivi de mise en oeuvre est réalisé à travers les réunions mensuelles et les missions conjointes sur le terrain. | DRC H4+ Annual Report 2013. (H4+ Canada 2014a: 9) |
| 22 | The available meeting minutes indicate that most H4+ technical team meetings took place without the participation of H4+ agencies (without the government counterpart). A meeting in May 2015 indicate that the H4+ agencies invited the PNSR to discuss the possibility of H4+ supporting the updating of national RMNCH strategies. | H4+ meeting minutes : *Note de la Réunion technique H4+, 22 mai 2015.* (H4+ Agencies 2012a: 2) |
| 23 | **In 2014, H4+ coordination with the government counterpart was effective :**<br>• *« Renforcement du leadership et des capacités de coordination du Ministère de la Santé Publique: un appui technique et financier a été apporté pour la tenue des réunions mensuelles des différentes commissions du Comité National du Pilotage (CNP). Une réunion du CNP extraordinaire a été organisée pour discuter des modalités de fonctionnement de nouvelles Divisions Provinciales de Santé (DPS) et de l'inspection provinciale de la santé. Cette réunion a réuni les cadres du MSP et des ministres provinciaux en charge de la santé.*<br>• *Tenue des réunions mensuelles sous la direction de la partie gouvernement au niveau des provinces et de coordination nationale réunissant tous les partenaires d'appui aux activités de santé de la mère, du nouveau-né, de l'enfant à base communautaire, a permis de réaliser une cartographie des interventions et intervenants en SMNE à base communautaire.* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 9-10) |

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| | • *Renforcement de la Task Force SMNE (Santé de la Mère, du Nouveau-né et de l'Enfant) a travers un appui financier et technique au niveau central et provincial. Des réunions trimestrielles de cette plateforme de partage d'expériences et d'orientations sur des actions basées sur les résultats ont été organisées et ont d'identifier les lacunes et formuler des directives et interventions correctrices.* | |
| 24 | *During the inter-agency annual retreat in January 2015, the H4+ partners discussed the need to strengthen quarterly H4+ coordination meetings with the MoH : « Il y a eu une discussion sur la coordination entre l'équipe H4+ et le Ministère de la santé. Suite à cette discussion, il y a eu un consensus d'avoir une réunion par trimestre entre les Chefs d'agences H4+ et le Ministre de la santé. »* | H4+ Country Team (2015). *Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015* |
| 25 | In 2014, the following coordination meetings took place: 14 internal (inter-agency) H4+ technical meetings, 12 H4+ coordinating meetings with the MoH at central level, and 2 meetings with MoH at decentralized levels | H4+ Global Technical Team (2015). *Overview of 2014 progress - Coordination Mechanisms (Jul 2013-Dec. 2014 – 18 months),* internal Power Point presentation<br>(H4+ Global Technical Team 2015b) |
| 26 | The H4+ partners organize annual retreats without the MoH counterpart to discuss strategic priorities of the H4+, how to strengthen joint advocacy efforts with the government, and determine joint H4+ actions. H4+ country members estimate that there is a need to organize this internal retreat without the participation of the MoH. The H4+ technical team meets the first two days, and the third day, the Representatives of the seven agencies (WHO, UNICEF, UNFPA, UNAIDS, UNWOMEN, World Bank, WFP) join. | • H4+ country team member<br>• H4+ Country Team (2015). *Draft TDR Retraite H4+ 2016. Internal document*. (H4+ Country Team 2015a)<br>• H4+ Country Team (2016). *Rapport de la Retraite H6+ République Démocratique du Congo 2016. Du 06 au 08 Avril 2016* (H4+ Country Team 2016)<br>• H4+ Country Team (2015). *Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015* (H4+ Country Team 2015c) |
| 27 | • Minute meetings indicate that coordination of RMNCH interventions at decentralized levels – and thus the catalytic nature of H4+ Canada funds - was challenging: « *Le caractère catalytique du fond canadien souffre d'insuffisance analytique au niveau décentralisé, une cartographie assez fouillée des intervenants et leurs interventions respectives pour permettre des actions ciblées au contexte spécifiques des ZS assistées et surtout pour éviter les doublons.* | H4+ meeting minutes : *Compte rendu de la réunion H4+ 10/12/2014.* (H4+ Agencies 2014a: 3) |

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| | • It was therefore recommended to « *Identifier les actions visant à renforcer d'avantage les mécanismes de coordination existante aux différents niveaux du système (DPS-BCZ-CODESA) » and « Le rôle de la partie décentralisée (au niveau DPS et Bureau central de la ZS) pour une meilleure analyse et coordination des intervenants »* | |
| 28 | • The 2015 interagency retreat defined the support to strengthen coordination at DPS level as one of three key priorities for 2015 and recommends that H4+ adapts to the reform (i.e. decentralization of health services management)<br>• *« Au niveau des DPS, travailler de manière convergente pour créer un modèle de collaboration « comment créer une synergie et converger vers les objectifs communs. » (p. 3)*<br>• *« Concernant la réforme, le présentateur s'est focalisé sur les Objectifs du processus de la réforme de l'administration Publique, le Cadre légal, réglementaire & stratégique, Principes directeurs, Mise en place des DPS et l'Intégration des programmes spécialisés dans les DPS. Il a insisté sur le fait que l'approche H4+ devra dorénavant s'aligner dans la réforme qui est en cours en la renforçant dans les zones ciblées qu'au niveau central. » (p. 5-6)* | H4+ Country Team (2015). *Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015.* (H4+ Country Team 2015c : 3, 5-6) |
| 29 | *« La grande innovation était le fait que 4 ou 5 agences ont bien collaboré ; il n'y a pas eu de sopoudrage. Il y a complémentarité de 4 qui intervenaient dans les zones. »* | Interview, provincial health department (Kongo Central). |
| 30 | *Normally, the Provincial Health Team (DPS) in Kongo Central organizes quarterly and annual review meetings in which the partners are invited to participate. In 2015, only one quarterly review meeting was organize with the participation of some partners. Ad hoc meetings with 1-2 partners are frequently organized. The DPS of Kongo Central has never organized a large RMNCAH focused coordination meeting with all H4+ partners and other partners, such as PATHFINDER, USAID, ICAP, PSI.* | Interview, provincial health department (Kongo Central). |
| 31 | In 2015, the Director of the Division for Family Health (MoH) recommended the integration of the joint H4+ coordinating meetings into the national RMNCH Task Force. However, the D10 did not convene any Task Force RMNCH meetings in 2015. | • Interview H4+ country team member<br>• Interview, senior official in MoH in Kinshasa |
| 32 | In 2013, the following platforms for coordinating RMNCH interventions, bringing together donors and partners, were established and active: *"1. Quarterly coordination MNCH Task force; 2. Quarterly coordination FP Task force; 3. Monthly meeting of the Inter-Donor Group."* | The H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 33 | An inter-agency mapping of H4+ agencies' RMNCH interventions specifies the link between interventions and the PNDS 2011-2015 and the CAO 4&5. | H4+ agencies (year unknown). *Cartographie des interventions des agences* |

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| | | *H4+ en RD Congo»,* internal document.. (H4+ agencies nd) |
| 34 | *« Le programme conjoint H4+ s'inscrit dans la plateforme du Cadre d'Accélération des Objectifs millénaire 4 et 5 défini par le Ministère de la santé de la RD Congo en 2012 pour répondre aux priorités du secteur santé du PNDS. »* | DRC H4+ Annual Report 2015. (H4+ Canada 2016) |
| 35 | « Il n'y a pas un mécanisme de coordination de vos activités par rapport aux autres associations. Les travaux se font d'une façon sectorielle. C'est dernièrement que, parfois, si nous avons des campagnes, l'UNFPA nous met ensemble avec les jeunes couples. Ce n'est pas régulier. Parfois cela crée un désordre. Par exemple, notre dernière campagne, nous allons sur terrain et l'équipe qui devrait aller quelque part nous appelle pour nous dire qu'il y a un autre service qui offre le service PEV dans le même endroit, et a opté pour un autre site. Dans ce côté la, il n'y a pas un cadre formel. Lors de notre dernière campagne, nous avions vu l'ABEF, les sages-femmes et les jeunes. Nous avions un trio et il y a eu un bon résultat. (…) Il n'y a pas de coordination formelle. » | Interview, implementing partner (NGO) |
| 36 | *« Il y a un peu trop de soucis par rapport à la coordination dans le cadre de H4+. Ce sont plus les agences des Nations-Unies (…) qui connaissent leurs différents partenaires, [mais ils] n'ont pas bien développé une bonne coordination entre nous [les partenaires d'exécution. Ils nous n'ont pas mis] ensemble pour nous informer, par exemple, qu'ils vont financer ceci et cela. Il n'y a pas eu des réunions. »* | Interview, implementing partner (NGO) |
| 37 | *« La coordination n'est pas aussi efficace, elle est faible et cela dépend aussi de la stratégie des partenaires [agences H4+]. En 2012, le fond a transité par ABEF, partenaire d'exécution, mais cela nous a posé un problème de coordination. (…) [Il n'y a pas eu] de réunions [H4+ régulières avec les partenaires d'exécution. »* | Interview, implementing partner (NGO) |
| 38 | The PBF unit has participated in several meetings with the WHO. They organized debriefing meetings after the field missions, and all H4+ agencies participated, except WFP. | Interview, senior official in MoH in Kinshasa |
| 39 | The teachers of University of Kinshasa was involved in meetings to coordinate H4+ JPCS+ support with regard to the midwife education programme and the EmONC trainings : *"Avec le coordinateur H4+ (UNFPA), il y a eu implication de l'université comme partie prenante."* | Interview, members of the Faculty of Medicine, University of Kinshasa. |
| 40 | H4+ has strengthened the collaboration between the Ministry of Higher Education and the Ministry of Health, particularly at the technical level, and that is an innovation. There is now a need to "institutionalize" or "formalize" that collaboration between the two ministers. | Interview, implementing partner (ISTM Kinshasa) |

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| 41 | UNAIDS took over the role as H4+ coordinator in DRC in the beginning of 2016. Since then, they have not experienced any difficulties in collaborating with the Division for Family Health, and MoH staff have started participating in the H4+/H6 meetings again. | Interview, H4+ country team member |

**Assumption 3.2:**

*Established platforms and processes for coordination of H4+ (and other RMNCAH initiatives) are led by the national health authorities and include as participants the H4+ partners, relevant government ministries and departments (including at the sub-national level) and key non-governmental stakeholders.*

| | **Information/data** | **Information sources** |
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| 42 | • The H4+ JPSC work plans includes activities to strengthen country-led coordination of RMNCAH interventions at all levels, including:<br>○ 2015-2016 work plan:<br>▪ Support the organisation of national and provincial RMNCH Task Force meetings<br>▪ Support the organisation of Board of Director meetings at HZ level<br>▪ Support the organisation of CNP-SS meetings<br>▪ Support the functioning of the H4+ coordination based at the MoH (Division for Family Health, *Direction 10*)<br>○ 2014-2015 work plan:<br>▪ Support the organisation of quarterly national and provincial RMNCH Task Force meetings<br>▪ Support the 2015 annual planning process (analysis, needs identification, prioritisation)<br>▪ Provide TA and support the organisation of monthly meetings of CNP-SS technical committees<br>▪ Provide technical and financial support to MoH (D5, D10, DEP) to conduct a mapping of all RMNCH interventions and present it to the Health Partner's Forum (GIBS) | • DRC H4+ annual work plan 2015-2016<br>• DRC H4+ annual work plan 2014-2015. (H4+ Canada 2013: 2, H4+ Canada 2014b: 1) |
| 43 | H4+ JPCS contributed to: *« Engagement des partenaires au Cadre d'Accélération des Objectifs du Millénaire pour le Développement 4 et 5 (CAO 4 & 5) : Ceci permit au Ministère de la Santé* ***de prendre le leadership dans la coordination des partenaires*** *de la santé maternelle, néonatale et infantile. »* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 27) |
| 44 | An annual review meeting at provincial level with the participation of the D10, H4+ partners and the provincial health team enabled H4+ country team to review progress, identify bottlenecks and | Compte Rendu de la Reunion d'Evauation de la Mise en Œuvre des Activite de |

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| | propose adequate solutions. In 2012, topics discussed included delays and gaps in procurement of essential MNCH drugs and equipment. | l'Initiative H4+ du 27/10/2012 dans la Salle de Reunion de la Division Provinciale de la Santé du Bas-Congo a Matadi (H4+ Country Team 2012d) |
| 45 | **Government leadership over H4+ programme has been mixed according to one H4+ member:**<br>• At sub-national level (province and health zone): *"The MoH has entirely shown leadership, in particular with regard to planning."*<br>• At national level: *"There are ups and downs. The MoH has asked us that we do not hold inter-agency meetings without them. MoH wants to convene the meetings, but they don't have the time to do so. Therefore, the monthly coordination meetings no longer take place; , because MoH simply does not have the time to invite and organize."* | Interview, H4+ country team member |
| 46 | **Direction10 views on coordination - weaknesses:**<br>• The H4+ coordination worked well in the early years. Around 2014/2015, the joint coordination broke down. According to the Director of D10, this is because H4+ (UNFPA) started implementing the program on their own, without involving the government counterpart. Examples given are: Annual retreats and field supervision visits to the field took place without the MoH; H4+ organized internal/inter-agency meetings without government counterpart; UNFPA produced a H4+ newsletter instead of a general RMNCH letter covering all interventions as requested by the D10; and the promise to support the D10 coordination (equipment, functioning etc.) was never kept (it was part of the 2015-2016 work plan)<br>- Only one *joint* annual review meeting was organized (in 2013)<br>- MoH asked that the H4+ coordinator is physically based in the PNSR office, and an office was created for him, but he was never present there.<br>- Different H4+ agencies had different disbursement procedures, and there is a need to harmonize (D10 called an individual meeting with each agency to discuss)<br>- The D10 indicate that UNFPA in particular was not responsive to their needs (as coordination unit for H4+), whereas UNICEF and WHO were<br>- "The programme was aligned – until it became "clandestine" in 2015-2016" | Interview, senior official in MoH in Kinshasa |
| 47 | In 2015, the MoH asked that there are no separate H4+ meetings, but that H4+ is coordinated through existing platforms, e.g. RMNCH Task Force. However, the MoH delays in convening the | Interview H4+ country team member |

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| | RMNCH Task Force meetings and no meeting took place in 2015. One meeting was organised in 2016 (until end of August). | |
| 48 | The support to the D10 for coordination of 2015 was less dynamic and "slipping"in 2015. In 2016, there has been only one RMCNH Task Force meeting (four were planned). | Interview, H4+ country team member |
| 49 | The collaboration between the D10 and the H4+ JPCS coordinator suffered in 2015. D10 did not organize any RMNCH Task Force meetings. H4+ JPCS did not deliver the things promised in the work plan, including support to the coordination of H4+ JPCS and a vehicule to conduct field missions. | Interview H4+ country team member |
| 50 | • *« Au départ, dans le cadre de H4+, nous avions eu une seule [mechanisme de] coordination. (..) ce qui nous a permis d'élaborer même un plan [conjoint] de travail. . La Task Force SMNE organise des rencontres périodiques qui rassemblent tous les intervenants en santé de la mère, du nouveau-né, de l'enfant et de l'adolescent [trimestriellement], indépendamment de l'initiative H4+. Mais dans le cadre du programme H4+, nous [le Ministère de la santé] avions [reçu]de l'argent pour appuyer la tenue des réunions de la Task Force SMNE. [Le sécretariat] du Task Force est constitué d'un représentant de la [Direction de Santé Familiale] comme président, l'OMS comme co-président, (…) et Programme National de Santé de la Reproduction (PNSR) comme rapporteur. »*<br>• *« En ce qui concerne la planification, nous n'avons eu qu'une seule revue [conjointe des activités]»*<br>• *« Il n'y a pas eu une franche collaboration avec les agences. Le bureau qui devrait être occupé par le coordinateur H4+ UNFPA est fermé jusqu'aujourd'hui. »*<br>• *« A cause des difficultés que nous avons rencontrées, j'ai préféré utiliser les mécanismes qu'on avait dans la commission « Prestation » [du CNP-SS]. En dehors de H4+, j'invitais l'Unicef et l'Oms mais UNFPA ne venait pas. »*<br>• *[Le manque de budget] n'est pas vraiment le problème. C'est le mauvais comportement. Il n'y a pas eu une bonne coordination. La dernière activité date de 2 ans.*<br>• A senior MoH official felt that the H4+ JPCS was well aligned to government priorities until the H4+ coordinator started implementing the programme independently without consulting and engaging the government. | Interview, senior official in MoH in Kinshasa |
| 51 | « En Janvier 2015, les agences H4+ ont réalisé une retraite au cours de laquelle des orientations stratégiques ont été formulées assorties des priorités et activités concrètes pour l'an 2015. Il s'agit de : (I) Au niveau des Division Provinciale de Santé (DPS), travailler de manière convergente pour créer un modèle de collaboration « comment créer une synergie et converger vers les objectifs communs » | DRC H4+ Annual Report 2015, p. 17-18. (H4+ Canada 2016: 17-18) |

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| 52 | The reason that H4+ members organized review and planning annual retreats without the MoH is that they needed to first plan and coordinate among themselves, to agree to common set of priorities, which could then be presented to the MoH with one voice | Interview H4+ country team member |
| 53 | Meeting minutes from September 2015 indicate that it was the H4+ agencies that led the planning of the H4+ global technical team joint mission to DRC, not the national counterpart: "Les points focaux des agences doivent appuyer la partie gouvernementale dans la préparation des différentes présentations à faire. (…) L'équipe doit s'assurer de l'implication du ministère pour mener le processus de la mission de la semaine prochaine mais aussi pour toute action H4+ au niveau national comme au niveau des provinces. » | Compte de Rendu de la Reunion H4+ du 28/09/2015 (H4+ Agencies 2015a: 1) |
| 54 | *« La planification conjointe 2015 a été effectuée en novembre-décembre 2014 sous la direction du Ministère de la santé publique avec la participation de toutes les agences H4+. »* | H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 55 | According to a H4+ focal point, the coordination of RMNCH takes place at several levels : the cabinet (for example when a major issue needs to be solved, or major decisions engaging the MoH (for example with regard to the GFF) need to be made.The Division for Family Health is responsible for the coordination of RMNCAH partners (through the RMNCH Task Force) and the implementation of all national RMNCAH plans and programmes. Finally, coordination also takes place at operational (i.e. provincial and health zone) levels. | Interview, H4+ country team member |
| 56 | • The 2015-2016 H4+ annual work plan contains an activity to support the H4+ coordination at the D10: *"1.1.1f - Appuyer le fonctionnement du secrétariat de la coordination de H4+ basé au MPS (D10) » (budget : 30,000 USD).* However, according to the UNFPA 2011-2016 activity report, the only activity implemented in 2015-2016 was payment of the internet subscription for PNSR | • DRC H4+ annual work plan 2015-2016. (H4+ Canada 2014b)<br>• UNFPA Activity Report 2011-2016 (Excel sheet) and follow-up email 20 Sep 2016. (UNFPA 2016b) |
| 57 | ***« La coordination du secteur présente quelques difficultés.*** *La coordination du secteur présente encore quelques difficultés malgré les efforts d'alignement aux priorités nationales. Le Comité National de Pilotage (CNP-SS) ne fonctionne pas encore de façon optimale. Les structures techniques (Commissions et Groupes de Travail) chargées de fournir la matière ne sont pas pleinement fonctionnelles. Un effort a été fourni en 2014 pour amener les différents partenaires à prendre une part active en assurant la co-présidence des commissions techniques. »* | MoH (2016). Plan national de développement sanitaire 2016-2020: vers la couverture sanitaire universelle. Mars 2016. Ministère de la santé publique, République Démocratique du Congo. (MoH 2016b) |

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| 58 | • In 2014, the MoH received the RMNCH Trust Fund and the Department for Family Health was going to implement. However, because of disagreement between the Department and H4+ members with regard to payment of perdiems to MoH staff, the implementation was delayed and no activities were implemented the first six months of the project. When the Minister of Health discovered this, he convened a meeting with his staff and relevant partners. Following this, the general secretary decided that the RMNCH Trust Fund would be managed directly by the director of the cabinet and thus transferred it from the Department for Family Health, which obviously caused frustration among the staff.<br>• This move "created fragmentation in the coordination of RMNCH" which also affected the coordination of the H4+ joint programme. The Director of the Cabinet started convening monthly RMNCH meetings, during which both the RMCNH Trust Fund and the H4+ joint programme were discussed. The RMNCH Trust Fund was considered part of the H4+ [approach] | Interview, H4+ country team member |
| 59 | It created frustration among staff in the Department of Family Health that it was decided that the RMNCH Trust Fund would be managed by the director of the cabinet and his team. | Interview, H4+ country team member |
| 60 | UNFPA decided to work directly with the director of the cabinet of the MoH (instead of the D10) for the RMNCH Trust Fund. The relationship between UNFPA and the director of the cabinet has been good, but it might not have pleased the Department for Family Health. | Interview H4+ country team member |
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| **Assumption 3.3**<br>*Programme work plans take account of and respond to **changes in national and sub-national needs and priorities** in RMNCAH as expressed in plans, programmes, policies and guidelines at national and sub-national level. H4+ partners consult and coordinate with stakeholders at both levels.* | | |
| | **Information/data** | **Information sources** |
| 61 | The original project proposal states that the H4+ joint programme work plan is aligned to the Health Systems Strengthening Strategy and contributes to the implementation of the national health sector development plan (PNDS) 2011-2015. | DRC H4+ JPCS proposal, p. 3. (H4+ Canada 2010b) |

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| 62 | MoH senior officials confirm that H4+ JPCS interventions are aligned to MoH priorities, as they are developed based on the MDG 4&5 Acceleration Framework. All new RMNCAH projects are now aligned to the Acceleration Framework. | Interview, senior official in MoH in Kinshasa |
| 63 | *« Les interventions de ce programme sont alignées au Cadre d'Accélération des OMDs 4 et 5 pour la réduction de mortalité maternelle et infantile qui est la feuille de route de Gouvernement de la RDC pour améliorer la santé maternelle et infantile. »* | H4+ Country Team (2015). H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+. République Démocratique du Congo. (H4+ Country Team 2015b : 8) |
| 64 | The 2014-2015 annual work is aligned to the Health Sector Development Plan (PNDS) 2015-2011 *« à travers (1) le renforcement du leadership et gouvernance de la santé et (2) le développement des zones de santé par biais de cinq stratégies identifiées dans le PNDS: (a) développement des ressources humaines pour la santé (renforcement de capacité en suivi intégré formatif, en Soins Obstétricaux et Néonatals d'Urgence, en Planification Familiale, formation initiale des Sages-Femmes etc.), (b) renforcement du sous-secteur médicaments et intrants spécifiques (approvisionnement en 13 médicaments qui sauvent les vies des femmes et enfants), (c) réforme du financement de la santé (à travers les mutuels pour la santé), (d) amélioration/modernisation des infrastructures et des équipements du Ministère de la Santé Publique (approvisionnement en équipements), et (e) renforcement du système national d'information sanitaire (formation des cadres à tous les niveau pour le suivi et utilisation des données pour prise des décisions). »* | DRC H4+ annual work plan 2014-2015. (H4+ Canada 2013: 1) |
| 65 | The PBF unit of the MoH has developed the national guidelines with minimum indicators (*paquet d'indicateurs minimum*), and requests that all development partners align with these indicators. | Interview, senior official in MoH in Kinshasa |
| 66 | For evidence of the **RMNCAH Acceleration Framework (CAO 4&5),** please refer to the matrix for question one, assumption 1.1, line 27 | |
| 67 | According to the Family Health Division of the MoH at central level, the Provincial Health Departments (DPS) did not clearly understand what H4+ was about. They thought that H4+ was a project that would bring them a lot of money at provincial and health zone level. They did not fully understand that H4+ JPCS was above all a partnership for improved coordination and that the funds were supposed to be catalytic. . The Director of the Family Health Division would have liked that the DPS come to Kinshasa | Interview, senior official in MoH in Kinshasa |

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| | to plan activities together. That would have helped them better understand the features of the H4+ JPCS, but such a meeting did not take place. | |
| 68 | In 2013, H4+ provided support to development and coordination of Operational Plans of Action in the nine Health Zones. | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 69 | H4+ provides support to the development of health zone operational plans. There are no problems with coordination at provincial and health zone level, as it is the Chief Medical Doctor of the health zone who coordinates all activities. | Interview, H4+ country team member |
| 70 | La planification est annuelle et la tenue de réunion est régulière, au niveau provincial et ZS les structures possèdent leurs organes de gestions entre autre le conseil d'administration des ZS le CPP et les sous commissions. Mais les réunions de RMNCH Task Force au niveau provincial ou les partenaires et gouvernement se rencontrent sont rare. | Interview, implementing partner (NGO) |
| 71 | L'identification des besoins non comblés de l'établissement est réalisée au sein de l' HGR MOSANGO qui va à son tour les intégrer dans le PAO de la ZS, la ZS va alors présenter aux partenaires après l'approbation au conseil d'administration de la ZS | Interview general referral hospital team (Mosango) |
| 72 | • *« Lors du premier atelier organisé en vrac au début de l'an 2013 les trois ZS été informées du programme H4+ et un exercice de planification a été réalisé et chaque ZS (NSELE, Mont NGAFULA II et MBINZA OZONE ) appuyée par ce programme a pu intégrer ses priorités dans son PAO . Au cours cet atelier la Direction d'Etudes et de Plannification (DEP) du niveau national nous a accompagné pour une bonne intégration des activités SMNE dans nos PAO respectifs. »*<br>• *« Une évaluation rapide SONU a été organisée au début de l'année 2012. Chaque année les membres des ECZS appuyés par les membres des ECP élaborent leur plan d'action opérationnel (PAO), pendant cet exercice de planification tous les partenaires sont invités, y compris les représentants du programme H4+, afin de terminer ensemble les interventions ou les activités qui seront appuyées par chaque intervenant (partenaire). »*<br>• *« La Communauté, membre des ECZS, les membres des ECP, les prestataires des soins et les agences L'UNICEF, UNFPA, OMS, ONUSIDA ont été les acteurs principaux dans la mise en œuvre du programme. Les différentes revues de suivi et d'évaluation des activités ont été tenues régulièrement en 2013- 2015 entre les membres des ECZS, l'ECP et l'UNFPA. Des missions conjointes de suivi, d'évaluation et de supervision des activités ont été réalisées ».* | Interview, health zone team (Nsele) |

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| | • *« Les membres de H4+ participaient à nos réunions de planification et d'évaluation, notamment les revues de validation des données mensuelles et la revue annuelle provinciale, la réunion du conseil d'administration pour valider le PAO, et le comité de gestion de la ZS. »*<br>• « L' appui [que H4+ JPCS a porté à] la tenue des différentes réunions de coordination et de la rédaction de notre plan d'action (PAO) nous a permis à mieux cerner notre planification et à résoudre certains problèmes de la santé [au niveau de] la ZS. »<br>• « dans le cas de la ZS, le leadership a été renforcé en appuyant la tenue des différentes réunions de coordination des membres des ECZS et de concertation des partenaires, de validation des données et de la collecte des données. » | |
| 73 | H4+ JPCS uses both top down and bottom up planning process. The PNDS 2016-2020 was developed that way: Data come from the HZ and DPS level – and the Provincial and HZ Development Plans inform planning at national level | Interview, senior official in MoH in Kinshasa |
| 74 | In 2013, H4+ JPCS supported HZ in the development of annual workplans: *Appui aux élaborations des Plans d'Action Opérationnels (PAO) des zones de santé. Les réunions sont organisées dans les 3 provinces concernées par le projet pour faire le bilan de 2013 et planifier les activités de 2014, les agences participent activement à ces rencontres pour que les activités de projet ACDI [H4+JPCS], ainsi que des autres partenaires soient alignées aux priorités identifiées par les zones de santé et inscrites dans le plan provincial de développement sanitaire. Le projet a contribué financièrement à la réalisation de ces réunions. »* | DRC H4+ Annual Report 2013. (H4+ Canada 2014a: 12) |
| 75 | *« Oui au niveau des priorités des ZS, chaque ZS produit son plan d'action opérationnel qui découle du plan du développement quinquennal de la ZS en tenant compte des PNDS national, ce PAO est présenté et discuté avec les priorité de H4+ qui se prononce sur quelle activités du PAO pourrait être financé en suite ce plan est validé dans CA , et le plan consolidé de la DPS est validé au niveau du CPP . (…) Les priorités de la PNDS découlent des engagements que le pays a pris vis-à-vis de la Stratégie Globale en rapport avec la SRMNE de la santé de la mère comme le CAO 4-5 ; l'accessibilité universel aux soins. (…) l'approche de planification a été suffisamment flexible pour répondre à ce besoins et s'adapter. Il y a eu flexibilité dans la planification avec les autres partenaires. »* | Interview, health zone team (Nsele) |
| 76 | • A provincial health director states that the programme was not particularly responsive to the needs ot the provinces and districts, as the major activities had already been defined at central level, and the subnational levels were merely asked to propose ativities that would fit into those categories and budget lines : *« En, réalité, la DPS n'a pas vraiment joué un grand rôle [dans l'identification des* | Interview, provincial health department (Kongo Central) |

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| | *priorités du programme H4+ JPCS]. La DPS a plus subi puisque le niveau central est venu simplement présenter le projet au niveau de la DPS pour son approbation. Tout a été défini dans le document du projet H4+ JPCS. »*<br>• On the other hand, he does recognise that the training of service providers, the refurbishment and equipment for maternities, and the medicines were useful and releant at the health zone level. | |
| 77 | There have been no major changes over the course of the programme. The H4+ is responsive to the needs of the health zones, as they are in charge of identifying needs and planning their activities in one unique operational plan, which is submitted to the central level for funding, through the DPS. WHO supports this process. | Interview, H4+ country team member |
| 78 | For evidence of **coordination issues at sub-national level** please refer to the matrix for question one, assumption 1.4., all entries. | |
| **Assumption 3.4**<br>*Platforms and processes for coordination of H4+ JPCS **do not duplicate or overlap with other structures for coordinating** activities in RMNCAH. Further, they provide a strong RMNCAH focus to national and sub-national health sector coordinating platforms.* | | |
| | **Information/data** | **Information sources** |
| 79 | • *H4+ supports the National Health Sector Coordinating Committee (CNP-SS). A temporary WHO staff member provided technical assistance to the national and the provincial CNP-SS, but has left now. The CNP-SS is functional now. WHO is responsible for supporting the MoH in leadership and coordination of the health sector.*<br>• *GIBS is the coordinating platform of development partners. H4+ has advocated for RMNCH within GIBS, including support for the development of the CAO 4&5.* | • Interview with former and current H4+ coordinator prior to field mission<br>• Email with former H4+ coordinator (Eugene) prior to field mission |
| 80 | • H4+ has "boosted" RMNCH collaboration in general:<br>- Through technical discussions, sharing and harmonization of approaches among partners in the SNME Task Force, for example on maternal deaths. WFP/PAM was not part of the Task Force in the beginning, but joined later, and has advocated for the integration of nutrition in all RMNCH activities.<br>- It was also H4+ approach that facilitated/led to the signature of the GIBS partnership chart. | Interview, senior official in MoH in Kinshasa |

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| | - H4+ was the first example of joint planning and implementation among partners – the Ministry of Health is using H4+ as a model (for other joint initiatives) | |
| 81 | *« Il y a les 4 grands piliers qui sont les partenaires [H4+] qui ont donné leur appui et puis il y a aussi 4 coordinations. Chacun avait un volet autonome, on devait quand même mettre le truc ensemble. En réalité, il y avait absence de coordination de l'appui. »* | Interview, Provincial Health Department (Kinshasa) |
| 82 | *"The H4+ provides financial and technical support to the national health sector coordination mechanisms. The role of H4+ is to support the Government so that these coordinating mechanisms are functional under the leadership of the Government. H4+ supported and still supports the RMNCH Task Force and Comité du Pilotage which is the overarching governance structure in the health sector."* | Email with H4+ country team member, 4 August 2016 |
| 83 | *« L'UNICEF, UNFPA ont financé l'étude portant sur la production de la cartographie des évidences des interventions permettant au PNSA de mieux coordonner ces dernières ainsi que des intervenants UNFPA, OMS, UNICEF, PATH FUNDER , Tulane University , Mzedecins Du Monde,Save Children, PSI T Funder ) dans ce domaine »* | Interview, senior official in MoH in Kinshasa |
| 84 | For evidence of the **government view on improved coordination among H4+ members** please refer to the matrix for question one, assumption 1.2., line 38. | |

**Area of Investigation 4: Innovation**

**Question Four: To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?**

a. **How do H4+ JPCS partners and health authorities and other stakeholders at national and sub-national level recognized potentially effective innovations in RMNCAH?**

b. **How is information on the success or failure of innovations supported by the programme gathered and made accessible to decision makers within and across H4+ JPCS countries?**

c. **What evidence indicates that successful H4+ JPCS supported innovations have been replicated across districts, at national level or in other programme or countdown countries?**

**Assumption 4.1**

*H4+ JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+ JPCS, from practices in other H4+ JPCS countries or from the expertise and experience of key stakeholders at all levels.*

| | Information/data | Information sources |
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| 1 | • The original project proposal identified the following **potential innovations** or significant changes in approaches to RMNCAH :<br>- Introduction of a new pre-service and in-service training methodology based on practice (and less on theory)<br>- Development of a package of integrated MNCH services<br>- Use of performance contracts to ensure motivation and retention of health personnel in the 9 target HZ<br>- Introduction of quality assurance, including LZAS and RDZS<br>- Introduction of a flat rate price for obstetric care to reduce financial barriers to access | DRC H4+ JPCS *proposal.* (H4+ Canada 2010b: 15-16) |
| 2 | « Initiative locales : (1) Mise en place d'un fond de solidarité pour évacuation des urgences depuis mai 2015 (Fonctionnement d'une ambulance et d'une moto-ambulance pour les références); (2) Mise | Mosango health zone team, Power Point presentation Aug 15 2016 |

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| | en place d'une solidarité des femmes enceintes 2009 (ceci a permis tant soit peu de casser la barrière financière" | |
| 3 | « *Une mutuelle de santé qui couvre la zone de santé de Mosango dans la Province de Bandundu permet aux femmes d'avoir l'accès à la césarienne lors d'accouchement en cas de besoin. Les femmes enceintes lors de la consultation prénatale paient 650 francs congolais (≈ 0.65 USD) une seule fois. Ce montant est mis dans un panier commun. La contribution est utilisée pour les femmes enceintes qui ont besoin de césarienne d'urgence lors de l'accouchement. (…) Sur les 300 accouchements par mois dans la zone de santé de Mosango, environ 22 femmes bénéficient de césarienne gratuite à travers la mutuelle de santé. La contrainte de cette mutuelle est qu'elle ne couvre pas d'autres urgences en dehors de césarienne. Le processus d'étendre cette mutuelle pour inclure les autres urgences, les enfants et les hommes est en cours ».* | DRC H4+ Annual Report 2015, p. 21. (H4+ Canada 2016: 21) |
| 4 | • The senior officials of the National Adolescent Health Programme (PNSA) identify the following innovations:<br>- *« La mise en place de la maison d'attente à Mosango et la formation en SONU B et C des prestataires dans les structures appuyées*<br>- *La disponibilité des kits familiaux qui ayant contribué à réduire la barrière financière et à améliorer la qualité de soins dans les FOSA, dans le cadre de CAO 4 et 5.*<br>- *La mise en place de la revue des décès maternels »* | Interview, senior official in MoH in Kinshasa |
| 5 | • An implementing partner identified the following innovations :<br>- *la disponibilité des kits familiaux qui ayant contribué à réduire la barrière financière et à améliorer la qualité de soins dans les FOSA ;*<br>- *rendre accessible les soins les plus pauvres (diminues), définir le paquet de 13 médicaments qui sauvent la vie de la femme et enfant et éliminer le goulot d'étranglement pour avoir accès aux 13 médicaments*. | Interview, implementing partner (NGO) |
| 6 | • An H4+ member noted the following innovations:<br>- The solidarity funds for caesarean sections targeting very poor women in need of EmONC in Mosango: *"It is generally difficult to get people to adhere [to the mutual health insurance schemes], but with the caesarean section solidarity fund it was possible".*<br>- Competency based EmONC training at national level, reducing the length of training from three weeks to five days, and introducing practical training on mannequins | Interview, H4+ country team member |

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| 7 | • Professors of the Faculty of Medicine, University of Kinshasa, point to the following innovations supported by H4+ JPCS:<br>- Use of mannequins as method to practice skills and competencies; the students are very satisfied because they get the chance to practice<br>- Maternal Death Reviews: Training of 30 persons in Maternal Death Reviews in BDD and 34 persons in Kinshasa (PNSR ensures supervision). The maternal death reviews are reported to the highest political and administrative levels (Minister of Health and Prime Minister)<br>- The catalytic effect of innovative, competency-based, in-service EmONC trainings. For example, during a professor's last field mission to the Equator province, he had observed that local partners used the EmONC training modules to train service providers. | Interview, members of the Faculty of Medicine, University of Kinshasa |
| 8 | *« Innovation : La formation en SONU basée sur les compétences en utilisant les mannequins a réduit la durée de formation SONU (EmONC) de 14 jours à 5 jours. L'utilisation des mannequins permet l'acquisition rapide des compétences. Les premiers résultats de cette formation documentés lors de mission des suivis en 2014 sont positifs. L'évaluation par un consultant est prévue en 2015. »* | H4+ Country Team (2015). H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+. République Démocratique du Congo. (H4+ Country Team 2015b) |
| 9 | During the inter-agency 2015 annual retreat, the following practices were identified as innovations in the DRC: *« (a) Formation d'infirmier-chirurgien dans les années 80-90, (b) Le programme de la filière sage-femme pure, (c) Le programme de la filière de reconversion, (d) Formation continue de prestataire basée sur la compétence, (d) Appel d'urgence de sage-femme dans le Bandundu ».* | H4+ Country Team (2015). Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015. (H4+ Country Team 2015c : 7-8) |
| 10 | • *"The Emergency Obstetric and Newborn Care (EmONC) Needs Assessment 2012 revealed that a small proportion of service providers working in the maternity know how to correctly manage obstetric complications: 0.4% of providers for obstetric haemorrhage, 1% for retained placenta, 0.8% for incomplete abortion and 0.4% for newborn care. (…).*<br>• *This observation was the reason behind the development of a new competency-based EmONC training curriculum by the National Reproductive Health Programme in 2013. The training is based on the use of anatomic models (mannequins) to simulate real life complications. The use of mannequins helps to shorten the duration of training while allowing trainees to develop full competency in the management of each obstetric complication. Previous EmONC training which did not use mannequins was too long and trainees ended up not acquiring the competency* | UNFPA DRC Office (2016). UNFPA Good Practices - EmONC Training Revised. (unpublished). (UNFPA nd: 1) |

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| | *required because they did not encounter enough obstetric complications during the training to allow them build the competency across all areas."*<br>• *"The new course is based on a Life Saving Emergency Obstetric and Newborn Care course developed by the Liverpool School of Tropical Medicine (LSTM) in collaboration with the Royal College of Obstetricians and Gynaecologists (RCOG) and the World Health Organisation (WHO), and has been introduced in more than ten African and South East Asian countries."*<br>• *"The intervention was a competency-based training of service providers in EmONC using mannequins. A new facilitator guide (in French) was developed based on the original guide (in English) developed by the Liverpool School of Tropical Medecine (LSTM) in collaboration with RCOG and WHO. Training started in 9 health zones in three (Kinshasa, Bas Congo and Bandundu) of the 11 provinces in DRC."* | |
| 11 | Midwives' association mention EmONC trainings as an innovation: *« La formation SONU a transformé la manière de travailler des professionnelles de la santé. »* | Interview, implementing partner (NGO) |
| 12 | *The family kit approach was developed based on the identification of three key gaps: (1) frequent stock outs of essential medicines and commodities at health facilities; (2) lack of training and motivation of health facility staff; and (3) financial barriers to access (high prices of services and drugs).* | Silene Martino Almeras (2015). Les Kits Familiaux, un pas important vers la couverture universelle en soins de santé. 12 mai 2015. (Almeras 2015: 1) |
| 13 | The family kit approach aims to improve home-based IMCNI and safe deliveries at community and health facility level. Different kits are distributed, including essential medicines to households to enable families to treat simple diarrhoea and fever; an ANC kit to pregnant women; and a delivery kit with essential supplies and commodities for safe deliveries. The kits also include subsidised vouchers for curative care, ANC and assisted deliveries in health facilities. The kits are distributed during the vaccination and ANC visits in order to stimulate demand and utilization of key services, including coverage of vaccinations (Penta 3); preschool consultations for children above one year; and the fourth ANC visit for pregnant women. Promotion of RMNCAH and essential family practices by CHW is an important component of the family kit approach. | Silene Martino Almeras (2015). Les Kits Familiaux, un pas important vers la couverture universelle en soins de santé. 12 mai 2015. (Almeras 2015) |
| 14 | The introduction of Maternal Death Surveillance and Response (20% of HZ notifying since June 2015) is described as an innovation in 2015 annual report. | Canada / H4+ Collaboration (2015). Accelerating Progress in Maternal & Child Health. Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 10) |

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| 15 | • Maternal Death Surveillance and Response: In 2014, maternal deaths were officially included in the list of weekly mandatory notifications. A workshop was organized to review the list, and subsequently, meetings were organized to develop necessary tools. At health facility level, the database was reviewed to integrate maternal deaths, and trainings were organized across the country. UNFPA and WHO supported the activities.<br>• According to a MoH senior official, the MDSR system works and 100% of health zones notify maternal deaths, as it is now mandatory.<br>• Challenges:<br>- Maternal Death Reviews are not organized or reported. Service providers have been trained in Kinshasa and Kwango, and some in Equateur, but no reports have been received so far.<br>- The term "audit" has created a fear of repercussions if the health personnel conduct review meetings. Three doctors were arrested, which has created resistance among health personnel to conduct reviews.<br>- To overcome this challenge, the term "audit" was replaced with "review". During trainings, the participants were told that the review was a learning tool, meant to learn from the experience, and save lives.<br>- *"La notification ne suffit pas, ne sert à rien, s'il n'y a pas de revue, pendant laquelle on analyse les causes et les leçons apprises ».* | Interview, senior official in MoH in Kinshasa |
| 16 | H4+ JPCS supported the MoH to establish a national committee for the surveillance of maternal deaths which has three levels: central, provincial and HZ. Maternal death is now included in the list of weekly notifiable diseases (*'évènement en déclaration obligatoire'*). H4+ JPCS also supported the training of ECZ in 39 HZ, including 35 in Kinshasa and 4 in other provinces. As of July 2016, 211 out of 518 HZ (40,7%) notify maternal deaths on a weekly basis. | H4+ JCPS Global Technical Team (2016). Documentation : l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint. (H4+ Global Technical Team 2016a: 2-3) |
| 17 | The flat-rate pricing approach is an innovation which has informed the national RBF/PBF programme. Another innovation is the EmONC training. | Interview, H4+ country team member () |
| 18 | The approach of UNAAC in Bandundu is recognized as an innovation :*"Lutte contre la mortalité maternelle et néonatale à Bandundu : Union Nationale des Association des Accoucheurs et des Accoucheuses du Congo (UNAAC) de Bandundu a lancé la lutte contre la mortalité maternelle par deux action concrètes; (i) l'assistance technique lors des complications à l'accouchement; (ii) la supervision formative des Accoucheuses non Sages-Femmes. S'agissant de l'assistance technique, le* | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 27) |

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| | *Comité de l'UNAAC Bandundu a mis sur pied un système d'appel d'urgence 24 heures sur 24; toutes les maternités de la ville ont deux numéros qu'il faut appeler en cas des complications à l'accouchement, la Présidente du Comité qui reçoit les appels, appelle et envoie à son tour une ou deux Sages-femmes les plus proches de la maternité qui a appelé. Avec ce système le comité reçoit en moyen 5 appels par semaine pour les urgences obstétricaux et néonatals. Cela a produit des résultats spectaculaires. Concernant la supervision formative, les missions selon un calendrier consensuel ont été réalisées dans 13 maternités de la ville de Bandundu. »* | |
| **Assumption 4.2**<br>*H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.* | | |
| | **Information/data** | **Information sources** |
| 19 | *« Le Médecin Directeur du centre hospitalier Roi Baudouin a été formé comme **formateur des formateurs en SONU (EmONC)** en 2007 au Burkina Faso avec l'appui de l'IRC, il est parmi les 125 personnes ayant beneficié la formation des prestataires dans les zones de santé appuyées par l'IRC (International Rescue Committee) »* | Interview, implementing partner (training institute) |
| 20 | The professors selected as EmONC trainers at the Faculty of Medicine of the University of Kinshasa have been trained in EmONC in Ouagadougou | Interview, members of the Faculty of Medicine, University of Kinshasa |
| 21 | In 2012, "*One hundred sixty (160) providers participated in training sessions on EmONC and FP conducted for the three districts of Bas-Congo (81) and Kinshasa (79). Pending the arrival of the equipment ordered, this training was provided by a training centre set up by the International Rescue Committee.*" | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |
| 22 | The original proposal identifies the need for international technical expertise to organise a national training of trainers (ToT) workshop and the introduction of the new pre-service and in-service EmONC training methodology based on practice. | DRC H4+ JPCS proposal. (H4+ Canada 2010b: 16) |
| 23 | The National School of Public Health of the University of Kinshasa received technical support from Columbia University in the USA (AMDD) to conduct the EmONC baseline survey ("Enquete de Besoin en Soins Obstétricaux et Néonatal d'Urgence (ESONU) 2012)". | H4+ Country Team (2012). Annual Progress Report 2012 (H4+ Country Team 2012e: 10, 15) |

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| 24 | *To introduce the course in the DRC, three international consultants (two from Madagascar and one from Liverpool, UK) were hired to train trainers."* | UNFPA (2016). UNFPA Good Practices - EmONC Training Revised. (UNFPA nd) |
| 25 | *« Une expert de Liverpool School of Tropical Medicine en collaboration avec le Royal College of Obstetricians and Gynaecologists et deux autres du programme de la santé maternelle du Madagascar sont venus renforcer l'équipe de formateur nationale constituée de professeurs de l'université de Kinshasa, des gynéco-obstétriciens et autres. ».* | H4+ JCPS Global Technical Team (2016) Opérationnalisation des services de SONU-B dans les dix pays du H6 Programme Conjoint. (H4+ Global Technical Team 2016d) |
| 26 | UNPFA has received technical support from regional and global level to implement H4+ JCPS interventions. The support includes guidelines and documents sent to UNFPA country office and participation in regional workshops organised by regional office, or H4+JPCS annual inter-country meetings. | Interview , H4+ country team member |
| 27 | UNICEF and WHO have mobilized regional/international experts to provide technical assistance to implement H4+ JPCS activities. | Interview, senior official in MoH in Kinshasa |
| 28 | UNICEF received support to develop the family kit approach from the technical teams based at headquarter in New York and the regional office in Dakar. | Interview, H4+ country team member () |
| 29 | UNFPA participated in a regional MDSR workshop organized by UNFPA and WHO with technical support from University of Pretoria. | Consolidated comments from UNPFA, WFP and UN Women on Zero Draft DRC Country Note, 8 November 2016 |
| 30 | Some members of the H4+JPCS country team had experience with maternal death surveillance and response from other countries, which facilitated the implementation of the approach in the DRC. | H4+ JCPS Global Technical Team (2016). Documentation : l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint. (H4+ Global Technical Team 2016a: 3) |
| 31 | H4+ JPCS (WHO) hired international consultants to assist the H4+ JPCS country team in the development and implementation of maternal death surveillance and response in the DRC. | H4+ JCPS Global Technical Team (2016). Documentation : l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint. (H4+ Global Technical Team 2016a: 3) |

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| 32 | *« Nous avons reçu l'assistance du bureau régional pour la mise en place des mutuelles en 2013, et on a eu des visites conjointes (deux ou trois fois) des différents sièges pour nous appuyer dans la mise en œuvre des activités en rapport avec les mutuelles. Pour les guides et document, nous avons utilisé le guide de mise en œuvre des mutuelles de l'OMS ainsi que les guides du Ministère de la Santé (…). Nous avons aussi collaboré avec le programme national de la mutuelle de santé »* | Interview, H4+ country team member |
| 33 | The community health fund was developed based on Congolese experiences and national experts supported the development and implementation of the approach. | Interview, H4+ country team member |
| 34 | The narrative 2015-2016 annual work plan identifies the following needs for technical assistance**:**<br>o Evaluation of experiences implementing community health fund<br>o Support the University of Kinshasa to integrate EmONC pre-service trainings in the curriculum for medical doctors | H4+ Country Team (2015). *H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+. République Démocratique du Congo.* (H4+ Country Team 2015b: 8) |
| 35 | H4+ members and MoH staff participate in inter-country workshops during which they received technical guidance in the implementation of midwife training:<br>o *« La Participation à l'atelier inter-pays sur l'amélioration de la qualité de la formation des sages-femmes à Abidjan a donné des nouvelles orientations pour la qualité du système éducatif des sages-femmes en RDC. »*<br>o *« L'atelier de Libreville sur l'analyse de Gaps de la pratique de sage-femme ou a participé une forte équipe de la RDC a permis d'élaborer le plan stratégique pour combler les Gaps de trois piliers de la pratique sage-femme."* | DRC H4+ Annual Report 2015, p. 9. (H4+ Canada 2016: 9) |
| 36 | H4+ country team uses international technical assistance to support strategic workshops for post H4+ phase:<br>- *« En RDC, les agences H4+ prévoit de tenir une retraite avec l'appui d'un expert international pour renforcer le leadership de cette approche [H4+] et surtout d'élaborer un plan annuel de travail 2016 et définir les sources de financement autre que le fond Canadien. A cette occasion des mécanismes efficaces seront mis en place pour mobilisation de ressources pour renforcer l'approche H4+ (…) L'agenda de la retraite H4+ RDC/2016 avec assistance technique d'un expert international a mis un accent particulier sur l'intégration de l'agenda 2030 dans la programmation et le cadre logique H4+ a été également revu en y intégrant tous ces aspects. »* | DRC H4+ Annual Report 2015, p. 21-22. (H4+ Canada 2016: 21-22) |

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| 37 | La particularité de la 2ème campagne d'offre des services intégrés (PF, santé de reproduction) en 2015, a commencé par une formation. L'UNFPA a recruté une consultante « sage-femme » avec un professeur venant du Bénin. Ils ont commencé une formation à partir d'une expérience qu'ils avaient dans leur pays et qui avait porté ses fruits. | Interview implementing partner ( NGO) |
| 38 | The H4+ global technical team conducted a joint review mission to the DRC in October 2015 during which they reviewed the whole programme and visited Mosango and Kenge HZ. A report was produced and shared with the H4+ JPCS country team including specific recommendations for all eight outputs. | • H4+ Global Technical Team (2015). Rapport la mission de visite conjointe H4 de terrain pour la mission H4+ global dans les zones de sante de Kenge et de Mosango, du 05 au 09.10.2015. (H4+ Global Technical Team 2015c)<br>• H4+ Global Technical Team (2015). H4+ Joint Mission Report: DRC – October 2015. (H4+ Global Technical Team 2015a) |
| 39 | • A joint mission was conducted by H4+ global technical team, RMCNH Trust Fund and the Canadian Global Affairs in 2014. The objective was to bring together key partners to support the CAO 4&5 and "leverage resources from all these partners in an aligned, focused approach."<br>• The recommendations of the mission led to the development and submission of the RMNCH Trust Fund proposal, which was funded. Representatives of the following institutions and organisations participated: WHO, UNFPA, UNICEF, UNAIDS, UN Women, World Bank, Global Fund, France, Canada, USAID, Sweden, and DFID. | • GIBS (20149. Recommandations de la Mission H4+ & RMNCH en RDC, 3-7 Février, 2014 (GIBS 2014)<br>• H4+ Global Technical Team (2014). Proposed TOR for the Joint RMNCH mission to the DRC 03 to 07 February 2014 (H4+ Global Technical Team 2014c)<br>• Interview, H4+ country team member |
| 40 | H4+ member participate in technical workshops organised by their regional office, including on EmONC. | Interview H4+ country team member |
| 41 | H4+ member note that the H4+ JPCS inter-country meetings provide an excellent opportunity for sharing experiences from the DRC with other countries, and discuss technical issues related to implementation. For example, the other countries are more advanced with regard to the introduction of the maternal death surveillance and response system, and the DRC can learn from them. | Interview H4+ country team member |
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| **Assumption 4.3** | | |

| *H4+ partners and national health authorities agree on the importance of accurately and convincingly **documenting** the success or failure of supported innovations and put in place appropriate **systems for monitoring and communicating the results** of these experiments.* | | |
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| | **Information/data** | **Information sources** |
| 42 | *« Les innovations ont été documentées dans les rapports des activités et dans les tenues des revues au niveau du pays. »* | Interview, senior official in MoH in Kinshasa |
| 43 | *« Les innovations ont été documentées dans les rapports des activités et dans les tenues des revues au niveau de la ZS et Province. »* | Interview, health zone team Nsele |
| 44 | *« Le rapport annuel H4+ a été élaboré, reproduit et partagé avec les partenaires, donateurs et le Gouvernement. »* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 17) |
| 45 | Good practices are documented through regular reporting. | Interview, senior official in MoH in Kinshasa |
| 46 | *"We also support sharing of good practices between health zones. For example, Mbanza-Ngungu has seen the largest improvement of indicators, and other health zones visit Mbanza-Ngungu to observe and learn from their experience with "tarification forfaitaire" and other practices. In Mosango, innovations include an approach to pay transport for women to facilitate access, the mutual health insurance to pay for caesarians. (…) there is a transfer of knowledge across health zones. The ECZS often visit Mosango and Mbanza-Ngungu to learn from their experiences."* | Interview, senior official in MoH in Kinshasa |
| 47 | UNFPA country office used the global guidelines for documenting innovations and submitted two documented innovations:<br>- Competency-based Emergency Obstetric and Newborn Training of service providers; and<br>- Participation of midwives in the fight against maternal mortality in Bandundu town. | UNFPA (2016). *Bonne pratique de l'UNAAC Bandundu* (UNFPA 2016a) |
| 48 | UNFPA country office responded to a request from headquarters to document good practices in July 2016 by documenting the following innovations:<br>- Institutionalization of maternal death surveillance and response<br>- Improving the quality of pre-service midwife training<br>- Operationalising BEmONC services. | • H4+ JCPS Global Technical Team (2016). Documentation : l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint (H4+ Global Technical Team 2016a)<br>• H4+ JCPS Global Technical Team (2016). La fortification de la formation initiale |

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| | | pour les services d'accouchement pour augmenter l'assistance qualifiée des accouchements dans 10 pays du H6 Joint Programme Intervention (L'amélioration de la qualité de la formation initiale des sages-femmes). (H4+ Global Technical Team 2016c)<br>• H4+ JCPS Global Technical Team (2016) Opérationnalisation des services de SONU-B dans les dix pays du H6 Programme Conjoint. (H4+ Global Technical Team 2016d) |
| 49 | The office for innovation at UNICEF in New York supported the UNICEF country team in documentation innovations. The has been a lot of promotion of the family kit approach within UNICEF and to other stakeholders at global level (for example through presentations in London and Tunisia). | Interview, H4+ country team member |
| 50 | *« [Les expériences aquises concernant la mise en œuvre] de la mutuelle ne sont pas encore documenté. Cela va être réalisé à la fin du projet H4+ JPCS »* | Interview, H4+ country team member |
| 51 | The documentation of the flat-rate price of obstetric emergency services has not yet been done, but is planned. | Interview, H4+ country team member |
| 52 | *Quant aux résultats obtenus dans les zones pilotes, ils sont en train d'être documentés pour être portés à échelle dans les autres zones.* | DRC H4+ Annual Report 2015, p. 10. (H4+ Canada 2016) |
| 53 | An inter-agency meeting held in December 2014 recommended that the H4+ partners organize quarterly H4+ meetings with the Minister of Health to share experiences at highest level: *"Le partage de l'information des actions avec les plus hauts niveaux (…) Organiser trimestriellement une réunion H4+ avec le ministre de la santé »*. | Compte rendu de la réunion H4+ 10/12/2014. (H4+ Agencies 2014a) |
| 54 | An H4+ inter-agency meeting recognized the need to document good practices and innovations, and suggested the production of a video: *"La fin de projet canadien est prévue à la fin de 2015. Il y a besoin de renforcer des stratégies de mobilisation de ressources. Faire une documentation des résultats atteints, des bonnes pratiques, des innovations, des contraintes et les gaps. Et Produire également une vidéo de 10 minutes".* | Compte rendu de la réunion des points focaux d'agences de l'initiative H4+, le 30 avril 2015. (H4+ Agencies 2015b) |

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| 55 | UNICEF documented and shared the family kit approach through a video which is accessible on YouTube (see the link in the bibliography) | UNICEF (2016). Des kits familiaux pour la santé des enfants? Une innovation réussie! (video film). (UNICEF 2016) |
| 56 | DRC experiences with EmONC trainings and other key H4+ JCPS interventions were selected (together with Sierra Leone) as good practices to be documented, and a brochure and a video were produced in 2014. | • H4+ (2014). Stories from Democratic Republic of Congo and Sierra Leone. May 2014 (H4+ 2014b)<br>• H4+ (year unknown). Saving Mothers' and Babies' Lives (video film) (H4+ nd) |

**Assumption 4.4**

*National health authorities are willing and able to adopt proven innovations supported by H4+ JPCS and to **take them to scale**. They have access to required sources of financing (internal and external).*

| | **Information/data** | **Information sources** |
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| 57 | For evidence of the **catalytic nature of H4+ JPCS support to RMNCAH and scale-up efforts,** please refer to the matrix for question one, assumption 1.2. , line 35 and 38 | |
| 58 | The family health kit approach was first piloted in Mbanza-Ngungu with support from H4+ JPCS, and then extended four other HZ in other provinces in 2014, with support from Management Sciences for Health (MSH) with funds from Canada and Sweden governments. : *« Après la zone de santé de Mbanza-Ngungu dans la province du Bas-Congo, la zone de santé de Ndekesha au Kasaï Occidental a été la deuxième Zone de santé où fut lancé le Cadre d'accélération des OMD 4et 5 (CAO) à travers la distribution des kits familiaux depuis le 29 août 2014. Les zones de santé de Dibaya au Kasaï Occidental, de Kandakanda et de Vangakete au Kasaï Oriental ont suivi dans la même lancée, le 8, 12 et 27 septembre 2014. […] Le passage à l'échelle du CAO 4&5 continue partant de la vingtaine d'aires de santé (22) actuellement engagées dans le processus. Les distributions vont maintenant avoir lieu dans d'autres aires de santé et autres zones de santé des Kasaï, du Katanga et ainsi que dans d'autres provinces. »* | Rie Takesue (2014). Des kits familiaux pour l'amélioration de la santé des mères et des enfants (Takesue 2014) |
| 59 | *"the Government and UNICEF have decided to implement [the family health kit approach] in other health centres throughout the country, in partnership with the World Bank, the Global Fund, the European Union and GAVI, the Vaccine Alliance."* | UNICEF (2015). A nurse and a family kit help save children's lives. By Yves Willemot (UNICEF 2015) |

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| 60 | The approach engaging CHW in community-based RMNCH supported by H4+ JPCS has been extended to other health zones*: « la même approche est en train de s'étendre dans les autres zones de santé dans le Cadre d'Accélération des OMDs 4 & 5 (CAO 4 &5), telles que les zones de santé de Kingandu, Ipamu, Koshibanda (pour la DPS Kwilu), et Wamba Luadi et Popokabaka (pour la DPS Kwango). »* | DRC H4+ JPCS annual report 2015 (H4+ Canada 2016: 14) |
| 61 | *"H4+ Canada (…) is strengthening training institutions through the training of trainers at the national level – **thus laying a foundation for expanding quality maternal and newborn care beyond the targeted regions**. Didactic materials and equipment, including computers and diagnostic devices, were also provided and Ministries of Health received support in developing user-friendly training modules and rolling out on-the-job programmes. "* | H4+ Global Technical Team (2014*). Canada Annual Narrative Progress Report 2013. H4+ Canada Initiative. Accelerating Progress In Maternal And Newborn Health Reporting period: 1 January 2013-31 December 2013.* June 2014. (H4+ Global Technical Team 2014a) |
| 62 | • *« A ce jour, 7 provinces de la RDC ont leurs pools de formateurs dont deux directement par le H6+. Les 5 autres ont été mise en place par l'appui technique de pool central mise en place par le H6+ mais avec l'appui financier des autres bailleurs. »*<br>• *« La formation continue des prestataires en SONU : les différents pools de formateurs mis en place, ont continué à former les prestataires dans les différentes zones de santé. A ce jour, ces différents pools ont déjà formé des prestataires dans 22 zones de santé dans le pays, dont neuf directement par le H6+. Les autres formations ont été réalisées par l'appui technique de ces différents pools mise en place directement ou indirectement par le H6+.* » | H4+ JCPS Global Technical Team (2016) Opérationnalisation des services de SONU-B dans les dix pays du H6 Programme Conjoint. (H4+ Global Technical Team 2016d: 4) |
| 63 | *« les résultats sont pérennes entre autres, la formation des prestataires en SONU B et C, en PF, PTME qui sont institutionnalisés dans notre pays, à notre niveau de la ZS cette même formation en SONU B et C demeure une formation en cours d'emploi appuyée par d'autres partenaires comme PASSKIN afin de compléter la liste des autres FOSA qui n'ont pas bénéficiés de la formation en SONU ».* | Interview, health zone team (Nsele) |
| 64 | • The competency-based EmONC training manual is now used by all development partners, including KOICA, USAID and Pathfinder. Before, each partner had its own curriculum which was very different. The MoH took the leadership in this matter.<br>• *"H4+ supported the development of competency-based training guide for emergency obstetric and newborn care at the national level and this training guide is now being used by several implementing partners in other others where H4+ do not have interventions. This is a good example of catalytic effect of the Canada funding."* | Interview with H4+ country team member prior to field visit, August 4 2016 |

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| 65 | • *« L'accroissement de la couverture en prestataires de qualité en offre de SONU : Plusieurs pools de formateurs ont été mis en place. Au niveau central, 26 formateurs ont été formés et les provinces de Bandundu et du Bas Congo(Kongo central) étaient également dotées chacune d'un pool composé de 16 formateur en Soins Obstétricaux et Néonatals d'Urgences (SONU). De plus, ces pools de formateurs ont bénéficié de matériels didactiques. »*<br>• *« Cette année, différents pools ont formé 180 prestataires en SONU Bandundu dans 8 zones de santé, dont Boko (25) et Kenge (25) avec le financement de KOICA, et Kingandu (25), Mosango (25), Koshibanda( 25), Popokabaka(25), Ipamu(25) et Wamba Luadi (25) dans le cadre de la mise en oeuvre du Cadre d'accélération des Objectifs Millénaires pour le Développement (OMD) 4 et 5 avec le financement de UNICEF. Le module de formation en SONU selon les nouvelles approches basées sur l'acquisition des compétences a permis la mise en place des autres pools de formateurs dans les autre provinces notamment dans le Katanga, Nord Kivu, Sud Kivu et Equateur. Le pool du niveau central a également formé les prestataires dans les autres provinces. A ce jour, on peut souligner l'effet très catalytique de formation continue en SONU renouvellée avec cette approche ».* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 10) |
| 66 | • H4+ JPCS supported the development of RMNCAH standards and guidelines, including the EmONC (SONU) training manual for competency-based, in-service capacity development, and data collection and reporting tools, which are used country-wide by other partners in other provinces, such as for example MSH and other USAID implementing partners.<br>• H4+helped accelerate the progress in RMNCH by training ECZ and pools of trainers in EmONC; and by supporting the development of national norms and standards, because there has been a standardisation. | Interview, H4+ country team member |
| 67 | • H4+JPCS funds were used to create a national 3-year midwife education curriculum with direct entry after the baccalaureate based on the existing midwife training programme. The curriculum was officially adopted by a ministerial decree and midwifery was recognised as a separate professional category by the human resources for health committee of the MoH. H4+ JPCS also supported the development of a curriculum to upgrade nurse-midwives to midwives.<br>• H4+ JPCS funds allowed: (1) integration of the new midwife curriculum in 38 training institutes (ISTM) that previously trained nurse-midwives; (2) provision of equipment and trainings to 12 ISTM; (3) training of 154 teachers in competency-based teaching methodologies; (4) technical and financial support to strengthen technical capacities of internship-mentors and clinical teachers. | H4+ JCPS Global Technical Team (2016). *La fortification de la formation initiale pour les services d'accouchement pour augmenter l'assistance qualifiée des accouchements dans 10 pays du H6 Joint Programme Intervention (L'amélioration de la qualité de la formation initiale des sages-femmes).* (H4+ Global Technical Team 2016c: 2-4) |

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| | • In 2016-2017, H4+/H6 plan support eight training institutes with a fully equipped room for practical exercise; train another 146 teachers and 105 internship-mentors and clinical teachers.<br>• Challenges for institutionalisation include: lack of funds to extend to national scale; low quantity and quality of teachers in the ISTM; the double 'tutuelle' of the MoH and MoHE. | |
| 68 | Based on the pilot experiences with the family kit approach and CHW involvement in the promotion of RMNCH, UNICEF provided policy advice to the MoH to develop a national strategy for the development of community participation in DRC and in promotion. | MoH (2016). La stratégie de développement de la participation communautaire en RDC. DRAFT. Kinshasa, June 2016 (MoH 2016a) |
| 69 | *« Les résultats atteints au niveau national ont eu des effets catalytique et déjà durables. Ils ont profité à tout le pays, au-delà des zones pilotes. Les exemples clés peuvent etre cites notament : (i) la mise en jours de documents de politique et des norms, (ii) au niveau de la ressources humaines, les modules SONU ont permis de mettre en place des pools de formateurs et les formations de prestataires dans plusieurs provinces ; le nouveau curriculum de formation de base de sage femme adopté dans tout le pays.(iii) les resultats de différents plaidoyes avec la mobilisations des engagements politiques et financiers mentionnés plus haut profite à tout le pays. Les décès maternels ont été a été intégrés dans les maladies ou évenement à declaration obligatoire et à ce jours plus de 40% de zones de santé du pays notifient systématiquement et hebdomadairement les cas de décès maternels. Ces données de surveillance constituent une bonne base qui va permettre d'orienter la riposte. »* | DRC H4+ Annual Report 201. (H4+ Canada 2016: 21) |
| 70 | *« En RDC, le gouvernement a inscrit la SDMR [MDSR] dans les stratégies de lutte contre les décès maternels. H6 demeure le principal partenaire qui accompagne le gouvernement dans ses efforts à ce propos. Les autres partenaires, ont été également mobilisés autour de cette stratégie notamment les ONG du groupe USAID. Ce dernier appui le renforcement de l'implémentation de SDMR dans les zones de santé qu'ils appuient. »* | • H4+ JCPS Global Technical Team (2016). Documentation: l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint. (H4+ Global Technical Team 2016a: 4) |

**Area of Investigation 5: Division of Labour and Value Added (Country Level)**

**Question Five: To what extent has the H4+ JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities?**

a. **Has the H4+ JPCS programme contributed to the development of effective and robust platforms and operational systems for coordinating support to RMNCAH at country level by the partners? Will these platforms and systems persist in one form or another beyond the period of programme funding?**

b. **Do the resulting programmes of support to RMNCAH at country level make best use of the individual strengths of H4+ partners? Is there a distinguishable value added over the existing programmes of the H4+ partners?**

c. **Do efforts at coordination result in collaborative programming which is more effective than separate initiatives?**

**Assumption 5.1**

*H4+ teams at country level in collaboration with key stakeholders have **established forums for coordinating programme action and division of labour** in H4+ JPCS financed and supported activities in particular and in RMNCH generally.*

| | Information/data | Information sources |
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| 1 | **Collaboration before to H4+ Canada funds:**<br>• *"The RMNCAH Task Force already existed before the H4+ Canada funds, and the UN agencies had already established collaboration and coordination in the context of the H4+ partnership."*<br>• *"Before the Canada funds, however, H4+ existed, but the coordination was not highly effective. Now we share information. We now have annual retreats during which we (UN agencies) agree to the major priorities for joint support, for example, one year it was "support to the PNDS 2011-2016). Before H4+ Canada funds, that did not exist."*<br><br>**The added value of the H4+ Canada Funds:**<br>• The Canada funds consolidated the idea of working together and the links between the agencies<br>• It also consolidated/strengthened the coordination with the MoH, as it is much easier to show the benefits of coordination when you have funds to implement a joint programme and demonstrate tangible results of the coordinated efforts. | Interview, H4+ country team member |

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| | • Today it is evident (natural) that we work together, both at technical level and among the Head of agencies. | |
| 2 | Active participation of H4+ agencies in monthly technical meetings is seen as strength. Expanding the H4+ membership to include the WFP in 2015 helped the agencies to give more attention to nutrition than was previously done. | Email with H4+ country team member 4 August 2016 |
| 3 | A 2014 H4+'s Representatives Meeting discussed how to harmonize approaches (e.g. RBF) and avoid duplication of activities (e.g. evaluation of community health insurances) and how to coordinate H4+ activities with the RMNCH Trust Fund.<br>• *« Evaluation des mutuelles : L'évaluation à mi-parcours a recommandé une évaluation des mutuelles. La Banque Mondiale prépare une étude/évaluation sur les mutuelles (TDR disponibles). Donc, il est plus indiqué de faire une seule évaluation des mutuelles en mettant les ressources ensemble. »*<br>• *« Briefing sur la mission du consultant du processus d'engagement RMNCH Trust Fund (…) Financement de 15 millions de $ pour 2 volets retenus : les intrants ($12.3m) et la coordination ($1.5m). L'UNICEF est responsable des intrants et l'OMS de la coordination, l'UNFPA n'a pas reçu des fonds RMNCH. »* | Note de la **Réunion de Chefs d'agences H4+** du 07 juillet 2014. (H4+ 2014a: 2-4) |
| 4 | **How has the H4+ Canadian funds contributed to improved coordination?**<br>• *« In the beginning, it was not that easy and took a while to understand what the H4+ approach entailed and how it could be implemented in practice. The H4+ Canadian funds have "boosted" the coordination in the sense that it allowed the H4+ partners and the government to better understand what the H4+ approach is all about. Moreover, the availability of the Canadian funds enabled the H4+ country team to illustrate how coordination can be implemented in the field and to produce tangible results of improved coordination. »*<br>• *« Before, there was no coordination of the activities in the field and each agency covered different health zones based on geographic breakdown ("répartition géographique"), but never intervened in the same health zone. Each agency had to defend its own mandate and flag. It is less like that now. »* | Interview, H4+ country team member |

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| | With the H4+ Canadian funds, it was decided to implement activities in the same health zones, which enabled the H4+ agencies to create synergies and plan activities jointly based on each agency's comparative advantage.<br><br>Based on the H4+ experience, the UN agencies increasingly develop and implement joint programmes.*"Now, our actions are joint, and mobilization of funds is joint".*<br><br>***One Place One*** and ***One UN Gender Team*** are important platforms that enable the agencies to harmonize their actions.<br><br>The H4+ approach was ahead of other UN joint platforms and the H4+ dynamic inspired other UN coordinating platforms, such as the M&E team, the communications team, One Place One, and One UN Gender Team. | |
| 5 | **What is the future of H6?**<br>• UNAIDS has become the H6 coordinator in the DRC, and the coordination between the H4+ agencies and the government has been relaunched. For example, the ToR for the evaluation mission has been developed jointly, which is a good start. UNAIDS suggested that the MoH invited the members of the ERG, which is the correct way of doing things.<br>• H6 is all about "Delivering as One", about creating synergies. The resources have to be used on a *joint* programme, with a joint budget.<br>• The MoH should be put in lead, and the H6 should keep its promises | Interview, senior official in MoH in Kinshasa |
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| **Assumption 5.2**<br>*The assigning of activities and investments in support of H4+ JPCS programme goals in participating countries is based on both* ***the distinct capacities and advantages of each H4+ JPCS agency*** *in that country and the national and sub-national context for support to RMNCAH.* | | |
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| 6 | • For evidence of the **division of labour among the H4+ members**, please refer to the matrix for question two, assumption 2.3. , line 76 | |
| 7 | **The original JPCS proposal clearly outlines the distinct roles and responsibilities of the H4+ agencies in the draft 2011-2012 work plan:**<br>• **UNFPA:** Introduction of EmONC in health facilities through support to training of health personnel, equipment and drugs for EmONC service delivery; strengthening FP service delivery, including for youth; introduction of a midwife programme in the ISTM training centres (Institut supérieur des techniques médicales); advocacy to revise existing RMNCH/FP legislation; standardize national RMNCH norms and standards and align all partners through harmonized RMNCH plans; support RMNCH Task Force meetings at national and provincial level.<br>• **UNICEF:** provision of drugs, supplies and equipment to HZ health facilities; strengthening referral system (referral tools and involving communities); engage communities in RMNCH through CHW; advocate for improved HRH management<br>• **WHO:** strengthening training in MNCH in reference hospitals; introduction of an obstetric flat rate; introduce performance-based contracts to increase motivation of health providers; advocacy to increase political support and mobilise funds for RMNCH; strengthen HMIS and support periodic diffusion of quality data reports | DRC H4+ JPCS proposal. (H4+ Canada 2010b: 17ff) |
| 8 | The six H4+ agencies have developed a mapping of their support to RMNCAH by province and intervention area which clearly illustrates the division of labour between the agencies. The mapping also specifies the HZ, the target groups, operational strategies, which activities of the minimum service package each agency supports, and the links to the PNDS 2011-2015 and the CAO 4&5. | H4+ agencies (year unknown). *Cartographie des interventions des agences H4+ en RD Congo.* (H4+ agencies nd) |
| 9 | *« Dans le cadre de la coordination des interventions H4+ des aires de responsabilités ont été attribuées aux agences impliquées ainsi :*<br>- *L'OMS sera chargée de la cartographie mondiale, du renforcement des capacités nationales ;*<br>- *L'UNICEF sera chargée du développement de la coopération sud-sud, l'introduction, la dissémination et l'utilisation des outils dans les pays, le suivi et l'évaluation du programme ainsi que l'approvisionnement en médicaments et intrants;*<br>- *L'UNFPA sera chargée de communication, des ressources humaines et de la gestion des fonds.»* | DRC H4+ *annual work plan 2011-2012.* (H4+ Canada 2010a: 1) |

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| 10 | • The activities targeting adolescents and youth included in the 2014-2015 work plan (indicator 7.2. p. 7) involve several H4+ agencies (UNFPA, WHO, UNICEF, UNESCO) in addition to the National Programme for Adolescent Health of the MoH. It is not specified which role each agency will play.<br>• UNICEF and UN Women are responsible parties for the majority of activities targeting adolescents and youth included in the 2015-2016 work plan (indicator 7.2. p. 4), with UNFPA and UNAIDS supporting. It is not clear why UNFPA, which was responsible for adolescent and youth activities in the 2014-2015 work plan, is no longer in lead in 2015-2016. | DRC H4+ JPCS 2014-2015 and 2015-2016 work plans. (H4+ Canada 2013, H4+ Canada 2014b) |
| 11 | There was a division of tasks among the H4+ agencies from the beginning. UNICEF was responsible for equipment and commodities, WHO for mutual health insurances and the flat-rate pricing approach, and UNFPA for reproductive health commodities and coordination. | Interview, senior official in MoH in Kinshasa |
| 12 | The World Bank is short of staff and does not participate frequently in coordination meetings. When they are chairing the meetings, they come (the Representative). They are responsive, after all, and inform us about their activities. | Interview, H4+ country team member |
| 13 | • Division of labour among the agencies is effective, for example: UNFPA – training; WHO – equipment/mannequins; UNICEF – medicines and equipment.<br>• H4+ Canada funds led to improved division of labour and has created a "culture of coordination."<br>• *"We have other joint initiatives, for example: UNICEF: Family Kits, WHO: strengthening coordination; UNFPA: medicines."* | Interview, H4+ country team member |
| 14 | UNICEF is responsible for supply of commodities and community support. At the annual review and planning meetings, each H4+ agency provides an overview of activities it supported and what it plans to do in the future. This ensures complementarity and avoids overlap. | Interview, H4+ country team member |
| 15 | For evidence of the **WHO and UNICEF engagement in the flat-rate procing approach**, please refer to the matrix for question two, assumption 2.2 , line 53 | Interview, H4+ country team member |
| 16 | • UN Women was included as an implementing partner in the 2015-2016 work plan and allocated a budget of 150.000 USD to implement activities targeting youth, men and boys, religious leaders, midwives, CHW and CBOs with messages on the prevention of GBV and HIV and the promotion of women's and girls' sexual and reproductive rights (p. 4-5). Another activity to be led by UN Women was the support to women's organisations for income-generating activities (IGA) linked to the mutual health scheme (p. 1). | DRC H4+ *annual work plan 2015-2016.* (H4+ Canada 2014b: 1, 4-5) |

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| | • UN Women was also identified as responsible party for the implementation of the activity *« Organiser un forum des partenaires autour de la problématique du financement de la santé de la femme et de l'enfant »*, while WHO is responsible for the other activities related to health financing (p. 4-5). | |
| 17 | • UN Women joined the H4+ coordinating meetings in 2013-2014. UNFPA agreed to fund UN Women activities in 2015-2016 to implement community based activities in two pilot districts: Mosango and Kenge. The memorandum of understanding with UNFPA was signed in March 2015, a UN Volunteer (UNV) was engaged mid-June and posted to Mosango, and activities were launched in September 2015.<br>• The primary target group was women who were already members of the mutual health scheme. By supporting income generating activities (IGA) for disadvantaged women, the UN Women support aimed to increase their membership in the mutual health scheme , which was an initiative supported by WHO. The target group included women of reproductive age who were already members of the mutual health scheme. The annual cost is 10 USD for one person.<br>• The project also targeted traditional leaders, men and boys with key messages on HIV, GBV, women's rights and reproductive rights. The boys are organized in clubs and receive equipment for the sensitization activities, including megaphones and brochures. Their capacity is strengthened through supervision while they implement activities. They also organized intergenerational dialogues on RH and GBV. We tried to engage the justice, but did not succeed (lack of positive response). In each health area ("aire de santé"), two clubs were created, adding up to a total of 72 clubs (20 health areas in Kenge, and 16 heath areas in Mosango).<br><br>**Results:**<br>• 152 women were members of the mutual health scheme mid-2015, and now 600 are members. The income generated through the IGA enables the women to pay into the scheme.<br>• In Mosango, which is a rural area, men have become very involved in women's RMNCH, while in Kenge, a commercial centre, there is much more resistance.<br>• Traditional and administrative leaders have become much more engaged in SRMNCH. After a public speech given by the "chef de secteur", who has been very engaged, 90 young girls and boys were tested for HIV. He called the other traditional leaders to become engaged, and his | Interview, H4+ country team member |

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| | leadership has played an important role [in mobilizing other traditional leaders and creating community support for RMNCAH].<br>• Kenge is a new province and therefore "has other priorities" [than the H4+ activities].<br>• We have not really obtained what we aimed for. The time was too short.<br><br>**Future:**<br>• UN Women does not have funds to continue supporting activities in the two HZ beyond the H4+ Canada fund, as most programmes are implemented in the west | |
| 18 | • UNFPA allocated 150.000 USD of its approved budget to UN Women as a local implementing partner to conduct community-based activities, including GBV, HIV and IGA, based on its distinct expertise in these areas. It was based on a local decision and agreement between the two country offices (CO) and funds were thus to be disbursed by UNFPA CO to UN Women CO.<br>• However, only 90.000 USD of 150.000 USD were disbursed and there is no evidence of the **reason why. Both UNFPA and UN Women were asked about this, but no clear answer was provided.** This had a negative impact at community level, as it caused certain activities in the approved work plan not to be implemented. | • H4+ country team member<br>• H4+ Global Technical Team Member |
| 19 | PAM/WFP asked if they could join the partnership. UN Women asked if they could join even before they became an official partner at global level. | Interview, H4+ country team member |
| 20 | UNESCO has expressed interest that they would like to join H4+/H6: « *Nous avons reçu l'UNESCO qui avait exprimé son désir de faire partie de groupe H4+ parce que pour lui, tout passe par l'éducation (…), donc il faut qu'il puisse faire partie pour s'enquérir de ce que les autres agences font et aussi apporter les informations et la communication.* » | Interview, H4+ country team member |
| 21 | • *« Au cours des différentes réunions de coordination inter-agences de Nations Unies, le PAM a reçu à mieux exposer son mandat qui est la prise en charge de la malnutrition aigüe et modérée chez la femme enceinte et allaitante, de prévenir la malnutrition aigüe chez ce groupe cible ainsi que l'approvisionnement des micronutriments auprès des enfants dans le pays.*<br>• *« Cette répartition des tâches permet une meilleure planification des interventions. (…)La tenue des revues annuelles et des retraites contribuent largement à fournir une analyse approfondie des* | Interview, H4+ country team member |

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| | *résultats atteints par [le programme H4+ conjoint. Lors de ces rencontres], chaque agence H4 + donne un aperçu des activités qu'il a menées [au cours de l'année passée], et ce qu'il prévoit de faire à l'avenir.*<br>• *« Les études du pays EDS 2014 ont démontré que 43 % de la population souffrent de malnutrition chronique. Le PAM a élaboré une proposition ou projet de la fortification généralisée en fer, acide folique et en vitamine A et a appuyé le gouvernement pour l'amélioration du protocole de la prise en charge de la malnutrition aigüe du groupe cible. Le PAM a consulté les autres agences de H4+ pour la rédaction du projet de la fortification généralisée des aliments et de la sensibilisation des ménages sur cette nouvelle approche. »*<br>• *« H4+ a offert un cadre adéquat pour l'organisation [conjoint] du travail entre agences, favorisant ainsi des analyses approfondies des problèmes identifiés et des interventions à mener. [Cela a également permis aux agences] de tirer des leçons apprises ensemble [en tant qu'équipe] et ainsi d'assurer une planification harmonisée. »* | |
| 22 | One H4+ member indicated that the joint planning is not really joint, as each partner continues to promote its "own" activities and approaches. When they developed the H6 joint work plan 2016, *"Nous avons constaté que chaque agence voulait inscrire ses activités. Un plan conjoint mais ce n'est pas vraiment conjoint. Chaque agence fait valoir ce qu'elle fait. Quand quelqu'un amène le feu, l'autre l'eau, l'autre les piments…finalement le met qui va sortir est le met de tout le monde. Cela ne va pas se sentir quand on va passer à l'action. Je pense que les données sur le terrain reflètent ça. L'agence qui va intervenir et non le groupe. (…) Mais dans le cadre de la mise en œuvre de H4+, comme les agences donnaient de l'argent, chacune veut apparaître, c'est l'OMS qui intervient ici. Sur le plan « intervention » sur le terrain, on doit vraiment améliorer. Il faut qu'au niveau de la planification, on s'aligne véritablement en termes de contribution et non en termes de « c'est mon activité ». C'est une question difficile au delà H4+, au niveau des Nations-Unies qui persiste dans le cadre One UN, nous continuons à avoir des difficultés. »* | Interview, H4+ country team member |
| 23 | **Visibility of H4+ JPCS:**<br>• *"There is an issue with visibility of the H4+. We participate in the meetings as individual agencies, not H4+."*<br>• *"We do plan together, for example, that we will support the development of the PNDS 2015-2020, but when we are there, we present our flag as individual agency. But we do look at all aspects [i.e. of all agencies, the entire H4+ programme]."* | Interview, H4+ country team member |

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| 24 | **Sustainability of H4+ JPCS:** *« Moi, je ne m'inquiète pas pour la pérennité, parce que nous allons continuer à nous coordonner après les fonds canadiens et du RMNCH Trust Fund, car nous allons voir comment faire des complémentarités avec nos propres fonds (…) Nous les techniciens, nous sommes convaincus des avantages [d'une étroite collaboration].»* | Interview, H4+ country team member |
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| **Assumption 5.3**<br>*H4+ JPCS partners have **used structures and processes established for programme coordination at country level** to rationalise their support to RMNCAH and to **avoid or eliminate duplication and overlap in support**. This trend is reinforced by **increasing levels of coordination** contributing to improved operational effectiveness and strengthened advocacy.* | | |
| | **Information/data** | **Information sources** |
| 25 | *During an inter-agency coordination meeting 17 June 2014, it was discussed how to report on H4+ in the broader health partner's forum, GIBS « Mettre la revue de progrès des activités H4+ à l'ordre du jour des réunions du GIBS ».* | Compte rendu de la réunion H4+ 17/06/2014. (H4+ Agencies 2014b: 2) |
| 26 | H4+ collaboration within the larger donor landscape (GIBS): *"All H4+ agencies are members of the GIBS. Decisions made, issues discussed and progress of H4+ work are shared in the larger donor groups (GIBS). The H4+ plays a convening role to bring partners together to support the Government priorities. For example in 2014, H4+ mobilized partners to commit to support the MoH Framework for Accelerating the Reduction of Maternal and Child Mortality.*" | Email with H4+ coordinator (UNFPA), 4 August 2016 |
| 27 | The coordination with other (RMNCAH) partners remains difficult. The MoH is dependent of the donors, especially those who bring large grants. | Interview, H4+ country team member |
| 28 | • The RMNCH Task Force is a large platform with multiple participants that meets quarterly.<br>• The secretariat of the Task Force meets regularly, and is functional. It receives projects, provides feedback on the projects. The secretariat is led by D10, WHO, Pathfinder and PNSR (they are most permanent/active). | Interview, H4+ country team member (WHO) |
| 29 | The 2015 H4+ agencies' annual retreat recommended to « Préparer la présentation sur la retraite au GIBS pour présenter la nouvelle vision de H4+ ». | H4+ Country Team (2015). Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015. (H4+ Country Team 2015c: 8) |

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| 30 | *« Pour la coordination H4+ elle [UNFPA Representative] a demandé à ce qu'elle collabore étroitement avec le GIBS, tout en renforçant le gouvernement pour qu'il joue effectivement son rôle dans la coordination pour les activités de SMNE en RDC. »* | H4+ Country Team (2015). Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015. (H4+ Country Team 2015c: 5) |
| 31 | The H4+ focal points participate and present the H4+ partnership in the GIBS meetings. When GFF and PNDS 2016-2020 were developed, we were invited as H4+ partnership to contribute (not as individual agencies). | Interview, H4+ country team member |
| 32 | **H4+ support to RMNCH coordination in 2014:**<br>• *Appui à l'organisation de la réunion Task Force SMNE, une plateforme pour partager des expériences et renforcement de capacité nationale.*<br>• *Un appui technique et financier a été apporté pour la tenue des réunions mensuelles des commissions du Comité National du Pilotage (CNP). Une réunion du CNP extraordinaire a été organisée pour discuter des modalités de fonctionnement de nouvelles Divisions Provinciales de Santé (DPS) et de l'inspection provinciale de la santé.* | DRC H4+ JPCS Annual Report 2014). (H4+ Canada 2015) |
| 33 | **H4+ support to RMNCH coordination in 2013:**<br>*Tenue de la réunion trimestrielle de la Task Force SMNE (Santé de la Mère, du Nouveau-né et de l'Enfant). Les cartographies des intervenants et des interventions SMNE/PF dans les provinces appuyées ont été actualisées. Les activités des différents projets SMNE par les partenaires techniques et financiers ont été harmonisées.* | DRC H4+ Annual Report 2013. (H4+ Canada 2014a: 5) |
| 34 | Pathfinder and WHO have provided technical support to the Secretariat of the RMNCH Task Force « Essentiellement l'assistance technique pour la préparation des réunions, des contenus, des outils en fonction des points retenus à l'agenda, la préparation technique des informations collectées, des supports élaborés et à partager avec les partenaires concernés pour des informations à partager, donc l'appui technique. » | Interview, RMNCH development partner |
| 35 | • UNICEF, UNFPA and WHO received two grants from the RMNCH Trust Fund to implement a joint RMNCH programme:<br>• Phase 1 grant (UNCoLSC) : « Augmenter l'accès, la demande et l'utilisation des 13 produits d'importance vitale et d'améliorer la santé des enfants et des interventions de santé reproductive », $3.4 million, October 2013-December 2015 ; | • RMNCH Task Force meeting minutes<br>• RMNCH Trust Fund (2016). La revue du rapport annuel 2015. République Démocratique du Congo. (RMNCH Trust Fund 2016) |

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| | • Phase 2 & 3 grant : « Fonds catalytiques de la SMNEA pour améliorer la disponibilité des intrants PCIME et accouchement (Delivery kits) », $22.8 million, Septembre 2014-Juillet 2016. | |
| 36 | H4+ agencies implement several joint programmes: Faire le suivi des projets conjoints (Canada, Muskoka, RMNCH ….) | H4+ Country Team (2015). Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015. (H4+ Country Team 2015c) |
| 37 | • *"This project will also be implemented in close collaboration with UNICEF, Global Fund, and GAVI in the targeted areas. UNICEF will not only contribute to the purchase of quality health outputs, but will also introduce Family Kits 14(both at the household and health facility level) as well as introduce and strengthen their community based interventions in the project targeted areas. The financing of the "household visit" as part of the PBF package of services will strengthen the delivery and the monitoring of the Family Kit approach. Collaboration with UNICEF, which has 510 staff on the ground, will greatly benefit the project and strengthen field support. GAVI and the Global Fund will finance medicines (antimalarial; anti-TB; and HIV medicines, as well as vaccines) and they will finance part of the PBF package of services both at the health facility and health administration level. In addition, GAVI is investing approximately US$53 million to support the distribution of the medicines nationwide. Alignment is an important characteristic of this project (see Annex 2 for further details as to what each partner will contribute to in the 140 health zones)."*<br>• *"The alignment between the Global Fund, UNICEF, World Bank and the Reproductive and Maternal Newborn and Child Health (RMNCH) trust fund will ensure complementarity, and ensure the efficient use of resources. The objective of this partnership is to support the Government's Acceleration Program to Achieve MDGs 4 and 5. This collaborative approach will contribute towards the provision of an integrated package of services implemented through PBF and offered to a larger portion of the population. It is expected that this alignment of development partners will contribute to not only strengthening the health system (efficiency, efficacy and better governance) both from a service delivery and stewardship perspective but will also achieve the intended results in terms of improving utilization and quality of care as well as achieving the anticipated maternal and child health results. Finally this alignment is very much in line with the Ministry of Public Health's objective to reduce partners' fragmentation and ensure harmonization. Discussions for future alignment with GAVI, USAID, UNFPA and the Gates Foundation are ongoing."* | World Bank (2014). PDSS Project Appraisal. (World Bank 2014b: 10, 22) |

**Area of Investigation 6: Value Added in Support of the Global Strategy**

**Question Six: To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Global Strategy and the "Every Woman Every Child" Movement"?**

a. **To what extent has H4+ JPCS contributed to more effective advocacy for international and national commitments to operationalize Global Strategy principles and accelerate actions to strengthen RMNCAH investments and systems?**

b. **During the life of the programme, how well did the H4+ partners support existing global structures (for example, the PMNCH, the iERG, the Commission on Information and Accountability) for supporting action in RMNCAH?**

c. **As programme funding ends, to what extent can the lessons learned in implementing H4+ JPCS inform the work of the H6 partnership, allowing it to better contribute to energizing global structures and processes in support of the Global Strategy 2.0**

**Assumption 6.1**

*The establishment of H4+ JPCS in 2011 and its expansion in 2012 helped strengthen the rationale for and extent of policy support for coordinated action in RMNCAH at global, regional, national and sub-national level by the H4+ agencies.*

| | Information/data | Information source |
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| 1 | • « Les documents des **normes et directives SMNE** ont été mise à jour en avril 2015, au cours d'un séminaire atelier multi produits préparatoire aux activités : (i) de la croisade de vulgarisation des normes SMNE, (ii) de la consolidation et compétences des prestataires SMNE, (iii) l'introduction de la chlorhexidine digluconate 7.1% dans les soins ombilicaux, (iv) adoption des normes, directives et du guides d'utilisation de l'amoxicilline comprimé dispersible 250 mg, du sulfate de magnésium, des préservatifs féminins et du dexamethasone en RDC. »<br>• « Au cours de l'atelier préparatoire de la vulgarisation des normes et directives, 20 superviseurs centraux ont été briefés sur l'utilisation des documents ces normes et directives ainsi que leurs annexes et sur les modalités d'application de ces normes et directive. A cette occasion des manuels destinés aux formateurs et utilisateurs des documents normatifs SMNE, une mallette pédagogique et un paquet logistique ont été constitués pour chaque vulgarisateur. Chaque mallette contient : (I) Un guide du vulgarisateur ; (II) 8 volumes des normes et directives SMNE ; (III) l'addendum ; (IV) le partogramme ; (V) un carnet de santé de l'enfant de 0 à 5 ans fille et garçon ; (VI) document des normes et directives d'utilisation de la chlorhexidine digluconate 7,1%, de l'ocytocine et du misoprostol 200µg et son guide d'utilisation ; (VII) document des normes et directives d'utilisation du préservatif féminin, du sulfate de magnésium, du gluconate | DRC H4+ JPCS annual report 2015. (H4+ Canada 2016: 3-4) |

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| | de calcium, de la dexamethasone et de l'amoxicilline comprimé dispersible 250mg et son guide d'utilisation ; (VIII) des outils de surveillance des décès maternels ; (IX) un document des normes et directives de la lutte contre les maladies diarrhéiques en RDC et fiches techniques pour la prise en charge de la diarrhée chez l'enfant de moins de 5 ans ; (X) des fiches techniques de lutte contre les IRA en RDC ; (XI) un document des standards des services de santé adaptés aux adolescents et jeunes ; (XII) un guide thérapeutique au niveau de l'hôpital général de référence (HGR). | |
| 2 | The **midwife curriculum** was officially adopted by a ministerial decree and midwifery was recognised as a separate professional category by the human resources for health committee of the MoH. H4+ JPCS also supported the development of a curriculum to upgrade nurse-midwives to midwives. | H4+ JCPS Global Technical Team (2016). La fortification de la formation initiale pour les services d'accouchement pour augmenter l'assistance qualifiée des accouchements dans 10 pays du H6 Joint Programme Intervention (L'amélioration de la qualité de la formation initiale des sages-femmes). (H4+ Global Technical Team 2016c: 10-12) |
| 3 | H4+ members participated in the development of the national family planning strategy 2014-2020 (2014) and contributed to its diffusion and distribution in 2015. | DRC H4+ JPCS annual report 2015. (H4+ Canada 2016: 6) |
| 4 | *« La révision des outils de SIMR (Surveillance Intégrée des Maladies et Riposte) intégrant les décès maternels dans la liste des maladies et évènements à déclaration obligatoire. »* | DRC H4+ JPCS annual report 2014, p. 6. (H4+ Canada 2015: 6) |
| 5 | *« Cadre de surveillance et riposte des **décès maternels** : des progrès ont été observes au niveau du pays dans le cadre de la surveillance de décès maternels. La direction de surveillance de la maladie, ayant obtenu l'appui, a pu intégrer le décès maternel dans les supports de surveillance de maladie à potentiels epidémique. Désomais le décès maternel est un évenements à declaration obligatoire. Les supports élaborés sont entrain d'etre vulgarisé progressivement. En ce jour, plus de 40% des zones de santé du pays notifient systématiquement et hebdomadairement le cas de décès maternels. »* | DRC H4+ JPCS annual report 2015, p. 12. (H4+ Canada 2016: 12) |
| 6 | H4+ JPCS support to **governance and leadership** in 2014 :<br>• *« Le plaidoyer pour le repositionnement de la planification familiale et l'adoption de la loi de santé de la reproduction a continué en 2014. La loi a été présentée au Parlement et envoyé à la Cour Constitutionnelle pour décider de son caractère législatif ou non. Des séances de sensibilisation ont été organisées pour expliquer l'importance de cette loi.(…)* | DRC H4+ JPCS annual report 2014. (H4+ Canada 2015: 5) |

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| | • *Appui à l'élaboration des comptes nationaux de santé pour renforcer la redevabilité des autorités politico-administratives dans le secteur santé.*<br>• *L'élaboration des normes et directives sur la SMNE y compris les directives sur la surveillance de décès maternelles et riposte (SDMR). »* | |
| 7 | • H4+ supported the revision of **RMNCAH norms and guidelines** and job aids *('fiches techniques')* for service providers, including:<br>• <u>2012</u><br>- Volume 1: Soins obstetricaux essentiels<br>- Volume 2: Soins obstetricaux d'urgence<br>- Volume 3 : Soins essentiels et d'urgence au nouveau-né<br>- Volume 4 : Interventions de santé de l'enfant<br>- Volume 5 : Interventions de santé adaptées aux adolescents et jeunes<br>- Volume 6 : Interventions de la planification familiale<br>- Volume 7 : Prise en charge des survivants des violences sexuelles<br>- Volume 8 : Interventions à base communautaire pour la santé de la mère, du nouveau-né et de l'enfant<br>• <u>2015 :</u><br>- Mise à jour dans l'édition 2012 :<br>- du document des normes et directives de la zone de sante relatives aux interventions intégrées de sante de la mère, du nouveau-né et de l'enfant,<br>- du carnet de sante de l'enfant de 0 à 5 ans, fille ou garçon et<br>- du partogramme<br>- Plan de vulgarisation des documents normatifs SMNEA<br>- Guide du vulgarisateur de documents normatifs SMNE<br>- Guide d'utilisation du préservatif féminin, du sulphate de magnesium, du gluconate de calcium, de l'amoxicilline comprimes dispersible, de la dexamethasone.<br>- Guide d'utilisation de la **chlorhexidine digluconate, de l'ocytocine et du misoprostol** | MoH (2015). Normes de la Zone de Santé Relatives aux Interventions Integrees de Santé de la Mere, du Nouveau-Né et de l'Enfant en Republique Democratique du Congo. Volume 1-8. Ministère de la Santé Publique (MoH 2015b) |

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| | - Normes et directives d'utilisation de la chlorhexidine, de l'ocytocyne et du misoprostol<br>- Normes et directives d'utilisation du préservatif féminin, du sulphate de magnesium, du gluconate de calcium, de l'amoxicilline comprimes dispersible, de la dexamethasone.<br>- Several job aids (fiches techniques) in different areas. | |
| 8 | H4+ members supported the MoH to develop the new PNDS 2016-2011 | Interview, H4+ country team member |
| 9 | • *« **Repositionnement de la Planification Familiale (PF) :** Le plan stratégique national à vision multisectoriel 2014-2020 a été élaboré et validé.*<br>• *Pour améliorer l'environnement juridique, un projet de loi sur la santé de la reproduction a été présenté au Parlement. Ce dernier l'a envoyé à la Cour Constitutionnelle pour décider de son caractère législatif ou non. . La mobilisation sociale pour éclaircir l'opinion sur l'importance de cette loi a été menée et continue dans différents secteurs de la vie nationale.*<br>• *Les normes et directives ont été mise à jour, en particulier : (a) les directives sur la surveillance des décès maternels et riposte (SDMR) ; (b) les directives sur l'utilisation de l'Amoxicilline comprimé dispersible, de la Chlorhexidine di-gluconate 7,1%, du misoprostol, contraceptif d'urgence et condom féminin ; (c) ainsi que les normes et directives de la zone de santé relatives aux interventions intégrées de la mère, du nouveau-né et de l'enfant y compris des outils clé et fiches techniques connexes.*<br>• ***Comptes nationaux de santé :** Appui à l'élaboration des comptes nationaux de santé pour renforcer la redevabilité des autorités politico-administratives pour le secteur santé.* | DRC H4+ JPCS annual report 2014. (H4+ Canada 2015: 11) |
| 10 | The H4+ Canada programme funded several studies, including the mapping of adolescents vulnerabilities and the EmONC survey, which generated important evidence that has supported/underpinned advocacy efforts. The adolescent vulnerability mapping study also informed the National Strategy for Adolescent Health 2016-2020 and sensitization campaigns targeting youth. | Interview, senior official in MoH in Kinshasa |
| 11 | H4+ JPCS contribution to heath reforms and policy:<br>• Preparation of policies and strategies (CAO 4&5, FP, Nutrition, HIV, Investment Case, etc.)<br>• National Health Development Plan 2016-2020<br>• Contrat Unique (Single Contract) at provincial level<br>• MoH Human Resources Commission validated a Ministerial Degree creating a professional cadre called Midwives in MoH | DRC presentation at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 12) |

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| 12 | H4+ JPCS contribution to advocacy and policy dialogue :<br>Alignment of partners to MDG4&5 Road Map<br>• Repositioning FP: 2.5 million USD to be disbursed by June 2016<br>• Task Force on Demographic Dividend<br>• Launching of Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)<br>• Government Project of Constructing & Equiping 200 hospitals and 1000 health centres.<br>• Reproductive/ FP Law | DRC presentation at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 26) |
| 13 | For evidence of UNICEF policy engagement with MoH to develop a national strategy for community participation refer to the matrix for question 4, assumption 4.4 | MoH (2016). La stratégie de développement de la participation communautaire en RDC. DRAFT. Kinshasa, June 2016. (MoH 2016a) |
| 14 | **Disponibilité de documents de protocoles à jour, politiques, guides, manuels de formation et de matériel d'IEC:** Nous notons que 82 pourcents des FOSA disposent des guides, normes et protocoles à jour, guides, manuels et de matériel d'IEC. Parmi ces protocoles et guides, certains n'ont pas été vulgarisés, et les modules de formation et de matériel en rapport avec la SMNE sont mieux connus par les uns que par les autres. La structure du centre Nsele en disposait moins que les autres structures visitées. | Summary of the evaluation team's health facility check list |
| 15 | • A travers l'initiative H4+, le PAM a largement contribué à l'élaboration de la nouvelle stratégie et politique nationale de la Prise en Charge de la Malnutrition Aigüe chez la femme enceinte et enfant et pouvoir améliorer la nutrition de la femme internée dans la maison d'attente.<br>• L'élaboration des protocoles de la prise en charge de la femme enceinte dans le domaine de la nutrition avec le gouvernement et l'adhésion de PAM à l'initiative H4+ influencent la politique national du pays. | Interview, H4+ country team member |
| 16 | *« le RMNCH Trust Fund de la commission des Nations Unies pour les 13 médicaments vitaux (…) ont permis de reproduire un lot de 8960 exemplaires des documents des normes et directives SMNE destinés à être vulgarisés à différents niveaux de la pyramide sanitaire.»* | MoH (2015). Plan de la croisade de vulgarisation des documents normatifs SM (MoH 2015c: 2) |
| **Assumption 6.2:** | | |

| *By providing targeted funding for global activities (and funding the coordinating office) H4+ JPCS programme funding facilitated the development of knowledge products and joint, coordinated advocacy in RMNCH by H4+ agencies which would not have otherwise been undertaken.* | | |
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| | **Information/data** | **Information source** |
| 17 | **Global knowledge products identified which can be linked to policy and advocacy outouts described under assumption 6.1.:**<br>• Toolkit for RMNCH strategic planning, implementation, monitoring and review (WHO, 2012)<br>• RMNCH policy compendium developed (WHO, 2013)<br>• Technical guidelines for maternal death surveillance and response (WHO 2013)<br>• MDSR implementation monitoring tool drafted (WHO 2014)<br>• Compilation of WHO recommendations on MNCAH (WHO, 2013)<br>• Development of the list of essential life-saving commodities/equipment for MCH/family planning by the UN Commission on Life Saving Commodities with H4+ input (UNICEF 2013<br>• MDSR sub-regional workshops (WHO 2014)<br>• Feasibility of indicators of Quality of Care for MNCH care in facilities tested in DRC, Chad, Tanzania, Zambia and Zimbabwe (WHO 2015)<br>• Midwifery Services Framework developed and CHW RMNCH training guidelines (UNFPA 2014)<br>• RMNH training guidelines developed. A mapping of existing training tools for CHWs in SRH/MNH (UNFPA 2013)<br>• Core competencies for adolescent health and development for health care providers in primary care settings published (UNFPA 2015)<br>• Template for documenting innovations (UNFPA 2015)<br>• Use of amoxicillin for treatment of pneumonia (WHO 2015)<br>• Development and release of the State of the World's Midwives Yearly report in June 2014 (WHO 2014) | H4+ Global Coordinator (2016). RMNCH Global Knowledge Products an Global Public Goods (2011-2015), June 2016. (H4+ 2016) |

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| 18 | • In 2014, WHO provided support to countries to strengthen use of chlorexhidrine (Pakistan, Sierra Leone, Ethiopia, Liberia, **DRC,** Malawi, Bangladesh, Kenya, and Nigeria<br>• In 2014, WHO organized a MDSR sub-regional workshop held in Libreville for eight countries - AFRO/CA (Angola, Burundi, Cameroon, Chad, Congo, Gabon, **DRC,** Sao Tome and Principe | H4+ Global Coordinator (2016). RMNCH Global Knowledge Products an Global Public Goods (2011-2015), June 2016 (H4 2016) (H4+ 2016) |
| 19 | H4+ members noted in interviews that headquarters had shared several global knowledge products (strategies, guidelines, training manuals, and tools) with them. Some of them mentioned specific documents (WHO guidelines for community health funds, UNFPA for participation in regional MDSR training workshop.<br>• See assumption 4.1. (tapping into technical expertise) for specific examples and reference to documents and interviews | Interviews, H4+ country team member |
| 20 | • H4+ members and MoH staff participate in inter-country workshops during which they received technical guidance in the implementation of midwife training:<br>- *« La Participation à l'atelier inter-pays sur l'amélioration de la qualité de la formation des sages-femmes à Abidjan a donné des nouvelles orientations pour la qualité du système éducatif des sages-femmes en RDC. »*<br>- *« L'atelier de Libreville sur l'analyse de Gaps de la pratique de sage-femme ou a participé une forte équipe de la RDC a permis d'élaborer le plan stratégique pour combler les Gaps de trois piliers de la pratique sage-femme."* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 9) |
| 21 | The 2011-2012 annual work plan contains an activity to launch the The State of the World's Midwifery (SoWMy) global report as part of advocacy efforts to increase political support for the introduction of an official midwife training programme in DRC. | DRC H4+ annual work plan 2011-2012. (H4+ Canada 2010a: 11) |

**Assumption 6.3**

*H4+ partners, assisted by programme funding, were able to be **more effective in advocating for commitments to Global Strategy principles and priorities** than they would have been without programme support. Their communications and advocacy work was made more consistent through collaboration on common products.*

| Information/data | Information source |
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| 22 | *« Le paidoyer (…) avait consisté à organiser les réunions ou rencontres d'informations avec des données de santé et des arguments solides pour influencer les décideurs, les dirigeants politiques et les personnes influentes de la communauté. Ce processus a été très utile pour obtenir un engagement d'un leadership politique en faveur de la mise en oeuvre des activités de santé de la reproduction. Aujourd'hui il existe une task force dividende démographique logée au niveau de la primature de la république avec comme l'une de stratégies clés la planification familiale qu'il finance de plus en plus. Le gouvernement a placé la santé materno-infatile comme une stratégie dans son effort vers la couverture universelle*. » | DRC H4+ JPCS annual report 2015. (H4+ Canada 2016: 20) |
| 23 | *"In the Democratic Republic of the Congo (DRC), with the support of H4+ advocacy, a component to reduce maternal and infant mortality was included in the National Health Development Plan 2011-2015; the government allocated funds for contraceptives, medical equipment, materials and the infrastructure of 198 hospitals and 1,320 health centres."* | H4+ Global Technical Team (2014). The H4+ partnership Joint support to improve women's and children's health. (H4+ Global Technical Team 2014b: 6) |
| 24 | *"H4+ advocacy also resulted in (…) the DRC Ministry of Higher Education established a three-year, direct-entry Midwives Education Programme."* | H4+ Global Technical Team (2014). The H4+ partnership Joint support to improve women's and children's health. (H4+ Global Technical Team 2014b: 4-5) |
| 25 | *"In DRC, provincial governments pledged to increase resources for MNCH through a budget line, which has already been included in the 2014 Bandundu provincial budget."* | *H4+ Global Technical Team (2014). Canada Annual Narrative Progress Report 2013. June 2014.* (H4+ Global Technical Team 2014a : 63) |
| 26 | • *Appropriation par le gouvernement ( SM 2.0, Task force Dividende Demographique, Groupe multisectoriel nutrition,)*<br>• *PF et Nutrition /GFF*<br>• *CARMMA (National /1ere Dame et provinciaux)*<br>• *Projet lois SR*<br>• *Repositionnement de la PF*<br>• *Mobilisation de ressources*<br>• *Conférence pour le repositionnement de la nutrition comme priorité de développement du Sud Kivu* | H6 Power Point presentation to evaluation team during ERG meeting 8 August 2016 (H6 2016: slide 30) |

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| 27 | H4+ JPCS enabled H4+ members to mobilise additional funds for RMNCAH in DRC:<br>• Mobilisation de ressources pour la SMNE<br>• RMNCH: 26 000 000 USD<br>• Fond achat contraceptifs: 2 500 000 USD<br>• Cadre d'investissement /GFF | H6 Power Point presentation to evaluation team during ERG meeting 8 August 2016. (H6 2016: slide 20) |
| 28 | H4+ *"changed the way of developing the PNDS"* and had significant influence on the PNDS 2016-2020: PNDS 2011-2016 was too focused on HSS, but H4+ agencies advocated for a stronger focus on the core health problems and on RMNCAH. H4+ has advocated for a stronger RMNCAH focus through many meetings and platforms: *"Dans toutes les forums, on a passé le message [RMNCAH]."* | Interview, H4+ country team member |
| 29 | *« C'est grâce à cette initiative [H4+ JPCS] de travailler ensemble que nous avons obtenu le financement dans le cadre d'EWK. Ils nous ont donné 3.5 millions pour faire beaucoup de choses. (…) Il y a eu une grande délégation venue du monde entier pour une grande réunion et c'était sous la houlette de H4+. Plus tard, ils ont envoyé une autre délégation venant de New-York conduite par Dr Boniface pour travailler avec nous pour un autre cadre de financement et c'est sous la houlette de H4+. Cela nous a permis de préparer le cadre de financement des activités des inséminés. Ils sont venus au nom de H4+».* | Interview, senior official in MoH in Kinshasa |
| 30 | Engagement des partenaires au Cadre d'Accélération des Objectifs du Millénaire pour le Développement 4 et 5 (CAO 4 & 5) : Le processus d'engagements des partenaires a été finalisé lors de la missions conjointes des représentants des agences H4+ et USAID en République Démocratique du Congo, en février 2014. Au cours de cette mission une analyse situationnelle a été faite et le processus d'engagement des partenaires au CAO 4 & 5 a été facilité. A l'issue de cette mission, les intervenants dans le secteur de la Santé se sont engagés à s'aligner à la stratégie nationale définie dans le Cadre d'Accélération des Objectifs du Millénaire pour le Développement 4 et 5 et une feuille de route a été élaborée par le Gouvernement appuyé par les Agences H4+. Cette feuille de route a permis de mobiliser 15 millions USD auprès de RMNCH (Reproductive, Maternal, Newborn and Child Health) Trust Fund. | DRC H4+ Annual Report 2014. (H4+ Canada 2015: 10) |
| 31 | • A meeting of the CPN-SS (around 2012-2013) was focused on SRMNE. During this meeting, the H4+ members presented the H4+ approach and the MoH asked other partners to align themselves to this approach.<br>• H4+ has helped the government raise other funds for RMNCH, for example from USAID. | Interview, senior official in MoH in Kinshasa |

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| 32 | • "Thanks to the H4+ initiative, we have received a fund from the RMNCH Trust Fund (3.5 million)."<br>• UNICEF funded the visits to the provinces to distribute the CAO 4&5MDG road map and to conduct advocacy with the governors. This was done with H4+ funds.<br>• The H4+ joint programme was catalytic in the sense of improved collaboration. It gave us the RMNCH Trust Fund - and now also the H6 and the GFF financing. | Interview, senior official in MoH in Kinshasa |
| 33 | • The H4+ Canada funds helped strengthen the collaboration between agencies<br>• It also improved our collaboration with other partners (more credibility due to ability to demonstrate results) and the dialogue on RMNCAH in general created credibility<br>• H4+ members are associated and invited to provide input on new RMNCAH projects, for example Save the Children signature project | Interview, H4+ country team member |
| 34 | • Le H4+ *« a permis d'avoir une position commune pour animer les mécanismes partenaires et que GIBS le donateur, c'est dire cela nous permis d'avoir un seul but et de savoir quand on est au niveau des partenaires, c'est des positions que nous défendons et la priorité de santé mère et enfant et la lutte contre des différentes formes de morbidité et de mortalité. Donc ce sont des questions qui étaient abordées. La même manière aussi, ce mécanisme a influencé beaucoup le PNDS (Plan National de Développement Sanitaire) qui a été évalué et actualisé. L'influence est dans la fluctuation des priorités parce que, quand vous prenez l'anscien PNDS, [il contenait trop de priorités à la fois]. Avant, il n'y avait pas de consensus lorsqu'il s'agit de la santé mère, maternelle, néonatale et infantile. Nous pensons que c'est un résultat très important."* | Interview, H4+ country team member |
| 35 | • H4+ has allowed the agencies to improve coordination and joint advocacy efforts to raise further funds for RMNCAH.<br>• For example, the H4+ has enabled the agencies to strengthen advocacy for RMNCAH through the GIBS, i.e. to influence other members of the GIBS to fund RMNCAH and to ensure synergies between the different interventions and partners: *« Le H4+ a permis aux agencies d'influencer les autres partenaires à travers le GIBS pour qu'ils s'investissent dans la SRMNE ».* This was facilitated by the fact that UNICEF was the lead agencies for the GIBS during two years, which strengthened its ability to influence other donors/partners. The H4+ agencies also influence other partners and the government through the technical committees (sous-commissions) of the National Health Sector Coordinating Committee (CNP-SS). | Interview, H4+ country team member |

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| | • The H4+ partnership has enabled the H4+ agencies to be more efficient in their advocacy efforts, which has led to the mobilization of additional resources for RMNCAH. So the H4+ has had catalytic effects at a broader, national level by raising additional funds.An example of this is that it was decided at the last H6 meeting that the Representatives of the H4+ agencies should try to influence the government to use the new Chinese funds for RMNCH.<br>• Another example of efficient coordination (in a broader perspective beyond H4+) is the MoU signed between the World Bank, UNICEF and the Global Fund which aims to create synergies and avoid duplication of interventions and support in Bandundu and Equateur provinces. | |
| 36 | *« L'UNFPA et le H4+ ont contribué beaucoup pour la visibilité de la sage-femme. Dans le temps, on ne parlait pas de l'accoucheuse, c'était une profession méconnue, une profession abandonnée. (…) L'UNFPA a valorisé l'association avec les cérémonies de sages-femmes et des formations à gauche et à droite. Le H4+ a fait prendre même au gouvernement la conscience qu'il faut investir dans la sage-femme si on veut lutter contre la mortalité maternelle et infantile. »* | Interview, implementing partner (NGO) |
| 37 | « A travers le plaidoyer [H4+ JPCS], le Gouvernement a créé une ligne budgétaire pour l'achat des contraceptifs en 2014. Le Gouvernement a mis en place un projet avec les fonds pour la construction et équipements des 200 hôpitaux de référence et 1000 centre de santé (Programme d'Equipement des Structures Sanitaires –PESS). » | H4+ Country Team (2015). *H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+.* (H4+ Country Team 2015b: 8) |
| 38 | « Le H4+ joue un rôle important au sein du groupe inter-bailleurs sante (GIBS) à travers la mobilisation des partenaires GIBS pour appuyer le Cadre d'Accélération des OMDs 4 et 5. Les points discutés dans les réunions des Chefs d'Agences H4+ sont mis dans l'agenda du GIBS pour mobiliser les autres partenaires. Au cours de ces réunions, sont aussi discutées des opportunités de collaboration et complémentarité entre les intervenants en SMNE et l'initiative H4+. » | H4+ Country Team (2015). *H4+ Accélération du progrès pour la Réduction de la Morbidité et Mortalité Maternelle, Néonatale et Infantile (OMD 4 et 5). Plan du Travail 2015-2016 Canada H4+.* (H4+ Country Team 2015b: 8) |
| 39 | A H4+ member noted that the advent of the H4+JPCS had helped the agencies become more effective and coordinated in their advocacy efforts with regard to RMNCAH *« J'ai pour mémoire l'engagement signé par le Premier Ministre un moment donné pour renouveler l'engagement de la République en ce qui concerne la santé maternelle, néonatale et infantile. Et ce sont les mêmes chefs d'agences, qui font partis du groupe H4+, qui ont [réussit] ces actions de plaidoyer»* | Interview, H4+ country team member |

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| 40 | H4+ partners' joint advocacy efforts led to increased political support and government commitment to RMNCAH :<br><u>2012:</u><br>• *"1. Parliamentarians sensitized to allocate more resources for MH at the provincial level.*<br>• *2. Supported the development of a framework for accelerating the reduction of maternal and infant mortality".*<br><u>2013:</u><br>• *"1. A component to reduce maternal and infant mortality was included in the National D4Health Development Plan*<br>• *H4+ Canada advocacy resulting in government commitments of US $300,000 for contraceptives and US $66 million for medical equipment beyond programme areas to strengthen the health system."*<br><u>2014:</u><br>• *"1. Provided technical support for the development of a roadmap to accelerate progress towards MDGs 4 and 5 (US$15 million were mobilized by the government to finance this roadmap).*<br>• *2. Supported the development of the Reproductive Health Law, including the strengthening of family planning. H4+ has also been involved in the advocacy for the adoption of the law, which has already been presented to the parliament and is under review by the constitutional court.*<br>• *3. Supported the development of national health accounts to increase the accountability of government and administration for health.*<br>• *4. Supported the development of RMNCH norms and standards, including on MDSR."*<br><u>2015:</u><br>• *« 1. Engagement de la RDC à la stratégie mondiale 2.0*<br>• *2. Engagement fort au plus haut niveau du gouvernement sur le repositionnement de la planification familiale*<br>• *3. Le plan stratégique de la planification familiale finalisé en 2014*<br>• *4. Plan de cadre d'investiment de GFF et stratégie de financement à long terme »* | H4+ Global Technical Team (2016). DRC 2011-2015 Key Achievements, internal document (Excel sheet). (H4+ Global Technical Team 2016b) |

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| 41 | • "Engagement de la RDC à la stratégie mondiale 2.0 : la RDC s'est engagée à la stratégie mondiale pour la santé des femmes, des enfants et des adolescents. Cet engagement s'est plus focalisé sur (i) la réduction sensible de décès évitables des femmes, des nouveaunés et des enfants, (ii) l'augmentation de dépense de la santé qui doit passer de 5% à 15% d'ici 2020, et (iii) le repositionnement de la planification familiale. C'est dans ce cadre que le gouvernement de la RDC a déboursé 2.500.000 USD pour l'achat de contraceptifs en vue d'augmenter la disponibilité l'offre de services de la planification familiale.<br>• Engagement fort au plus haut niveau du gouvernement sur le repositionnement de la planification familiale: Le 1er Ministre de la RDC a présenté personnellement la vision Planning familiale 2030 de la RDC à la 4ème Conférence internationale sur la planification familiale Indonésie. Cette vision qui place la planification familiale comme une des stratégies clés pour amener les pays à tirer le dividende démographique (…) d'ici 2030." | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 6) |
| 42 | • *"Les activités de la CARMMA lancée en 2013 continue à être menées dans les trois provinces. Suite de la CARMMA : la CARMMA lancée en Province en 2013, continue à porter ses fruits car tous les partenaires s'alignent aux priorités gouvernementales (Cadre d'Accélération des OMDs 4 & 5) et le Gouvernement Central appui également la construction des centres de santé, maternités et surtout les équipements.*<br>• *Médicaments au niveau des zones de santé, cas de la zone de santé de Bandundu ; le Gouvernement Provincial a quant à lui doter quelques centres en matériels (appareils d'Echographie).*<br>• *Un autre plaidoyer mené de haut niveau est mené par le H4+ a permis la réhabilitation et l'opérationnalisation du laboratoire au Katanga pour prendre en charge le diagnostic précoce du VIH chez les enfants nés exposés et les examens de la charge virale.*<br>• *Célébration de la journée internationale de Sages-Femmes a été un moment de plaidoyer très fort pour le renforcement de capacités de l'association de sages-femmes, l'accroissement de la couverture de l'intégration et de l'application de nouveaux curricula sur l'étendue du pays. "* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 17) |
| 43 | During the annual inter-agency retreat in January 2016, the H4+ country team identified four strategic objectives, of which one of then was to continue to support the government in RMNCH policy and strategy development, as well as mobilizing funds: *"assurer un appui au Gouvernement dans l'élaboration/révision des documents stratégiques : Investment Plan de la RDC 2016-2020 pour le GFF, Plan du Financement de la santé à longue terme, Plan National du Développement Sanitaire* | DRC H4+ Annual Report 2015. (H4+ Canada 2016: 19) |

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| | *(PNDS), Revue du Plan National ETME, Plan National Stratégique de la Nutrition etc.. Suivi des projets conjoint (Canadien, Muskoka, RMNCH ….), l'agenda post 2015(ODD) etc.* | |
| 44 | "Provincial Governments of Bas Congo and Bandundu created a budget line for RMNCH." | Canada / H4+ Collaboration (2015): Accelerating Progress in Maternal & Child Health. Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 5) |
| 45 | Joint H4+ JPCS advocacy efforts in 2013 led to increased government commitments to increase budget for RMNCAH : *« Suite au plaidoyer fait auprès du Gouvernement pour l'appropriation des interventions de la santé, le Gouvernement a alloué pour la première fois depuis de nombreuses années, un montant de 300.000$Us pour l'achat des contraceptifs et plus de 66 millions de $US pour achat des équipements et matériels médicaux pour 66 Zones de Santé. A cela s'ajoute la mise à disposition des fonds par le Gouvernement pour la réhabilitation/constructions des 198 Hôpitaux généraux de références et 1320 centres de santé de référence"* | DRC H+4 Annual Report 2013. (H4+ Canada 2014a: 11) |
| 46 | ***Key Achievements: Communication and Advocacy***<br>• *"Advocacy and policy dialogue*<br>• *Alignment of partners to MDG 4&5 Road Map*<br>• *Repositioning FP: 2.5 million USD to be disbursed by June 2016*<br>• *Task Force on Demographic Dividend*<br>• *Launching of CARMMA*<br>• *Government Project of Constructing & Equiping 200 hospitals and 1000 health centres.*<br>• *Reproductive/ FP Law*<br>• *UN SG Global Strategy 2.0*<br>• *SUN (Scaling Up Nutrition) Movement*<br>• *Signature indicator*<br>• *All the targeted 9 health zones have social mobilisation programmes with a Road Map developed after launching CARMMA*<br>• *2 Provincial Gov'ts set up budget lines for RMNCH "* | Canada / H4+ Collaboration (2015). *Accelerating Progress in Maternal & Child Health.* Presentation given at inter-country meeting in Douala. (Canada/H4+ Collaboration 2015: slide 26) |

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| 47 | *"The mission has been very successful in bringing together, with support from the H4+, various partners behind the government's MDG acceleration framework for women's and children's health. Specifically, partners aligned behind the basic package of services that will be introduced in all health districts of the country, including the regions that so far didn't have any support from donor partners."* | H4+ DEDS Monthly Teleconference, Thursday, 27 February 2014, p. 1 |
| 48 | H4+ inter-agency meetings discussed joint advocacy strategies and how to integrate the objectives of other RMNCAH initiatives in their advocacy plan (A Renewed Promise, HeforShe, Every Women Every Child etc.) "Les actions des plaidoyers de H4+ devront prendre en compte toutes les initiatives lancées sur la SMNE, les jeunes, le VIH ». | Compte rendu de la réunion H4+ 10/12/2014. (H4+ Agencies 2014a: 2) |

**Assumption 6.4**

*Where H4+ JPCS has contributed to improvements in service quality and access for RMNCAH these have in turn made a contribution to positive outcomes in RMNCAH including the targeted operational outcomes of the Global Strategy and "Every Woman Every Child".*

| | **Information/data** | **Information source** |
|---|---|---|
| 49 | It has not really accelerated RMNCH until now, as there were many "left and right maneuvers", but it was a trial and error phase, the first important experiences which now allow us to start the acceleration (démarrer) | Interview, senior official in MoH in Kinshasa |
| 50 | • Oui le programme H4+ a contribué efficacement à l'accélérer le progrès en RSS et résultat SRMNE de cette manière :<br>• Améliorer la qualité de la prise en charge des enfants et femmes enceintes à travers la distribution des kits familiaux, au renforcement des capacités des prestataires en SONUB et C, PF, à rendre disponible les 13 médicaments qui sauvent la femme et l'enfant , ceci conduit à l' amélioration de l'utilisation des services de soins et rendre accessible les soins aux plus démunis ;<br>• Effets catalytiques est de réunir les différents intervenant autours de la même table pour discuter ensemble le problème de la santé, à redynamiser le plateforme SRMNE et planifier, à organiser ensemble la campagne de sensibilisation de programme de l'élimination du goulot d'étranglement de l'accessibilité aux 13 médicaments qui sauvent la vie;<br>• De rendre la coordination de l'intervention effective | Interview, implementing partner (NGO) |
| 51 | **How did H4+ contribute to health systems strengthening?** | Interview, senior official in MoH in Kinshasa |

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| | • Collaborative spirit among the agencies<br>• The EmONC baseline survey provided an evidence base that the MoH often uses and refers to<br>• The RMNCH norms and standards which fosters harmonization in practice<br>• GAPA – teaching methods based on practice<br>• EmONC didactical materials<br>• Strategic changes: PTME approach from A to Option B+<br>• "All that strengthenes the system"<br>• At operational level: Equipment, drugs and capacity development | |

## ANNEX 2 VOCABULARY OF MEDICAL TERMS USED IN THE REPORT

| Medical terms used in the report | |
|---|---|
| BEmONC | Basic emergency obstetric and newborn care (BEmONC) is defined as seven essential medical interventions, or 'signal functions,' that treat the major causes of maternal and newborn morbidity and mortality and should be available as close to the community as possible. These signal functions include antibiotics to prevent puerperal infection; anticonvulsants for treatment of eclampsia and preeclampsia; uterotonic drugs (e.g., oxytoxics) administered for postpartum hemorrhage; manual removal of the placenta; assisted vaginal delivery; removal of retained products of conception; and neonatal resuscitation. |
| CEmONC | Comprehensive emergency obstetric and newborn care (CEmONC) includes all the signal functions of BEmONC plus blood transfusions, surgery (e.g., caesarean section), and advanced neonatal resuscitation. The skills, equipment and conditions for these functions should be made available at the referral level such as a district hospital. |
| EmONC | Emergency obstetric and neonatal care is a package of services provided to the mother-baby couple that includes urgent services to prevent maternal death (e.g., access to essential pharmaceuticals, including antibiotics, anticonvulsants, and uterotonics) and a life saving measures for newborns (e.g., clean cord care and neonatal resuscitation). |
| Fistula | A childbirth injury. An obstetric fistula is a hole between the vagina and rectum or bladder that is caused by prolonged obstructed labour, leaving a woman incontinent of urine or faeces or both. |
| Infant mortality | The death of a child between one and twelve completed months of life. |
| Mama Pack/ Mama Kit | A collection of useful baby things like a receiving blanket, a diaper, Vaseline, a bathing basin and a wrap. Mama packs were given to women in Liberia, Zambia and elsewhere after they attended antenatal care, a skilled delivery and a postnatal visit. |
| Maternal death | The death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes. |
| MDSR/ MNDSR | Maternal Death Surveillance and Response/ Maternal and Neonatal Death Surveillance and Response: A continuous action and surveillance cycle of identification, quantification, notification and review of maternal deaths followed by the interpretation of the aggregated information on the findings and the avoidability of the maternal deaths which is the used for recommended actions that will prevent future deaths. The primary goal of MDSR/ MNDSR is reducing future preventable maternal (and neonatal) deaths. |
| Micronutrients | Micronutrients are nutrients required by organisms throughout life in small quantities to orchestrate a range of physiological functions |
| Misoprostol | Used to induce the uterus to contract and thus to control post-partum haemorrhage or initiate labour. Misoprostol is on the WHO Essential Medicines List. |
| Neonatal death | The death of an infant during the first month of life. |
| ORS/Zinc | The internationally recommended way to treat childhood diarrhoea is to start with zinc and oral rehydration salts (ORS). Together, Zinc+ORS are proven to stop diarrhoea, restore strength, and even save lives. |

# ANNEX 3 FINANCIAL PROFILE OF H4+ JPCS IN THE DRC

**Table 7: H4+JPCS Expenditures in the Democratic Republic of the Congo**

| US$ | 2011 | 2012 | 2013 | 2014 | 2015 | Total | % |
|---|---|---|---|---|---|---|---|
| UNFPA | 4,603 | 775,901 | 642,797 | 681,552 | 1,171,329 | 3,276,182 | 37% |
| UNICEF | 0 | 633,548 | 737,719 | 940,104 | 432,318 | 2,743,689 | 31% |
| WHO | 0 | 444,616 | 1,016,706 | 892,412 | 538,311 | 2,892,045 | 32% |
| TOTAL US$ | 4,603 | 1,854,065 | 2,397,222 | 2,514,067 | 2,141,958 | 8,911,916 | 100% |

**Figure 8: H4+JPCS Expenditures by Year and Agency in the Democratic Republic of the Congo**

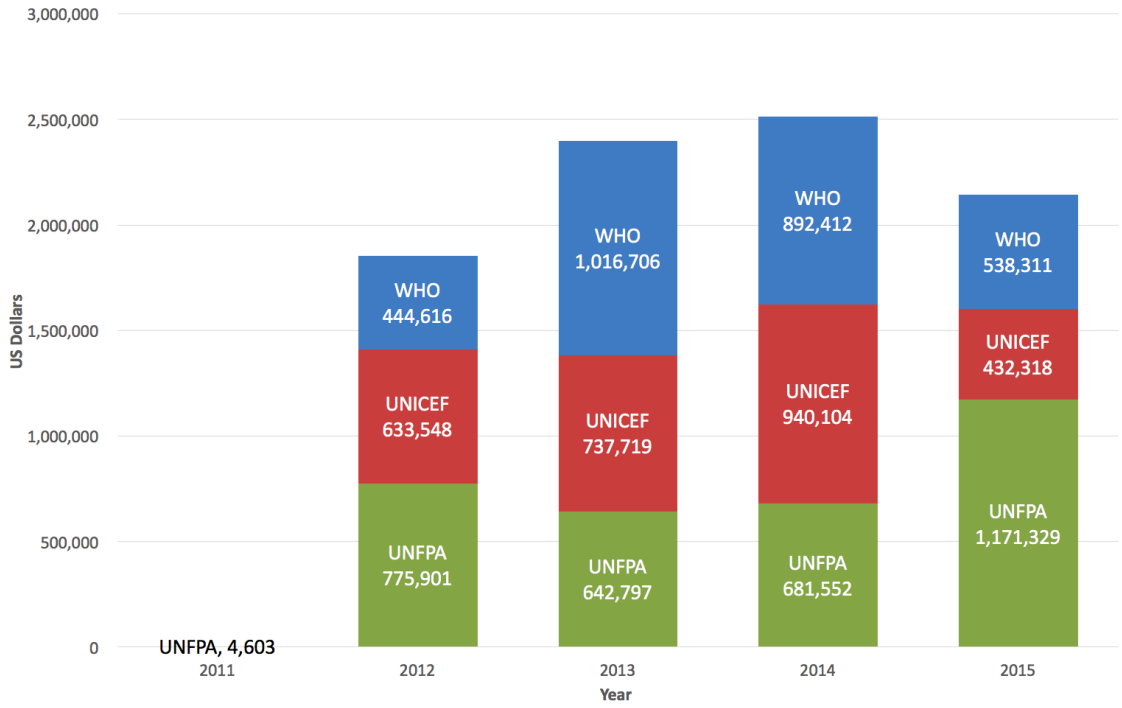
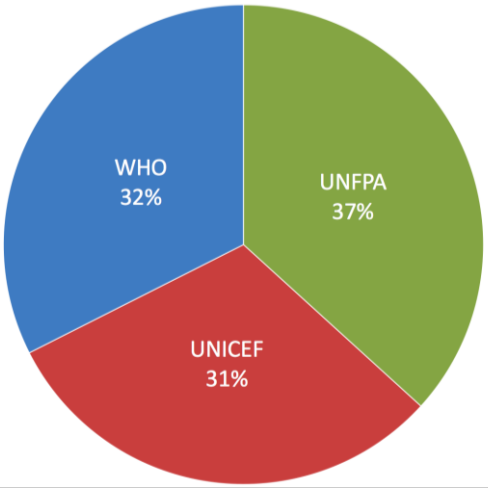



**Figure 9: H4+JPCS Expenditures in the Democratic Republic of the Congo: 2011-2015**




*Source*: (UNFPA 2016c)

# ANNEX 4 OUTCOMES OF RMNCAH

## Democratic Republic of the Congo

### Table 1: Basic info

| | | |
|---|---|---|
| **Country income level** | Low-income | |
| **Population 2014** | 74.9 million | (World Bank 2016i) |
| **Literacy rate 2012** | 75.02% | (World Bank 2016i) |
| **Political/administrative system** | 10 provinces, 1 city province, 26 districts | |

### Table 2: Health Expenditures: 2010-2014

| Health Financing | Type | Share | Percent | Source |
|---|---|---|---|---|
| Health expenditure | Private | % of GDP, 2013 | 1.6% | (World Bank 2016d) |
| Total expenditure on health | Public | % of GDP, 2013 | 1.9% | (World Bank 2016e) |
| Out-of-pocket health expenditure | Public | % of THE, 2013 | 32.7% | (World Bank 2016h) |
| Out-of-pocket health expenditure | Private | % of PHE, 2013 | 69.8% | (World Bank 2016g) |

### Table 3: H4+JPCS Profiling Indicators 1990-2015

| Indicator | 1994 | 1999 | 2007 | 2010 | 2014 | Source |
|---|---|---|---|---|---|---|
| Demand for family planning satisfied, % women age 15-49 | - | - | 43% | 43% | 42% | (Countdown 2015a) |
| **Indicator** | **1992** | **2001** | **2004** | **2009** | **2011** | **Source** |
| Adolescent Fertility Rate, per 1,000, women age 15-19 | 125 | 117 | 127 | 135 | 135 | (Countdown 2015a) |
| **Indicator** | **1994** | **1999** | **2007** | **2011** | **2013** | **Source** |
| Teenage mothers, % women age 15-19 | ... | ... | 23.8% | ... | 27.2% | (World Bank 2016j) |
| **Indicator** | **1995** | **2000** | **2005** | **2010** | **2015** | **Source** |
| Maternal Mortality Ratio, per 100,000 live births | 914 | 874 | 787 | 794 | 693 | (Countdown 2015a) |
| Neo Natal Mortality Rate, per 1,000 live births | ... | ... | ... | ... | 30 | (Countdown 2015c) |
| Infant Mortality, per 1,000 live births | ... | ... | ... | ... | 75 | (Countdown 2015c) |
| Under Five Mortality, per 1,000 | 176.4 | 161 | 138.4 | 116.1 | 98.3 | (Countdown 2015a) |
| **Indicator** | **1991** | **2001** | **2007** | **2010** | **2014** | **Source** |
| Contraceptive Prevalence Rate, % aged 15-49 | 7.7% | 31.4% | 20.6% | 17.3% | 20.4% | (World Bank 2016c) |
| **Indicator** | **1995** | **2000** | **2007** | **2010** | **2014** | **Source** |
| Unmet need for contraception, % aged 15-49 | ... | ... | 26.9% | 24.2% | 27.7% | (World Bank 2016k) |
| **Indicator** | **1994** | **1999** | **2007** | **2010** | **2014** | **Source** |
| Antenatal care, rural, ≥ 4 visits, % | - | - | 47% | 45% | 48% | (Countdown 2015a) |
| **Indicator** | **2005** | **2009** | **2010** | **2012** | **2014** | **Source** |
| Percent of HIV+ pregnant women receiving ARVs for PMTCT | <1% | 1.4% | 7.8% | 12.4% | 46.8% | (Countdown 2015a) |
| *Lower bound* | <1% | 1.2% | 6.9% | 10.8% | 41.0% | |
| *Upper bound* | <1% | 1.6% | 9.0% | 14.2% | 53.7% | |
| **Indicator** | **1994** | **2001** | **2007** | **2010** | **2013** | **Source** |
| Skilled attendant at delivery, % | ... | 61% | 74% | 74% | 80% | (Countdown 2015a) |
| Postnatal care for baby, % | ... | ... | ... | ... | 8% | (Countdown 2015a) |
| Postnatal care for mother, % | ... | ... | ... | ... | 44% | (Countdown 2015a) |
| Exclusive breastfeeding (<6 months), % of babies age 0-5 m | 24% | 24% | 36% | 37% | 48% | (Countdown 2015a) |
| Facilities providing BEMoNC, number | ... | ... | ... | ... | 140[a] | (MSP 2015: 67) |
| Facilities providing CEMoNC, number | ... | ... | ... | ... | 47[b] | (MSP 2015: 73) |
| C Section Rate, % of live births, women age 15-49 | ... | ... | 4%7% | 7% | 5% | (Countdown 2015a) |
| **Indicator** | **1995** | **2000** | **2005** | **2010** | **2015** | **Source** |
| Community Health Workers, per 1,000 people | ... | ... | ... | ... | ... | (World Bank 2016b) |
| **Indicator** | **1995** | **2000** | **2004** | **2010** | **2015** | **Source** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Nurses and/or midwives, per 1,000 people | … | … | 0.53 | … | … | (World Bank 2016f) |

[a] 140 *soins obstétricaux d'urgence de base* (SOUB) (9%) of 1,555 health facilities in total
[b] 47 *soins obstétricaux complets* (SOUC) (3%) of 1,555 health facilities in total

## ANNEX 5 PEOPLE MET

| Name | Position | Institution |
|---|---|---|
| **KINSHASA** | | |
| Akawakow, Arthur, Mr | Chef de deivision MSP | D1 |
| Alladji, Osseni Yessifou | H4+ coordinator | UNAIDS |
| Badibanga, Patrice, Mr | Programme officer nutrition &VIH-TB | PAM |
| Biyanga, Eugene, Mr | M&E | ABF –ND |
| Bokoko, Dr Marie Jeanne | Conseillère Santé | Ambassade du Canada |
| Bolotsi, Nzee, Dr | Directeur /point focal UNFPA H4+ | ISTMKIN |
| Bukanga Lugezi, Celestin, AG | Cellule technique du FBR | Coordinateur |
| Chikuru, Albert, Mr | Directeur santé de la reproduction | PSI ASF |
| Dibinga, Fredy, Mr | ASS CP | Centre de jeunes BOMOTO |
| Elima, Carine, Ms | DAF | ABF-ND |
| Kabya, Ambroccha | Présidente | Association des sages femmes RDC |
| Kambala, Luhata | DIR CAB DG | ISTMKIN |
| Kantang , Yomuamua, Mr | Chef Clinique/ass D10/MSP | D10 |
| Kini Nsiku, Brigitte, Dr | Responsible for maternal, newborn , Children and adolescents | WHO |
| Kongnyuy, Eugene | Former coordinator H4+ in DRC | UNFPA |
| Kunduma, Maggy, Dr | NPOL SMNE/H6+ | UNFPA |
| Lukomba, Prof | Gyneco- obstétrique | UNIKIN/CUK |
| Makwam, Kabula | Assist principal DG | ISTM KIN |
| Mbila, Moise, Dr | Directeurexécutif | ABF |
| Mboko Iyeti, Alain, Dr | Directeur /MSP | DEP |
| Mboloko Esimo, Justin, Prof | Chef de service de Gynaecology | UNIKIN/CUK |
| Mbuyi, Marie Claude, Dr | Coordinatrice | Pathfinder |
| Mongo, Mpanzi | Logistique | ABF-ND |
| Muanda, Mbadu, Mr | Directeur/MSP | PNSA |
| Muela Difunda, Victor, Dr | Vice Président / chef de service HPGRK | SocietéCongolaise de G.O. |
| Mukumpani, Guy, Dr | Chef de division MSP | PNSR |
| Mulimbi, Jules, Dr | Programme Officer/SGBV | UN Women |
| Muvudi, Michel Dr | Chargé de RBF | Banque Mondiale |
| Ndaya, Rachel, Ms | Coordinatrice | RACOJ |
| Ngumbu Mabanza, Epiphane, Mr | Directeur /MSP | D1 |
| Ntwa Mbey, Modeste, | ASS/SGAC | ISTMKIN |
| Oyema, Hiombo, | DIR SAC | ISTMKIN |
| Salumu, Freddy, Dr | Health speculation | UNICEF |
| Seck, Awa Ndiaye | Représentante Résidente a.i. | UN Women |
| Shanga, Shama, AG | CT-FBR | CAF |
| Smard, Annie | 1ère Secrétaire de la Coopération Canadienne | Ambassade du Canada |

| | | |
|---|---|---|
| Timi Timi, Odon, Mr | Programme Associate Nutrition VIH | PAM |
| Tutu, Kalume, Dr | Directeur /MSP<br>Chef de service | D10 |
| Villeneuve, Susie, Dr | Spécialiste santé | UNICEF |
| **CENTRE COULYBALY 09/08/2016 A KINSHASA** | | |
| Buya, Mpemba | Chargé de la communication | COULIBALY |
| Kabasele, Steve, Mr. | Chargé d'EC/CCC | COULIBALY |
| Kalala, Trésor, Dr | Médecin | COULIBALY |
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| Cinkobu, Israël, Mr | I S | BCZS NSELE |
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| Landu | Chauffeur | BCZS NSELE |
| Lupaka, Fabien, Mr | DATA MANAGER | BCZS NSELE |
| Makwanzo, Luc | ISBCZS | BCZS NSELE |
| Mpasi, Mido | Direction | BCZS NSELE |
| Ndala | Secrétaire | BCZS NSELE |
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| Kileri, Bosco | Précodesa | CS KASAY |
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| Kipulu, Claver | T.L | CS KASAY |
| Mafuta, Josée | Accoucheuse | CS KASAY |
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| Mupopo, Sylvie, Ms | Accoucheuse | CS KASAY |
| Ngombe-Empue, Silas, | Infirmière | CS KASAY |
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| Butele, Fide | ELEVE | FONAMES |

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| Gabula, Olivier, Mr | ELEVE | FONAMES |
| Kapita | ELEVE | FONAMES |
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| Kasongo Ngonzi, Patrick, Mr | ELEVE | FONAMES |
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| Katika, Tonton | ELEVE | FONAMES |
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| Kibala, Gede | ELEVE | FONAMES |
| Kimwanza, Fils | ELEVE | FONAMES |
| Kipilu, Uliriche | ELEVE | FONAMES |
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| Ndanga, John, Mr | ELEVE | MAJORITE |
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| Ngogo, Teo | JOUEUR | FONAMES |
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| Ndala, Marie, Ms | | ONATRA |
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| Nzuzi, Massamba, Ms | | NSONA NKULU |
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| Bansimba, Mr | Community member | KUMBI |
| Dienda, Manuana, Mr | Community member | KUMBI |
| Kiwulu, Nsangu, Mr | Community member | KUMBI |
| Kueyi, Mr | Community member | KUMBI |
| Lumbakiladio, Mr | Community member | KUMBI |
| Mabeka, Fils, Mr | Community member | KUMBI |
| Mantomina, Mr | Community member | KUMBI |
| Mindeki, Mr | Community member | KUMBI |
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| Sakananu, Mr | Community member | KUMBI |
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| Munima, Mr | Community member | NGUNGU |
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| Nsoki, Mr | Community member | NGUNGU |
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| Mapangula, Watanda, Ms | INF. ACCOUCHEUSE | HGR.NS-NK |
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| Wumba, Bulisi, Ms | INF. ACCOUCHEUSE | HGR.NS-NK |
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| Malanga, Mr | INF. TRAIT. | CSR MAT CITE |
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| Masamba, Ms | MENAGERE | KONGO CENTRAL |
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| Makiese, Ms | | |
| Masamba, Fany, Ms | | |
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| Nsimba, Nkiadiama, Ms | | |
| Nzuzi, Mbongo, Ms | | |
| Opes, Mwes, Ms | | |
| Tambi, Luzala, Ms | | |
| Tsasa, Mabiala, Ms | | |
| | | |
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| Kimfuetete, Mbuaku, Mr | IS. SSP | ECZS |
| Leon, Levo, Mr | 4G/ZONE | ECZS |
| Malongo, Leba, Mr | DN/HGR | ECZS |
| Ntele, Mr | NUTRITIONNISTE | ECZS |
| Nzita, Mr | MDI+/HGR | ECZS |
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| | | |
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| Kahunda, Cathe, Ms | | |
| Kambamba, Agnes, Ms | | |
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| Kitoko, Florence, Ms | | |
| Lukela, Chaïda, Ms | | |

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| Mboma, Patience, Ms | | |
| Mbuku, Heleinne, Ms | | |
| Sona, Florence, Ms | | |
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| **FOCUS FEMME** | | |
| Kipulu, Kisiangu, Ms | | |
| Kisala, Sona, Ms | | |
| Kitadi, Lyly, Ms | | |
| Lumeya, Tshoyo, Ms | | |
| Mananga, Lea, Ms | | |
| Mandefo, Lumingu, Ms | | |
| Mbusu, Veronique, Ms | | |
| Mesa, Manisa, Ms | | |
| Modha, Patience, Ms | | |
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| Nzongo, Marie, Ms | ELEVE | KONGO CENTRAL |
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| **ENTRETIEN AVEC LES PRESTATAIRES** | | |
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| Lumba, Dikiladio, Ms | CHEF. MATERNITE | CS. KUMBI |
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**MEETING MINUTES:**

*Réunion sur la préparation du plan de travail pour l'implantation du SONU dans les 3 provinces*
*Mercredi 28 Avril 2010*

# ANNEX 7 KEY CAUSAL ASSUMPTIONS FOR THE DRC THEORY OF CHANGE

**1. Key Causal Assumptions for the Theory of Change of H4+JPCS in the DRC**

1. H4+ partners, in a process led by national authorities and encompassing key stakeholders, are able to develop and operationalize a coordinated process and platform for planning their joint support to RMNCAH while taking full account of the role of other relevant initiatives. The process is able, over time, to overcome barriers to integrated and coordinated planning which may have obstructed joint support in the past. Complementarity and synergy in efforts by H4+ enabled joint support to be more integrated and coherent, which provided more added value than the independent support (without complementarity & synergy with others) by H4+ members.
2. H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unserved needs in the eight areas of health systems support. These include needs which are not fully met by other sources of support and, importantly, where programme support can build on investments and activities already underway.
3. H4+ JPCS support at national and sub-national levels can be sequenced appropriately[70] with support to RMNCAH from other sources. (Relates to area of investigation one: strengthening health systems and two: expanded access to integrated services along the continuum of care).
4. H4+ JPCS support to capacity development has adequate reach and is sustained enough over time so that it can effect access to quality services for marginalized groups. In combination with contributions from other programmes and sources of investment, H4+ JPCS support addresses the three dimensions of sustainable capacity improvement: capability in terms of skills and supportive supervision; opportunity in terms of the availability of adequate facilities, equipment and supplies; and incentives for provision of quality care. The reach of H4+ JPCS support is extended by identifying and implementing experimental innovative approaches to health systems support and the provision of quality care in RMNCAH.
5. Demand creation activities and investments have sufficient resources, and are sustained enough over time, to make enduring positive changes in the level of trust between service users (especially including youth and adolescents and other members of marginalised groups in the community) and service providers. These investments and activities are not limited to demand side interventions, but also aim to change the attitude and behaviour of service providers toward users in an effort to build mutual trust. This further implies that improvements in service quality and access are not disrupted by failure to provide adequate facilities, equipment and supplies of crucial commodities.
6. The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services, and to overcome barriers to access which existed in the past. *(Relates to areas of investigation one: strengthening health systems for RMNCAH; two: expanded access to integrated services along the continuum of care; and three: responsiveness to national needs and priorities).*

[70] Because H4+ JPCS support is meant to be catalytic and operates in conjunction with other programmes and investments in health systems support, it must provide resources in a timely way and take into account the planned and actual delivery of support from other sources. For example, support to training of clinicians by H4+ JPCS can have little effect if infrastructure support or commodities provided by other programmes is delayed.

**2. Key Causal Assumptions for the Theory of Change for Innovation in H4+ in the DRC**

1. H4+JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+JPCS, from practices in other H4+JPCS countries or from the expertise and experience of key stakeholders at all levels.
2. H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.
3. H4+ partners and national health authorities agree on the importance of accurately and convincingly documenting the success or failure of supported innovations and put in place appropriate systems for monitoring and communicating the results of these experiments.
4. National health authorities are willing and able to adopt proven innovations supported by H4+JPCS and to take them to scale. They have access to required sources of financing (internal and external).
5. H4+JPCS mechanisms for promoting successful innovations across the 10 programme countries and among non-programme countdown countries are effective.
6. Global knowledge products produced with support of H4+JPCS incorporate examples of successful innovations for strengthening RMNCAH that can be adopted in non-programme countries.