FINAL REPORT - ANNEXES

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

Volume 2 – ANNEXES

UNFPA Evaluation Office

May 2017

Global Affairs Canada

Affaires mondiales Canada

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

Evaluation Management Group

Louis Charpentier	UNFPA Evaluation Office (Chair)
Beth Ann Plowman	UNICEF Evaluation Office
Pierre J. Tremblay	Global Affairs Canada Evaluation Division

Evaluation Reference Group

Åsa Andersson	Sweden/ Sida
Camille Bouillon Bégin	Global Affairs Canada
Nazneen Damji	UN WOMEN
Hemant Dwivedi	UNFPA (H6 Global Coordinator)
Dirk van Hove	UNAIDS
Anneka Ternald Knutsson	UNFPA
Blerta Maliqi	WHO
Jeremy Veillard	World Bank
Willibald Zeck	UNICEF

Euro Health Group Core Evaluation Team

Lynn Bakamjian	Euro Health Group
Dr Allison Beattie	Euro Health Group
Ted Freeman	Euro Health Group (Team Leader)
Erling Høg	Euro Health Group
Jette Ramløse	Euro Health Group

National Consultant Evaluation Team Members

Beyant Kabwe	Zambia
Prince Kimpanga	Democratic Republic of the Congo
Minnie Sirtor	Liberia
Thenjiwe Sisimayi	Zimbabwe
Léon Tshiabuat	Democratic Republic of the Congo

Any enquiries about this evaluation should be addressed to:
Evaluation Office, United Nations Population Fund

E-mail: evaluation.office@unfpa.org
Phone number: +1 212 297 5218

Full document can be obtained from UNFPA web-site at:
http://www.unfpa.org/admin-resource/evaluation-h4-joint-programme-canada-and-sweden-2011-2016

For further information on the evaluation you may contact Louis Charpentier at Charpentier@unfpa.org

Cover photos: Karen Schermbrucker, Abbie Trayler-Smith, Charmaine Chitae, Marguerite Kunduma, Abraham Gelaw

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS USED IN THE EVALUATION MATRIX

ADBC	Community Distribution Agent (DRC) (*Agent de Distribution à Base Communautaire*)
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ART	Anti-Retroviral Therapy
AWP	Annual Work Plan
DCZS	Health Zone Central Office (DRC)
BEmONC	Basic Emergency Obstetric and Newborn Care
CAO	Millennium Development Goals (DRC)
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHAI	Clinton Health Access Initiative
CHT	County Health Team (Liberia)
CHW	Community Health Worker
CNP-SS	Health Sector Coordinating Committee (DRC)
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CYP	Couple Years of Protection
DBS	Dried Blood Spot (Zimbabwe)
DED	Deputy Executive Director
DEP	Department for Planning and Studies (DRC)
DFID	Department for International Development (United Kingdom)
DHE	District Health Executive
DHIS	District Health Information System
DHS	Demographic and Health Survey
DIU	Inter-Uterine Device (DRC)
DPS	Provincial Health Department (DRC)
DRC	Democratic Republic of the Congo
D10	Division for Health and Family Groups (DRC)
ECZ	Eglise du Christ au Congo
EGPAF	Elizabeth Glazer Paediatrics AIDS Foundation
EmONC	Emergency Obstetric and Newborn Care
ENAP	Every Newborn Action Plan
EpMM	Ending Preventable Maternal Mortality
ESO	Emergency Surgery Officer (Ethiopia)
EU	European Union
EWEC	Every Women, Every Child
EVD	Ebola Virus Disease
FP	Family Planning
FGD	Focus Group Discussion
FANC	Focused Ante Natal Care
FMOH	Federal Ministry of Health (Ethiopia)
FOSA	Health Facility (DRC)
GBV	Gender Based Violence
gCHV	General Community Health Volunteer (Liberia)

GE	Gender Equity
GAVI	Global Alliance for Vaccines and Immunizations
GFF	Global Financing Facility
GIBS	Health Development Partners Forum (DRC)
HGR	General Referral Hospital (DRC) (*Hôpital Général de Référence*)
HBB	Helping Babies Breath
HCC	Health Centre Committee (Zimbabwe)
HCW	Health Care Worker
HDF	Health Development Fund (Zimbabwe)
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HQ	Headquarters
HSDP	Health Sector Development Plan (Ethiopia)
HTF	Health Transition Fund (Zimbabwe)
HRH	Human Resources for Health
HZ	Health Zone (DRC)
H4+JPCS	H4+ Joint Programme, Canada and Sweden (Sida)
IFC	Individual Family Community
IFYC	Integrated Feeding of the Young Child
IESO	Integrated Emergency Surgery Officer (Ethiopia)
IMNCI	Integrated Management of Newborn and Child Illnesses
INESOR	Institute for Social and Economic Research (Zambia)
ISP	Integrated Support Program
ISTM	Higher Medical Technology Institute (DRC)
JANS	Joint Assessment of Annual Health Strategy
KII	Key Informant Interview
KMC	Kangaroo Mother Care
KOIC	Korea International Cooperation Agency
LARC	Long Acting Reversible Contraceptive
LLIN	Long Lasting Insecticide Nets
LTSM	Liverpool School of Tropical Medicine
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program (Zimbabwe)
MDG	Millennium Development Goal
MDGi	Millennium Development Goals Initiative
M&E	Monitoring and Evaluation
MICS	Multi Indicator Cluster Survey
MINSAP	Ministry of Health (French) Guinea Bissau
MMR	Maternal Mortality Ratio
MNDSR	Maternal and Newborn Death Surveillance and Response
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care (Zimbabwe)
MOHS	Ministry of Health and Sanitation (Ethiopia)
MSH	Management Sciences for Health
MVA	Manually Vacuum Assisted Delivery
NASG	Non-Pneumatic Anti-Shock Garment
NGO	Non-Governmental Organization

NIHFA	National Health Facility Assessment (Zimbabwe)
NHA	National Health Accounts
OIC	Officer in Charge
OPHID	Organization for Public Health Interventions in Development
PBF	Performance Based Financing
PCIME	Integrated Management of Child Illness (DRC)
PDSS	Health Systems Support Project (DRC)
PESS French?)	Health Facilities Equipment Programme (DRC)
PLWHA	People Living with HIV and AIDS
PMD	Provincial Medical Directorate (Zimbabwe)
PMNCH	Partnership for Maternal Newborn and Child Health
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Postnatal Care
PNDS	National Health Development Plan (DRC)
PoC	Point of Care
PPH	Post-Partum Haemorrhage
PSM	Procurement and Supply Chain Management
RBF	Results Based Financing
PTME	Prevention of Mother to Child Transmission *(PMTCT)*
RHB	Regional Health Bureau (Ethiopia)
RHC	Rural Health Centre (Zambia)
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RO	Regional Office
SCF	Save the Children Fund
SDGs	Sustainable Development Goals
Sida	Swedish International Development Agency
SMAG	Safe Motherhood Action Group (Zambia)
SMS	Short Message Service (text message)
SONU	Obstetric and Neo-Natal Emergency (DRC, Guinea Bissau)
STI	Sexually Transmitted Infection
TA	Technical assistance
ToR	Terms of Reference
ToT	Training of Trainers
TTM	Trained Traditional Midwife
TWG	Technical Working Group
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
UHC	Urban Health Centre (Zambia)
USD	United States Dollar
USG	US Government
WAG	Women's Action Group (Zimbabwe)
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WHO	World Health Organization
YFC	Youth Friendly Corners
YFS	Youth Friendly Services
VHW	Village Health Worker

ANNEX 1 EVALUATION MATRIX

Strengthening Health Systems

1. 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?[1] **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?** **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?** **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?** **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 *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] While the term 'health systems strengthening' applies to the entire health system rather than a specific sub-element, the inception phase has shown that by and large, 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.

Theme: Alignment with national plans and priorities (DRC, Liberia, Zambia, Zimbabwe)		
1	**Democratic Republic of the Congo** 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. Interview: MoH.
2	**Liberia** H4+ focus on maternal mortality reduction, newborn survival, the prevention of mother to child transmission (PMTCT) and adolescent health were consistent with the Liberia National Health Strategy and are clearly identified in the 2011-2015 Roadmap as high priorities).	Interview: Ministry of Health Technical Team.
3	**Zambia** National Health Strategic Plan sets out the following targets for Zambia as a whole: • Reduce the under-five mortality rate from the current 119 deaths per 1000 live births to 63 deaths per 1000 live births by 2015 • Reduce the maternal mortality ratio from the current 591 deaths per 100,000 live births to 159 deaths per 100,000 live births by 2015 • Increase the proportion of rural households living within 5 km of the nearest health facility from 54 percent in 2004 to 70 percent by 2015 • Reduce the population/doctor ratio from the current 17,589 to 1 to 10,000 to 1 by 2015 • Reduce the population/nurse ratio from the current 1,864 to 1 to 700 to 1 by 2015 • Reduce the incidence of malaria from 252 cases per 1000 in 2008 to 75 per 1000 in 2015 • Increase the percentage of deliveries assisted by skilled health personnel from 45 percent in 2008 to 65 percent by 2015, and • Reduce the prevalence of non-communicable diseases associated with identifiable behaviours. *"Government desire is for all partners to abide to the Global Declaration which encourages partners to channel their support for Aid Effectiveness by utilising existing government systems. Sweden continues to use GRZ funding channels to support the MoH, with the application of external financial controls. The World Bank provides sector budget support to the MoH and the Zambia National AIDS Council; Non-earmarked health sector support from CPs represented less than 3.5 percent of all financial contributions in 2011-2013*."	Ministry of Health (2011) National Health Strategic Plan 2011-2015. (Ministry of Health 2011a: 16-18)
4	**Zambia**	H4+ and Ministry of Health (2012) H4+ *Progress Report for April 2011 to June 2012*.

	Annual progress reports identify inputs from the H4+ to national policy level support. For example, in 2011-2012, H4+ JPCS resources were used by the H4+ to support the revision of the national Reproductive Health Policy "to promote safe motherhood".	(H4+ and Ministry of Health 2012)
5	**Zimbabwe** In planning the programme there were two sides to keep in balance while thinking of "every woman, every child": • From the H4+ side the agencies looked to their mandates, capacities and historical roles and advantages (especially in Zimbabwe). From the government side, the Ministry of Health and Childe Care (MoHCC) looked to the commitments made to the Global Strategy and to the three core documents **(The National Health Strategy; The Maternal, Newborn and Child Health Road Map and, the Child Survival Strategy).** • The government (MoHCC) looked at low-performing reproductive maternal newborn child and adolescent health (RMNCAH) indicators on a national basis to help prioritize the implementation areas for H4+ to work in (the eight programme outputs). It also was the main actor in the choice of six hardest-to-reach, lowest performing districts in 2011.	Interview: H4+ country team, UNFPA. Confirmed in interviews with Ministry of Health and Child Care (MoHCC) staff at Director and Deputy Director level at headquarters.
6	**Cameroon** Needs were initially identified with reference to the National Strategic Plan for Health.	Interview: H4+ Country Team (UNICEF).
7	**Ethiopia** The H4+ proposal/Workplan for 2013-2015 is based on the "Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality Ethiopia (2012-2015)". This Road Map draws on the National Reproductive Health Strategy and Health Sector Development Plan (HSDP) IV and includes health system strengthening as a priority area. The proposal background includes sections on maternal health analysis, which included a national Emergency Obstetric and Newborn Care (EmONC) assessment undertaken by the Federal Ministry of Health (FMOH) in collaboration with UN partners WHO, UNFPA and UNICEF in 2010 (p. 11). A bottleneck analysis was done via a desk review of reports and interviews with health workers, health managers and other stakeholders (p. 16), complemented by a desk review of documents and data.	*United Nations and SIDA Collaboration in Reproductive Maternal, Newborn and Child Health in Ethiopia, Work Plan 2013-2015.* (UN and SIDA 2012)
8	**Sierra Leone** • Programme proposal is directly linked to the goal of accelerating progress in maternal and newborn health as described in the 2010-2-15 National Health Sector Strategy Plan (and the 2011-2015 Reproductive Newborn and Child Health Strategic Plan (RNCH) (p.ii) (p.4) • Proposal is jointly signed byH4+ members and the MOHS (p.46)	*Accelerating Progress for Maternal and Newborn Health in all 13 Districts of Sierra Leone in Collaboration with Canada H4+ Global Initiative*. Joint

	• Proposal identifies national plans for health systems strengthening in MNCH including payment of incentives for hardship postings, upgrading number and skills of midwives and other skilled birth attendants (three cadres of 100 midwives to be trained with H4+JPCS support) (p6) • H4+JPCS support to training is planned to be complemented by national programmes to improve accommodations, infrastructure and transport and strengthen incentives with support from the World Bank and the Department for International Development, (DFID) (p.7) • H4+JPCS is intended to continue to support the implementation of the newly established Free Health Care Initiative which provides free services to pregnant and lactating mothers and newborn (p.12).	Programme Document (2011). (Ministry of Health and H4+ Canada 2011)
9	**Online Survey – H4+ Partners and stakeholders** Respondents indicate H4+ work plan seeks to support National Health Plan (88.9% of respondents) and National RMNCAH Road Map (84%).	On-line survey of H4+ Country team members and partners in 33 countries.
10	**On-line Survey – H4+ partners and stakeholders** 76 percent of respondents agree that the H4+ partners work together effectively to ensure national priorities are met.	On-line survey of H4+ Country team members and partners in 33 countries.
Theme: Consultative planning and needs identification (DRC, Liberia, Zimbabwe)		
11	**Democratic Republic of the Congo** 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 Bankand UN Women did not participate but UN Women was later provided funding by UNFPA to act as an implementing partner .	Interview: H4+ coordinator, (UNFPA).
12	**Democratic Republic of the Congo** The original proposal was developed jointly by the Ministry of Health and the H4+ agencies and the main priorities were identified during an off-site planning workshop in Matadi. *« Cet atelier a été sous le leadership du gouvernement notamment la Division for Family Health and Special Groups (D10) qui avait délégué deux de ses représentants. Il y avait également la DEP. »*	DRC H4+ JPCS: *proposal*. (H4+ Canada 2010b: 11) Email: H4+ coordinator 20 Sep 2016.
13	**Democratic Republic of the Congo** • 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 Department for Planning and Studies (DEP) did participate in a field mission with UNICEF in May 2016, however, this was not with H4+JPCS funding	Interview: senior official in MoH in Kinshasa.

	• 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 Provincial Health Department (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. • MoH senior official recommended that the agencies should not conduct supervision visits without informing the government.	
14	**Liberia** There exists close implementation with the national Ministry. This has contributed to results that would not have existed without the partnership. All agency strengths were integrated to have required results.	Interview: H4+ country team: UNICEF.
15	**Liberia** Coordination meetings to plan for the H4+ global technical team visit in April 2016 show large MoH presence.	*Minutes H4+ Technical Working Group (TWG) 17* March 2016. (TWG 2016)
16	**Zimbabwe** *"From the ministry perspective, there were important issues which needed to be addressed nationally, such as Maternal Death Surveillance and Response systems, dealing with obstetric fistula and the need for better mentoring and supportive supervision throughout the health services. So, they needed H4+ to intervene and both the national and district levels. H4+ partners have responded well."*	Interview: senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).
17	**Zimbabwe** In planning activities with support from different H4+ agencies, strong emphasis was placed on the need for hands-on in service training and continued follow up on training in EmONC to address the *"challenge observed during assessment that there was a gap between knowledge and skills for those who were trained in EmONC*". P.5 *Participants* included MoHCC senior management, provincial and district health executives for the six H4+ districts, H4+ country team staff and representatives of non-governmental organisation (NGO) implementing partners (WAG, Katswe Sistahood).	MoHCC, *H4+ Planning and Review Meeting, 23-24 September 2014* (H4+ Zimbabwe 2014b).
18	**Zimbabwe** Consultative meetings with young people from the six districts and representatives of the national Youth Network on Sexual and Reproductive Health solicited views from young people on how sexual and reproductive health services can be strengthened in their respective districts. Recommendations to be used to scale up the Adolescent Sexual and Reproductive Health (ASRH) component of the programme.	H4+, *Interim Progress Report on H4+/CIDA Collaboration*. August, 2012 (H4+ 2012b: 18)

19	**Zimbabwe** Senior staff of MoHCC confirms that coordination and national leadership were greatly strengthened by the establishment of the National H4+ Steering Committee in June 2014. Further, this reflected a decision by MoHCC ot assert leadership and, along with the H4+ partners, identify needs at national, provincial and district level and promote the programme at district level to ensure greater acceptance and implementation in the target districts.	Interviews: MoHCC staff at Director and Deputy Director Level.
20	**Burkina Faso** The proposal was developed jointly by the MoH and the H4+ member agencies (UNFPA, WHO and UNICEF), i.e. "*under the leadership of the government using a participatory approach*" (p. 12).	*Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011,* Ministère de la Santé (Proposal to H4+ CIDA. (Ministry of Health 2011b: 5)
21	**Cameroon** • MoH leadership at central and regional level has been strong since the beginning, and Minister of Health/ Secretary General frequently participates in annual review and planning meetings, or any other major event. For example, the Secretary General chaired one of the H4+ JPCS quarterly review and planning meetings. • The Director of Family Health (MoH) chairs the H4+ JPCS monthly coordination meetings and the regional health director chairs the weekly H4+ JPCS meetings.	Interview: H4+ Country Team (UNICEF).
22	**Cameroon** • The first two-year workplan (2013-2014) was developed by all key stakeholders during a 3-day planning workshop with all the target districts. • Needs are identified on a regular basis through the district review and planning meetings, during which their "micro-plans" are developed and submitted to the regional heath department and partners. The H4+ coordinator participates in these meetings and can provide feedback/responses to the district teams immediately, when they raise a need/request for support. • The programme has been flexible in responding to changing contexts and needs, as revisions/adaptations took place when the 2015-2016 workplan was developed. Several activities were reprogrammed based on uncovered needs and necessary modifications. There has been "*a lot of flexibility*" in the approach, also by the Global Technical Team, which allowed for activities to be reprogrammed.	Interview: H4+ Country Team (UNICEF).
23	**Guinea Bissau** The Health Director General of the Ministry of Health co-chairs the H4+ with the UNFPA Representative.	*H4+ Stakeholders in Guinea-Bissau* (One-page

		submission on stakeholders), no date. (H4+ Stakeholders nd)
24	**Online Survey of H4+ Partners and stakeholders** Agencies regularly attend national RMHCAH coordination meetings in conjunction with national health authorities and other partners (80.4 percent).	On-line survey of H4+ Country team members and partners in 33 countries.
25	**Online Survey of H4+ Partners and stakeholders** Split of respondents regarding whether H4+ partnership is represented as an overall partnership (45.7 percent of respondents) or as individual UN agencies (37.0 percent of respondents).	On-line survey of H4+ Country team members and partners in 33 countries.
Theme: Identifying critical unserved needs		
26	**Democratic Republic of the Congo** A rapid 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: MoH in Kinshasa.
27	**Democratic Republic of the Congo** The DRC H4+ JPCS proposal identifies the main causes (and thus under-served 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 Prevention of Mother to Child Transmission (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.	DRC H4+ JPCS: *proposal*. (H4+ Canada 2010b: 6-7)
28	**Democratic Republic of the Congo** The following data sources were used to identify gaps and needs and to establish the baseline indicators: Demographic Health Survey (DHS) 2007, Multi-Indicator Cluster Survey (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 mortalité maternelle est très élevé dans la province du Bas-Congo, ce qui suggère que la qualité des EmONC est très loin d'être optimale ».*	H4+ Country Team (2012). Annual Progress Report 2012 (H4+ Country Team 2012a: 15)

29	**Democratic Republic of the Congo** 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: 1) A study to identify socio-cultural barriers to use of family planning services in the 9 health zones (HZs) 2) A client satisfaction study to assess the level of satisfaction with RMNCH services among women of reproductive age 3) A national study to assess the availability of Reproductive, Maternal, Newborn and Child Health (RMNCH) services (including family planning) and to map existing RMNCH interventions, covering 97% of all health zones (HZ) and 89% of all health facilities in DRC 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 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 was supported by UNFPA. 6) A result based financing (RBF) baseline study to inform the introduction of RBF in the H4+ health zones conducted in 2013 7) In 2014, a feasibility study to document lessons learned of existing community health insurances in Bas Kongo 8) Baseline studies evaluating the level of knowledge and skills of health workers in EmONC. 9) Population Media Centre conducted a baseline study to identify barriers to improved RMNCAH.	• MoH (2013). *Etude des facteurs socio-anthropologiques limitant l'utilisation des services de planification familiale* • (MoH 2013a) • 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.* • (MoH 2013b) • MoH (2012). *Cartographie des interventions et intervenants de la santé de la mère, du nouveau né et de l'enfant, y compris la planification familiale en RD Congo.* • (MoH 2012) • H4+ Country Team (2012). *Annual Progress Report 2012*. • (H4+ Country Team 2012b: 10, 15) • MoH (2015). *Évaluation des indicateurs pour le*

		Suivi du Programme de Sécurisation des Produits de Santé de la Reproduction…. • (MoH 2015a: 25) • DRC H+4 Annual Report 2013. • (H4+ Canada 2014a: 5) • DRC H4+ Annual Report 2014. • (H4+ Canada 2015c: 12) • Interview Prof Lokoma et Prof Mboloko, Universite de Kinshasa; interview with ISTM Kinshasa • Interview with Population Media Centre.
30	**Liberia** Situational analysis pre-H4+ Sida programme identifies weak health system, poor utilisation, underserved areas, high anaemia, lack of female (especially adolescent) empowerment, deeply held cultural traditions and harmful practices.	*Accelerating Progress in MDG 4 and 5: A proposal for Sida/ H4+ collaboration. Situational Analysis Liberia. Undated*. Approved by Heads of Agencies in February 2013. (H4+ 2013a).
31	**Liberia** Notes from planning meeting show that selection of health facilities for the H4+ at county level would be based on the following criteria: • MoH supported facilities • Accessibility by car or bike or walking not more than one hour	*Minutes of H4+ MoH Technical Working Group (TWG) planning meeting*, August 20, 2013. (TWG 2013)

	• High catchment population area • Geography equity – be able to reach other areas not one-sided • Health facility utilisation • Facility without trained staff – MoH Intervention is needed • Staff accommodation to maintain staff • Facility with skilled staff but poorly performing.	
32	**Zambia** One of the key challenges faced in Zambia has been that of shortage of skilled/trained health personnel. For instance, according to the Sixth National Development Plan (SNDP), even though the number of frontline health workers (doctors, medical licentiates, clinical officers, nurses and midwives) increased to 17,168 as of March, 2010 from 12,173 as at end of 2005, it is still lower than the required establishment number of 39,360 in 2010. Further, the number of public sector "frontline health workers" was 0.93 per 1,000 populations in 2009 against the World Health Organization (WHO) recommended figure of 2.5 per 1,000 with the situation being more acute in rural areas.	Institute for Economic and Social Research (2014) *Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia, Highlights of Achievements on Selected Core Indicators*, March 2014. (INESOR 2014: 6)
33	**Zambia** "*The Health Management Information System (HMIS) data shows a low coverage of key indicators. For example, skilled birth attendance, facility delivery assisted by skilled attendants, family planning, EmONC services, integrated management of childhood Illness (IMCI) and newborn care services. [There exists an] inadequate number of skilled clinical staff and lack of midwives in most health facilities … [and] limited referral practices exist with no feedback loop. Most of the districts are cut off during the rainy season for as long as six months. [There exists an] extremely high turnover of community volunteers due to lack of community kits and other incentives. Most districts do not have maternity waiting shelters, and this encourages home delivery*."	H4+ and the Ministry of Health (2012) Progress Report: April 2011 – June 2012. (H4+ and Ministry of Health 2012: 3)
34	**Zambia** "*The main objective [of H4+] is to contribute to the improvement of maternal, neonatal and child health and nutrition in Zambia through increased utilisation of quality health and nutrition services by vulnerable women, adolescents and child in selected rural and urban districts comprising 30 percent of the Zambian population*."	H4+ (2013) *Report for the 2013 CIDA H4+ Annual Review and Planning Meeting, held at Gonde Lodge, Kabwe, 4-8 November 2013*. (H4+ 2013g: 2)

35	**Zimbabwe** The programme addressed procurement of selected EmONC commodities, equipment and sundries to support EmONC. *"Based on the gaps in commodities identified in the H4+ planning meeting and the preliminary results of the National Integrated Health Facility Assessment."*	H4+, *Interim Progress Report on H4+/CIDA Collaboration. August, 2012* (H4+ 2012b: 12)
36	**Zimbabwe** The H4+ review and planning meeting also allowed each district to detail specific needs including lack of functional theatres and unreported home deliveries (Mbire), underutilisation of "youth friendly corners" and high perinatal mortality (Hurungwe), shortages of midwives (Chipinge) and problems with infrastructure and supplies medicines for MNCH (all districts).	MoHCC, *Summary Report of the H4+ Review and Planning Meeting, 11-12 September 2013* (MoHCC 2013c)
37	**Sierra Leone** • Gap analysis of 2009 maternal and child health (MCH) Aides curriculum carried out with H4+ support identified inadequate content on family planning, gender based violence (GBV), adolescent health, ante-natal care (ANC), PTMCT and EmONC was used to review and update curriculum • Gap analysis used to develop in-service road map for all health care providers (MCH Aides, nurses, community health workers and was developed collaboratively by MoHS, WHO, UNFPA, UNAIDS and UNICEF.	*H4+ Canada Annual Report 2012.* (H4+ Canada 2012a)
38	**Sierra Leone** In aiding the recovery process from the Ebola Virus Disease (EVD) WHO has developed mapping tool to determine needs for RMNCAH service delivery at basic (BEmONC) and comprehensive emergency obstetric and newborn care (CEmONC) level facilities. Information is being collected on the level of support provided in each facility (and district) on infrastructure improvement, medicines and commodities, training, and supportive supervision; and which partner is providing (UN or other NGO) the support. The tool will enable the identification of gaps and information used to direct resources to the facility (and district). Once completed, findings will be shared with partners for use as well as to update and cross check information that has been provided from the districts.	*Minutes of UN Heads of Agencies H4+ Meeting October 2015*. (UN 2015a: 3)
39	**On-line survey of H4+ partners and stakeholders** Survey respondents ranked Human Resources for Health as the highest priority need of national health systems (73.9 percent) with Leadership and Governance (63 percent) and Financing and Financial Management (50 percent) next in order of priority. **Lowest ranked at just 8.7 percent was demand creation.**	On-line survey of H4+ partners and stakeholders in 33 countries.
Theme: Selection of Target Health Districts/Zones		

40	**Democratic Republic of the Congo** The selection of the nine 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 Nzele, WHO and UNFPA already had a joint project. Another criterion was to intervene in HZs 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, WHO.
41	**Democratic Republic of the Congo** *"We [MoH] selected the HZs 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.
42	**Liberia** The H4+ Programme is implemented in six counties, selected on the basis of a number of key health indicators agreed upon by the Government of Liberia and the H4+ team. The selected counties, Maryland, River Cess, Grand Cape Mount, Gbarpalu, River Gee and Grand Kru, are underserved, with none or very few health partners; they have poor geographical access; they have very remote, large populations with very limited means of income and surviving on subsistence farming.	*Behaviour Change for Maternal Health Study, Search for Common Ground, July 2015*. (Search for Common Ground 2015: 4)
43	**Liberia** *"The Swedish International Development Agency (Sida) support will be both catalytic and gap filling in the sense that community based care is nearly non-existent in the project areas and then Sida grant will be catalytic in establishing and rolling out community care in those areas."* Counties selected based on agreed criteria including: - No or few other partners - An underserved area - Performing poorly - Poor geographical access - Remote rural populations - Limited means of income - Surviving mainly on subsistence farming.	*H4+ Sida Collaboration on Accelerating progress in MNH: Liberia Proposals and M&E Plan*, 2013. (H4+ nd-a)
44	**Liberia** MoH technical and senior staff reflected on the H4+ selection of six facilities in each of three counties in the South East region of the country. They wondered why the decision was taken to operate in five	Interview: MoH Technical Staff.

	primary health facilities plus one referral hospital rather than try to cover all the health facilities in one county only. For example, River Gee County has 21 health facilities in total including health clinics, centres and the county hospital. The H4+ selected five clinics and centres plus the hospital; but that meant that fifteen facilities across the county were not supported.	
45	**Liberia** H4+ partners identified the challenge of selecting a few facilities in three counties rather than all facilities in one county. They aimed to demonstrate that it was possible to work in these difficult to access locations. Their criteria included a minimum level of service in each facility they worked in (in terms of accessibility, possibility of reaching the clinic by road within some hour or two of travelling in a car; minimum staff requirement such as midwives etc.). They wanted to be catalytic across the whole south east region and kick start quality improvement over a wider area. They pointed out that there are clinics and facilities in River Gee (let alone Maryland and Grand Kru) that are ten hours by road and then one still has to walk for an hour off-road. "*These places almost need a helicopter,"* as the County Health Officer suggested in River Gee.	Interviews: H4+ country team (WHO, UNFPA, UN Women, UNAIDS, UNICEF) and discussions in the national Evaluation Reference Group, 31 May 2016.
46	**Zambia** Selected districts covered five percent of the Zambian population (districts that are sparsely populated and hard to reach). Operational costs are high in these areas. The bottleneck analysis approach was employed to identify constraints and challenges. The Institute of Social and Economic Research (INESOR) assisted with this process. The Government of Zambia selected the districts from among the seventeen worst performing districts based on indicators including poor maternal health, no other significant donor support.	Interviews: H4+ National Evaluation Reference Group.
47	**Zambia** The government selected the districts based on the poorest maternal health indicators. The selected districts had the lowest indicators and were in geographical locations that made them hard to reach. Also, the districts were within provinces with lowest donor support and those that were not performing or progressing in RMNCAH outcomes.	Interview: Heads of H4+ Agencies.
48	**Zambia** Lukulu was selected as an H4+ focus district According to key informants at the District Health Office, Lukulu was included in H4+ programming for a range of reasons: • Health facilities were dilapidated • No equipment in health facilities • The maternity waiting shelters are in poor condition	Interview: Lukulu, District Health Office.

	• Low post-natal coverage • High rate of maternal deaths • Inactive community based volunteer programme • Skills in need of strengthening amongst health workers. The population of Lukulu is 65,375. There are 14 rural health centres (RHCs), 1 urban health centre (UHC), 9 health posts, 1 referral hospital.	
49	**Zimbabwe** There is a near universal consensus that the choice of the six H4+ supported districts originated with the MoHCC and that these six districts are the hardest to reach and most under-served in the country. They also have high incidences of malaria and very high levels of poverty and illiteracy.	Interviews: MoHCC staff at national, provincial and district level and with H4+ partner staff and representatives of NGO implementing agencies.
50	**Burkina Faso** Target regions chosen based partly on high maternal and infant morbidity and mortality.	*Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011, Ministère de la Santé* (Proposal to H4+ CIDA). (Ministry of Health 2011b)
51	**Cameroon** Based on the results of a regional disparity analysis in the ten regions of the country, the Far North region (districts: Maroua rural, Maroua urban, Guidigis, Moulvoudaye and Koza) was selected because it presents: a low coverage in RMNCH health interventions, the highest proportion of home deliveries, the lowest contraceptive prevalence rate, one of the highest neonatal, and child mortality rates and the highest prevalence of poverty.	*Initial program proposal, H4+,* July 2013. (H4+ 2013e)
52	**Côte d'Ivoire** The H4+ interventions were carried out in the eight districts presenting the most urgent needs in MCNAH (including poor indicators in maternal and child health) belonging to the health regions: Gbéké, Hambol and Kabadougou-Bafing-Folon.	*Rapport d'étape de la mise en oeuvre des activités de l'initiative H4+ Sida en Cote d'Ivoire* (Aout 2013-Avril 2014). (H4+ 2013f)
53	**Ethiopia** The activities noted in the outputs section of the results framework for the 2013-2014 workplan do not articulate which districts, if any, are targeted for most of the activities, except for one (related to	*United Nations and SIDA Collaboration in Reproductive Maternal,*

	Outcome 1: To train 1,364 midwives through Accelerated Midwives Training Programme (515 Amhara, 696 Oromiya and 153 Somali regions). However, many of the activities do take place within district hospitals and the district health management level.	*Newborn and Child Health in Ethiopia,* Workplan 2013-2015. (UN and SIDA 2012)
54	**Guinea Bissau** H4+ efforts are aimed at supporting all the regions to manage essential medicines better especially for RMNCAH (Outcome 2 of Output 3 on the Annual Work Plan (AWP). The AWP also anticipates H4+ support to the seven H4+ regions of the country for equipment required to support the delivery of quality RMNCAH services.	*H4+ Annual Workplan* Guinea Bissau 2013-2015. (H4+ 2012a)
55	**Guinea Bissau** Regions with the highest child and under 12 months mortality are Guinea Bissau, Bafata, Bolama/ Bijagos, Cacheu, Gabu, Quinara, SAB and Tombali. H4+ works in Bafata, Bolama/ Bijagos, Tombali, Quinara and SAB so almost all the worst affected regions.	UNICEF, Contribution Summary to the H4+ Annual Report for 2014, March 2015 (UNICEF 2015a)

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****.*

	Information/data:	**Information sources:**
Theme: Complementing other programmes and investments		
56	**Democratic Republic of the Congo** The Health Facility Equipment Project (PESS) (construction, renovation and equipment of health facilities) is a government project developed by the MoH with support of UNICEF. PESS rehabilitates and provides a package of basic equipment to health facilities.	Interview: Senior official in MoH.

	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 government approach.	
57	**Democratic Republic of the Congo** When the PESS provided equipment to the H4+ health zones, H4+ partners had to reorient the equipment delivered by H4+ to other structures. 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.
58	**Democratic Republic of the Congo** Other programmes fund post-training supervision visits to complement H4+ JPCS investments in EmONC trainings: *« Ces acquis se font remarquer pendant les visites de suivi et de supervisions organisées trois et six mois après les séances de formation. Ces visites de suivi et supervision ont été appuyées par d'autres partenaires comme IRC, Pathfinder, Care, Save the Children et World Vision. »*	Interview: Implementing partner (training institute).
59	**Democratic Republic of the Congo** A UNFPA meeting with headquarter participation recommended that UNFPA should meet the World Bank to coordinate H4+ planned activities with the WB funded RBF programme and support to rehabilitation *« 1. Faire le suivi auprès de la banque mondiale pour l'achat de performance. 2. Voir avec la Banque Mondiale pour les réhabilitations, directement ou au travers le fond social. 3. Favoriser le partenariat diversifié en vue de couvrir les 6 blocs. »*	*Compte rendu réunion H4 avec Dr Luc de Bernis*, le 12/05/2011. (H4+ Agencies 2011 : 1)
60	**Zimbabwe** In addressing the need to revitalize the health sector and address critical needs in RMNCAH the MoHCC received strong moral and financial support from DFID, Sweden and Irish Aid to help H4+ ensure it was integrated with the Health Transition Fund (HTF) which provided incentives to health workers and sustain infrastructure. The HTF helped stop health workers from leaving the country *en masse* and meant H4+ could have an impact in the six hardest to reach districts.	Interviews: H4+ country team: UNFPA.
61	**Zimbabwe** The new Health Development Fund (HDF), which is coming out of the experience of the older HTF will build on the work of H4+. For example, it includes many outcome indicators in RMNCAH and supports all the pillars of the WHO health systems building blocks. Alongside the HTF and its successor, the new HDF, the two large programmes of health sector support are the Integrated Support Programme (ISP), which among other things deals with HIV and the World	Interview: MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services.

	Bank-supported results-based financing (RBF) programme. H4+ is more integrated with and complementary to the HTF/HDF and RBF.	
Theme: Avoiding overlap and duplication with other programmes?		
62	**Democratic Republic of the Congo** *« La coordination des différents interventions a connu quelques problèmes en rapport avec la dotation des équipements, par contre certains partenaires étaient flexibles et s'alignaient sur le PAO de la ZS. Il y eu complémentarité des interventions entre les partenaires grâce à une bonne coordination, sauf dans le cas de la dotation de certains équipements des FOSA appuyée par H4+ où une inégalité de la répartition a été vraiment remarquée. La flexibilité des autres partenaires est venu combler le manque dans d'autres structures. La réhabilitation des maternités de trois FOSA a été réalisée en complémentarité avec les autres appuis. (…) La bonne synergie des interventions avec les partenaires UNICEF, UNFPA , World Vision, Handicape international, Diocesan Office of Medical Works (BDOM), WHO a induit une disponibilité de l'offre de service MNCH et des résultats escomptés avec et une augmentation de la fréquentation des services. »*	Interview, health zone team (Nzele).
63	**Liberia** H4+ investments in establishing, maintaining and technically supporting the maternal and newborn death surveillance and response process at national level while supporting application of maternal, and newborn death surveillance and response (MNDSR) reviews in H4+ focus counties avoided overlap. Interviews with county health teams indicate this is first sustained support health facilities had received.	Interviews: County Health Teams (CHTs) in three counties in South Eastern Liberia.
64	**Zimbabwe** When H4+ was being planned in Chipinge, the district hospital took part in a joint planning session with the District Health Executive (DHE), the Provincial Health Directorate, the MoHCC headquarters, the Ministry of Education and active NGOs. UNFPA was involved for H4+ along with the Organization for Public Health Interventions in Development (OPHID). These plans took account of other large programmes such as RBF and HTF. From 2014 on, plans were continuously refined through joint planning and review meetings. Chipinge is a World Bank RBF district so that is their main source of support with H4+, and the United States Agency for International Development (US-AID) Maternal and Child Health Integrated Programme (MCHIP) the other significant sources. H4+ has considerable impact and reach on training and plays a unique role in its support to mother waiting homes.	Interviews: Chipinge District Health Executive members.

65	**Burkina Faso** The health districts/regions develop and present consolidated annual work plans to the MoH and development partners at central level for funding. Prior to work plan development, the H4+ provides guidelines to the districts and regions on what activities can be funded under H4+. According to interviewed stakeholders, this process ensures better coordination and prevents duplication and overlap of activities.	Interview: H4+ Country Team, UNFPA.
66	**Sierra Leone** "*Deliberate efforts have been put in place to avoid duplication of activities in the proposal with those supported under existing support to RMNCH through the UN Joint Programme and World Bank Support to Performance Based Financing in Peripheral Health Units*". (p.21) Proposal identifies support to national plans for health systems strengthening in MNCH including payment of incentives for hardship postings (p6) and upgrading of housing for health services staff.	*Joint Programme Document (2011).* (Ministry of Health and H4+ Canada 2011: 21)
67	**Sierra Leone** Impact of EVD Crisis on all activities: • The EVD outbreak occurred in March/April 2014. At the end of March, 2014 they saw the first cases confirmed • EVD crisis was fully on them by May 2014 • After May 2014, all health-related activities and projects were on hold unless they related to the control of EVD • Two months after the full outbreak in May 2014 they had to re-programme all activities • It was even forbidden to have meetings so that coordination was very difficult to have real coordination after the second quarter of 2014 • From June 2014 to March 2015 all efforts were focused on Ebola.	Interview: H4+ JPCS Country Team, UNFPA.
Theme: Contributing to the effectiveness of other programmes		
68	**Democratic Republic of the Congo** The EmONC training manual is now used by all development partners, including the Korea International Cooperation Agency (KOICA), USAID and Pathfinder. Before, each partner had its own curriculum, which was very different.	Interview: former H4+ coordinator.
69	**Zambia** Sida support started during the first quarter of 2016 (and will extend to 2019). This support will build on some of the work of H4+ districts, which have been given a budget to procure items and to do child	Interview: Provincial Health Office, Eastern Province.

	health weeks and SMAG training. Sida funds will focus on all the health facilities including those that are not H4+ facilities in Chadiza District and the other districts of Eastern Province.	
70	**Zimbabwe** The Health Transition Fund is credited with ensuring human resources capacity through the provision of retention bonuses. This is a critical input that enables H4+ activities to be implemented. At the same time, H4+ support helps make those health staff receiving retention bonuses more effective. Doctors are bonded to a district for a year and then are free to go elsewhere. When the retention bonuses are reduced, people will be "*flocking out*" of remote districts. In addition, the HTF supported other costs of the primary health care, so that the facilities would not require/charge user fees. The DHE was not clear on an exit strategy for H4+. There is concern about sustainability and that the improvements gained will not last once H4+ ends.	Interview: District Health Executive, Chitsungo District Hospital, Mbire.
71	**Zimbabwe** In almost every meeting and discussion outside Harare, the evaluation encountered the view that H4+ was genuinely catalytic in its support of other, more standardised, larger scale programmes of support to the health sector. This catalytic role and response of H4+ at a micro level was most often attributed to its flexibility and the continuous process of review and planning based on quarterly planning and review meetings. Examples varied but covered every different output area of the programme.	Interviews: Provincial Health Executives, District Health Executives, District Hospitals, Health Centres and Clinics and with implementing partner NGOs.
Theme: Mobilising other resources for RMNCAH		
72	**Democratic Republic of the Congo** *"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.
73	**Democratice Republc of the Congo and Côte D'Ivoire** H4+JPCS helped secure a national commitment to the Global Strategy for Women's, Children's and Adolescent's Health (2016 to 2030). DRC (58), Côte D'Ivoire (71).	*Annual Report of the H6 Joint Programme*, 2015
74	**Burkina Faso** H4+ supported the development of a system for budget subventions for safe deliveries and EmONC and provided complementary funding to government financial commitments for caesarean sections. (p.39)	*H4+ JPCS Annual Report*, 2014.

75	**Democratic Republic of the Congo** The H4+ approach enabled the agencies to work together and put resources together. It was also catalytic in the sense that the agencies also mobilised their own funds for RMNCAH in addition to the H4+ Canada funds. The partners coordinate their work through the Health Sector Coordinating Committee (CNP-SS) commissions, for example UNICEF, UNFPA and USAID for commodities.	Interview: senior official in MoH.
76	**Sierra Leone** H4+ Canada supported advocacy helped civil society lobby for increased financial support to SRMNCH, especially procurement of contraceptives and maternal death reporting. Between 2011 and 2014, government budget allocations for the Directorate of SRMNCH more than doubled from USD 2.689 million to USD 5.757 million.	*H4+ Canada Annual Report, 2013* (H4+ Canada 2013a)
77	**Zambia** Technical support to sensitization of 38 parliamentarians so that they could advocate for funding for RMNCAH during budget debates. (42).	*H4+ Annual Report,* 2014*.*
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****.*		
Information/data:		**Information sources:**
Theme: Gains in competencies and skills		
78	**Democratic Republic of the Congo** 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: <u>In 2012:</u> 1. Training modules reflecting new EmONC methodologies were developed. 2. Three training sites were identified and training materials for EmOC and, including models and other basic equipment, were purchased.	H4+ Global Technical Team (2016*). DRC 2011-2015 Key Achievements,* internal document. (H4+ Global Technical Team 2016b)

	3. One hundred sixty (160) providers participated in training sessions on EmONC and family planning 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. 4. Forty-three (43) healthcare providers received capacity strengthening in the provision of family planning services in the districts of Bandundu. 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 (ISTM); and (2) revision of training curricula of midwifery by the mentioned Institute. 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 bachelor degree, without going through the training of nurses (4 years) and also without two years of experience. 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 family planning; and (b) a week of free ANC consultation services performed by midwives in the communes of Kinshasa. <u>In 2013:</u> 1. Seven health care training institutions received support from H4+ Canada. 2. At the national level, 21 EmONC instructors were trained. 3. Eighty service providers were trained in EmONC. 4. Fifty service providers were trained in Family Planning. 5. Fifty patient peer educators were trained. 6. Sixty trainers and coaches in midwifery received instruction in the new competency-based methodology 7. Training modules for HIV management. Midwife training institutions received mannequins. <u>In 2014:</u> 1. Strengthened the capacities of two midwifery schools through the supply of technical equipment and mannequins and the training of tutors. 2. Supported the set-up of two training centres on EmONC and family planning 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 family planning; 60 providers trained in management of reproductive health medicines. <u>In 2015</u>	

	1. 2 ISTM of Kisantu and Kimpese received teaching materials to improve the quality of basic training of midwife. 2. 15 teachers and coaches of course have been strengthened on pedagogical techniques in the use of educational materials. 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. 4. Strengthening capacity of the beneficiaries in SONU on offer. 50 service providers (doctors, 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. 5. At the central level 26 trainers have been trained and the provinces of Bandundu and Bas Congo (Kongo central) had also with each pool consisting of 16 trainers for care obstetric and neonatal of emergencies (SONU). 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) Framework implementation framework for acceleration of the objectives of Millennium Development (Goals MDGs) 4 and 5 with the UNICEF funding. 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. 8. Formation of 105 providers in provision of the PF allowed improving an increased coverage of area of health in family planning service offering. 9. 25 providers have been trained in rational use of medicines including the health of the mother and child. 10. A technical and financial support was provided to the Government side in the organisation 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 H4+ Global Technical Team (2016).	
79	**Democratic Republic of the Congo** Based on the results of an assessment of ISTMs, the midwives programme was revised and upgraded 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 MoH.	Interview: implementing partner, ISTM-Kinshasa.

80	**Democratic Republic of the Congo** H4+ has had catalytic effects as it has supported the development and institutionalization of the EmONC training modules at national level, an official 3-year midwife training programme, and a programme to upgrade nurse-midwives (‘*accoucheuses’*) to midwives: a new competency-based EmONC training module was developed; 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). They conducted the training of doctors in Mosango, HZ health teams, midwives and health managers (administration). The Faculty of Medicine has integrated a 10-day EmONC training into the medicine programme.	Interview, Member of the Faculty of Medicine, University of Kinshasa.
81	**Democratic Republic of the Congo** Participants reported an increase in satisfaction with the quality of services and also improved outcomes for women and newborns in facilities supported by H4+JPCS.	Focus Group Discussions (FGD): Mosango Province.
82	**Liberia** Staff have had training in emergency obstetric and newborn care (EmONC) and Helping Babies Breath. Training was done in 2014 and again recently. The clinics at Jarkaken and Cheboken and the River Gbeh Health Centre practiced “kangaroo mother care” (KMC); staff at Fish Town had not heard about it. Only one midwife (trained in 2014) had enough knowledge of and confidence in herself to use misoprostol. There was misoprostol in every facility but most about to expire.	River Gee Facility observations and record by the Evaluation Team, June 6-8 2016.
83	**Liberia** Both trained traditional midwives (TTMs) and general community health volunteers (gCHVs) have participated in training in the areas that they need to know in order to provide appropriate health services at community level. Both CHVs and TTMs said they have attended training for diarrhoea, malaria control, acute respiratory infections, family planning and nutrition.	Community health volunteers, FGDs, June 2-9, 2016.
84	**Liberia** Training of health workers and support staff in essential newborn care, prevention of obstetric fistula and infection prevention control and care of pregnant women in context of Ebola with emphasis on early detection through triage at health facilities and community outreach. 72 health workers trained in 26 facilities across the six targeted counties. Pre-test 38% to 78% and post training results were 70% to 100%. 26,000 USD budget/ spent.	Ministry of Health Activity Report by UNFPA, July-September 2015 (MoHSW 2015)
85	**Zambia** Support was provided to pay the salaries of six retired midwives, of whom three have been retained at Dongwe, Lishuwa and Luvuzi. Training courses conducted in Lukulu and Mitete were:	INESOR (2014) H4+ Highlights of Achievements on

	<table><tr><th></th><th>EmONC</th><th>LARC*</th><th>IYCF*</th><th>FANC*</th></tr><tr><td><2011</td><td>4</td><td>0</td><td>0</td><td>0</td></tr><tr><td>2011</td><td>0</td><td>2</td><td>0</td><td>0</td></tr><tr><td>2012</td><td>6</td><td>4</td><td>11</td><td>13</td></tr><tr><td>2013</td><td>13</td><td>3</td><td>0</td><td>13</td></tr><tr><td>2014</td><td>7</td><td>4</td><td>0</td><td>0</td></tr><tr><td>2015</td><td>8</td><td>6</td><td>0</td><td>0</td></tr><tr><td>2016</td><td>1</td><td>5</td><td>0</td><td>0</td></tr><tr><td>Totals</td><td>35</td><td>22</td><td>11</td><td>26</td></tr></table> *LARC: Long acting reversible contraception (such as implants) IYCF: Infant and young child feeding FANC: Focused Antenatal Care	Selected Core Indicators, March 2014, Lusaka. (INESOR 2014: 7)
86	**Zambia** • 25 health workers trained in Focused ANC (FANC) and 21 in long acting reversible contraception (LARC) • 43 people trained in paediatric ART which has enabled the district to open more facilities • EmONC training is valued for its transformative effects.	Chadiza District Health Office, Eastern Province, KII, 18th July 2016.
87	**Zambia** Midwife reports use of new skills "*made her feel strong to able to save the life of this baby"* which she could not have done without the training provided.	Interview: Lukulu District Hospital.
88	**Zambia** Nurses are given training about referral when they complete EmONC training. The Midwife is trained on partograph. There are certain things that cannot be done in the BEmONC (for example, blood is only given at the CEmONC facility). The transport issue is overcome with the ambulances.	Interview: H4+ Country Team (UNICEF).
89	**Zambia** Training for midwives: Training used to be just one intake per year but now there are two intakes within a year. Nurses are sponsored to enrol in midwifery training in every H4+ district. Retired midwives: The employment of retired midwives has also meant that there have been no gaps in service provision when nurses go for training. Some facilities had no nurse; part of the government strategy was to ensure a network of BEmONC sites that referred to a CEmONC facility (the district hospital) and ensure there were trained midwives in each of the BEmONC facilities at a minimum. The government said every district would have one CEmONC site and five BEmONC sites.	Interviews: H4+ Zambia Evaluation Reference Group.

90	**Zimbabwe** Training and mentoring supported by H4+ improved skills in: • Basic Emergency, Obstetric and Newborn Care (BEmONC) • Infant and child feeding practices • Option B+ management • Anti-Retroviral Therapy (ART), especially paediatric ART • Integrated management of childhood illnesses (IMNCI) • Infant/child feeding • Manually vacuum assisted (MVA) deliveries Staff also report improved trust between the community and the health facility staff: • *"BEmONC training has resulted in fewer maternal complications and infant deaths. High risk cases are referred to the district hospital, while others can be managed by the health centre."* Kariangwe Mission Hospital, Binga • *"Skills have greatly improved through one to one mentorship and provision of supportive supervision which works better than regular supervision. All of this is more effective than sending staff away to workshops."* Siabuwa Primary Health Centre, Binga. • *"There is a clear link between the training of nurses in Youth Friendly Services (YFS) and the work done by Katswe Sisterhood to engage young married and unmarried girls and the recognizable improvement in attitudes by nurses and trust by young people."* Chipinge District Health Executive.	Interviews: staff of district health executives, district hospitals, mission hospitals, rural hospitals, and health centres in Chipinge, Mbire and Binga.
91	**Zimbabwe** Improvements in skills and attitudes of facility staff, especially in EmONC but also in RMNCAH due to clinical mentoring and improved, supportive supervision (with ongoing challenges for transport and fuel in support of supervision)	Interviews: Provincial Health Executives in Manicaland (Chipinge), Mashonaland Central (Mbire) and Matabeleland North (Binga).
92	**Zimbabwe** "*With H4+ training health care workers are more vigilant and confident regarding testing and prescribing ART for infants diagnosed with HIV, it's a big improvement.*" "*In particular, counselling for children and adolescents on HIV treatment has really improved as practitioners have been trained and gained experience*."	Interview: MoHCC PMTCT and ART team.

<table>
<tr><td>93</td><td>Burkina Faso
“HUMAN RESOURCES FOR HEALTH: Trained a total of 1,316 health providers from 2012 to 2014. In 2014, eight doctors were trained in essential surgery, 147 health workers in basic emergency obstetric and newborn care, 124 in antenatal care, 40 in post-abortion care, 115 in monitoring of health centres and Sexual and Reproductive Health (SRH) interventions at community level, 52 in IMCI, 180 in newborn care and 45 in the management of obstetric fistula at the National Hospital in Ouagadougou. In addition of in-service training, H4+ is supporting the strengthening of pre-service training, such as training of 50 regional trainers in maternal MDSR, 25 national trainers in PMTCT and support of the three EmONC labs of the National Public Health School with mannequin, and reproduction and dissemination of cursus/modules for students. In addition, the H4+ supported EmONC modules to strengthen the skills of 247 last year students of the School of Public Health.”</td><td>Annual Report 2014 of the H4+ Canada and Sweden Collaborations, September 2015.
(H4+ 2015b: 39)</td></tr>
<tr><td>94</td><td>Ethiopia
The final phase of the program included an accelerated training agendas noted in the table below. Several of the indicators include the phrase “with adequate skills and knowledge.”
<table>
<tr><th>Training outputs in 2015 SIDA Workplan</th><th>Baseline 2014</th><th>Target mid-2016</th></tr>
<tr><td>Number of trained midwives (with adequate skills and knowledge) to provide midwifery services in the targeted districts</td><td>139</td><td>350</td></tr>
<tr><td>Number of trained tutors (with adequate skills and knowledge) to mentor midwifery students and new graduates in the targeted districts by mid-2016</td><td>0</td><td>40</td></tr>
<tr><td>Number of Health Care Workers (HCWs) trained (with adequate skills and knowledge) to provide CEmONC services in the targeted districts by mid-2016</td><td>153</td><td>283</td></tr>
<tr><td>Number of active Health Extension Workers (HEWS) trained on fistula identification in the targeted districts by mid-2016</td><td>0</td><td>1,200</td></tr>
<tr><td>Number of mid-level HCWs trained (with adequate skills and knowledge) to provide Fistula repair services in the targeted institutions by mid-2016</td><td>11</td><td>115</td></tr>
<tr><td>Number of HCWs trained (with adequate skills and knowledge) to provide BEmONC services in the targeted districts by mid-2016</td><td>213</td><td>560</td></tr>
</table></td><td>H4+ SIDA Workplan-2015-16 Ethiopia, January 2015.
(H4+ 2015j)</td></tr>
</table>

	Number of health workers trained for ToT (with adequate skills and knowledge) in Pediatrics treatment of HIV (including for adolescents) in the targeted districts by mid-2016	0	50	
	Number of teams trained (with adequate skills and knowledge) to provide CEmONC services in the targeted districts by mid-2016	0	15	
	Number of HCWs and reps from Regional Health Bureaus (RHB) trained (with adequate skills and knowledge) in GBV identification and response and gender responsive service delivery in RMNCH in the targeted districts by mid-2016	341	800	
	Number of HCWs trained (with adequate skills and knowledge) to manage MNH programme in the targeted districts by mid-2016	Na	500	
	Number of HCWs trained (with adequate skills and knowledge) to provide advanced newborn care services in the targeted districts by mid-2016	0	450	
	Number of HCWs trained (with adequate skills and knowledge) to provide essential newborn care by mid-2016	0	600	
95	**Guinea Bissau** In the AWP 2013-15, the H4+ will recruit 8 international experts per year (4 obstetrician-gynacologistes, 3 paediatricians, 1 anaesthetist) to support training of national staff. They will also support the national health training schools with the objective to train midwives (pre-service and in-service); support the management system for human resources, train 172 *prestataires des 5 HR en charge SONUC* (CEmONC) (45 *médecins* and 127 *paramédicaux*); and train 191 technicians in "*SONUB*" (BEmONC), family planning, post-natal care, VBG, PTME/ TARV (41 doctors and 150 nurses and midwives). The H4+ training programme includes supervision of staff every month for six months after training and then every trimester after that.			H4+ Annual Workplan Guinea Bissau 2013-2015. (H4+ 2012a)
96	**Guinea Bissau** By mid-2014, 159 service providers trained in maternal health services especially in the use of the EmONC guide. 11 obstetrician-gynacologistes and midwives were trained to review maternal deaths; 1000 copies of obstetric records and 200 copied of grid analysis reviews of maternal deaths were produced. Training 88 health care workers in 5 regional hospitals in CEmONC; Recruit Community Health Workers (CHWs) and train 64 People living with HIV/AIDS.			*H4+, Guinea Bissau 2013-2014 intermediary report to SIDA*, 2014. (H4+ 2014b)

97	**Guinea Bissau** In-service training: During 2015, 1) 270 health staff received training in emergency obstetric and neonatal care including human rights, gender-based violence and PMCT dimensions; 2) 25 health staff of Quinara and Tombali regions, 25 health staff of Bafata and Gabu regions, and 23 health staff of Bissau Autonomous Sector received training in ANC and PMCT; 3) 40 health staff received training in BEmONC.	The H4+ partnership: Joint support to improve women's and children's health. *Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations,* Guinea Bissau 10 Feb 2016. (H4+ Global Technical Team 2016d)
98	**Guinea Bissau** Training for 130 health care workers in basic protocols for the detection and management of child health (measles, malaria, diarrhoea, pneumonia).	H4+ Annual Workplan Guinea Bissau 2013-2015 (H4+ 2012a)
99	**Sierra Leone** • RMNH and HIV national standards and guidelines developed in 2013 with H4+ support • MCH Aides curriculum modules developed with H4+ support include recommendations on MNH • H4+ Canada supported advocacy helped civil society lobby for increased financial support to SRMNCH, especially procurement of contraceptives and maternal death reporting. Between 2011 and 2014, government budget allocations for the Directorate of SRMNCH more than doubled from USD 2.689 million to UDS 5.757 million • 802 health care workers of all types trained in 2013 • NGOs providing continuous medical education in all 74 primary health units (PHU) in Pujehun district • Two midwifery schools receiving continuous support (247 of a target of 300 trained since 2011) • H4+ Canada funds used to support development of a comprehensive training curriculum and update training modules • In-service training design framework developed with H4+ support being implemented by MOHS • 65 BeMONC facilities supported (out of 1,205 PHUs); these 65 allowed for 5 BeMONC facilities in each of the 13 districts and one CeMONC as per below • 13 CeMONC facilities.	H4+ Canada Annual Report 2013. (H4+ Canada 2013a)
100	**Sierra Leone**	*Minutes of UN Heads of Agencies H4+ Meeting September 2015.*

	Contributing to strengthened supervision in post-EVD environment: In September 2015, UNFPA to deploy 5 international midwives to regional hospitals to support quality service delivery, mentoring and supportive supervision. This was confirmed in interviews with the H4+ Country Team Roll out of the BEmONC training including refresher training of trainers, a re-start of the programme of work of UNICEF and the Liverpool School of Tropical Medicine.	(UN 2015b) Interview: H4+ Country Team, UNFPA.
101	**On Line Survey of H4+ Partners and Key Stakeholders** The need to strengthen the capacity of human resources for health was ranked highest (73.9%) in priorities for strengthening health systems in respondents' countries.	On-line Survey of H4+ partners and key stakeholders.
Theme: Testing and follow up of training		
102	**Democratic Republic of the Congo** 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)
103	**Democratic Republic of the Congo** *« Pour le suivi des personnes formées, les enseignants de la faculté de médecine ont parfois assuré la supervision (voir si le protocole est affiché, vérifier les compétences, l'utilisation de fiches de compétence). »*	Interview, Member of the Faculty of Medicine, University of Kinshasa.
104	**Democratic Republic of the Congo** In 2015, 50 health facility staff from Kwilu and Kwango provinces (former Bandundu) were trained in EmONC. The Provincial Health Department (DPS) conducted post-training supervision with UNFPA support. 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	MoH (2015). *Rapport d'activité, 4 ème PROGRAMME D'ASSISTANCE UNFPA* , juillet - septembre 2015, DIVISION PROVINCIALE DU KWANGO (Excel sheet).

	« *Cette activités [supervision post-formation] a permis d'améliorer la qualité de l'offre de service qui est un élément clé pour la réduction de la mortalité maternelle dans la zone de Kenge. Cette activité a également contribué à l'accroissement de la couverture de la zone à l'offre de SONU, car le nombre de structures offrant le SONU de qualité a augmenté. »*	(MoH 2015c) MoH (2015*). Rapport d'activité, 4 ème PROGRAMME D'ASSISTANCE UNFPA* , juillet - septembre 2015, DIVISION PROVINCIALE DU KWILU (Excel sheet). (MoH 2015d)
105	**Liberia** The county health team (CHT) supervises each level of the health system individually and separately (there is not a cascade system). The CHT supervises the hospital and the two health centres and the fifteen health clinics.	River Gee Facility observations and record by the Evaluation Team, June 6-8 2016.
106	**Zambia** WHO officials said that in their trainings, pre-test and post-test assessments were done and improvements could be noted from comparing results of these tests. When observing EmONC and family planning practical training, it was possible to see improvements, for example in skills like the insertion of implants. The trainings were structured to cover EmONC theory in the first week, assimilation and practical review in the second week and competency-based training and assessment in the third week. Each participant is also assessed at the end of each session. Follow up visits were conducted to assess the trainings, observe if skills are improved or there are challenges. However, follow up has not been systematic due to limited resources and transport in some districts. E.g. Kalabo and Chandiza have no transport. [Note: the pre and post testing for EmONC training was corroborated verbally by MoH technical staff.]	Interview: H4+ Country Team, WHO.
107	**Zimbabwe** • Report details a post-training follow up with supportive supervision for BEmONC training in Mbire district in 2014. Identified a considerable number of deficiencies. A day was spent by a three-person team of trainers in each facility checking on conditions, availability of needed supplies and assessing skills. They also assisted nurses in making emergency trays, delivery packs, post-partum haemorrhage (PPH) packs, eclampsia packs and other preparatory materials. • Frequent positive elements: o Partograph being used	Manicaland Provincial Health Executive. *Provincial BEmONC Post-Training Follow-up for Mbire District. November, 2014*. (Manicaland Provincial Health Executive 2014)

	○ Delivery packs available ○ Oxytocin and magnesium sulphate available ○ Nurses with knowledge on pre-eclampsia, eclampsia and HBB ○ Handbook and guidelines on BEmONC available and in use • Frequent negative elements ○ Lack of standard delivery packs ○ Dust and general conditions of the labour and delivery wards ○ Wrong documentation on the partograph ○ Lack of Post-Partum Haemorrhage (PPH) packs • Actions/Recommendations ○ Review team assisted nurses in preparing PPH packs and other materials and in cleaning labour and delivery wards ○ Refreshed nurses on practices such as HBB, including the use of the mannequin ○ Mentorship to be continued in the district ○ Encouraged nurses to read and practice recommended standards ○ One doctor sent for mentorship at provincial hospital ○ Further follow up/support meeting scheduled for December 2014 (one month later).	
108	**Zimbabwe** • The review team visited seven sites in Binga including the district hospital, three health centres and three clinics • Frequent positive observations: ○ Retention of mothers on option B+ was good ○ HIV testing of pregnant mothers was high ○ Retention of care good through active tracking and tracing by village health workers ○ Male participation good (60%) because of active male mobilisers ○ Registers complete • Frequent negative comments ○ Low male partner participation in some clinics ○ Problems with motorised (motorcycle) transport of samples due to maintenance issues and lack of fuel ○ Dried blood spot tests (DBS) turnaround time increased due to transport problems (especially when RBF funds are delayed).	MoHCC PMTCT Programme: *Post Training Support for Binga District: Report of a Four Person Team.* July, 2015 (MoHCC 2015b).

109	**Zimbabwe** • *"Trainee interviews focused on knowledge and skills, especially with regard to life threatening events during and after child birth." P.2* • Results: o Management of postpartum haemorrhage – 80 percent trainees with acceptable knowledge/skills o Pre-eclampsia – 75 percent with knowledge of main elements of treatment o Knowledge of neonatal resuscitation – 68 percent with satisfactory knowledge • Availability of supplies o Magnesium sulphate and oxytocin available everywhere o Other supplies often lacking, including in the provincial hospital • User satisfaction o *"Users reported improved satisfaction with services at district hospitals, but staff attitudes at health centres raised concerns. Users were well aware of the existence and importance of antenatal and post-natal care."* P.3 • Conclusion o *"The findings of this assessment indicate that the capacity to manage obstetric emergencies has improved since the national health facility assessment in 2012 (NIHFA)."* P.3	MoHCC. *H4+ Basic Emergency Obstetric and Neonatal Care (BEmONC) training assessment: Binga, Cihpinge, Chiredzi, Gokwe North, Hurungwe, and Mbire.* September, 2015 (MoHCC 2015a).
110	**Zimbabwe** Senior Ministry of Health and Child Care (MoHCC) officials indicate that H4+ JPCS has "*led the shift to more follow-up and ongoing assessment of training initiatives as well as the shift to more in-service and competency-based training."*	Interviews: Director and Deputy Director level, MoHCC.
111	**Burkina Faso** • 2013 IRSS annual report: identified "challenges in post-training follow-up" and equipment issues during field supervision visits in 2013 • 2015 annual report: 3/9 districts conducted supervision of service providers in clinical IMCI, prenatal consultations, and PMTCT; all 9 districts conducted an integrated supervision of RH/family planning (p. 10) • Joint monitoring visits and supervision visits are organised to supervise integrated RH service delivery, the doctors trained in basic surgery, supervision of IMCI, including IMCI-HIV and newborn care (2013 annual report, p. 9) • A visit to supervise health service providers trained in newborn care was conducted in the Centre North region in 2014 (2014, annual report p. 11)	• *"Les activités menées par l'IRSS en 2013"* (annual report, no date). • (IRSS nd) • *Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations*. Format 10 Feb 2016

	• In 2014, integrated formative supervision visits was conducted in all 63 health districts of the country (EmONC, family planning, adolescent SRHR – H4+ supported this activity in 9 districts - 2014 annual report p. 12).	• (H4+ Global Technical Team 2016d) • 2013 *Annual Narrative Progress Report – Burkina Faso*, Jan-Dec 2013 • (H4+ 2013b) • *Canada Annual Narrative Progress Report 2014*, Burkina Faso. • (H4+ Global Technical Team 2014b)
112	**Ethiopia** "*The activity reports on the regional level training workshops and reviewed during the Mid-Term Review lack the necessary details about the trainings include: the duration of training, topics covered, and materials used during trainings." "Some of the pre-and in-service trainings supported by the program are carried out with the complementary financial support from multiple donors. Often this was found to be a sticky point for the review team to corroborate the output/results of some of the training to the financial support provided by the H4+/SIDA program."* (p. 39)	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program.* (H4+ 2015m: 39)
113	**Ethiopia** • Post-training follow-up was done (Ethiopian Medical Association in collaboration with UNFPA and FMOH) to support and mentor newly graduated midwives. Each mentorship activity lasted for three weeks and covered four areas – ANC, labour and delivery, PNC and family planning. *"The mentorship program is going well, however, there is unavailability or inadequate equipment and supplies in some health centres and as a result, mentors could not show the mentees some procedures such as insertion of the IUCD."* (p. 13) • Support for two rounds of integrated supportive supervision (ISS) at three tiers of the health system was conducted by FMOH with support from H4+. H4+ also supported regional ISS in Tigray. • An assessment of quality of care (obstetric, maternal and newborn care) was conducted through WHO in 27 hospitals located in seven regions. Based on the assessment, each hospital developed an	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program.* (H4+ 2015m: 13)

	action plan which aimed at addressing the availability of essential emergency drugs, supplies, equipment, laboratory services and skilled personnel. • H4+ supported the adoption, development and printing of job aids/guidelines for RMNCH, including PMTCT and paediatric HIV. This included a draft national guideline on PMTCT.	
114	**Sierra Leone** Most of the in-service training programmes that are being rolled out in the districts are not allied with supervision and mentoring for the health workers that are being trained. More focus on improving, coordinating and implementing a functioning and sustainable supportive supervision and mentoring system were highlighted as a priority moving forward. Information and experiences were shared by UNICEF on its approach to mentoring, through the On-the-Job Training that is being rolled out in the districts in October and November. More support for proper implementation is however required. It was also noted that the OJT trainings are deliberately not fully competency based.	*Minutes of the UN H4+ Heads of Agencies RMNCAH Meeting 21 October, 2015.* (H4+ Agencies 2015a)
115	**Sierra Leone** National supervisors supported to undertake supervision of the 11 midwife training schools including how to apply the school assessment protocol.	H4+ Canada Annual Report 2012. (H4+ Canada 2012a)
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.***		
	Information/data:	**Information sources:**
Theme: Supervision		
116	**Democratic Republic of the Congo** • The DPS Bandundu organised a 3-week post-training supervision mission to supervise the staff trained in EmONC in all health areas of Mosango and Bandundu HZ. The supervision report documents: • Strengths: *« 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*	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,

	compétences SONU; Suivi du travail d'accouchement à l'aide du partogramme, existence des registres d'accouchement » • Weaknesses : (PNC): « *PNC 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 PNC ; Ignorance des éléments de surveillance de la PNC; Faible couverture (Accouchements 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. »*	Programme National de Santé de la Reproduction, Ministère de la Santé Publique. (MoH 2015f: 17-18)
117	**Zambia** The provincial medical officer mentioned the concept of 'talking walls' which consisted of the public presentation of targets, achievements, and information. The clinics displayed 'talking walls' and worked with communities to engage them in using them. Talking walls are used to transmit and discuss information with communities in an open way and to promote decision-making.	Provincial Health Office Staff, Western Province, KII, 11th July, 2016
118	**Democratic Republic of the Congo** Mosango health zone team reveals several issues with sequencing and quantity of inputs: • *Faible couverture de la Zone en PTME(suite au faible approvisionnement en tests de dépistage et appui à la supervision)* • *Difficultés dans l'évacuation des dystocies référés (axe Kinzamba 2, moto ambulance non adaptée aux réalités du terrain et actuellement en panne)* • *Maternité faiblement équipée en kit d'énergie* • *Faible taux de pénétration de la mutuelle de santé (faible pouvoir d'achat)* • *L'ETME faiblement intégrée* • *Pesanteur culturelle: Utilisation des ocytociques traditionnelles, Mariages précoces, Rejet de la PF surtout les injections et les pilules (préfèrent les implants)* • *Ignorance des signes de danger.* • *Quasi-inexistence de services de santé de la reproduction pour adolescents et jeunes* • *Difficultés de communication* • *Formateur en SONU ont été mutés* *Recommandations:* • *Capitalisation/mutualisation des experiences de Mosango vers l'exterieur et vice-versa* • *Approvisionner régulièrement les FOSA en intrants SR*	Power point presentation given to evaluation team 15 August 2016, Health zone team Mosango.

	• *Doter la mutuelle de santé de Mosango en subsides nécessaires pour le fonctionnement et la sensibilisation* • *Renforcer le système d'évacuation des urgences obstétricales et pédiatriques par la dotation d'une ambulance 4x4 pour l'axe Kinzamba* • *Construire une maternité à Kinzamba 2 pour améliorer l'accès, car pas de SONU-C dans cette zone juqu'à maintenant*	
119	**Zimbabwe** *"Supervision is being done regularly, though not necessarily jointly. Monthly reports are being done regularly to higher authorities by each level. There were no major stock outs of essential drugs that are necessary to provide CEmONC and no acute shortage of essential equipment necessary to provide CEmONC."*	UN Women, Harare. *Report of a Joint Supervision Mission to Mutare and Masvingo for H4+.* 201.4 (UN Women 2014)
120	**Ethiopia** UNFPA supported the equipping of 10 district hospitals for comprehensive emergency obstetric surgery (output 3) *"Various equipment and supplies have been procured and distributed by FMOH. The equipment and supplies enabled IESO officers to provide emergency obstetric care. Supervisory visits have confirmed that there are reduced referrals to specialized hospitals and health facility deaths have also reduced where these officers have been deployed."* (p.12)	*UNFPA Ethiopia, Progress Report, 2015.* (UNFPA Ethiopia 2015)
121	**Sierra Leone** National supervisors supported to undertake supervision of the 11 midwife training schools including how to apply the school assessment protocol.	*H4+ Canada Annual Report 2012.* (H4+ Canada 2012a)
Theme: Equipment, supplies and infrastructure		
122	**Democratic Republic of the Congo** *La dotation de l'ambulance n'a pas été réalisée. Les activités de référence et contre-référence n'ont pas bien fonctionné dans la ZS par manque d'outils et d'ambulance.*	Interview: Health zone team, Nzele.
123	**Democratic Republic of the Congo** • In 2015, important equipment and supplies were missing during the practical module (internship) of a family planning training in Bandundu HZ: o *« <u>Sur le plan Matériel et Intrants</u> : Pas de COC; Insuffisance en test de grossesse ; Pas de registres de PF dans les structures ;*	MoH (2015). Rapport de l'atelier de formation des prestataires de la zone de sante de Mosango en planification familiale selon la nouvelle

	o *Sur le plan technique : 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 Intra-Uterine Devices - DIU) ; Difficultés dans le counseling spécifique avec les clientes* o *Problèmes rencontrés : insuffisance en intrants ; Pas de moyens pour atteindre les femmes des autres aires de santé pendant le stage »* o *« Points faibles : Rupture des 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 »*	approche du 30 Août au 10 Septembre 2015. Province de Bandundu, Ministère de la santé publique, République Démocratique du Congo. (MoH 2015e: 3-4, 31)
124	**Democratic Republic of the Congo** 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."*	Interview: Provincial Health Department Head.
125	**Liberia** There are two ambulances for use in all 21 facilities in River Gee County. One from H4+ and one on loan from International Rescue Committee. Both currently working.	Presentation: County Health Team, River Gee, 6 June 2015.
126	**Liberia** Transfer of three ambulances, three long-range radios as a "*contribution to health system strengthening of the country*". Donation valued at 200,000 USD (including the fifteen laptops listed). The Deputy Minister replied in a subsequent letter to acknowledge receipt and said the items will be used for data collection and reporting. Ministry of Health with support from H4+ turned over two laptops to the Data Office and County Reproductive Health Supervisor of River Gee County. This is to strengthen the data office reporting and enhance the RH supervision in reporting.	WHO Country Representative letter to the Minister of Health, Liberia, 31 December 2015. *UNFPA Activity Report*, December 31, 2015. (UNFPA 2015a: 2)
127	**Liberia** Blood supplies were a major problem everywhere**.** There used to be a functional blood bank in Liberia. It collapsed during the war and has not been reinstated. Blood is not free or freely available. People who need blood need to bring relatives or friends who will donate. The blood is taken from one and injected immediately into the other person. Blood is not stored as there is no functional cold chain (lack of generators, lack of fridges, etc.). The lack of a blood bank is a major obstacle to saving women's lives.	Observations and record: River Gee Facility, June 6-8 2016.

128	**Liberia** The duration of stockout of medicines and medical supplies at service delivery points minimised.	River Gee County Health Team presentation on implementation of H4+ Programme in River Gee County, April 26 2016. (River Gee County Health Team 2016)
129	**Liberia** The evaluation team conducted a tracer drug study in River Gee to assess availability of 5 tracer drugs including oxytocin, gentamycin, ampicillin, chlorhexidine and depo Provera since mid-2013 to April 2016. The results show periods of stockouts for all these drugs and some for long periods.	H4+ Facility River Gee Essential Maternal Drugs Tracer study (Annex 7) (H4+ 2016d).
130	**Liberia** **Stockouts** of essential medicines are reported frequently in quarterly reports (see 4.2 below on chlorhexidine). For example, the MOHSW report says: "*Stock-outs of essential drugs, RH commodities and equipment in almost all the supported health facilities attributed to inadequacy of top-up system and irregular distribution of near expiry products to address actual consumption needs at field level.*"	*MOHSW Project Activities Report* April 1 to June 30 2014 (UNFPA 2014).
131	**Liberia** The essential maternal and newborn tracer drugs are sometimes in stock and sometimes not. UNFPA supports the delivery of maternal health supplies through the National Drugs Service but at the moment, ampicillin, gentamycin, and chlorhexidine are out of stock in Fish Town. Most clinics had a small amount of chlorhexidine gel; all had oxytocin. No facilities had a full store of drugs (for example, no erythromycin anywhere and very uneven supplies of ampicillin and gentamycin). All have misoprostol but only one midwife (in Jarkaken) was found who actually used it regularly to treat post-partum haemorrhage where an initial dose of oxytocin had failed to stop bleeding. Stockouts are common. The team traced five drugs from mid 2013 to April 2016, some facilities record more stock-outs than others (for example, Fish Town, the referral hospital, had a high level of stock-outs in 2015). In Cheboken, there are no cannulas so patient IVs can only be done if the patient buys a cannula from the pharmacy. There was no sign of the tricycle purchased by UNFPA in Cheboken. It would be difficult to see how it could be used on the roads though. Motorbikes are much more appropriate.	River Gee facility observations and record by the evaluation team, June 6-8 2016.
132	**Zambia** Do you work with the district authorities? "*For the first boreholes, the districts were asked to go through the provincial procurement system. But according to UNICEF regulations, they said no, they must go through the UNICEF WASH system. WASH*	Interview: H4+ Country Team, UNICEF.

	team in UNICEF was overlooked in the first round – which was cheaper and faster – and in the second round they said we must go through WASH according to UNICEF policy." So although it is cheaper, faster, more efficient and more empowering to work through the district, they now have to go through an implementing partner and contractor. They will go through the district medical office and the WASH will assist. UNICEF is meant to be doing procurement for WASH equipment, as well as capacity building. UNICEF also does the training for nurses, clinical officers (and SMAGs) to cover HIV, Integrated Management of Childhood Illness (IMCI), and PMTCT. UNICEF also provides training in treating children in three common childhood illnesses: diarrhoea, malaria and respiratory illnesses. Mostly neonatal care/ care of the newborn.	
133	**Zambia** Equipment given to Lukulu hospital: Maternity equipment, blankets, incubator, theatre table, mama packs and other supplies. Also the H4+ helped construct the maternity waiting shelters.	Interview: Staff at Lukulu General Hospital.
134	**Zambia** "*Equipment has not been as comprehensive as it could/ should have been. So midwives are trained in EmONC but then return to the facility without the equipment they've been trained to use."*	Interview: District Health Office Staff, KII, Chadiza District, Eastern Province.
135	**Zambia** Sometimes condoms are unavailable (male and female). This is a worry to them because young people are likely to have unprotected sex and also be discouraged from visiting the centre if commodities are not reliably available. The volunteers felt strongly that basic tools and equipment would help them to be more effective in their work. They need transportation (bicycles) as they are walking to the villages to do outreach (as they are sometimes walking 2 hours or more to reach villages outside of town). ID cards and T-shirts would ensure "*that we are known*" in the community as working for the Ministry of Health.	FGD: Youth and Adolescents, Lukulu District.
136	**Zimbabwe** • All three reports indicate there are some persistent issues of supply and some which become more positive over time: • Persistent Issues o Transport, especially lack of funds for maintenance of vehicles and motorbikes and purchase of fuel (with a negative effect on both transport of DBS samples for HIV testing and the ability of Provincial Health Executives and District Health Executives/District Hospitals to carry out supportive supervision	MoHCC, *Minutes and Reports on Joint Review and Planning Meetings, 2013, 2014, 2015.* (MoHCC 2013c, MoHCC 2013a, MoHCC 2014b, MoHCC 2015c, MoHCC 2015d)

	o Problems with lack of reliable electrical supply and, especially, water shortages o Difficulties with the transfer of funds from Harare to provinces and districts. • Improving Issues (2014 and 2015) o Availability of PoC CD4 machines for PMTCT (Option B+) and equipment for theatres to support CS and CEmONC o Availability of Oxcytocin and Magnesium Sulphate o Improvements in infrastructure, especially mother waiting homes with support from the community and sometimes other funding sources, particularly RBF.	
137	**Zimbabwe** • *"Equipment supplied to the district has come on time. It includes anaesthesia machines, hospital beds, operating theatre beds, lighting for theatres, and MVA machines among others."* • *"H4+ helps with the procurement of essential medicines for RMNCH. They have not experience stock outs since support was started by H4+ with some brief exceptions. When short term stock-outs in some facilities occur, they can use RBF funds for replenishment."* • *"Without H4+ these improvements would not be there. Chipinge would disappear from the radar."*	Interview: District Health Executive, Chipinge.
138	**Burkina Faso** Training of community health workers delayed because the "financial motivation system" issue was not resolved (insufficient funds) (p. 1) Necessary equipment/materials to deliver community-based new born care were ordered during the same period that the trainings of health personnel in community-based new born care in took place (p.1)	*Compte rendu réunion de coordination H4+ Canada*, 25 June 2015 (H4+ Canada 2015b)
139	**Cameroon** To improve health service delivery, a total of 12 motorbike ambulances for emergency transportation of pregnant women and children were purchased and 24 drivers were trained. The project also supported outreach activities in remote area through the provision of 95 motorcycles.	*Annual Report*, H4+ JPCS, 2015. (H4+ 2015k)
140	**Ethiopia** The mid-term review noted implementation challenges faced by the partnership: "*Delay in implementation of some of the key program activities and related delay in delivering outputs were observed. It was also found out that some of the program activities were dripped off and/or their outputs changed or modified without adequate consultation between the TWG that coordinates the H4+/SIDS collaboration and the relevant units of the FMOH."* (p. 37)	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program* (H4+ 2015m: 37)
141	**Côte d'Ivoire**	*Rapport d'étape de la mise en oeuvre des activités de*

	The report indicated that the delay in receiving funding by the different H4+ agencies, delayed the implementation of the planned activities (40% not initiated activities planned between 2013 and 2014). • The Ebola outbreak in Guinea was a barrier to the implementation of some H4+ interventions between March and April 2014 as MoH efforts (and other governmental agencies such as National Institute of Public Hygienic) were oriented towards preventing this epidemic. • The report pointed a delay in the implementation of several outputs part of the Initiative H4+ Sida 2013-2014, cote d'Ivoire: • UNFPA : delay in outputs 3,4,5,6,7 • WHO: delay in outputs 1,3,4,5 • UNICEF: delay in outputs 3,5,6,7 • UN Women: delay in outputs 5,7 • UNAIDS: delay in outputs 7 • The purchasing process is slow delaying the implementation of some activities between 2013 and 2014 related to UNFPA 's output 3 "commodities and technologies available in health facilities to deliver comprehensive RNMCH services to women and their children (implementation rate between 6% and 39.5%) such as: Provision of 38 health centres with necessary equipment and medicines.	*l'initiative H4+ Sida en Cote d'Ivoire (Aout 2013-Avril 2014).* (H4+ 2013f)
Theme: Incentives and motivation		
142	**Zimbabwe** Under the Health Transition Fund, retention allowances go to MoHCC staff, doctors at district level, midwives, tutors for midwives, PMD staff, DHE staff. This policy is nation-wide. In 2016, allowances were adjusted downward with variations by category, some as little as 15 percent and some by 85 percent. Decisions on adjustments are made by the MoHCC and the Health Services Board. The HTF retention bonus is used to supplement all other sources of funding for a position.	Interview: Health Transition Fund team (UNICEF).
143	**Zimbabwe** "*Incentives available from the World Bank RBF programme had a very positive impact on institutions they worked with under H4+ to promote Point of Care (PoC) use of CD4 machines*."	Interview: J.F. Kapneck Trust.
144	**Burkina Faso** *Supported the implementation* of the national subvention strategy for deliveries and emergency obstetric and newborn care, including both through dissemination of management tools for the implementation of the strategy and complementing funding for 741 C-sections.	*Annual Report 2014 of the H4+ Canada and Sweden Collaborations*, September 2015 (p. 39). (H4+ 2015b)

145	**Cameroon** There is still a need to assess the voucher scheme for coverage and scope to assess its suitability to benefit the poorest of the poor.	*H4+ Joint International Mission report* (Annex 1), July 2015. (H4+ Global Technical Team 2015)
146	**Côte d'Ivoire** Collaboration by H4+ JPCS with the WB to provide performance based financing.	*Rapport d'étape de la mise en oeuvre des activités de l'initiative H4+ Sida en Cote d'Ivoire (Aout 2013-Avril 2014).* (H4+ 2013f)
147	**Guinea Bissau** It was assumed that professionals would get an additional 20% of their salary as an incentive. Eventually the EU took over the gratuity programme so all the health workers should be on performance contracts with 20% incentives. The costs amount to about Central African Francs (CFA) 52 million per month or about USD 530,000 per year. The H4+ budget would not stretch to cover the incentives (and the medicines and fees of pregnant women and children) for multiple years in 7 regions but their work demonstrated the value of tackling this policy issue and how to combine removal of fees with increased incentives for staff and the improved availability of drugs.	*Joao Costa, Estudo de viabilidade da gratuidade para a prestação de cuidados de saúde materno-infantis na Guiné-Bissau no contexto do Projeto H4+,* Relatório Final, Abril 2014. (Costa 2014) H4+ viability study for free of charge services (2014). (H4+ 2014f)
148	**Sierra Leone** *"Support to RMNCH through the UN Joint Programme and World Bank Support to Performance Based Financing in Peripheral Health Units*". (p.21) Proposal identifies support to national plans for health systems strengthening in MNCH including payment of incentives for hardship postings (p6) and upgrading of housing for health services staff.	Joint Programme *Document* (2011). (Ministry of Health and H4+ Canada 2011)
149	**Sierra Leone**	*H4+ Canada Annual Report*, 2012. (H4+ Canada 2012a)

	• H4+ supported MOHS in development of operational guidelines for a national voucher system and in-kind package of services for vulnerable pregnant girls and women and hard to reach groups in 2011 and 12. Operational guidelines completed in 2012. • Voucher system and package to cover ANC, delivery, PNC and family planning including conditional transfers to beneficiaries (vulnerable, pregnant teenage girls and women).	
150	**Sierra Leone** At the same time as the mobile health initiative was discontinued the decision was taken to implement the combined in-kind and voucher package in the two districts since this could have a direct impact on users access to services.	Interview: H4+ Country Team, UNFPA.
Theme: Improved service quality		
151	**Democratic Republic of the Congo** Health facilities supported by UNFPA are more likely to offer RMNCH services and reduce stock outs than those who do not receive UNFPA support: *"Performance de Formation sanitaire selon l'appui UNFPA"*	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: 163)
152	**Democratic Republic of the Congo** 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: • Integrated management of neonatal and child illnesses (IMNCI) • Active management of the third phase of labour, including management of post-partum haemorrhages • Management of eclampsia, chock and neonatal infections • Patient-centred antenatal consultations • Improved attitudes towards women in labour.	*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. Summary of the evaluation team's health facility check lists. (MoH 2015f)

		Interview: Faculty of Medicine and ISTM of University of Kinshasa.
153	**Liberia** County level health staff reported that in-service training in basic EmONC, use of the partograph and effective referrals made a significant difference to the quality of care because midwives were more confident about available tools. This meant that they were able to recognise the point at which they needed to refer the patient to a higher level and were prepared to do so. Similarly, and more importantly, trained staff encountered at the health facilities were able to identify the key steps to managing different kinds of emergencies when asked, as well as how to use most of the equipment, drugs and procedures they had been taught, including the use of the non-pneumatic anti-shock garment (NASG), chlorhexidine gel and Kangaroo Mother Care (KMC).[2]	River Gee Facility observations and record by the evaluation team, June 6-8, 2016.
154	**Liberia** The referral system relies on the radios, mobile phones, the ambulances and the knowledge of community health workers (CHVs and TTMs) and clinic staff. It helps address the three delays most commonly associated with maternal emergencies: delay taking the decision to seek care, delay reaching appropriate care, delayed referral. Many community members have mentioned the referral system as a major success and a notable difference to the quality of the system. The TTMs often said that women used to die but "*these days they don't die*". The main complaint from the staff regarding the referral system from both Cheboken and Gbepo (but not Jarkaken) was the lack of feedback on progress of patients sent by ambulance. The male community in Jarkaken thought the ambulance should "*bring their wives back*" since it took them away.	River Gee Facility observations and record by the evaluation team, June 6-8 2016.
155	**Zambia** District staff are motivated and know their clients and can identify each death. Engaging with the issues. Major issue is human resources for health (HRH) and transport. Birth attendants are classified as midwife, doctor, clinical officers. Direct midwifery training and hiring retired midwives. Distances are long and difficult.	Interview: Institute for Economic and Social Research (INESOR), 14th July, 2016.
156	**Zambia** Staff focus on maternal health quality	Interview: INESOR, 14th July, 2016.

[2] Kangaroo Mother Care (KMC) is an approach to nurturing small and sick babies using skin to skin contact.

	District staff are motivated and know their clients and can identify each death. They engage with the issues. Major issue is HRH and transport. Birth attendants are classified as midwife, doctor, clinical officers. Direct midwifery training and hiring retired midwives. Distances are long and difficult.	
157	**Zimbabwe** MoHCC staff see real improvements in quality of care in the H4+ districts: o Three of the six districts had no capacity for Caesarean Sections but now they are carrying out the procedure. o Outcome data is improving in the six H4+ districts and they are doing relatively better than other districts. For example, Mbire and Chipinge were the worst for outcomes and now are doing better than many districts. Year on year, the absolute numbers of maternal deaths in the H4+ districts are declining. o Nationally, in 2011, there were 1,300 maternal deaths in institutions. This has since declined to 660 in 2014. o At national level, caesarean sections have risen from just 3 percent of those needed in 2011 to 77 per cent in 2014. Neonatal deaths have come down, however for both maternal and neo-natal deaths there is still room for improvement. They still see avoidable deaths reported in the DHIS.	Interview: Senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).
158	**Zimbabwe** • *"Chipinge has been performing better than other districts in the province partly due to H4+. In particular, Chipinge is able to perform caesarean sections and is doing more than other districts in the province."* • *"Motor bikes provided by H4+ have been important in helping the PM Directorate to cover all aspects of RMNCH with supportive supervision. Has an effect across the province, not only in H4+ districts."* *"By providing small amounts of funds for infrastructure in Chipinge, H4+ was really useful in overcoming some infrastructure challenges but others remain."*	Interview: Provincial Health Executive, Manicaland Province (oversees Chipinge district).
159	**Zimbabwe** • Training and mentoring supported by H4+ improved skills in: o BEmONC o Infant and child feeding practices o Option B+ management o ART, especially paediatric ART o IMCI o Infant/Child feeding	Interviews: Staff of District Health Executives, District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres in Chipinge, Mbire and Binga.

	o MVA • Staff also report improved trust between the community and the health facilities based in improved services and skills. • "*BEmONC training has resulted in fewer maternal complications and infant deaths. High risk cases are referred to the district hospital, while others can be managed by the health centre.*" Kariangwe Mission Hospital, Binga • *"Skills have greatly improved through one to one mentorship and provision of supportive supervision which works better than regular supervision. All of this is more effective than sending staff away to workshops."* Siabuwa Primary Health Centre, Binga. • *"There is a clear link between the training of nurses in Youth Friendly Services (YFS) and the work done by Katswe Sistahood to engage young married and unmarried girls and the recognizable improvement in attitudes by nurses and trust by young people."* Chipinge District Health Executive.	
160	**Burkina Faso** Implemented community-based newborn care and IMCI in 90% of all 257 CSPS and 50% of the 1825 villages *(service delivery),* UNICEF	2012 Annual Narrative Progress Report; 2013 Annual Progress Report, Burkina Faso; Canada Narrative Progress Report 2014, Burkina Faso; Annual Report 2015 of the H4+ Canada and Sweden Collaborations. (H4+ 2013b, H4+ 2013c, H4+ Global Technical Team 2014b, H4+ 2015b)
161	**Guinea Bissau** Referral system: *"Increased reference and evacuation capacity through adequate means of transport. During 2015 10 moto-ambulances were donated to Bafata region, 10 moto-ambulances to Gabu region, 8 moto-ambulances to Bijagós and 2 moto-ambulances for Bolama region. Two ambulances were donated to the National Hospital Simão Mendes, the main hospital of the country, in the capital Bissau."*	*Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations,* Guinea Bissau 10 Feb 2016.

		(H4+ Global Technical Team 2016d)
162	**Guinea Bissau** The H4+ aimed to ensure that BEmONC or CEmONC was available at all health facilities in their seven regions of support. Their support included developing basic guidelines for the management of BEmONC or CEmONC, and also for child health (measles, malaria, diarrhoea, pneumonia).	*H4+ Annual Workplan,* Guinea Bissau 2013-2015. (H4+ 2012a)
163	**Online Survey of H4+ partners and stakeholders** Seventy percent of respondents indicate that the H4+ partnership approach delivers high quality programmes. Fifty-six percent of respondents indicate that the H4+ partnership approach is more effective than working with individual UN agencies.	Online survey of H4+ stakeholders and partners in 33 countries.
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:**
164	**For evidence regarding increased quality of services see assumption 1.4 above.**	
Theme: Sustainability		
165	**Democratic Republic of the Congo** • The Performance Based Financing unit explained to WHO that one year for 4 health zones is too short a period. • 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. • *"We will go back to zero if there is no longer funding, as the motivation will suffer"*	Interview: Senior official in MoH in Kinshasa.

	• It is possible that the World Bank Health Systems Strengthening (PDSS) project will continue to fund PBF in Kenge and Mosango (but not the two other H4+ HZs). The training of provincial trainers for the new PDSS project will take place early September, and the activities will start in October.	
166	**Democratic Republic of the Congo** Strategies to ensure sustainability include: • The Reproductive Health Law, including articles on Family Planning, will set the stage for improvements in family planning 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. • The National Reproductive Health Programme includes modules that are being used to train EmONC providers, including in OJT. • The availability of appropriate training modules and management tools as part of Mutual Health Insurance plans will ensure the standardization of this approach. • The national RH and HIV programmes contain guides and training modules in HIV management that will improve the integration of HIV services in RH. • 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. • The maternity waiting facility that was repaired in Mosango provides improved access for all members of the community. • 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).
167	**Liberia** Key informants were vocal about the continued vulnerability of the H4+ programme (and indeed other health programmes) to the weaknesses of the HRH system. Examples of the weak HRH system, identified by key informants included the overall size of the workforce (the number of health workers for the population falls well short of WHO guidelines); half of health staff are not on the government payroll but rather paid only by a donor funded "incentive" from the Pooled Fund; staff can be moved to a health facility anywhere in the country and many leave their families for many months at a time, even for years. Furthermore, there is no methodical promotion or career path available, nor are there incentives to encourage staff to volunteer to work in remote areas (such as further education after five years of service, or priority choice for the next posting).	Interviews: Staff of health facilities in River Gee County.
168	**Zambia**	Interviews: Lukulu District Health Office, 11th July 2016.

	Training, infrastructure and transport: Project funding is now gone so they will have to reduce funding of activities. Activities have been integrated into the action plan so the number will be reduced as funding is more constrained. Nevertheless, funding from government budget will be used for: • Retention of retired midwives: the government funding cannot be used for retired midwives (or salaries outside the agreed salaries) but there is a discussion going on in Lusaka about how to re-hire the retired midwives using government funds • Training: some health facilitates do not have any trained staff at all and so training will continue but at a slower rate. • Infrastructure, including for the health centre, staff accommodation and more transport will continue to be supported.	
169	**Zambia** An example of activities that H4+ initiated and supported, but are now supported by the government budget or other donors include the training of midwives for the five districts. This was taken up by the H4+ first but, as the H4+ ends, the training will continue using government funds. However, if before there were six midwives being trained under the H4+, and now, under the government budget may only train two unless other donors are found to support it. The government are training midwives and contracting retired midwives in reduced numbers. Comprehensive Sexuality Education (CSE) is now recognised by government and is being scaled up. It is policy now but the scaling up is slow.	Interview: H4+ Country Team, UNFPA.
170	**Zimbabwe** Health Transition Fund and H4+: The HTF is credited with ensuring HR capacity through the retention bonuses. This is a critical input that enables H4+ activities to be implemented. Doctors are bonded to a district for a year and then are free to go elsewhere. When the retention bonuses are reduced, people will be "*flocking out*" of remote districts. In addition, the HTF supported other costs of the primary health care, so that the facilities would not require/charge user fees. The DHE was not clear on an exit strategy for H4+. There is concern about sustainability and that the improvements gained will not last once H4+ ends.	Interview: District Health Executive, Chitsungo District Hospital, Mbire.
171	**Zimbabwe** The Provincial Medical Directorate (PMD) team discussed the issue of reductions or cutbacks in the level of retention bonuses from HTF/HDF. In combination with the end of H4+ which provides funding for materials and supplies (alongside RBF) these reductions could seriously hamper motivation and incentives.	Interview: Provincial Health Executive, Mashonaland Central Province (oversees Mbire district).
Theme: Increased use of services in RMNCAH		

172	**Democratic Republic of the Congo** **H4+ JPCS contributed to a three-week long media campaign and free offer of family planning 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."* *"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)
173	**Democratic Republic of the Congo** 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+ DRC 2016)
174	**Democratic Republic of the Congo** In 2015, H4+ supported 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 family planning services at community level in Bandundu town and Kikwit, which created **400 new users of family planning methods.**	DRC H4+country team (2016). *H4+JPCS Annual Report 2015*. (H4+ DRC 2016: 14)
175	**Liberia** Health facilities have reported that there has been **an increase in the number of clients** seeking and using prevention of mother to child transmission (PMTCT) services. Data show that in the January-March quarter, the number tested for HIV doubled.	Interviews: Implementing Partners.
176	**Liberia** The Interviews suggested there has been an increase in the number of women who are referred to the clinic for deliveries and for family planning, and that generally the referral system has made significant progress for the health and wellbeing of women and children. Midwives in River Gbeh mentioned the Community Leader fines imposed on the father (Liberian Dollars 2,500), if the baby is delivered at home.	FGD: Community health volunteers (TTMs and gCHVs), River Gee, 7-9 June 2016.
177	**Liberia** The H4+ implementing partners said the impact of their work can be seen in: • An increase in the number of ANC visits • An increase in facility deliveries	Interviews: Implementing Partners, June 3, 2016.

<table>
<tr><td></td><td>• Increase in referrals
• In the new counties, only H4+ facilities in Gbarpalu have mama-baby kits and ‘Big Belly” cards.</td><td></td></tr>
<tr><td>178</td><td>Zambia
“Community involvement and having a committed Health Centre Advisory Committee has improved uptake of maternal and child health service.”</td><td>Interviews: Luvuzi Rural Health Centre Staff, 12th July 2016.</td></tr>
<tr><td>179</td><td>Zambia
“Many more women come for delivery and accept referral than before. There has been some resistance to family planning, especially long acting reversible methods.”</td><td>Interviews: Chadiza District Health Office, Eastern Province.</td></tr>
<tr><td>180</td><td>Zambia
Successes: Skilled birth attendance has increased from 48 to 64 percent since the H4+ started. There has been a change in culture and people seem to expect to deliver in the health facility now. There have been some maternal deaths but far fewer. Some have been exacerbated by the lack of infrastructure, e.g. no lighting at night.</td><td>Interviews: Lukulu District Health Office.</td></tr>
<tr><td>181</td><td>Zambia
<table>
<tr><th>Indicator</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>2015</th></tr>
<tr><td>% Institutional Deliveries (National)</td><td>58</td><td>64</td><td>68</td><td>72</td><td>73</td></tr>
<tr><td>% Institutional Deliveries (Chadiza District)</td><td></td><td></td><td>54</td><td>77</td><td>83</td></tr>
<tr><td>Maternal deaths (Chadiza District)</td><td>3</td><td>2</td><td>10</td><td>4</td><td>6</td></tr>
</table></td><td>Chadiza District Health Office (2016) Progress report to the evaluation team, Power Point Presentation, Eastern Province.
(Chadiza District Health Office 2016)</td></tr>
<tr><td>182</td><td>Zambia
Many more women come for delivery and accept referral than before. There has been some resistance to family planning especially long acting reversible methods. They hope to get further information/ do some research to help identify the causes. Also, some people still practice traditional medicine, for example using herbal medicines to accelerate labour. The programme includes a component to sensitise and train teachers to enable them to teach young people about HIV, pregnancies, abortions, Sexually transmitted Infections etc. The safe motherhood action groups (SMAGs) are seen as important contributors to helping increase institutional deliveries.</td><td>Interviews: District Health Office Staff, Chadiza District, Eastern Province.</td></tr>
<tr><td>183</td><td>Zimbabwe
• Significant increase in number of live births at hospitals from 7,909 in 2012 to 11,456 in 2015
• Live births at home peaked at 1,199 in 2014 and declined to 813 in 2015</td><td>District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by</td></tr>
</table>

	• All maternal deaths at home and in facilities peaked in 2013 at 16 and declined to 8 in 2015[3] • Caesarean sections increased from 291 in 2012 to 827 in 2015 • Repeat antenatal visits increased from 8208 in 2012 to 17,330 in 2015.	MoHCC office of Health Information and Disease Surveillance for Chipinge District. (DHIS2 2015)
184	**Zimbabwe** • Slight increase in live births at hospitals/clinics from 2,026 in 2012 to 2,265 in 2015 • Decrease in live births at home from 467 recorded in 2013 (no data for 2012) to 254 in 2015 • Caesarean sections increase from 0 in 2012 to 20 in 2015 • Repeat antenatal visit (all ages) increased from 2,487 in 2012 to 4,217 in 2015.	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Mbire District.
185	**Zimbabwe** • Slight increase in reported live births at hospitals and clinics from 3,707 in 2012 to 4154 in 2015 • Live births at home peaked in 2013 at 413 and declined to 272 in 2015 (no data for 2012 • All maternal deaths: no pattern year by year • Caesarean Sections increased from 33 in 2012 to 262 in 2015 • Repeat Antenatal Visits (all ages) increased from 4,034 in 2012 to 7,908 in 2015.	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Binga District. (DHIS2 2015)
186	**Zimbabwe** • *"MoHCC can already see the evidence that the H4+ approach is working in the targeted districts and they don't need another pilot study to take elements of the H4+ approach to scale on a national level, for example in the HDF programme*." • *"It is important to note that H4+ support to areas such as policy, operational guidelines, and innovation has effects way beyond the borders of the six selected districts."*	Interviews: MoHCC staff at Director and Deputy Director Level at Headquarters.
187	**Zimbabwe**	Interview: Chipinge District Health Executive.

[3] Maternal deaths reported at the district level are difficult to interpret because complicated deliveries are often referred to the Provincial hospitals after significant delays; as a result many mothers from the districts will have their deaths recorded at the provincial hospitals.

	• They definitely see the demand side increasing and facilities being accessed and used more. In fact, "*as demand increases, there is now a risk that the supply side will be overwhelmed. Since they have a common border with Mozambique, people from there are willing to travel to Chipinge to deliver their babies."* • *"The relatively small scale and narrow reach of the demand side work is an issue, however. Chipinge has 38 wards and only three or four get support on the demand side to increase community access and involvement with funding from UNAIDS and UN Women."*	
188	**Zimbabwe** • Institutional deliveries have increased from 68 percent of live births in the catchment area to 98 percent in the period of H4+. • Numbers coming to the youth friendly corners (YFC) are low and conditions not so good because of inadequate space. The numbers coming to the YFCs are particularly low for girls.	Interviews: Mushumbi Health Centre, Mbire district
189	**Ethiopia** "*The DHS 2014 report indicates that skilled birth attendance is increasing slowly but steadily from 6 percent in 2005 to 10 percent in 2011 and 16.4 percent in 2014. The trained and deployed midwives, reproductive service officers have contributed to this increase one way or another."*	UNFPA Ethiopia, *Progress Report*, 2015. (UNFPA Ethiopia 2015: 2)
190	**Sierra Leone** • Anecdotal evidence shows significant improvements in service delivery for antenatal, postnatal and skilled birth attendance. Data gathered from the main referral hospital in Freetown show that obstetric admissions rose from 1,533 in 2009 to 7,309 in 2013 and hospital deliveries increased from 1,709 in 2009 to 3,717 in 2013. • Adolescent-friendly standards are being disseminated to all key implementing partners in four provinces; the process has been completed in two provinces. • H4+ funds enabled six districts to conduct integrated, community-based outreach to improve access to high-impact MNCH interventions among hard-to-reach populations. • Two CEmONC facilities serving marginalized groups received generators for electricity and one Centre providing prevention, treatment and support for fistula patients also received an incinerator. • H4+ Canada funds supported the installation of solar suitcases4 in 40 BEmONC facilities country-wide, as well as supporting the recommissioning of 27 rehabilitated health facilities in five districts, complementing an ADB/UNFPA district-strengthening project.	*H4+ Canada Annual Report* 2013. (H4+ Canada 2013a)

[4] Portable, cost-effective Solar Suitcases power critical lighting, mobile communication and medical devices in low-resource areas.

	• In partnership with VSO and CUAMM, H4+ catalytic funds supported OJT in providing supervision, mentoring and coaching of community-based MNH workers in hard-to-reach areas in all 14 districts of the country. • However, only 58 percent of ANC and delivery PHUs provided PMTCT services.	
191	**Sierra Leone** • By 2014 and as a result of the EVD crisis, the progress reports were no longer aiming to achieve improvements over the 2011 or 2013 baselines. A comparison of the two indicates: o MMR was probably higher in 2014 than the 2013 DHS figure of 1,165 and expected to continue increasing due to the EVD crisis and its effect on RMNCAH service use. o Against an original goal of 25% CPR for us of modern methods among women of child bearing age (set in 2011 for 2015) the figure in the 2013 DHS was 16% and the target for 2015 (unlikely to be met) was 15% o Against an original (2011set goal for 2015) of 100% coverage by PNC within two days of childbirth the 2013 DHS indicated 73% and the new target for 2015 was set at 50% but was reportedly not met due to the severity of the EVD crisis. o The original target of 60% skilled birth attendance by 2015 was achieved in 2013 when the DHS recorded a figure of 59.7% but the target was reduced to 50 percent for 2015 because of the EVD crisis. o An original national target of 80% of pregnant women accessing four focus ANC visits by 2015 was almost achieved in 2013 (DHS) at 76% but had declined to a targeted 50% by late 2014. o *"The current EVD outbreak is expected to increase the mortality and morbidity of other health conditions as a result of public fear of catching Ebola in health facilities that communities are currently experiencing which is leading to avoidance of utilizing functioning facilities.*" (p.1)	*Progress Report on the M&E Framework* (Jan-Sept 2014). (UNFPA Ethiopia 2014)

Expanded Access

2. 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?

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)?**

b. **To what extent have H4+JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women?**

c. **How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care?**

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

*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:
Theme: Increasing access to services for marginalised groups		
1	Some evidence concerning the H4+ JPCS approach to targeting marginalised and underserved districts and zones is in Lines 26 to 39 under Assumption 1.1 above.	
2	**DRC:** 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.	DRC H4+ JPCS proposal. (H4+ Canada 2010b: 14-15)

	While the proposal presents a vision for involving men and boys in reproductive, maternal, newborn, child and adolescent health (RMNCAH), and young girls in general, there is no specific strategy for targeting the most vulnerable and marginalized adolescents.	
3	**DRC:** 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: • 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 health facilities in the target HZ"* and an indicator related to contraceptive prevalence rate among youth. • However, the final approved 2011-2012 and 2013-2014 work plans do not include any activities specifically addressing adolescents and youth. • Work plans for 2014/15 and 2015/16 did incorporate specific results indicators relating to adolescent and youth participation.	DRC H4+ JPCS proposal (H4+ Canada 2010b: 18) DRC H4+ JPCS annual work plans 2011-2012, 2013-2014, 2014-2015 (p. 7), and 2015-2016 (p. 3-4) (H4+ Canada 2010a, H4+ Canada 2012c, H4+ Canada 2013c: 7, H4+ Canada 2014b: 3-4)
4	**DRC:** *"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+, à l'exception de quelques initiatives [HIV/ family planning] avec ONU FEMME [UN Women] dans l'encadrement des jeunes filles et garçons".*	Interview: General Referral Hospital Team, Mosango.
5	**DRC:** In Mosango, the health zone team reports that sexual and reproductive health services for adolescents are *"quasi-inexistents"*, and they experience issues with the referrals/evacuation of women with labour dystocia from the isolated area of Kinzamba Two. 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.	Health zone team Mosango power point presentation, 15 August 2016. (Mosango Health Zone Team 2016) Interview general referral hospital team (Mosango).
6	**Liberia:** Increasing access to services for marginalised groups: The RMNCAH Investment Case includes access barriers, *"… Low availability of, limited access to and demand for adequate health facilities and RMNCAH services. Evidence of inequality of resource division with the three south-eastern counties being the most deprived. There is widespread poor service delivery in relation to RMNCAH." p.2*	Liberia RMNCAH Investment Case (MoHSW 2016: 10)

	"Special attention should be given to sexual and reproductive health because an improvement in this area has a direct effect on maternal and child health, education, skills acquisitions, eventual employment and poverty reduction. Surveys have indicated that over 55 percent of neonatal mortality occurs among girls under 15 compared to 6 percent for over 19 years… More investments are especially needed in adolescent sexual and reproductive health to decrease the high maternal mortality and infant mortality…" p.12	
7	**Liberia:** Major causes of maternal deaths include: • Delayed decision to seek care • Cultural practices linked to maternity, family power structures, permission needed by men, male control of women • Bad road network – delays in reaching care • Communication – no or limited cell phone network – people have to climb trees to make a call to request a referral.	Interview: Cape Mount County Health Team, Sinje Palaver Hut, Grand Cape Mount.
8	**Liberia**: The community is concerned about the difficulties pregnant women and girls face (particularly those who live greater distance from the health facility). The **main problems and gaps in relation to maternal and child health** (particularly pregnant and postnatal women) were mentioned as: • Lack of **transportation** to reach the clinic. "*Some live four to five hours away and some end up delivering on foot."* The community articulated the need for another community ambulance • Some live great **distances** away and poor condition of roads makes travelling difficult and risky for pregnant women • **Living quarters for medical staff** posted to the county were insufficient and needed to be improved to support staff morale • **Communications** are poor and it is difficult to communicate with those who live far away • Need for a **maternity waiting shelter**. A waiting shelter would remove the risk of travelling when about to give birth as the woman and her carer would travel to the shelter ahead of time. The clinic and its community has been aiming to build a waiting home for some time. They have been given the task of contributing local supplies and labour but need more information. Specifically, they need the H4+ to identify the plan for the shelter and tell them what is needed in the way of local materials (number of bricks, quantity of sand, planks of wood etc.) after which they will accumulate these	Focus group discussions (FGDs): community leaders, Sinje, Grand Cape Mount.

	supplies and get started with building. The H4+ programme is contributing part of the supplies for the waiting home as well. • **Medicines stockouts**: "*Most of the time you go to the clinic but they will say you have to go and buy it,"* as the clinic does not have it in stock.	
9	**Liberia:** "*The Sida support will be both catalytic and gap filling in the sense that community based care is nearly non-existent in the project areas and the Sida grant will be catalytic in establishing and rolling out community care in those areas.*" The areas were selected using agreed criteria that included: - No or few other partners - An underserved area - Performing poorly - Poor geographical access - Remote rural populations - Limited means of income and surviving mainly on subsistence farming.	H4+ Sida Collaboration on Accelerating progress in MNH: Liberia Proposals and M&E Plan, 2013. (H4+ nd-a)
10	**Zambia:** "*The objective being that, women and children from the five underserved and highly vulnerable districts (Chama, Chadiza, Lukulu, Kalabo and Serenje) to receive increased equitable access and utilisation of high impact quality MNH and FP [maternal and newborn health and family planning] services by 2015*."	H4+ (2013) Report for the 2013 CIDA H4+ Annual Review and Planning Meeting, held at Gonde Lodge, Kabwe, 4-8 November 2013. (H4+ 2013g: 2)
11	**Zambia:** Districts that are hard to reach which were the most disadvantaged selected districts covered five percent of the Zambia population (sparsely populated, hard to reach). So operational costs are high. Used the bottleneck analysis approach to identify the constraints and challenges the Institute for Economic and Social Research (INESOR) helped with this process).	Interview: H4+ Evaluation Reference Group, Lusaka.
12	**Zambia** **Extending services to the hard to reach** Regarding services for the vulnerable, and for people with disabilities, according to key informants from the Ministry of Health, the H4+JPCS has not achieved much in terms of supporting minority groups and in particular mentioned people with disabilities. "*We haven't done too well on supporting minority groups, for example, the disabled who were vulnerable, we haven't taken advantage of the linkages*." H4+ is however working in the most remote and hard to reach and underserved areas.	Interview: Senior Officials, Ministry of Health, Lusaka.

13	**Zimbabwe:** The six districts were selected on the basis of their high maternal, neonatal and child mortality and morbidity, and because they are notoriously difficult to access, particularly in the rainy season. At the time of the baseline, none of the districts was benefiting from other initiatives to improve maternal and child health. *"Some communities are marginalised. They stay far away from health facilities and there are challenges with wild animals."*	CCORE, *CIDA H4+ Baseline Assessment Report,* 2013. p. 30. (CCORE 2013).
14	**Zimbabwe:** The six districts were chosen and were the ones with the worst outcomes in RMNCAH and the hardest to reach. The Government of Zimbabwe was the main actor in selecting the districts and looked at low-performing RMNCAH indicators on a national basis to help prioritize the implementation areas for H4+ (i.e. the eight programme outputs).	Interview: Senior officials in the MoHCC, Harare. Interview: H4+ country team members, Harare.
15	**Burkina Faso:** There are three main strategies to reach the most vulnerable and marginalised: • *Stratégie avancée* (outreach strategy): District hospital health teams visit the most rural and hard-to-reach villages to provide family planning services, they approach the population which cannot travel to the health facilities • Community-based distribution of contraceptives by community health workersStrategy targeting young handicapped persons "*… le programme a contribué à adapter des modules sur la SR à la langue des signes pour ces personnes… (Fédération de l'association de Burkina pour les handicapes) pour permettre à sensibiliser les handicapées dans les centres (encadreurs/superviseurs) – certains élèves ont été renforcés…. Certains agents de santé ont été formés en langue de signes, donc quand les personnes handicapées était réfèrées, ils pouvaient les prendre en charge.*"	Interview: UNFPA, Burkina Faso.
16	**Côte d'Ivoire** **Mobile RMNCAH teams:** To support the 2011 national policy to make RMNCH services free of charge (in particular contraceptives), H4+ JPCS supported mobile RMNCH service delivery to the most marginalized and underserved areas: • The principle was to "reach people where they are" with services, i.e. at community level • Services provided by the mobile teams: ANC, family planning services, HIV testing, sexually transmitted infection (STI) treatment, cervical cancer and cancer of the uterus. • H4+ JPCS first supported the training of "pools of trainers" (midwives and doctors) in the provision of these services.	Interview: H4+ JPCS Coordinator, Côte d'Ivoire.

	• The pools of trainers visited remote areas – sometimes there was a health centre, sometimes not. If there was a health centre, they also trained the midwife/doctor in that centre, while/after they delivered the services, to make sure there is a follow-up after. So the mobile teams both trained others, and provided services while they were there.	
Theme: Increasing access to services for youth and adolescents		
17	**DRC:** H4+ JPCS supported three youth centres to deliver youth-friendly SRH services (Bomoto and Coulibaly in Kinshasa and Centre des Jeunes 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 Bomoto and Coulibaly, and Etonga health centre in Nsele Health Zone in Kinshasa.	DRC H4+ JPCS Annual Report 2015, p. 13 (H4+ Canada 2016: 13).
18	**Liberia:** H4+ has supported the delivery of youth friendly services, focus groups discussions and the establishment of health clubs in schools. As a result of these activities, it was recommended that the government includes health education in the school curriculum. Most of these activities were supported by Save the Children. But at some of the schools, UNICEF is implementing the school health club project (outside of the H4+). The project trains health educators, peer educators, and set up/ established male and female health groups and clubs.	Interview: Youth and Adolescent Health Department, County Health Team, River Gee County, Liberia.
19	**Liberia:** **Peer educators for youth and adolescents**: Peer educators said they had been briefed on gender based violence (GBV) and were able to respond to questions and advise young people on this theme. They said, "*a woman has the right to say no; men should never force women against her will; if not this results in rape*." They also explained what could be the psychological and medical effects of forced sex. They stressed the issue of equality between men and women and the fact that "*everyone is equal*" in the home, relationships, at work and in school. Peer educators felt they were not sufficiently empowered: they would need more material to engage students on sexual and reproductive health and rights (SRHR) issues; they also felt that sex education should be integrated in the school curricula. The female participants in the group discussion stressed that peer educators provided them with **comprehensive information** on each commodity and felt like they made informed choice. When asked	FGDs: Youth and adolescents, River Gee communities.

	by the evaluator to list a number of advantages and side effects of modern methods, the peer educators were indeed able to provide comprehensive information.	
20	**Liberia:** An insufficient number of staff at the local clinic affects the quality of service (time available for the patient; long wait). Youth also stressed the lack of staff in school as well as the lack of education material, which, they felt, limited their knowledge.	FGDs: Youth and adolescents, River Gee communities.
21	**Liberia:** Regarding **health facility staff**, one group of youth said that the nurses were "*nice*" and "*easy to speak to*" at the River Gbeh rural health centre. The group stressed that they received excellent advice and guidance at the heath centre, where the staff were very welcoming. Two young women aged 17 and 24 (one with a one year-old and the other with a 3 year-old) felt they were provided with all information to inform their choice of method (depo; implant). The quality of sexual and reproductive health services provided at the H4+ health centres showed **noticeable differences between rural** (Cheboken, Jarkaken, River Gbeh) **and urban** (Fish Town) areas. In Fish Town, health providers are less accessible to adolescents. In rural areas, all groups stressed the youth-friendliness of staff while in urban areas, nine out of 19 participants mentioned that they either had a bad experience at the Fish Town hospital, or heard of the health providers not welcoming youth when seeking family planning services. They "*don't talk nicely*" and, at times, "*shout at* [them]" and "*send* [them] *away*". This resulted in a certain "*fear to go back*". Peer educators, on the other hand, gave a different picture, stressing that the health staff give students their "*full attention*". This observation, they said, was based upon their own experience as well as what they observe when they escort students to the hospital.	FGDs: Youth and adolescents, River Gee communities.

<table>
<tr><td>22</td><td>Liberia:
Community leaders said they were actively promoting family planning amongst youth. Messages are shared with young people through posters and also through meetings held within the community. Both male and female youth are encouraged to learn about family planning. A person is assigned to a family planning role at the clinic. Plan International also support family planning and offer a package/ resource pack free of charge.</td><td>FGD: Sinje community leaders, Grand Cape Mount County.</td></tr>
<tr><td>23</td><td>Liberia:
Across all the communities where youths and adolescents participated in focus group discussions, two common issues were raised: the first was the long wait at the hospital or health facility due to the staff shortages; the second was the lack of resources to support peer educators with information materials, incentives, or bicycles to help them do outreach.

<table><tr><th>Year</th><th>Total attendances</th><th>Number of youth (10-19 years)</th><th>% of attendances 10-19 years</th><th>% of attendances under 10 years</th></tr><tr><td>2014</td><td>1.396</td><td>151</td><td>11%</td><td>45%</td></tr><tr><td>2015</td><td>1.201</td><td>232</td><td>19%</td><td>44%</td></tr><tr><td>2016</td><td>1.235</td><td>316</td><td>26%</td><td>47%</td></tr></table></td><td>Interview: Health staff, River Gbeh Clinic, River Gee.

Clinic data, Ricer Gbeh Clinic, River Gee.</td></tr>
<tr><td>24</td><td>Zambia:
According to the peer educators there is a very strong demand from young people seeking information about sexual health and also access to the commodities including condoms (male and female). Sometimes, however, condoms are not available, which they see as a serious problem because of the risks of unprotected sex and also because an unreliable supply may discourage young people from approaching them for sexual health education and supplies in the future. On average, there are about ten treatments per day at the centre, with young people seeking condoms, family planning and treatments for STIs (mainly syphilis). Some HIV awareness is provided by schools through civic education, starting at age ten or eleven although the girls in this focus group discussion were not certain about its content or level of detail. There are not enough peer educators: “We are only ten for the whole of Lukulu, so others [in areas where there are no peer educators] are missing out.” If there were other peer groups in other communities, there would be a platform but for now, the work is just done centrally [in and around Lukulu town). More peer educators and a system of ‘peer-to-peer exchange visits, to spread</td><td>FGD: Youth and Adolescent Peer Educators, Lukulu District, Western Province.</td></tr>
</table>

	the concept and learning would be good. Need for **blood testing supplies** and equipment at the Youth Centre. **Youth Friendly Spaces** (treatment, attitude, support, advice): The youth-friendly corners have provided safe spaces to obtain information. Even 14 year-old girls are now able to come to the youth friendly centre and are given chance to be heard and can speak freely. Before the project, young people had no space to talk about the issues that concern them on reproductive health, sexuality and family planning. Comprehensive Sexuality Education "*is a good innovation brought by the project and should be replicated in other locations*." Services that can be accessed through the **youth centre** in Lukulu include comprehensive sexuality education, Family Planning, STI, voluntary medical male circumcision, HIV counselling, gender based violence, girl empowerment, safe abortions and unplanned pregnancy services. **Quality and access to SRH services in the health facility:** Peer educators said that staff at the health facility welcomed young people and provide a good and friendly service. Staff always make them welcome at the facility. However, young people prefer not to go because of shyness (or fear of being seen by people who know their parents). Therefore, young people prefer to approach the peer educators or seek assistance at the youth centre.	
25	**Zambia:** The group said they had learned about STIs, teenage pregnancy, early marriage, the dangers of getting married early and also HIV and AIDS. The group said they learn about comprehensive sexuality education in school do although no one could offer any specific information about what they themselves had learned. Later on, they mentioned what out-of-school youth learn about sexuality and reproductive health. Girls can get married at 14, 15 or 16 years. Some girls get pregnant at 13 or 14 years of age. No one in the group said they go to or had ever been to the centre although they may have been hesitant to disclose this within the group because the centre offers advice about sexual health and family planning. The Community Based Distributors (CBD) working at the centre mentioned that the youth friendly space offers a private space for youth to learn about the dangers of teenage pregnancy, HIV and family planning. There are ten peer educators attached to the centre who were trained in 2012. **Youth awareness:** The youth in this focus group appeared to have a limited understanding of gender issues, particularly gender based violence. The group were asked if they had discussed gender based	FGD: Adolescents and Youth, Tafelansoni Rural Health Centre, Eastern Province.

	violence in school or through the youth centre and did not appear very familiar with the term. One boy gave an example of how he thought the hospital helps prevent gender based violence. One girl in the group showed some understanding of gender bias and explained how parents prefer to support boys in education because "*girls soon get pregnant and are then unable to go to school – she can get pregnant at any time*." This girl was a member of the HIV AIDS prevention club.	
26	**Zambia:** **Addressing the needs of adolescents and youth:** Following focus group discussions in the districts, it was clear that the needs of adolescents and of the youths are yet to be fully addressed. There is no objective focussing solely on adolescents/youth in the H4+ programme. However, one of the programme's operational strategies i.e. communication for development to promote girl child education to discourage early marriages and promote institutional deliveries somewhat targets the group. In addition, only one activity i.e. *"Reproduction of IEC materials or posters on family planning targeting teenagers and the youth"* is the only one targeting adolescents and youths. Strengthening of adolescents' community involvement, mentorship and use of youth friendly services is much needed, as well as **strengthening family planning interventions** to prevent early or unplanned pregnancies.	H4+ (2014) Mid Term Review in Zambia, Country Report, 2012-2013. (H4+ 2014i: 11)
27	**Zambia:** • Youth friendly services means they can choose who they want to talk to, can come at any time, can receive all the services, are entitled to privacy, can get peer to peer counselling • UNFPA is funding teacher training in youth sexuality education and also teacher – nurse joint training so nurses and teachers can support each other to support the youths. • Ideal result will be fewer youth dropouts, fewer pregnancies, more knowledgeable youth.	Interview: Provincial Medical Office, Western Province.
28	**Zimbabwe:** The National Adolescent Sexual and Reproductive Health strategy defined an essential set of adolescent sexual and reproductive health services to be delivered through three programming routes: 1. Community-based (*youth centres* offering counselling, recreational activities and condoms); 2. Health facility-based (onsite *youth-friendly corners* which were planned to offer voluntary counselling. and testing as well as condoms and other family planning methods); 3. School-based (life skills training and counselling). The "*presence of older males at youth centres acts as a deterrent to younger adolescent females using the family planning services"* that may be provided there. Training providers in youth friendly approaches alone does not appear to increase adolescent utilization. "*It appears that the central problem is not*	Johns Hopkins University: *ASRH Strategic Plan Review*, 3 November 2015) (John Hopkins University 2015).

	youth-friendliness, but rather the opposite – barriers to youth services." If adolescents are to utilize such services, the focus of service delivery programs should not only focus on making the centre or clinic "*youth friendly*" but also on the identification and elimination of barriers (human and structural) that impede adolescent utilization of services. For youth-friendly health services to be effective they must, from the beginning, have strong community support.	
29	**Zimbabwe** Attention to adolescent issues in RMNCAH have come late in the program, mainly through the advocacy of UNAIDS and often around HIV issues: • Counselling for children and adolescents has improved as practitioners have been trained and gained experience. H4+ has developed counselling tools and providers have been trained in testing and rapid treatment of children and adolescents • H4+ has supported youth friendly services; however, there is no evidence yet that they are effective.	Interview: Senior officials, MoHCC, Harare.
30	**Côte d'Ivoire** **Youth friendly services – focusing on family planning and sexuality education:** From the beginning of the programme, H4+ JPCS supported the integration of youth-friendly SRH services **into the existing school health clinics** (*services de santé scolaire et universitaire*) in all 8 districts (good coverage). Before, these clinics provided general primary health services to youth, but not RMNCAH specific services. With H4+ JCPS support, the MoH in collaboration with the Ministry of Education were able to: a. Train service providers in these school-based clinics in sexuality education and youth-friendly RMNCAH services, with a heavy focus on family planning methods. b. Integrate RMNCAH services, including provision of contraceptives, in those clinics, increasing access to contraceptives among youth and adolescents. c. As a result of H4+ advocacy, the Minister of Education agreed to allow the clinics to offer contraceptives to students. d. The clinics are visited both by students and out-of-school youth living within the catchment area of the schools. e. UNFPA provided contraceptives and other commodities to the clinics.	Interview: H4+ JPCS Coordinator, Côte d'Ivoire.
Theme: Increasing access to HIV and AIDS services		
31	**Zambia** The clinic is a HIV zonal centre. It managed and supports patients out of its own catchment area. There are a number of services delivered together to support quality patient care and privacy: STIs, HIV/AIDS,	Health Staff, Luvuzi Health Facility, Lukulu

	TB, family planning. At the time of the evaluation team's visit there were stockouts of male condoms and IV fluid. "*Some members noted that there were no male condoms at the moment. Most people expected/ accepted dual protection for family planning and for sexually transmitted infections/HIV. They complained that there were not enough drugs or supplies and when the drugs were delivered, they were used really quickly. They wanted bicycles to do their job better*."	District, Western Province.
32	**Zambia** UNAIDS and the government implemented radio campaign in Lukulu about the importance of male circumcision for reducing the risk of heterosexually and acquired HIV infection. The peer educators felt the radio show is making a difference [about the importance of male circumcision and HIV] although they believe that peer educators also play an important role.	FGD: Youth and Adolescent Peer Educators, Lukulu District, Western Province.
33	**Zimbabwe** **Reaching youth and adolescents with HIV and AIDS services:** What H4+ brought to the table was an integrated approach and a stronger focus on rights and the need to reach the unreached – this was reinforced by Canada and Sweden and their track record on rights. Adolescents need and are receiving more attention, starting at the 2014 Global AIDS conference. UNAIDS works with AFRICAID to support its peer educator model. UNICEF supports AFRICAID to extend the Community Adolescent Treatment Supporters (CATS) programme in Binga and Gokwe South. • This model was first piloted by the MoHCC in 2009 and is intended to assist youth to overcome their fears of stigma and ease their access to adolescent-friendly HIV treatment Services. • CATS are supervised by the DHE's primary health care coordinators and are stationed in some health centres with funding from UNICEF. The work is not very widespread; it started in Harare and is working in four of the six H4+ districts. • CATS are able to reach youth and provide young people who have not revealed their status and help connect them with health services. H4+ funding to OPHID in Mbire supported integrated HIV treatment within PMTCT and RMNCAH, especially for adolescents. They were effective in supporting Mberika Groups (Mberika is the local word for the cloth used by mothers to carry their babies). H4+ emphasised integration of PMTCT and HCT into RMNCAH.	Interview: H4+ country team members, Harare.
34	**Guinea Bissau**	H4+ Annual Workplan 2013-2015, Guinea Bissau.

	Regarding HIV/AIDS, the H4+ partnership will train 362 service providers to identify and reduce stigma and discrimination against people living with HIV, women who are victims of gender based violence, basic tenants of human rights and the rights and needs of adolescents.	
Theme: Increasing access for the poorest		
35	**DRC** **Support to demand side financing schemes** • 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. A survey was conducted on community's perception about health mutual. 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."* • 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."* • In 2014, H4+ partners *"strengthened the management capacities of health insurances ('mutuelles de santé') reaching 3,654 beneficiaries, including 1,240 women and 1,458 children".* • In 2015, H4+ supported: "*the empowerment of women to reduce financial barriers and facilitate access to the SRMNE. 4 women's cooperatives have been created and strengthened with the support of two mutuelles de santé of Mosango and Kenge sensitizers, the approach of the project was presented to communities in the 36 health areas."*	The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet) (H4+ Global Technical Team 2016c).
36	**DRC** The women can only benefit from the subsidised price if they attend all four ANC visits. A woman has to be referred by a first line health centre in order to benefit from the subsidised price for caesareans, 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.
37	**Burkina Faso** The project supported the implementation of the **national strategy to subsidize assisted deliveries** by developing tools; and also implemented a "cost sharing system" through community health insurance funds (*mutuelle de santé*) in 7 out of 9 target districts in the two provinces.	Canada Annual Narrative Report 2014. (H4+ Global Technical Team 2014b: 21)

	The aim was to remove the financial barriers of the poorest women/families to access assisted delivery.	Interview: UNFPA, Burkina Faso.
38	**Côte d'Ivoire** **Increasing access through eliminating user fees:** The provision of free RH medical consultations is considered an innovative strategy to improve the access of marginalized groups to RH services namely family planning services: it covered 41 percent of family planning needs in 2012 according the demographic and health survey (DHS). As part of the Social Franchise Strategy, women's and adolescents' groups (19 community distribution agents *(ADBC)* and seven groups with 79 in Samatiguila and 100 ADBC and 17 groups in Toumodi, Yamoussoukrou, and Bouaké) received microcredit and micro financing provided by local NGOs (NGO VIF and NGO Renaissance Santé Bouaké). The micro financing contributed in improving women's and local authorities' involvement in the H4+ activities.	Rapport de mise en œuvre des activités des initiatives H4+ Sida, August-December 2013. (H4+ SIDA 2013) Rapport standard de progrès annuel de la mise en œuvre de la 6e programme 2009-2015 prolongé à 2015, Côte d'Ivoire. (H4+ SIDA 2015d)
39	**Guinea Bissau** **Increasing access through reducing user fees:** The Gratuity Programme (lifting user fees for pregnant women, children under five and the elderly) was implemented in December 2013 and its effects were observed immediately. The demand for health care by the targeted population increased rapidly. H4+has been directed to extend the same strategy to the remaining 6 regions of the country. For that purpose, the feasibility study in this report was carried out and focused on the costs of the three components of the strategy (payment of services, medicines, incentives to health staff). The demand creation activities linked to the free of charge programme (lifting user fees) were so successful that demand immediately increased according to numerous records and reviews.	João Costa, Estudo de viabilidade da gratuidade para a prestação de cuidados de saúde materno-infantis na Guiné-Bissau no contexto do Projeto H4+, Relatório Final, Abril 2014. (Costa 2014)
40	**Sierra Leone** a. H4+ supported the Ministry of Health in development of operational guidelines for a national voucher system and in-kind package of services for vulnerable pregnant girls and women and hard to reach groups in 2011 and 12. Operational guidelines completed in 2012. Voucher system and package to cover antenatal care, delivery, postnatal care and family planning including conditional transfers to beneficiaries (vulnerable, pregnant teenage girls and women)	a. H4+ Canada Annual Report, Sierra Leone, 2012 (H4+ Canada 2012b)

	b. In 2013, processes were developed for the implementation of the voucher system and in kind packages for vulnerable, pregnant girls and women in remote areas to commence in 2014 in two pilot districts of Port Loko and Pujehun. c. The original plan for the programme developed in 2011 to develop and implement a voucher system for free provision of in-kind services in RMNCAH to pregnant and lactating mothers, and marginalized adolescents had still not been implemented by the end of 2015. The 2015/16 Results Framework and Plan indicated the system would be implemented in two target districts (programme focus since 2014) in the first quarter of 2016.	b. H4+ Canada Annual Report, Sierra Leone, 2013 (H4+ Canada 2013b) c. H4+ Results Framework 2015/2016 (H4+ 2016e)
41	**Online Survey: Question concerning the use of H4+ global knowledge products by H4+ Country Teams:** 37 percent of respondents mentioned the Community Health Workers RMNCH Training Guidance from 2014/15. Of these, only 10 percent actually used the guidance.	H4+ Awareness Survey; question 11.
42	**Online Survey: H4+ Partners and Stakeholders Survey** Among countries that responded to the survey, 78 percent list demand creation as an objective of the H4+ programme in their country, the same number referencing essential commodities. However, this was less than the 91 percent citing service delivery support, 87 percent citing leadership and governance, and 84 percent citing human resources for health as key objectives. Least cited was financing and financial management investments.	H4+ Partners and Stakeholders Survey; Question 22.
43	**H4+ Partners and Stakeholders Survey**: Among 46 respondents, 21 (26%) believed the H4+ partnership approach had led to much better or considerably better outcomes for hard to reach populations.	H4+ Partners and Stakeholders Survey: Question 43
44	Additional evidence regarding national scale incentives to health workers including salary top-ups is in lines 99-112 in Assumption 1.3.	

Assumption 2.2

*H4+JPCA 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:

Theme: Capacity strengthening and capacity development of formal and informal health workers		
45	For evidence regarding capacity strengthening of formal health workers, see lines 75-98 in Assumption 1.3	
Theme: Building effective demand for quality services		
46	**DRC** The "family kit" is distributed by community health workers (CHWs) to families with pregnant women and children below five. It contains essential drugs, including ORS/Zinc, Paracetamol, and Micronutrients to treat diarrhoea, fever and malnutrition. The "family kit" also includes vouchers that women can use to access services at a fixed/subsidised flat-rate price (*tarif forfaitairz*), including ANC services (USD 1.50 instead of USD 3.00), assisted delivery (USD 7.50 instead of USD 15.00) 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. »* CHWs conducted "*an important number*" of 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 led 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 kit".	FGD: Mothers in the community, Mbanza, Nsona, Nkulu.
47	**DRC** *« En 2014, les ménages et centres de santé ont été approvisionnés régulièrement en médicaments essentiels et 45,553 kits familiaux pour accouchement ont été rendus disponibles 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 2015c: 13).
48	**DRC** **La démotivation des ADBC** (*community-based distribution agents*) et RECO (*community health workers*) conduit à la perte des acquis de la communauté en rapport avec les bonnes habitudes de la planification familiale lors des campagnes sensibilisation. Cette perte en acquis serait dûe au manque d'intrants, rupture de stock en intrants. La perte en acquis de certains ADBC formés qui au début de la formation ont créé des vraies besoins dans la communauté **qui pour l'instant sont considéré comme des menteurs** en plus ils sont restés sans activités et ceci va induire la perte de la confiance de la	Interview: Health zone team, Mbanza-Ngungu.

	communauté auprès des ADBC. **La faible réalisation** des supervisions des relais communautaires par les infirmiers titulaires en rapport avec les ADBC, les supervisions ne se réalisent plus régulièrement.	
49	**DRC** **La démotivation des ADBC** *(community-based distribution agents)* • 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. • Il y a de 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 du bénévolat, et cela démotive quand il n'y a pas de moyens de transport. • Les RECO ont été formés en planification familiale et distribution à base communautaire, mais n'ont jamais reçu les contraceptifs pour distribution.	FGD: Community health workers, Kasayi, Mosango.
50	**DRC** • 12 functional community networks for RMNCH (religious and traditional leaders, women associations, youth networks) were supported to mobilise the community & create demand. • 1830 health extension workers trained • Home visits, health talks, referrals and provision of services (family planning). • 300 religious and traditional leaders trained to promote RMNCH • Population Media Centre covering 84 community radios and 3 TV stations **Training of Community Health Workers (CHW)** • In 2012, *"One hundred twenty (120) community-based agents were trained on distribution of contraceptives in the targeted districts"* • In 2013, *"410 community health care providers were trained, compared to 136 in 2012, and 138 were trained in Family Planning and Maternal and Newborn Health."* • There are no CHW activities reported in the table for 2014-2015	Canada/ H4+ Collaboration (2015). *Accelerating Progress in Maternal & Child Health.* Presentation given at inter-country meeting in Douala (Canada/H4+ Collaboration 2015: slide 28). The H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements,* internal document (Excel sheet) (H4+ Global Technical Team 2016c).

51	**DRC** **Increased demand influences quality of care:** *« La formation nous a aidées à connaitre d'autres choses qu'on ne connaissait pas avant mais 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 une 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, on réfère à temps. (…) Avant, on n'avait pas l'information, on a tâtonné et c'est pourquoi on encaissait souvent beaucoup des morts maternelles et des morts nés. Mais après la formation, on a appris à reconnaitre les signes de danger et donc à référer plus tôt. »*	Interview: Health Facility Staff, Lomé Health Center, Mbanza-Ngungu.
52	**DRC** **Increased demand influences quality of care:** *"In DRC, a social mobilisation campaign was carried out to increase demand for family planning 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."* <u>In 2012:</u> • 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 <u>In 2013</u> • Social mobilization campaign at community level to increase demand for family planning services and institutional delivery; training of300 religious leaders in RMNCAH. <u>In 2014:</u> • Blood donation campaign initiated under the leadership of the First Lady; campaign to increase demand for family planning (in 44 health facilities, radio messages, churches, boards on roads, etc.). <u>In 2015:</u> • 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; voluntary counselling and testing (VCT) testing campaigns in Kinshasa. 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	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). H4+ Global Technical Team (2016). *DRC 2011-2015 Key Achievements*, internal document (Excel sheet) (H4+ Global Technical Team 2016c).

	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.	
53	**Ethiopia** The H4+ AWP targeted the following activities for marginalised groups and in support of gender equality: **Outcome 1:** Gender responsive health plans and implementation; **Outcome 2:** Gender responsive health plans and M&E frameworks in place.	H4+ Annual Workplan, 2015-2016, 4 February 2015, Ethiopia. (H4+ 2015c)
54	**Zimbabwe** **Demand for quality services:** There have been tangible improvements in quality of care in the H4+ districts: • Three of the six districts had no capacity for C-sections but now are doing them. [Mentorship has had its biggest impact on EmONC and the availability of skilled anaesthetists and technicians] • Outcome data is improving in the six H4+ districts and they are doing relatively better than other districts, e.g., Mbire and Chipinge were the worst for outcomes and now are doing better than many districts • Nationally, the number of maternal deaths reported in institutions declined from 1,300 in 2011 to 660 in 2014 • At national level, C-sections have risen from just three percent of those needed in 2011 to 77 percent in 2014.	Interview: Senior officials in MoHCC in the capital (Harare), District Health Executives, Health facility staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres. Zimbabwe.
55	**Zimbabwe** **Demand for quality services:** Key activities supported by H4+ in Mbire: • A major contribution was the resuscitation of the OR (provision of an anaesthesia machine at the Mbire District Hospital so that it could perform C-sections). Prior to H4+, difficult cases were referred to the provincial capital. The mentorship programme was key in capacity development as *"training is not enough".* • Training of nurses in youth friendly services (YFS), including the set-up of youth-friendly corners in some facilities, including the creation of support groups in some schools. Mbire has two centres. This component needs strengthening; in particular, there isn't a clear policy on provision of contraceptive services (pills, condoms) in schools.	Interview: Provincial Health Executives, Mashonaland Central Province.

	• Mentorship is done by persons with skills in a particular topic area. The mentor spends a whole day walking through steps in the procedure, helping the mentee conduct a self-assessment, and then coaching and monitoring for improvement. H4+ supported the practice of supportive supervision, with a change from a focus on quantitative indicators to qualitative indicators. The PHE just conducted a supportive supervision to Mbire, and they consider the district their "baby" that they want to catch up with the rest of the districts in the province. The PHE plans to integrate supportive supervision for the many different programs that are being implemented in the province. **Regarding the delivery of information and services:** • Village health workers (VHWs) are the main source of information for the community; VHW training is supported mainly by UNICEF with resources from the Global Fund. District has monthly meetings with VHWs to discuss issues and services, e.g., Mazowe District is piloting self-testing for HIV; VHWs testing for malaria, indoor spraying, use of nets. • Adolescent pregnancy is a major challenge. • Unsafe abortion is a problem. • A mother receives the following continuum of care (from antenatal to delivery to postnatal): o 1st ANC visit: education on nutrition and PMTCT, individual counselling and testing, medical history, exam, anaemia, blood grouping, syphilis screening, blood pressure, package for ANC (antimalarial, ITPT), schedule subsequent ANC visits; VHW encourages mother to delivery at facility o Labour and delivery: oxytocin for PPH, mother stays for 3 days - discharge depends on whether baby is HIV+ o Mother returns 7 days postpartum, VHW monitors at home; family planning info is provided In Mbire, community leaders are supporting male involvement and facility deliveries (if delivery takes place at home, the woman is fined a goat). WAG organizing traditional leaders to provide information about the importance of delivering in facilities.	
56	**Côte d'Ivoire** **Engaging communities to build demand:** • The creation of 25 husbands' schools in 2014 (in the districts Bouaflé, Odienné and Niakara, Duékoué and Guigolo) contributed in the training of 469 husbands, 29 supervisors and 47 Coaches); • As part of the promotion activities in 2014, 298 agendas were distributed and two documentaries related to the activities if Husband schools were realised and broadcasted by the international radios and TV (Al Jazeera and BBC);	H4+ JPCS, UNFPA progress report, Côte d'Ivoire, 2014. (H4+ JPCS 2014)

	• As part of the reproductive health/ family planning awareness campaigns; "*Ciné village*", 33 films were distributed by the NGO REPMASCI in the health districts (Toumodi, Guiglo, Katiola); • 7624 persons were sensitized at the health centres; • Two radio programmes related to maternal mortality and family planning were broadcasted by the Ivory Coast radio.	
57	**Guinea Bissau** **Building demand:** Support to building demand included providing food support for maternity waiting homes which involved more than 300 CHWs in the promotion of the Key Family Practices.	H4+, Global 2014 Annual Report, UNFPA, New York 2015. (H4+ 2015e)
Theme: Investing in strengthening opportunity and motivation		
58	**DRC** "Family kits" • 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 diarrhoea, 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 (USD 1.5 instead of USD 3), assisted delivery (USD 7.5 instead of USD 15) 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.*" • CHW conducted "*an important number*" of 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 led to an increase in ANC consultations and it is estimated that 60 per cent of all women attend for at least four visits now. The CHW first counted the families and then distributed the Family Kits.	FGD: Mothers in HGR de Mbanza Nsona Nkulu.
59	**DRC** Young girls in Loma express that there has been a reduction in maternal mortality in their neighbourhood since H4+ trained CHW and provided "family kit": *« Un autre changement constaté par le groupe est la réduction de la mortalité maternelle. »*	FGD: Girls in Loma, Mbanza-Ngugu.
60	**DRC** **Motivation to deliver quality of care:**	Interview: Health facility staff, Kumbi Health Center, Mbanza-Ngungu.

	« 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 elles ont un kit complet d'accouchement. Avec la baisse aussi des frais d'accouchement car avant les mamans payaient 18 000 FC, mais maintenant elles payent 7 000 FC et les enfants payent 1000 FC pour les soins. »	
61	**DRC** **Staff feeling motivated to deliver quality of care:** *« 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.
62	**DRC** The **"family kit"** approach aims to improve home-based integrated management of newborn and child illnesses (IMCNI) and safe deliveries at community and health facility level. Different kits are distributed, including (1) 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 community health workers (CHWs) 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)
63	**DRC** **Maternity Waiting Shelter:** 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.
64	**Liberia** **Training volunteers to support quality:** Both community health volunteers (CHVs) and trained traditional midwives (TTMs) have participated in training in the areas that they need to know in order to provide appropriate health services at community level. Both CHVs and TTMs said they have attended training for diarrhoea, malaria control, acute respiratory infections, family planning and nutrition.	FGDs: Community health volunteers, focus group discussions.
65	**Liberia** All the **TTMs showed a good understanding about the aims of the maternal health programme** to reduce maternal death. They said they were motivated by a desire to "*educate my community about*	FGDs: TTMs and general Community Health

	disease", "*to minimise the risks to health and educate my community*", "*I want to work for the community's sake – to reduce the death rate of under-fives and pregnant women.*" They also considered that they were having an impact which they said, "*is because of us – we are the bridge – and we are doing the awareness and things are improving*."	Workers (gCHVs), River Gee.
66	**Liberia** H4+ procured **material and supplies to facilitate the work of the Community Health Volunteers**. After the training, each participant was supplied with a backpack, flash light, hand towel, soap, umbrella, a set of rain suits and boots, flashlight batteries, consoling booklet for the use during home visits, ledger for recoding client information and reporting forms as per the national guidelines.	Summary of trainings and activities supported under the H4+ Project, January-December 2015.
67	**Liberia** **Opportunity and incentive:** Community leaders stated that the education provided to TTMs and the level of coordination existing between the health facility and the TTMs as well as the support from the health facility staff has greatly helped in the reduction of home deliveries. "*TTMs are now one of the major cadres of health workers who are referring pregnant women to the health facility for ANC services and deliveries.*" Community leaders mentioned they would like the TTMs to have an identification card, more training, some basic equipment like torches and raincoats, and incentives.	FGDs: Community Leaders, Jarkaken, Cheboken, and River Gbeh communities in River Gee County.
68	**Liberia** **Opportunity: Lack of transportation to reach the clinic:** "*Some live four to five hours away and some end up delivering on foot*." The community articulated the need for another community ambulance. Some live great distances away and poor condition of roads makes travelling difficult and risky for pregnant women. Lack of transportation to reach communities and assist in transporting people to the health facility slows down referral. Both TTMS and CHVs mentioned that walking on foot to carry out the work is tiring. They often pay their own way hiring motorbikes. More worrying for them are long distances that many women have to walk to give birth. While they manage the walk of up to two, three or four hours on a regular basis, this can be risky for women in the throes of labour. There are still cases of women giving birth on the way to the clinic.	FGD: Sinje Community Leaders, Sinje County. FGDs, Community Health Volunteers (TTMs and gCHVs), River Gee.
69	**Liberia** **Opportunity and incentive:** The Officer-In-Charge (OIC) from Gbepo Health Centre mentioned:	Interview: County Health Team, River Gee County.

	"*One TTM escorted a pregnant woman to the health facility for delivery using her own funds for transportation. There was a complication that could not be managed at the health facility."* This patient was later referred to the Fish Town Hospital and again referred to J.J. Dossen Hospital in Maryland for further management. Again, the only person from her community with her was the TTM. No relative including her husband followed. The TTM along with the health staff went with the ambulance to J.J. Dossen. The woman's life was saved and she and her newborn are stable. She has been discharged but there are no funds to transport the TTM back to her community. The OIC stated that at the time this meeting is being held, "*the TTM is still in Maryland County due to the lack of transportation.*"	
70	**Liberia** **Opportunity to deliver quality care:** There is a midwife (male) and two cleaners, both male. Two women had given birth before we arrived; one in the night (a 4.4 Kgs boy); and one in the early morning. Another woman was in the postnatal ward already from earlier yesterday. Three observations from the visit to Lishuwa: A woman from the waiting shelter was carried over to the clinic after we arrived. She had had a spontaneous abortion and had been bleeding continuously since the day before. (*Why had the midwife not addressed her case when she arrived the day before?)* She had six children and was probably 2 months pregnant so it is likely it was a spontaneous abortion. The midwife was unable to insert a line as her veins had collapsed. She was given oxytocin. Her blood pressure was 80/60 but the sphygnometer was not working well so difficult to be sure. Neither the UNICEF paediatrician nor the MCH coordinator for the district were able to insert the line. She was transferred to hospital in the district vehicle (and later reported to be recovering but very weak). Ten minutes later, a Scotch cart came into the clinic yard bringing another woman with her family. She had been intending to come to the waiting mother's shelter from their home 20 kilometres away but had delivered on the road. She was transferred to the delivery room and given oxytocin and a check-up before being admitted to the post-natal unit. Within 30 minutes, the woman who had delivered in the early morning before the evaluation team arrived was found collapsed on the floor with a post-partum haemorrhage. She was assisted to the delivery room again. Her womb was massaged and she was given more oxytocin. The womb contracted she expelled a significant amount of birth material.	FGD: Lishuwa Rural Health Centre, Western Province.

	Thus, the morning's visit to the clinic was marked by these maternal health incidents and borderline emergencies reinforcing how quickly and how frequently maternal health needs arise.	
71	**Liberia** The repurposing of traditional birth attendants into Trained Traditional Midwives (TTMs) whose primary role was to refer women for antenatal care and to accompany women to the clinic for delivery, enabled these community- based volunteers to retain an important function. Furthermore, mama-baby kits were considered a major incentive for women to deliver at the clinic rather than at home as well.	FGDs: TTMs, River Gee.
72	**Liberia** **"Mama-baby packs"** were not widely available after the middle of 2015. They were widely reported as being an important factor in motivating women to come to the clinic. For example, in Cheboken Health Centre, the midwife named the "mama-baby pack" as the most important intervention to increase attendance for skilled births at the clinic by women in the community. "Mama-baby packs" were mentioned during both County Health Team meetings and at every facility meeting or focus group discussion. They were widely seen as highly motivational, and a very successful activity to support changing community approaches to childbirth and delivery.	FGD: Nurses and midwives, Gbepo Health Centre, River Gee.
73	**Liberia** **"Mama-baby packs"**: these provided clothes and useful things for the baby including soap and diapers as an incentive to mothers to deliver in the facility. They were available until 2014 but have been out of stock for 18 months to date. The midwives everywhere were very enthusiastic about the kits and wanted them to be re-started as soon as possible. Gbepo and Cheboken had small packets with a blanket and soap that apparently comes from UNFPA as a holding measure. The County Health Team Reproductive Health Supervisor said that the buckets were in the store room and baby clothes were being procured so that the distribution of the packs could start up again. None of the other facilities had packs.	Observations and record by the evaluation team: River Gee Facility, June 6-8 2016.
74	**Zambia**: **The "Mama Pack" innovation was subjected to a rigorous evaluation**. (*) The final report found that for a 4 USD input, the "mama pack" increased attendance for pregnancy and delivery care by 44 percent and in Zambia would avert 457 deaths for a total cost of 3490 USD per death averted. This is comparable to the costs per death averted of long acting insecticide treated bed nets (LLIN) for malaria at USD3400. (*)Demand Driven Evaluations for Decisions (3DE) team (2014) "*Measuring the impact of mama kits on facility delivery rates in Chadiza and Serenje Districts in Zambia*", End of Project Technical Report, Zambia	Interview: H4+ Technical Working Group, Zambia.

	Ministry of Health, Zambia Ministry of Community Development, IDinsight, Clinton Health Access Initiative Lusaka, 28 April 2014.	
75	**Zambia** **Procurement of "mama packs" by UNICEF:** With the last tranche of funding, UNICEF used about USD 150,000 on the equipment for labour ward to procure delivery beds, obstetric care kits, suction machines, wheelchairs, weighing scales, Ambu-bag, incubators (in some health facilities), blankets, mama packs (which contain a blanket, baby bag, nappy, bath).	Interview: UNICEF, Lusaka
76	**Zambia** **Why are more women coming to the maternity waiting home?** More women are coming to the maternity waiting home because of the SMAGs; they now have an understanding about coming. The mama packs they are getting also have an influence. The maternity waiting shelter is almost ready for commissioning. There will be beds for 12 mothers in two rooms with two toilets and showers. There is another room accessed by a covered walkway for a kitchen which will have cooking facilities. There is already a solar panel connected to the lights. The shelter will be up and running in a month. The H4+JPCS will provide beds, mattresses, blankets, cooking facilities.	FGDs: Safe Motherhood Action Group, Luvuzi and Lishuwa.
77	**Zambia** Three of the five H4+ facilities have **maternity waiting shelters** as well as the hospital. The maternity waiting shelters at the clinics were refurbishments. At the hospital, it was a new building.	Interview: Senior officials, Provincial Health Office, Eastern Province.
78	**Zambia** **The Maternity Waiting Shelters** were valued where they were installed. In Chadiza hospital, it is a pre-fabricated type of building. There are toilets, two showers and a kitchen with no facilities. There are no solar panels in the waiting shelter.	Interview: Chadiza District Hospital Staff, Eastern Province.
79	**Zambia** **Maternity Waiting Shelters** were made to cater for a certain population but people have been coming from far off places to use them. Also, there is "spill-over" to other districts (people coming from other districts), so it is not possible to say what the improvement has been with precision (in terms of baseline). It is the same with midwife training. Midwives have been trained to serve the facility but also the whole district. Plus, they have trained other midwives from within the same district and some have been transferred to new facilities.	Interview: H4+ and Evaluation Reference Group, Lusaka.

80	**Zambia** "*By 2014, **nine delivery rooms and nine maternity waiting shelters** were rehabilitated and equipped with essential maternal and newborn survival equipment. The procurement of high frequency radios, ambulances, boat engines and motorcycles has improved referral system*."	H4+ (2015) Annual Narrative Progress Report, Lusaka, January 1 – 31st December 2014. (H4+ 2015a: 6)
81	**Zambia** The **maternity waiting shelters** attracted women and created an effective bridge between the advice for women to attend the health facility with the challenges many faced due to the enabling environment including poor roads and long distances. They came to the shelter in greater numbers according to the health facility staff and the safe motherhood action groups (SMAGs). For some community leaders, these shelters were the main contribution of the H4+ and its most visible outcome. The health centre advisory committees, made up of community leaders from the catchment areas, were also clear about the role and value of the shelters. However, the advice to attend plus the availability of a modern, clean and safe shelter was not enough to fully overcome all the access barriers, notably the challenges of acquiring and bringing enough food to last through the delivery plus two days for the postnatal check. Many could not bring enough food for themselves and also leave enough food for the family that stayed behind. One solution was that whole families moved to the shelter. Another was that women did not attend. For example, at a shelter in Chadiza District Hospital, admissions vary dramatically according to the time of year, the agricultural season and the availability of food (Table 11). During periods of food scarcity (for example, the period immediately before the harvest), three women discharged themselves because, according to the district health authorities, they probably did not have any more food. **Maternity waiting shelter admissions January 2015 to July 2016, Chadiza District Hospital** Quarter | Q1 2015 | Q2 2015 | Q3 2015 | Q4 2015 | Q1 2016 | Q2 2016 Number of Admissions | **13** | **52** | **24** | **2** | **22** | **14** This is an important secondary problem that H4+ programme investments uncovered. The H4+ JPCS progress review in the first half of 2013 identified food for mothers in the waiting shelter as a problem and pointed out that in some locations "*neighbourhood health committees engage in works in order to contribute money for food for their food banks*". Lack of food for mothers and their relatives was also identified as a challenge in the September 2014 H4+ review meeting in Chaminuka. The solution identified was to engage both the "*community and [the]*	Observations during the country field visit to Zambia, July 2016; Interview: Health facility staff, Lukulu District. INESOR (2013) Preliminary results for Quarter One and Quarter Two 2013, H4+ JPCS, Lusaka, 2013 (INESOR 2013)

	SMAGs involvement for preparedness and income generation activities (IGAs) and to identify strategic partnerships to focus especially on IGAs linked to agriculture". Furthermore, WHO was also tasked with documenting "*potential income generating activities related to food security for [maternity waiting shelters] linked to SMAGs*". There is no evidence that this documentation process ever happened.	H4+ (2014) Review of 2013 Mid-Term Review & Joint Monitoring visit Findings, 18-22 August 2014, Chaminuka Lodge, Chongwe (H4+ 2014m)
82	**Zambia** **Opportunity for skilled birth attendance:** About two thirds of women delivering at health facilities are attended to by skilled personnel. This means that about a third of women are not attended to by skilled health personnel despite delivering at health facilities. Chadiza had the highest proportion of deliveries by skilled personnel and had the highest number of skilled staff (39) compared to Lukulu (3).	Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia, Highlights of Achievements on Selected Core Indicators, March 2014, INESOR in partnership with WHO, UNICEF and UNFPA. (INESOR 2014: 7)
83	**Zambia:** EmONC training has been highly valued. "*Among all the activities supported by H4+, EmONC training has been the most effective"* (in the words of one key informant) and EmONC training was his 'top pick' out of all the H4+ support in terms of having a transformative effect. For him, it was as if a different person had come back from training. One midwife was excited by the fact that the previous week she had resuscitated a newborn and she said that it made her feel proud and strong to be able to intervene that way to save a life. We saw the newborn later during the visit to the district hospital. However, before the training, the midwife did not know how to resuscitate a newborn and so it was a completely new skill to her. She also commented that having new and powerful skills was the best thing about the programme. Several training reports were seen at the health office, including EmONC, Option B+ management, paediatric ART, training for SMAGs and community health workers. In all of the reports, students were tested at the end for knowledge and had to achieve a minimum grade or else take the test again.	Interview: Chadiza District Health Office, Eastern Province.
84	**Zambia** **Challenges to Motivation and opportunity** • *Delay in funds being disbursed*	H4+ Field Mission to Build Capacity for Monitoring and

	• *Staff were not oriented on H4+ reporting format* • *Delay of reports from health facilities due to various forms introduced* • *Activities not implemented according to [planned] schedule* • *Inadequate number of motorbikes in some facilities* • *[Limited] availability of antenatal, family planning and under-five cards as a result data is compromised.* • *Inadequate commodities for family planning and antenatal care e.g. (long acting family planning commodities, lignocaine, RPR kits, urine test kits, etc)* • *Inadequate technical support and mentorship for health facilities and communities.* ***Discussions about solutions to the challenges*** *"Progress has been made in implementing various programmes aimed to improve mother and child health in the district. Measures are being undertaken to sensitize women on the importance of attending antenatal care (ANC) early. The challenges still remain with the distances that women have to cover to access ANC services.* • *There were suggestions during the workshop meeting that pregnant women should be encouraged to move to areas where they can easily access health services to avoid complications.* • *It was also suggested that there is need to have more functional mothers' shelters so that women can be waiting from there.* • *Safe Motherhood Action Groups (SMAGs) have worked well, it was suggested that there is need to incentivize active members of SMAGs.* • *It was also discussed that there is need for funds to be disbursed on time for continuity of programme implementation.* • *Health staff brought up suggestions that the H4+ should harmonise the tools with that of the HMIS to reduce on the amount of work that has to be done.* • *It was also discussed that there is need for MNCH commodities to be made available to the district because most of the times the commodities were in short supply district.* • *There is also need to strengthen technical support and mentorship to facilities as well as to the communities."*	Evaluation of Maternal and Child Health Activities in H4+ Districts and Indicator Harmonization, University of Zambia, Institute of Economic and Social Research (INESOR) October, 2013.
85	**Zambia** **Opportunity varies by year:**	Interview: Senior Staff, Chadiza District Hospital, PowerPoint Presentation, July 2016.

	<table><tr><th></th><th>Admissions</th><th>Deliveries/ discharge</th></tr><tr><td>Quarter 1 2015</td><td>12</td><td>11</td></tr><tr><td>Quarter 2 2015</td><td>52</td><td>52</td></tr><tr><td>Quarter 3 2015</td><td>24</td><td>24</td></tr><tr><td>Quarter 4 2015</td><td>2</td><td>1</td></tr><tr><td>Quarter 1 2016</td><td>22</td><td>22</td></tr><tr><td>Quarter 2 2016</td><td>14</td><td>11 (2 still waiting)</td></tr></table> Status of maternal admission at mother's shelter, 1st Quarter 2015 to 1st Quarter 2015. Note that in this period there were three women who self-discharged reportedly because of lack of food.	
86	**Zambia** **SMAGs reported a big change in the health facility** in recent years and that this change has also affected the community perception of the health facility and what it can do for them. Strong influence on maternal and newborn health survival: the SMAGs believe they have had strong influence on community thinking and behaviour relating to safe motherhood and generally the health of the community. One SMAG member said: *"H4+ actually changed things because now every delivery happens at the facility. I brought many, many women here. Before, they were all resisting but now we are assisting them to come and everything turns out alright."* Another said: *"Before, so many women used to deliver in the villages. This was the problem, but since we started this work, things have changed a lot. The bicycles have made a difference because we can get about to see people… the bicycles help us a lot."*	FGD: Safe Motherhood Action Group, Tafelansoni Rural Health Centre.
87	**Zambia** "*I would like to tell them to continue the good work! They should not stop here. If possible they should build more shelters in other clinics which don't have one. I would also like to urge them to provide us with running water, beds, flushing toilets and bathrooms which are currently the only things missing from the shelter. For me, I can say the maternity home encouraged me to come and deliver at the clinic, and when I go back home, I will encourage other women in my village to also come and deliver their babies here.*"	H4+ (2014) Human Interest Stories, UNFPA, Zambia, 2014. (H4+ 2014h)
88	**Zambia** **Influence on maternal survival:** The SMAGs believe they have had a strong influence on community thinking and behaviour relating to safe motherhood. They believe they have played a critical role in the reduction of maternal death. SMAGs reported a big change in the health facility in recent years and that	FGD, Safe Motherhood Action Group and Community Based Distributors, Tafelansoni

	this change has also changed the community perception of the health facility and what it can do for them. **What methods do you use to influence people's decisions? What kind of activities do you do in your community?** Role play, "*for example, this can be about someone who lost a baby because of late antenatal;*" meetings with the household (visiting each family); meetings with all the community – both men and women together; follow-up visits; offering to accompany the women to the health facility.	Rural Health Centre, Eastern Province.
89	**Zimbabwe** Establishment of maternity waiting homes by UNFPA, including cooking facilities for mothers who live far from the facility. At the district hospital in Mbire (Chitsungo Hospital), there were 52 mothers in the waiting home, and it can accommodate up to 70. (Families accompanied mothers and there was a camp atmosphere outside the several buildings in the complex housing the mothers.) Women's vitals are checked daily, and every week they are giving a full exam. High risk mothers are examined daily. If a problem is noted, the woman is referred to a doctor. Women receive information on immunization, nutrition, PMTCT (family planning not mentioned here). 3 out of 20 are young mothers.	District health executives, including District Medical Officer.
90	**Zimbabwe** **Sustained provision of better quality care:** Key activities supported at Mushimbi Health Centre (Mbire), serving a population of 11,500 (but similar sets of activities across all the H4+ JPCS supported facilities and districts): • Maternity waiting home was built in 2011 and opened in 2012, and is credited with an increase in the number of births at the facility. The waiting home was built for 8 mothers, but they accommodate up to 20 with 596 births in 2015. • Institutional deliveries have increased and staff believe that women come from outside the catchment area because of the quality at the facility. Only 12 home deliveries were reported by VHWs. Only 16 cases were referred to the District Hospital for complications as they are now able (as a result of H4+ support) to manage PPH and eclampsia, do manual delivery of the placenta, manage breach births, and support healthy baby breathing. • No maternal deaths have occurred in the facility since 2014. • H4+ resources supported: waiting mother shelters, delivery beds, resuscitators, and medicines (oxytocin- although didn't receive adequate amounts). A CD4 machine was provided, but isn't working. While it is being served, they were able to use one from another centre. • Contraceptive services offered include OCs, injectables, and implants (Jadelle and implanon). There is not a demand for IUCD. Forty to fifty percent of births are to married, mainly out of school, teens age 15-19.	Health facilities staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres.

	Mushumbi PHC is a HTF/HDF facility.	
91	**Zimbabwe** H4+ inputs at Karinyangwe Mission Hospital (owned by Catholic Mission and staffed by the MoHCC): • Waiting mother shelter, including a cooking area • Training in breastfeeding support • Supportive supervision - doctors come from Binga hospital to "*see the registers, verify the numbers*" as part of the RBF scheme. Karinyangwe is "*losing a lot of money*" because it does not provide family planning, which is incentivised under the RBF. The process of supervision includes the review of partographs, complications and case management. QA includes internal audits. Supervisors sit down with staff to rectify problems. • Point of care CD4 machines are functional. Most important changes since H4+: • Integrated services across the continuum of care (with the exception of family planning for religious reasons). The facility receives several requests a month for implant removals (as PSZ is active and offers services via outreach). • Hospital relationship with community has been strengthened through the engagement of local leaders. Teenage pregnancy remains a major challenge and it is perceived to have gotten worse in the past two years. • BEmONC training as resulted in fewer maternal complications and infant deaths. High-risk cases are referred to the district hospital, while others can now be managed by the health centre. • There are no reported maternal deaths (definition of maternal death is a death during pregnancy or within 6 weeks of birth). VHWs are supposed to report deaths to health centre or to chief. Health centre will notify the police, as the community is afraid of doing so. Staff indicate they will be able to sustain improvements because of the RBF and because they might be able to obtain additional support from the Catholic Mission. The major issue is that the catchment area is so spread out, as more than ¾ of the population is far away.	Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres
92	**Guinea Bissau** **Increased opportunity:** 1. The dedication of staff at Bijago Region is noted and a call made to accelerate the shipment of hospital surgery equipment and staff in order to meet the needs. Evacuations to Bissau often "*unsuccessful*" from Bijago resulting in preventable deaths.	Trip report "Mission to Bijagos" 21-22 October 2015 (H4+ 2015p)

	2. Basic guidance to health staff in Buba to manage medicines stocks more effectively and to attract more staff to the regional hospital.	Trip report "Mission to Quinara and Tombali" 29 September to 1 October 2015, Guinea Bissau. (H4+ 2015q)
93	**Guinea Bissau** Community engagement and demand creation activities in 2015: • *38 motos for community health workers (CHW) advanced strategy implementation and supervision;* • *Support to NGOs which work with HIV positive pregnant women and children and promote SRMNCH and FP, both within communities and local schools;* • *ADPP NGO project, funded by H4+ SIDA, provided training to 50 future teachers on SRMNCH issues;* • *Another H4+ SIDA project developed by AIFO NGO in the administrative sectors of Gabu and Boé, worked closely with 31 local associations; 50 women clubs; 237 Community Health Workers (CHW); and Gabu's Regional Health Directorate, in order to facilitate implementation of the community-based surveillance system; follow up of maternal deaths occurring in communities; and promote utilization and ownership of Sexual and Reproductive Health services by local communities* • *1000 training BEmONC books, including gender and human rights dimensions produced;* • *19 200 young people trained in GBV, HIV and RH to act at community level, in all H4+ regions;* • *100 communication booklets and 50 flyers on GBV, HIV, RH disseminated to the communities;* • *Identification, training and follow up of CHW, which are now working in 2 H4+ regions;* • *200 «Peer Educators Manual» books printed.* • *Communication activities at regional level, including radio shows in local radios of Gabu about SRMNCH, FP, GBV and HIV subjects in 2 different local languages (creole and fula).* • *Awareness raising activities in local communities, involving women's associations, farms clubs and religious and community leaders, in several regions.*	The H4+ partnership: Joint support to improve women's and children's health. *Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations,* Guinea Bissau, 10 Feb 2016. (H4+ Global Technical Team 2016d)
94	**Sierra Leone** **Increased opportunity:** • In all 13 districts, communities were sensitized about MNCH. Traditional birth attendants, now called Community Wellness Advocates (*CAGs*), trained to promote MNCH, received support in conducting outreach activities to refer clients for institutional delivery, family planning and GBV. H4+ Canada	H4+ JPCS Canada Annual Report submitted to Canada, 2013. (H4+ JPCS 2013)

	funds continued to support integrated community interventions in SRH/GBV through the training of *CAGs*. • Male peer educator resource centres that mainstream men in SRH/GBV interventions and refer clients for SRH/GBV services are fully functional in two pilot districts. Twenty-eight peer educator coordinators were trained to coordinate all activities of PENs in the target communities. Outreach sensitization activities by *CAGs* were supported in all the districts, increasing access to MNCH services through referrals. • To enhance gender equality and rights, a community outreach sensitization programme on legal advice and social counselling was carried out in four communities, two of them disadvantaged. This programme reached 300 women, men and adolescents in 2013. The NGO called *LAWYERS* supported two health facilities in providing free medical care for 500 GBV victims	
95	**Online Survey: Awareness Survey** 75 percent of respondents said they thought the H4+ JPCS would help reach 'hard to reach' women and children and almost 80 percent thought it would improve ways of working in countries.	Online Awareness Survey; Question 17.
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.***		
	Information/data:	**Information sources:**
Theme: Sequencing inputs and processes		
96	**DRC** 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 income generating activities, based on its distinct expertise in these areas. It was based on a local decision and agreement between the two	Interview: H4+ country team members, Kinshasa. Interview: H4+ Global Technical Team Member.

<table>
<tr><td></td><td>country offices and funds were thus to be disbursed by UNFPA country office and to UN Women country office.
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. This occurred because UNFPA received less funding at global level than was originally planned which impacted the amount which could be transferred to UN Women at country level.</td><td></td></tr>
<tr><td>97</td><td>DRC
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 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. »
<table><tr><th>Activités partiellement réalisées</th><th>Activité non réalisée</th></tr><tr><td>Appuyer les organisations des femmes en âge de procréer en coopératives et activités génératrices de revenus en lien avec les mutuelles</td><td rowspan="3">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</td></tr><tr><td>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</td></tr><tr><td>Organiser la sensibilisation de la population sur les barrières culturelles d’accès des femmes à des soins de qualité</td></tr></table></td><td>Interview: H4+ country team members, Kinshasa.</td></tr>
<tr><td>98</td><td>DRC
CHWs were trained as community based distributors (CBDs) 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 provenant des relais communautaires, malgré les promesses formulées après la formation. Par ailleurs nous notons que les intrants au niveau des CS sont disponibles ».</td><td>FGD: Health Zone Team, Mbanza-Ngungu.</td></tr>
<tr><td>99</td><td>DRC
Stockouts of commodities reduce demand and trust, especially when the community has been specifically mobilised to build demand for these (for example, family planning</td><td>FGD: Community health workers, Kasay, Mosango.</td></tr>
</table>

	« La rupture de stock des intrants spécifiques du 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 toutes les besoins.»	
100	**Liberia** **Coherence of inputs:** The County Health Team said that the H4+ activities match their own priorities, but during implementation, the County was not fully involved. County operational plans are kept at the central ministry and partners can access these, the operational plan guides the implementation plan of each partner.	River Gee CHT presentation to the Evaluation Team, Liberia, 6 June 2016.
101	**Liberia** Community leaders in Jarkaken, Cheboken, Sinje and River Gbeh all spoke about the process of agreeing to invest in new structures to improve the outcomes of childbirth. Included among these interventions was the wish to see maternal waiting shelters built near the health facility. No health facility had yet had a maternal waiting shelter built and communities expressed impatience. They also saw the need for better staff accommodation to support the staff living conditions and increase their motivation to stay near the clinic during weekends.	Community Leaders, FGDs, 6-8 June and June 2, Jarkaken, Cheboken, and River Gbeh communities in River Gee County, and Sinje, Grand Cape Mount County.
102	**Liberia** "*All the facilities face serious issues with water for quality service provision. The provision of water at the facilities is important and thus must be fast tracked to prevent cross infection, especially nosocomial infections. UNICEF is starting the vetting process to get a contractor for the activity*."	Interview: UNICEF Country Team, Liberia.
103	**Liberia** **"Mama-baby kits"**: these provided clothes and useful things for the baby including soap and diapers as an incentive to mothers to deliver in the facility. They were very popular and many midwives said they considered the "mama-baby kit" to be a major incentive to encourage women to deliver at the health facility. The kits were available until 2014 but have been out of stock for 18 months. The midwives everywhere were very enthusiastic about the kits and wanted them to be re-started as soon as possible. Gbepo and Cheboken had small packets with a blanket and soap that apparently comes from UNFPA as a holding measure. The County Health Team Reproductive Health Supervisor said that the buckets were in the store room and baby clothes were being procured so that the distribution of the kits could start up again. None of the other facilities had kits.	River Gee Facility observations and record by the evaluation team, June 6-8 2016.

104	**Zambia** "***Drugs supplies*** *are inadequate, stocks only last for a few days. Here we are using a kit system and sometimes we have two months stock outs as supplies only last for 30 days.*"	FGDs: Luvuzi Rural Health Centre, Western Province.
105	**Zambia** **UN systems use slow processes**: "*We were not happy with the UN because we want to see them scale up – and we have wanted help in scaling up ourselves. We see the UN as the second government, so we want to see good things replicated. However, there is too much red tape in UN processes. We find that every project has to fit with their processes and we have to follow them, i.e.: we can't fast track when we need to in order that the procurement keeps pace with the rest of the project. The RMNCAH Trust Fund project is an example. It goes through the UN system. You find the funds hit only after a very long time. Then their procurement processes are also very long. Certain things should be fast tracked. For example, there are practical processes getting the timing right but they're just very, very long. They really clog up situations where people are ready to go and then there are no funds/ no products*."	Interview: Senior Ministry Officials, Ministry of Health, Lusaka.
106	**Zambia** **Sequencing of activities and coordination:** Where the H4+ is supporting the construction of a maternity waiting shelter, the equipment and furniture is arriving much later and the building is being used without beds or mattresses. Another example is the Safe Motherhood Action Group members (SMAGs) who only getting initial training. As a very important group in terms of driving improvement, they need additional/ on-going training, supervision and follow-ups.	Interview: The Institute of Economic and Social Research (INESOR), University of Zambia, Lusaka.
107	**Zambia** **Late disbursement of funds**: Funds arrive late (at the end of February in the first quarter and a month in during the other quarters) and there are challenges getting the funds on time. As a result, the programmes have to be readjusted constantly as the funds are not available. The funding hiccups and irregularities slow down the programme delivery.	Interviews: Chadiza District Health Office, Eastern Province, (18 July) and Lukulu District Health Office, Western Province.
108	**Zambia** **Gaps and challenges:** Staff houses to motivate the health workers; a water connection at the health facility; the health facility needs to be stocked with beds and mattresses; staff should be supported with transportation (e.g. bicycles); the Neighbourhood Health Committee would like more members to be trained since only a few have received training in community mobilisation; the provision of food stuffs to the maternity waiting	FGD, Neighbourhood Health Committee, Tafelansoni Rural Health Centre, Chadiza District.

	shelter, mostly during hungry season; they think also that the facility needs more staff, as the current establishment is not adequate to cater for current demands.	
109	**Guinea Bissau** **Gaps and challenges:** Challenges listed/ impediments to progress include: procurement delays, inadequate technical assistance, delayed recruitment, lack of human resources, low salaries and motivation, a difficult context (political instability), poor supervision, need for additional funding.	H4+, Global 2013-2014 intermediary report to SIDA. 2014. Guinea Bissau (H4+ 2014a)
Theme: Interaction of the H4+ JPCS with other programmes		
110	**DRC** **Interaction of programmes (unintended consequences):** • When the flat-rate pricing approach was introduced in the health zone, 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 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. • Before, the maternity ward (*La Cité de la Maternité)* was highly frequented by women, 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 percent, causing demotivation and absenteeism among the staff. • *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.	Interview: Health staff, Cité de la Maternité Hospital (referral maternity ward), Mbanza-Ngungu.
111	**Zambia** **Interaction with other programmes:** Influence on national policy by the H4+ JPCS includes changing to a 48-hour postnatal practice for mother and baby; expanding the recruitment of retired midwives; strengthening the investment in community participation and demand.	Interview: Senior health officials, Ministry of Health, Lusaka.
112	**Zimbabwe** Complementary Zimbabwe initiatives and strategies/policies (current): • Reproductive Health Policy and Guidelines	H4+-Zimbabwe, *Revised Canada Proposal,* November 2012 (H4+ Zimbabwe 2012: 12)

	• Ministry of Health and Child Welfare comprehensive maternal and newborn health (MNH) assessment (2004) and the Maternal and Newborn Health Road Map (2007-2015) • 2011 National Integrated Health Facility Assessment providing updated and specific information on the gaps and needs (including for EmONC services) – providing a baseline for this prosed programme • Child Survival Strategy 2010-2015. • RHCS situational analysis and related strategy • Community based distributors (CBDs) programme including improvements to family planning services and re-orientation of traditional birth attendants (TBAs) • Kangaroo Mother Care promotion • Expansion of comprehensive PMTCT and more efficacious ART regimen • Promotion of Baby Friendly Hospital Initiative (BFHI) • Adoption of Integrated Management of Newborn and Childhood Illness (IMNCI) approach • Expanded Programme on Immunisations (EPI) including Vitamin A supplementation • Adoption of Integrated Infant and Young Child Feeding and Counselling (IYCF) • Introduction of new cadre called Primary Care Nurses as well as task shifting (empowering midwives and volunteer health workers to perform key procedures).	
113	**Zimbabwe** H4+ and other programs (results based financing and the Health Transition Fund): The programmes complement each other, but there are still gaps where support is needed and where H4+ has made a big difference in access to maternal and child health services and quality of services.	Staff of District Health Executives, including District Medical Officer, Binga.
114	**Cote d'Ivoire** **Interaction with other programmes:** • It seems that there is a good synergy between H4+ agencies and other organizations working in RMCAH; the H4+ Sida funding supports other existing funding to implement the following interventions: • Working in collaboration with Muskoka to reinforce the capacities of maternal health key actors regarding maternal deaths surveillance and riposte • Support the mobile consultations in collaboration with the Global Fund • Support training in family planning in collaboration with French Development Agency • Support the training of basic schools' supervisors in collaboration with Muskoka and West African Health Organization	Rapport d'Etape, H4+ Sida, Cote D'Ivoire, Aout 2013-Avril 2014. (H4+ SIDA 2014)

Theme: Community health governance structures or advisory committees		
115	**Ethiopia** 114 government representatives and 228 health workers underwent training in gender mainstreaming in the health sector, clinical responses to GBV, and respectful service delivery sensitive to the particular needs of women.	*H4+ Annual Report,* 2014.
116	**Liberia** Engagement of communities, including through men's groups, community leaders, informal health workers, adolescents and youths, and young mothers' groups, supported by the H4+ JPCS through its implementing partners, was seen as an important contributing factor to the reduction of home births (confirmed by hospitals and clinics visited). This engagement also contributed to increased awareness at the community level and among health staff of the importance of antenatal care, family planning and of adolescent health and better relations between the community and health facilities, including the active role of the Community Health Development Committee which in Jarkaken constructed the fence around the health facility (twice). Increased attendance for skilled deliveries was supported by clinic data.	Views of community leaders in Jarkaken, River Gee.
117	**Zambia** **Accountability:** "[H4+] *has taught us how to be accountable not just with H4+ but also with others. Also, an improvement in terms of focus – more focus on delivery. Undertaking the Bottleneck Analysis was important – now we need to do this with our own funding."*	Interview: Senior Officials, Ministry of Health, Lusaka.
118	**Zambia** **Community engagement/ governance for health:** At the community level, the Neighbourhood Health Committee plays an integral role in strengthening service delivery. **What does the Neighbourhood Health Committee do?** • The Neighbourhood Health Committee acts as a link between the community and the health facility; they report cases and refer mothers and other community [members] to health services • They conduct community sensitisations and create demand for health services • They educate traditional and other community leaders on maternal and child health issues like on the importance of institutional delivery, water, sanitation and hygiene. • They promote adherence to ART for HIV+ clients • They mobilise the community in the maintenance of the health facility **Who provides the services, costs and integration?**	FGD: Neighbourhood Health Committee, Rural Health Centre, Meeting Note, Tafelansoni.

	The health facility has seven trained staff, (1 clinical officer, 1 environmental health technician, 3 nurses, and two cleaners. In terms of costs, antenatal care cards are provided for free.	
119	**Zambia** **The Community Health Advisory Committee supports and extends H4+ achievements**: "*They have been trained to maintain the facility and the health posts; they have been trained to recognise danger signs (e.g. referral for pregnant women, malaria; HIV+ positive individuals and follow-up); they have been trained to refer any form of bleeding (and to avoid the use of traditional medicines); they were trained in July 2015 and again in 2016.*" The committee has met twice in 2016. The issues discussed in the last meeting included the health centre's human resources needs. They would like to have a Clinical Officer to join the staff; they have prepared a list of items that they would like to purchase for the facility and have raised donations within the community for this purpose. They have only been able to purchase wooden poles needed to build a temporary shelter outside of the maternity shelter for cooking.	FGD: Community Health Advisory Committee, Lishuwa Rural Health Centre, Western Province.
120	**Zimbabwe** Mushimbi Primary Health Clinic (Mbire): There is an active Health Centre Committee (HCC) which holds regular meetings every two weeks. The HCC is composed of the head nurse, the ward councillor, business and other leaders in the community, as well as CHWs, male mobilizers, caregivers and others. The community has been supportive, including helping to build the maternity waiting home by procuring bricks. The HCC shares community input on programs and progress, including complaints such as long distances, concerns about stock-outs and drug shortages, and the on-going need for an ambulance. For example, the MoHCC policy is to refer all first births to the district; however, since there is no transport, the HC manages at its level. This strengthened link has resulted in both increased trust as well as increased complaints.	Interviews: District Health Executives, including District Medical Officer, Mbire.
121	**Zimbabwe** Binga District Hospital is the secretariat for the Health Centre Committee (instituted under the RBF). Representation includes VHWs, youth representatives, business leaders, local leaders, traditional healers, church representatives, people living with HIV and AIDS (PLWHA) and NGO representatives. (There is one active NGO working on environmental issues and deforestation). • HCC meets quarterly to review issues at the health centre, how the community interacts, to help disseminate information and education to the community. Examples of issues discussed include support to renovate the staff house destroyed by a storm and how to arrange for training for VHWs from remote villages • HCC supported increase in early booking for delivery at the facility (to prevent home delivery)	Interviews: District Health Executives, including District Medical Officer, Binga.

	• Major challenge remains with teen pregnancy. It has gotten worse in the past two years (20% of girls have dropped out of school.) Because of drought, parents are marrying off their children. Poverty and distances from school are the main reasons for dropping out, rather than pregnancy.	
122	**Multiple Countries** (*Cameroon*, *Côte D'Ivoire*, *DRC, Liberia and Zimbabwe)*, mass media programmes including radio talk shows, were supported alongside activities that focused on specific communities. (17)	*H4+ Annual Report, 2014.*
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:**
Theme: Community and user views about services		
123	**For evidence of increased use of services, see lines 102 to 118 under Assumption 1.5**	
124	**DRC** **User views about services:** *« Il y a eu des changements après la formation, du point de vue technique, car la zone de santé connaissait beaucoup de décès maternels mais après la formation le taux de mortalité maternelle avait baissé.(…) En terme de fréquentation de notre centre de santé, nous avons maintenant 30 accouchements, au lieu de 18, et en général nous avons 400 à 500 cas par mois. »*	Interview: Health facility staff, Kumbi Health Center, Mbanza-Ngungu.
125	**DRC** **User views about services:** • The women confirm that they have acquired new knowledge and skills, particularly related to exclusive breastfeeding, HIV, family planning and hygiene. One testifies that she practiced exclusive breastfeeding with her second child (but not with the first) because she now understood the importance of it.	FGD: Women community members, Mbanza Nsona Nkulu.

	• 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 that 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. • Certain women refuse to receive the "family kit" due to ignorance and cultural barriers.	
126	**Liberia** **User views about services:** In answer to the question "*did the nurse treat you with respect and courtesy?*" all but one of the 40 responses in the exit interview conducted by the evaluation team were positive.	Health facility exit interview, River Gee County, June 2016.
127	**Liberia** **Dedication of staff and attitude to patients:** The evaluation team heard high praise for most of the staff in the health facilities visited in River Gee. With a couple of exceptions, the staff we encountered were clearly dedicated, motivated, keen to learn and do well at their jobs, and proud of their contribution to their communities. Patients, staff and community members reported several instances where staff used their own money to buy generator fuel to manage a night time emergency or to buy patients some food. As an exception, there were some reports that hospital staff were not always entirely respectful of TTMs (as opposed to clinic and health centre). The TTM in question said she was asked to stay at the hospital all day to monitor the pregnant woman that she had accompanied to hospital during the night. When the woman was fully dilated she had to then call the midwife once stage two had started. Thus she said she was in fact performing the duties of the midwife.	River Gee facility observations and record by the evaluation team, June 6-8 2016.

128	**Zambia** **Views from the SMAGS on the utilisation of the clinic:** "*H4+ actually changed things because now every delivery happens at the facility. I brought many, many women here. Before they were all resisting but now we are assisting them to come and everything turns out alright*." "*Before so many women used to deliver in the villages. This was the problem, but since we started this work, things have changed a lot. The bicycles have made a difference because we can get about to see people… the bicycles help us a lot*." "*Now there are no women dying in our community. This year there were no deaths. Yes, it is because we are telling them and bringing them ourselves*."	FGD: Safe Motherhood Action Group and Community Based Distributors, Tafelansoni Health Facility, Eastern Province.
129	**Cameroon: User views about services** Services are underused not only due to objective reasons, but because they are often not gender and culture friendly eight barriers related to perception of diseases, barriers related to perception of pregnant women and childbirth, low male involvement, barriers related to perceptions of maternal and child health services and providers, fear, stigma and discrimination, lack of resources, poor infrastructure and poverty.	H4+ JPCS: Report on Gender and culture-related barriers to access Mother and Infant Health Services – including PMTCT – in the far north of Cameroon.
Theme: Results and evidence of growth in utilisation		
130	**Zambia** **Results in Lukulu** Skilled deliveries: Increase from 48 percent in 2012 to 64 percent in 2015 Facility deliveries (absolute numbers): Luvuzi: 2011 (112) 2015 (210); Lishuwa: 2011 (111) 2015 (382) Confirmed maternal deaths: 2012 (1); 2014 (6); 2015 (2) Percentage of women attending for four or more ANC visits: 2012 (50); 2013 (52); 2014 (49); 2015 (64) Percentage of mother-baby couples getting a post-natal check within 48 hours: 2012 (34); 2013 (26); 2014 (43); 2015 (49).	Implementation of CIDA H4+ Initiative, Power Point Presentation, Lukulu, 9th July, 2016.
131	**Zambia** **Increased utilisation:** Male involvement (measured by accompaniment on the first ANC visit) has increased from 8 percent to 91 percent and facility delivery is now 89 percent in 2016 (from a baseline in 2013 of 60 percent.	Interview: Health Staff, Tafelansoni Rural Heath Centre, Eastern Province.

132	**Zambia** **What has affected maternal deaths reduction?** • Quick referral using the partograph and supported by mentoring and technical support • Meetings with gate-keepers (the traditional leaders and community elders, mothers in law etc). There were four in 2015 and so far two in 2016 • The referral system enabling women to be transferred quickly to hospital • EmONC training • Hospital support through mentorship • Maternity waiting shelters	Interview: Chadiza District Health Office Staff, Eastern Province.
133	**Zimbabwe** **Views about services and improvements:** The changes in capacity and quality of services over the past few years was noted as follows: • *Before*, the patients didn't go to the health facility or accept services; women delivered at home, there were many child deaths before immunization; women with HIV didn't know their status; women were using traditional family planning methods; most children were born HIV+. Immunization programs at school were ineffective because parents were telling children not to participate. Notably, community advocates were not concerned about the lack of integration of family planning as they said that commodities are "*always available*" and referrals are made to community based distributors for access to contraceptives. The advocates were taught by WAG to counsel abstinence for unmarried youth. If the youth ask for contraception they teach them the importance of abstaining. They will not provide contraceptives to youth under 18 because of cultural sensitivities. • *Now*, partners are being tested, homes are sprayed with insecticide, male partners are being circumcised; "*great improvements*" in clinic; trust has increased between health workers and community members. There were also some challenges and complaints: • Mothers waiting shelter is too small; there is no linen at the shelter and there are not enough beds • There are stock-outs of medicines at the clinic; not enough beds • Patients treat the clinic as a hospital and prolong their stay, leading to overcrowding • Need to address staff shortages • Facility should be upgraded to a hospital status; provide more accommodations for staff • Address drug shortages • Procure an ambulance	FGDs: Village Health Workers and Community Based Advocates, Mushimbi and Chiruya, Mbire District.

	• Procure IEC materials for VHWs • No incentives for VHWs - they get some incentives "here and there" but it has been a long time since there were any t-shirts, promotional materials (bags, etc.) • PLHIV caregivers are not giving transport; they use their own personal funds. There is a good relationship between the advocates and the PHC. Advocates have a phone number to use in case there are problems experienced by a community member. Most people are accessing services because there is an increase in trust between the community and the PHC.	
134	**Liberia** **Overcoming barriers and increasing access/ utilisation:** The County Chief said that the health service in the town was making progress, especially in the wake of the Ebola crisis. Comments from **community leaders** suggest the health facility provides a valued and improving service. The community leaders in Cape Mount have a close relationship with the County Health Team (this was validated by both sides). They meet on a regular basis and discuss the health challenges of the community. The community is very involved in promoting and contributing to the development of the county health service for example by helping spread key health messages in the community like attending the clinic for antenatal care and for delivery (referred to as "Big Belly Business" in the community). They request TTMs to actively persuade people to use the clinic. They are also particularly keen to support youth and adolescents, having established a youth group which offers support and advice on sexual and reproductive health to both girls and boys. Regarding sexuality of young people, the elders said that they did not approve of it but accepted that it happened and it was important for young people to have access to services to avoid unwanted pregnancies. The community leaders promote and encourage use of the clinic amongst the community members – especially pregnant women. The community leaders recognise the importance of and try to fulfil their role in family planning. The Town Chief said they try to influence the youth so that girls and women do not to become pregnant too early. "*We try to encourage them not to do that.*"	FGDs: Community leaders in Sinje, Sinje, Grand Cape Mount.
135	**Zambia** **SMAGs are volunteers:** SMAGs said how difficult it was to survive as volunteers. They believe they should be compensated (paid a salary or receive an incentive) because they are carrying out a vital role, essentially that of a health worker.	FGD: Safe Motherhood Action Group, Luvuzi and Lishuwa, Western Province.

136	**Zambia** **What would you have changed/added/improved?** *"I would add an income generating initiative, like growing cassava, for the SMAGs themselves to help sustain their work*." "*Doing the work voluntarily, we often pay for transport out of our own pocket. We are not paid for this important job*." "*Maybe extend the clinic, bringing some water, a borehole – a water supply.*" "*Provide shelter for the relatives when the women come to the maternity waiting shelter*." "*Station an ambulance at the clinic as at the moment, they have to call for one to come, pick up and then go back to the hospital. It all takes time.*" "*Things have completely changed. We need this support to continue yet be more than this.*"	Interview: Lukulu District Health Office, Western Province.
137	**Zambia** **SMAG in Eastern Province, examples of how they have helped change behaviour in their communities:** *"A couple who had tested HIV positive in the catchment did not want to go back to the hospital for medication. Their health condition started to deteriorate and I went there to encourage and educate them the importance of treatment. I personally persuaded and brought them to the clinic. Until now they are on medication and their health conditions have improved,"* male SMAG. *"Another mother had an abortion but did not want to go to the hospital, but after I counselled her she came to the hospital and now has been able to get pregnant again and delivered her baby,"* female SMAG. *"An 18 year-old in-school girl with HIV was pregnant and did not know what to do. I encouraged her to go to the hospital for medication. Her health condition started to deteriorate and I went there to encourage and educate the family about the importance of treatment. I personally persuaded and brought them to the clinic. Until now, they are on medication and their health conditions have improved. A female SMAG encouraged her also to go to the hospital where she enrolled in ANC, delivered and was then admitted back into school," male SMAG*	FGD: Safe Motherhood Action Group, Chadiza Rural Health Hospital, Eastern Province.
138	**Zimbabwe** **Overcome barriers to access: Maternity waiting homes** Key activities supported at Mushimbi Health Centre (*) (Mbire), serving a population of 11,500: • Maternity waiting home was built in 2011 and opened in 2012, and is credited with an increase in the number of births at the facility. The waiting home was built for 8 mothers, but they accommodate up to 20 with 596 births in 2015.	Health facilities staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres. Zimbabwe

	• Institutional deliveries have increased and staff believe that women come from outside the catchment area because of the quality at the facility. Only 12 home deliveries were reported by VHWs. Only 16 cases were referred to the District Hospital for complications as they are now able (as a result of H4+ support) to manage PPH and eclampsia, do manual delivery of the placenta, manage breach births, and support healthy baby breathing. • No maternal deaths have occurred in the facility since 2014. • H4+ resources supported: waiting mother shelters, delivery beds, resuscitators, and medicines (oxytocin- although didn't receive adequate amounts). A CD4 machine was provided, but isn't working. While it is being served, they were able to use one from another centre. • Contraceptive services offered include OCs, injectables, and implants (Jadelle and implanon). There is not a demand for IUCD. Forty to fifty percent of births are to married, mainly out of school, teens age 15-19. (*) Mushumbi PHC is a Health Transition Fund facility.	
Theme: Fistula		
139	**DRC** 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."*	The H4+ Global Technical Team (2016*). DRC 2011-2015 Key Achievements*, internal document (Excel sheet) (H4+ Global Technical Team 2016c)
140	**Liberia** **Training of health workers and support staff** in essential newborn care, prevention of obstetric fistula and infection prevention control and care of pregnant women in context of Ebola with emphasis on early detection through triage at health facilities and community outreach. 72 health workers trained in 26 facilities across the six targeted counties. **Pre-test 38% to 78% and post training results were 70% to 100%**. 26,000 USD spent.	Ministry of Health Activity Report by UNFPA, July-September 2015. (MoHSW 2015)
141	**Zimbabwe** In Mbire, there are fewer maternal deaths because of the decentralised capacity to address emergencies at the district level and bring mothers closer to the facility prior to delivery. Fistula cases can now be referred to Harare as there is money for transport. However, there is no clear answer regarding the low	Interviews: District Health Executives, including District Medical Officer, Mbire.

	number of reported deaths as compared to the maternal mortality rate reported in the recent DHS (600 per 100,000 live births).	
142	**Burkina Faso** Campaign on treatment of obstetric fistula conducted, leading to surgery/treatment of 16 women	Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations. Format 10 Feb 2016, Burkina Faso (H4+ 2016a: 11)
143	**Côte d'Ivoire** Ten operating mobiles units/ caravans were organised in 2014 to reach a larger numbers of women suffering from obstetrics fistula; The training of 60 religious leaders regarding fistula issues contributed in reinforcing the knowledge about fistula	H4+ JPCS, UNFPA progress report, Côte d'Ivoire, 2014. (H4+ JPCS 2014)
144	**Ethiopia** 4,000 fistula cases identified and referred; Two health institutions targeted for capacity building (training) in fistula repair and improving care to GBV survivors	H4+ Annual Workplan, 2015-2016, 4 February 2015, Ethiopia. (H4+ 2015c)
145	**H4+ Partners and Stakeholders Survey**: Half of respondents considered the H4+ partners continued to engage in advocacy as individual organisations although more than 85 percent considered they were becoming increasingly more effective at joined up advocacy over time.	H4+ Partners and Stakeholders Survey; Question 27.
146	**H4+ Partners and Stakeholders Survey**: In countries with an active H4+ team and which also responded to the online survey, only 15 percent of health sector coordinating committees included community group representation at the national level, although 67 percent included civil society organisations.	H4+ Partners and Stakeholders Survey: Questions 33 and 35.

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 toward users*** *in an effort to build mutual trust.*

*Improvements in s**ervice 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.*		
	Information/data:	**Information sources:**
147	**DRC** In 2015, H4+ supported the National Union of Midwives (Union Nationale des Accoucheuses et Accoucheurs) we provided them with bicycles, 2 motorbikes and IT equipment, which enabled them to promote family planning services at community level in Bandundu town and Kikwit, which created 400 new users of family planning methods	DRC H4+ country team (2016). *DRC H4+JPCS Annual Report 2015* (H4+ Canada 2016: 14)
148	**DRC:** **Increased trust and quality sustained over time** Le programme H4+ a contribué efficacement à l'accélérer le progrès en RSS et résultat SRMNE de cette manière : • Améliorer la qualité de la prise en charge des enfants et femmes enceintes à travers le renforcement des capacités des prestataires en soins maternelles et néonatals, planification familier, PTME créant la confiance entre les prestataires et la communauté • Supervisions régulières du BCZS vers les FOSA ont contribué à améliorer la qualité de soins	Interview: Health Zone Team, Nsele District.
149	**DRC:** **Increased trust and quality sustained over time:** *« Avec l'arrivée du programme H4+ , il y a eu assez d'amélioration en rapport avec l'accès et la qualité, surtout avec la survenue de PBF et CAO 4-5, la formation en SONU, PTME, planification familier, PCIME , nous avons remarqué une nette amélioration des soins. La qualité d'accueil, notamment, a été améliorée ; il y a eu aussi amélioration de la qualité de la prise en charge et nous avons accès à l'ambulance. »*	FGD: Community health extension workers, (RECO), Kasay, Mosango.
150	**Liberia** **Increased trust and quality sustained over time:** **H4+ funded incentives**: Some staff and community health workers benefitted from small incentives paid by the implementing partner in the River Gee facilities and communities. For example, midwives received	Interviews with staff at Jarkaken Clinic, River Gee, 8 June 2016 and from Save the Children,

	an extra 20 USD per month to remain near the clinic over the weekend in order to be available to support deliveries at any time. When Save the Children stopped being an implementing partner in December 2015, the incentives stopped and have not been paid since.	quarterly and annual reports, 2014 & 2015.
151	**Liberia** *Investments in building community demand for better health services funded and supported by the H4+. For example, funds support the county health teams to:* • *Conduct the reproductive health technical coordination meetings at county level* • *Deliver an awareness campaign in Q2/ 2015 aimed at galvanising support among youth, women, men's groups, community leaders, health facility staff and others about the interventions that can save a woman's live in pregnancy, and the idea that it is not necessary for women to die in pregnancy* • *Meetings with community leaders, staff, women, men and youth about building a maternity waiting shelter* • *Joint review meetings with communities to discuss the proposed activities and create ownership and involvement.* *Participants reiterated their commitment to reducing maternal and newborn death by encouraging the TTMs and gCHVs to continue with referral of pregnant women to health facilities for provision of maternal and child health (MCH) care.*	H4+ Draft Annual Report 2015 (H4+ 2015k)
152	**Liberia** **Changed provider attitude and behaviour towards users** Before the H4+ programme there was a preponderance of home deliveries as well as limited number of **referral by TTMs**. But under the programme, training and incentives to TTMs have increased referral and the introduction of the mama-baby kits encouraged mothers to deliver at facilities. Staff were trained to deliver better quality care.	County Health Team presentation to the evaluation team, River Gee, June 6, 2016.
153	**Liberia** Changes to **social norms** **Social norms around pregnancy** were evolving in H4+ supported communities in that communities were less likely to blame women who were having difficulties in pregnancy and childbirth as somehow responsible or being punished for their behaviour. This was still a tendency to blame women but part of the H4+ support was aimed at engaging communities about this belief and encouraging better knowledge and understanding.	Interviews: UN Women, Monrovia.

154	**Liberia** **Communities promoting deliveries at health facility:** Comments from community leaders in Jarkaken indicate an increased trust in the health facility and its capacity to the extent the leaders mentioned: "*They have instituted a law for the community with reference to home deliveries. Any community member (husband) as well as TTM who allowed a pregnant woman to deliver at home will be fined three thousand five hundred Liberian dollars."* (Approximately 40 USD so actually quite a lot of money).	FGDs: Community leaders, River Gee County.
155	**Zambia** Over the lifetime of the programme, the H4+ support adapted to include more focus on youth, more focus on the role of men in supporting maternal health outcomes, and more support to identifying and addressing the deeper cultural barriers including early marriage.	Interview: H4+ technical team, Lusaka.
156	**Zimbabwe** Regarding quality of care, the Province Health Team conducted a mystery client (with study participants posing as clients for MNCH services) study in five districts including Binga. Findings included: • Reception areas are tidy and clean • Male nurses treat clients better than female nurses; some nurses were abusive and slapped women in labour • Only 40 percent would refer their daughters to the facility; Seven percent would never refer their daughters.	Provincial health executives, including the provincial medical officer.
157	**Zimbabwe** Increased trust: • In Binga, local leaders have great influence. Giving health messages to local leaders is critical. Working with them has increased male attendance at ANC with partners to 60 percent in Binga as opposed to 11 percent in other districts • A major success of H4+ (along with other programs) has been the increased trust between facilities and communities. PMO receives regular calls from MP who is quite alert to complaints. One example shared was a complaint from a community about how RBF funds are being spent, indicating that there is increased transparency and communities are holding facilities accountable. Other community issues include increased coverage and staffing by doctors, more say in how RBF resources are used (bottom up versus top down).	Interview: Provincial Health Executives, including the Provincial Medical Officer. Interview: Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.
158	**Zimbabwe**	Interview: H4+ country team members, Harare.

	• Community activities came too late within the programme, and there is a need to better balance supply and demand, as supply side activities outweighed the demand side activities. • UN Women is in only three of the six districts, and in only two wards per district. In those districts there have been significant changes in behaviour, but there is no opportunity with the programme ending for taking this work to other wards within the district.	
159	**Zimbabwe** Country team members noted that at the time when UNAIDS and UN Women began to participate in H4+, services were improving in quality and quantity, the communities were inadequately engaged, the demand side was missing and *"women were dying and the level of trust by the community was nil".* UN Women and UNAIDS were unable to influence the program until there was *"money on the table"* that enabled them to showcase their capabilities. The other groups realised their importance, but too late within the programme.	Interview: H4+ country team members, Harare.
160	**Burkina Faso** **Increased use of services including new attenders:** • The NGO RENCAP has strengthened community-based distribution of contraceptives. In 2015, 1,114 clients/women were referred from community to health facility level (805 for family planning, 223 for pre-natal consultation, 86 for assisted deliveries (p. 11) • Achievements of the "husband's schools" (p.13): o 49 group discussions (*causeries éducatives*) reached 514 women and 654 men o 459 home visits reached 1909 married men and 2056 married women o More than 1440 pregnant women were accompanied by a man o 71 men accompanied their wives for family planning o 875 new users of a family planning method • 136 men accompanied their wife for the 1st pre-natal consultation (p.13) • The national family planning week (H4+ contributed the event in the two target regions) led to 56 632 new users, representing a contribution of 8% to the family planning repositioning plan (p. 11, 39) • Intervention to reach handicapped adolescents and youth: CORAH animators referred 1127 handicapped clients to health facilities for reproductive health and family planning services: 369 for family planning, 403 for STI treatment, and 355 for HIV testing. 202 new users of contraceptives corresponding to 288 couple years of protection (CYP).	Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations. Format 10 Feb 2016, Burkina Faso (H4+ 2016a)

Theme: End of the programme, sustainability, continuity		
161	**DRC** **Sustainability:** • Ensuring sustainability is challenging, as it is still not clear whether results based financing will continue to be funded by other partners in the 4 health zones. The Results Based Financing Unit communicated the end of financing to WHO but still has not received a response. • *"We will go back to zero if there is no longer funding, as the motivation will suffer"* • It is possible that the World Bank PDSS project will continue to fund results based financing in Kenge and Mosango (but not the two other H4+ health zones). The training of provincial trainers for the new Results Based Financing project will take place early September, and the activities will start in October.	Interview: Senior official, Ministry of Health, Kinshasa.
162	**DRC** **Sustainability was considered in 2013. Strategies to ensure sustainability identified by the H4+ JPCS team included:** • *The Reproductive Health Law, including articles on family planning, will set the stage for improvements in family planning 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.* • *The National Reproductive Health Programme includes modules that are being used to train EmONC providers, including on-the-job training.* • *The availability of appropriate training modules and management tools as part of Mutual Health Insurance plans will ensure the standardization of this approach.* • *The national reproductive health and HIV programmes contain guides and training modules in HIV management that will improve the integration of HIV services in reproductive health.* • *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.* • *The maternity waiting facility that was repaired in Mosango provides improved access for all members of the community.* • *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)
163	**DRC** **What elements of the H4+ JPCS will endure:**	Interview: H4+ country team member, Kinshasa.

	H4+ agencies will make sure that when new funding for RMNCAH is in the pipeline, it is targeted to the 9 health districts. For example, the new Global Financing Facility (GFF) and the memorandum of understanding between UNICEF, World Bank, and Global Fund will provide support to the three H4+ health zones in Bandundu. In Central Kongo, UNICEF will provide family kits. The RMNCH Trust Fund will also support the nine health zones until it too ends in 2016.	
164	**DRC** **What elements of the H4+ JPCS will endure:** Bandundu will be covered by the World Bank Results Based Financing, and certain health zones will be covered by UNICEF (non H4+) funds. Funds to sustain activities in Kongo Central have not yet been guaranteed. In Kinshasa, Canadian funds will support the continuation of activities.	Interview: Senior health official, Ministry of Health, Kinshasa.
165	**Liberia** Community engagement efforts have been mobilised across the facilities visited and were expressed in a number of ways. One of these was around the commitment to support the construction of the maternity waiting shelters, an issue that was raised by every community visited. In particular, there was a strongly expressed interest in seeing the shelter built and a clear understanding that it had been promised. In one community, during the focus group discussion with the men, they identified a good site for the shelter and itemised the elements that they themselves could contribute. For example, they said they could make the bricks, collect and filter the sand and plane the boards if they could have access to a power saw. In another community, they had already made the bricks, which were starting to disintegrate with the onset of the rainy season. According to the H4+ national coordinator, the tenders for the construction of the maternity waiting shelters were in the final stages of negotiation. The main challenge was that they would only be able to construct four or five in each district rather than six (one at each health centre, plus the referral hospital). The decision they still needed to take was where to site the shelters and consultations were on-going. Another threat to maintaining an upward trend would be weakening quality of care at the facility as a result of the persistent lack of vital medicines or the movement of trained staff. While there is evidence that attitudes have changed, it is not yet clear that these changes are so deeply embedded they could not slip back again once the programme ends if the quality improvements weaken. Other factors that could affect community attitudes and demand include staffing changes, the failure of the programme to deliver commitments (such as the maternity waiting shelters) or other quality of care weaknesses. The lack of public or low cost transport options is a major barrier to access for everyone, but in particular, for those who require regular contact with the health facility such as HIV positive mothers and	Observations, June 2016, Liberia Interviews: Health facility staff, River Gee County.

	those who have non-communicable diseases. Overcoming this barrier has been difficult and, although it is not the role of the H4+ programme alone, it is nonetheless an obstacle to improving maternal and newborn health. So far, H4+ partners report that they have been unable to engage with other UN or government entities to start working on a solution.	
166	**Zambia** **Future concerns especially as they are to be 'abruptly weaned':** The hospital would prioritise an ultrasound machine, more training: EmONC, IMCI, Paediatric ART, essential newborn care, family planning including Long Acting Reversible Contraception (LARC). There is no maintenance plan for equipment (such as the autoclave which is broken etc.) There are some stockouts of key maternal drugs although at the moment all in stock.	FGD, Chadiza District Health Office, Eastern Province.
167	**Zambia** **Sustainability**: 1. An example of activities that H4+ initiated and supported, but are now supported by the government budget or other donors include the training of midwives for the five districts. This was taken up by the H4+ first but, as the H4+ ends, the training will continue using government funds. However, there used to be six midwives being trained under the H4+; now, under the government budget, only two may be trained unless other donors are found to support it. The government are training midwives and contracting retired midwives in reduced numbers. Comprehensive Sexuality Education (CSE) is now recognised by government and is being scaled up. It is policy now but the scaling up is slow. 2. What will happen when this project ends? "We w*ill have to look for further funds. The government has taken it up but it remains a problem*. *We plan to advocate as much as possible*." *"Sustainability is not a big problem as such because all of the activities the H4+ embark upon come from the government's midterm work plan. Activities are not isolated; they are part of the activities the government has already been planned. Some will be incorporated into the government budget. Some of them may have other donors who will take it up. So there is a budget line already for all the activities."*	Interview: UNFPA, Lusaka. Interview: UNICEF, Lusaka.
168	**Zambia:** **What makes programmes sustainable?** *"In general, the H4+ activities being implemented were perceived to be sustainable because:*	H4+ (2014) Mid Term Review on Canada supported H4+ activities in

	i) There was ownership of the programme at the district level *ii) Some H4+ activities were seen to be self-perpetuating, thus sustainable by themselves* *iii) There were positive signs from the ministry indicating that replication of pilot models was possible and also scalable* *However, for some it was too early to tell if the results would be sustainable or not and there were uncertainties about the Millennium Development Goals (MDGs) beyond 2015."*	Zambia, Country Report, Period 2012-2013, 24 April 2014, Zambia. (H4+ 2014i)
169	**Zambia:** **What will continue?** Training, infrastructure and transport: Project funding is now gone so they will have to reduce funding of activities. Activities have been integrated into the action plan so the number will be reduced as funding is more constrained. Nevertheless, funding from government budget will be used for: • Retention of retired midwives: the government funding cannot be used for retired midwives (or salaries outside the agreed salaries) but there is a discussion going on in Lusaka about how to re-hire the retired midwives using government funds • Training: some health facilitates do not have any trained staff at all and so training will continue but at a slower rate. • Infrastructure, including for the health centre, staff accommodation and more transport will continue to be supported.	Interview: Lukulu District Health Office, Lusaka.
170	**Zimbabwe** **Sustainability:** *"H4+ funding ended abruptly in November 2015 when planned disbursements were not allocated to UN Women in Zimbabwe. The young women in their groups wanted to know why planned funding was not forthcoming and they (Katswe) had no reasonable answer. It seemed strange to them that some H4+ members (UNAIDS, UNICEF) had funding for activities but another (UN Women) did not. They were told that it had something to do with UN Women suffering a reduction in the allocation of H4+JPCS funds at a global level. The abrupt ending to planned funding was very damaging to young women's confidence."*	Interview with implementing partner NGO: Katswe Sistahood and with H4+ country team member: UN Women.
171	**Zimbabwe** **Financing following the end of the programme:** In addition, the Health Transition Fund supported other costs of the primary health care, so that the facilities would not require/charge user fees. The DHE was not clear on an exit strategy for H4+. There is concern about sustainability and that the improvements gained will not last once H4+ ends.	Interview: Chitsungo District Hospital, Mbire District Health Executive, Mbire.

172	**Côte d'Ivoire** There was little concrete data identified on the outputs and effectiveness of the youth and adolescent strategy. However, **it seems an example of a more lasting change to the joint education and health system** as these services were integrated into an already existing system and not "tapped on" to a stand-alone youth centre, which is "left on its own" once the funds end. Elsewhere in the programme however, the imminent end is more likely to cause a rupture: • There is a risk that the programme activities will be suddenly disrupted as the H4+ JPCS was the only programme supporting RMNCAH in the target district besides UNFPA and UNICEF core funds (which cannot pick up and sustain all H4+ JPCS activities). No further funding for RMNCAH is in the pipeline (at least not for the eight target districts). • The districts are supposed to continue the mobile services delivery but often do not have sufficient budget even to conduct routine supervision and it is uncertain whether they will be able to deliver the supplies/commodities for mobile services that H4+ JPCS did (HIV tests etc. which are not provided for free) – although UNFPA will continue to provide condoms and contraceptives. • *"Il y est risqué d'arrêter brusquement les activités"*	Interview: H4+ JPCS Coordinator, November 28 2016, Côte d'Ivoire.
173	**H4+ Partners and Stakeholders Survey**: **When asked "*What three national systems priorities are most pressing in your country?"*** four out of 31 respondents (9%) said demand creation and six (13%) named advocacy and communication. Leading priorities were human resources for health (74%), leadership and governance (63%), and financing and financial management (50%).	H4+ Partners and Stakeholders Survey: Question 40.

Responsiveness to National Needs

3. 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?

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?

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?

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 (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:
Theme: Responsiveness/alignment to national plans and priorities in RMNCAH		
1	**Burkina Faso:** The H4+ Canada programme was designed to contribute to The National Strategy for Socio-Economic Development (SCADD 2011-2015) and the National Health Development Plan (PNDS 2011-20210) which includes a strategic objective to strengthen governance, and a strategic plan for the development of the national HMIS (p. 11). The monitoring and evaluation (M&E) framework presented in the proposal is directly linked to the National Health Sector Development Plan (PNDS) strategic objectives and the UNDAF outputs related to maternal and child health.	Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011, Ministère de la Santé (Proposal to H4+ CIDA. (Ministry of Health 2011b: 11ff)
2	**Democratic Republic of the Congo:** 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 PNDS 2011-2015.	DRC H4+ JPCS proposal, p. 3 (H4+ Canada 2010b).

3	**Democratic Republic of the Congo:** MoH senior officials confirm that H4+ JPCS interventions are aligned to Ministry of Health (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.
4	**Ethiopia:** H4+ activities are aligned with national Health Sector Development Plan (HSDP) and maternal and newborn health (MNH) Roadmap.	United Nations and SIDA Collaboration in Reproductive Maternal, Newborn and Child Health in Ethiopia, Work Plan 2013-2015. (UN and SIDA 2012)
5	**Zambia** **The H4+ are aligned with national priorities/plans. The 2011 – 2015 National Strategic Plan includes the following objectives:** to support the National Health Strategic Plan 2011-2015, the following four national human resources objectives have been developed: 1. Increase the number of employed and equitably distributed health workforce with appropriate skills mix 2. Increase training outputs harmonised to the sectors needs 3. Improve performance and productivity of health workforce 4. Strengthen systems and structures to support HR expansion and performance.	*Zambia National Health Strategic Plan, 2011-2015*. (Ministry of Health 2011a)
6	**Zimbabwe:** During original programme planning, and in the first years of the programme, the H4+ members (with inputs from the Ministry of Health and Child Care (MoHCC)) had to be responsive to the plans and priorities expressed in key national documents: • The National Health Strategy for Zimbabwe: 2009-2013 by MoHCC • The Zimbabwe National Maternal and Neonatal Road Map: 2007-2015 • Final National Integrated Health Facility Assessment Report (FNIHFA): 2013 • MoHCC Service Guidelines on SRHR and HIV Linkages: 2013.	Interviews with H4+ country team (UNFPA, UNICEF, WHO, UN Women, UNAIDS).
Theme: The establishment of effective H4+ coordinating mechanism (basic structure and timing)		
7	**Burkina Faso:** Established platforms / frequency of meetings:	• Meeting minutes and workshop

	• National level: Inter-agency coordination meetings: H4+ country team meets regularly/quarterly (WHO, UNICEF, UNFPA and sometimes IRSS) (since 2014, no record of 2013 coordination meetings); in 2015, 3 H4+ country team meetings were organized. No record of participation of UNAIDS and World Bank. • National level: WHO, UNFPA, UNICEF and Ministry of Health (MoH) partners (national and provincial levels) organized several coordination meetings, including (a) workshop to discuss results of MTE, (b) annual national coordination/planning meeting (2012 and 2014), and regular coordination meetings (c, d, e, f) – few records of meetings 2011-2012, they seem to have intensified 2013/2014 -present • Regional/district level: In January 2015, the H4+ country team (WHO and UNICEF) participated in a workshop organized by the DRS in the North Region and with the participation of DRS staff, hospital directors, "médicins chefs des districts sanitaires" – main objective was to support the DRS clarify H4+ programme and solve issues. • Regional/district level: in 2015, two regional coordination meetings were held in the two target regions (2015 annual report p. 14)	reports from 2012-2015 as they appear in *Google Drive*. • *Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations*, 10 Feb 2016 (p. 14). (H4+ 2016a)
8	**Burkina Faso:** • The mid-term evaluation (MTE) covering the period 2012-2013 stated that there was **no real coordination mechanism or platform at the time of the MTE**, and recommended that WHO supports the establishment of such coordination platforms at both national and regional levels (p. 11) • As example, there were no specific meetings to coordinate H4+ activities, but they were "generally integrated in the statutory meetings of the districts, regions and national level" (p. 32)	*Revue à mi-parcours des activités H4+ supportés par le Canada au Burkina Faso. Rapport pays. Période couverte : 2012-2013*. Avril 2014. (H4+ 2014n)
9	**Burkina Faso:** Effectiveness of H4+ coordination platform: • The Regional Health Directorate (DRS) of the Centre North Region (coordination meeting Oct 2014) reporting: ***Insufficient coordination meetings take place; recommendation to organise regular coordination meetings at all levels*** *(p. 3)* • At the same meeting, the National School of Public Health (ENSP) reports: *"The coordination activities (monitoring field visits and meetings), documentation activities and strengthening the capacity of the H4+ country team are the activities that suffer the most"* (i.e. nine planned activities not implemented in 2013) (p. 5)	*Rapport de la rencontre bilan de mise en œuvre du programme H4/CIDA au Burkina Faso,* Ouagadougou le 23 *Octobre 2014.* (H4+ 2014l: 3-5)

	• The 2013 annual progress report confirms that coordination, supervision visits, documentation activities are *"suffering"* (p. 20) and defines (lack of) *"regular coordination meetings between key activities"* and (weak) *"coordination of RH interventions due to multiple partners"* as key challenges (p. 24)	*2013 annual narrative progress report,* Burkina Faso, reporting period: Jan-Dec 2013. (H4+ 2013b)
10	**Democratic Republic of the Congo:** • At the beginning of the programme (2011), there was no H4+ coordination mechanism. The H4+ work was coordinated through the Commission for Health Services (*Comité de prestation des services*) of the National Health Sector Coordinating Committee (*Comité National de Pilotage du Secteur de la Santé, CPP-SS*). • 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.	Interview, senior official in MoH in Kinshasa.
11	**Democratic Republic of the Congo:** The evolution of H4+ JPCS coordination in DRC between 2011-2016: • *"From 2011 to January 2016, UNFPA was the lead agency for H4+, but early 2016, this coordination role was handed over to UNAIDS.* • *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.* • *The strategic meetings between H4+ heads of agencies are organized every two months.* • *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."*	Email with H4+ country team member, 4 August 2016.
12	**Democratic Republic of the Congo:** • In 2015, the Director of the Division for Family Health, MoH, decided to integrate the coordination of H4+ JPCS back into the existing government-led RMNCAH Task Force meeting in order to reduce the number of meetings to attend. This replaced the monthly joint H4+ meetings between the MoH and H4+ members. However, the Division for Family Health did not convene any RMNCH Task Force meetings in 2015 and the joint coordination (government and H4+ members) became much less effective. One meeting took place in March 2016.	• Interview H4+ country team member. • Interview, senior official in MoH in Kinshasa.

	• The internal inter-agency meetings continued to take place, and the MoH was invited, but only participated once in a while.	
13	**Ethiopia:** The main mechanism for program coordination is a H4+ technical working group (TWG), with WHO Ethiopia Country Office serving as the coordinating agency and focal point for the TWG. The Federal Ministry of Health (FMOH) focal point is also a member of the TWG. Each agency is tasked with implementing activities in line with their respective areas of technical competence and mandates.	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program* (H4+ 2015m)
14	**Liberia:** *"The Liberia H4+ Agencies and partners developed and implemented the H4+ programme. A **Technical Working Group** (H4+ TWG) comprising of the agencies and the Ministry was established and meets monthly and quarterly to review progress made in implementation of the programme. The team also forms part of a national reproductive health committee that meets monthly to discuss and join efforts in improving SRH/MNCH services in the country."*	*H4+ Draft Annual Report for the three counties: Grand Kru, Maryland and River Gee,* H4+ 2015 (H4+ 2015f)
15	**Sierra Leone:** There is no new coordinating mechanism established for the Canada initiative of H4+; **rather the programme will rely on existing mechanisms as follows:** • Implementation will be under the leadership of the Ministry of Health and Sanitation (MOHS) which provides guidance for identifying priority interventions • Implementation is the responsibility of the director of Reproductive and Child Health and the Manager of Reproductive Health/Family Planning and MOHS • Overall coordination is under the existing Reproductive and Child Health (RCH) committee which reports to the National Health Steering Group chaired by MOHS and with the heads of the H4+ agencies participating • The working coordination of the country programme will be done under the existing Technical Working Group on the Joint UN Programme in Health - no special working group will be formed for the Canada grant (p.14) however, • The three executing agencies (WHO/UNICEF/UNFPA) to present annual budgets to the Local Steering Group composed of the five H4+ participating agencies (UNFPA, WHO, UNICEF, UN Women, UNAIDS and the Director of Reproductive and Child Health (RCH) and only on approval will the proposed budget be submitted to the global level. (p.14)	*Joint Programme Proposal (2011)* (H4+ Canada 2011)
16	**Zambia:** How coordination of H4+ was established, initially: *"…The 2012 interim H4+ progress report states that a project coordinator for H4+/CIDA collaboration was appointed to provide technical and*	Interim Progress Report H4+/CIDA Collaboration, 1st

	programmatic support and to liaise with the UN for project oversight. The coordinator was to be supervised by the Deputy Director of Public Health and the UNICEF Chief of Health and Nutrition."	August 2012. Reporting period: April 1st 2011- June 30th 2012. (H4+ 2012b: 10)
17	**Zambia:** The H4+ JPCS coordinating group, called the Technical Working Group (TWG), is chaired by the MoH jointly with the H4+ National Coordinator. National authorities have taken a consistent interest in the H4+ programme and it is considered a significant contributor to the MoH reproductive maternal neonatal child and adolescent health (RMNCAH) programme. As a group, the H4+ meets monthly in principle. In practice, based on minutes of meetings, this is closer to every two to three months. There are meetings every 4 to 6 months with the heads of H4+ agencies (two to three meetings per year) and the minutes of these meetings suggest that these meetings afford opportunities to shape policy and support problem solving. The H4+ agencies appear to work as a cohesive group alongside with national counterparts to produce their work plans and deliver monitoring reports.	Interview, H4+ Technical Working Group, Lusaka, Zambia.
18	**Zimbabwe:** • The main feature is a national steering committee for H4+ with the UN agencies, the Ministry and the non- governmental organisations (NGOs). There are regular (biannual) provincial and district planning and review missions. • H4+ JPCS is dealt with at a higher level in the Ministry (since beginning of 2014) where it is linked to the Director of Family Health (one level down from the Permanent Secretary), instead of the Reproductive Health unit.	Interviews, H4+ country team (UNFPA).
19	**Zimbabwe:** • The H4+ Steering Committee (national) gave the UN and the MoHCC the opportunity to sit down and plan together. This is followed up by the quarterly District Review meetings where they can have the same kind of interaction with the District Health Executives, the facilities and the communities • Coordination was weak and the H4+ agencies did not really act in a joined up way until the national Steering Committee was established at the 2013 Victoria Falls meeting.	Interviews with MoHCC staff at Director and Deputy Director Level, MoH Headquarters.
20	**Zimbabwe:** • This was the first meeting of the National H4+ Steering Committee set up after the planning and review meeting in Victoria Falls in September 2013 and the Victoria Falls country to country meeting in April 2014. At this meeting the Director of Family Health at MoHCC and chair of the H4+ steering committee made it clear that: *"H4+ had poor recognition as an initiative in government*	*Minutes of the 1st National H4+ Steering Committee 18th June 2014* (H4+ Zimbabwe 2014a).

	circles, more specifically in the provinces and the districts, which was one of the reasons for provinces and districts to be not very responsive to H4+." P.1 • The meeting also highlighted poor coordination (p.2).	
21	**Zimbabwe:** *"After the Vic Falls meeting in 2013, MoHCC really took the lead and got coordinated planning really moving. From that point on the Ministry took on the challenge of integrating the programme (including with other programmes supporting health care) by taking on ownership and accountability."*	Interviews, H4+ country team members (UNICEF).
Theme: H4+ members speak with one voice *(more coherent advocacy and policy advice)*		
22	**Democratic Republic of the Congo:** MoH views on coordination - strengths: • Before, each agency operated independently: *"Chacun faisait de son coté."* Now, the partners (H4+ agencies) speak with the same voice.	Interview, senior official in MoH in Kinshasa.
23	**Democratic Republic of the Congo:** *"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 (…) "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.
24	**Liberia:** Senior MoH staff commented that H4+ partners are more likely to speak more consistently around the same policy messages and focus on the same priorities.	Interview, Senior MoH Department Director in Monrovia.
25	**Zimbabwe:** *"Before the steering committee: WHO would come and say let's do X, then UNFPA would come and say let's do Y. The visibility of H4+ was very low. This improved after the Victoria Falls meeting and the advent of the national Steering Committee in part because of the provincial and district review Meetings and the engagement of the District Health Executives."*	Interviews, MoHCC staff at director and deputy director level, MoH Headquarters.
Theme: Role of joint programming of H4+ JPCS funds (the necessity of funds)		
26	**Democratic Republic of the Congo:** MoH views on coordination - strengths: • 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	Interview, senior official in MoH in Kinshasa.

	resources will be necessary to sustain the collaboration (i.e. support for meetings, joint field visits etc.) *« La pérennité demande un minimum de resources. »*	
27	**Zambia:** What made the H4+ work is the availability of catalytic funding. One Head of an H4+ Agency said "*We need the funds 'to gel'. The funding helps us mobilise to do the work – to 'gel as a movement together'. A little funding helps us to work well together. With H4+ funds coming to an end we may rely again on our own funding which may not have the same 'gelling effect'*." Another said, "W*e are making sure that the funding is going to the right places and at the same time, coming together in terms of our thinking*."	Heads of Agency Meeting, 7th July, 2016.
28	**Zimbabwe:** • Improved coordination has been the major positive improvement due to H4+ JPCS. **With the advent of the funds needing to be programmed** they collaborated first on the needs assessment to underpin a coordinated response. • They focused on the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best).	Interview, H4+ country team (WHO).
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:**
Theme: Coordination of H4+ JCPS is *led by the national health authorities (ownership and leadership, placing the MoH at the centre of the programme)*		
29	**Burkina Faso:** • Due to high turn over at MoH level (the Director of the General Direction for Family Health changed three times over the course of the programme; the last one was just a few months ago)	Interview, H4+ team member

	there has been a lack of ownership of the H4+ programme, and it has rather been WHO, UNFPA and UNICEF advising/suggesting the MoH to organise planning and coordination meetings (lack of leadership) • **The joint coordination and review meetings (MoH and UN agencies) are difficult to organise,** as the MoH is very busy. They are supposed to take place twice a year, but rarely do so. But we do meet ad hoc and coordinate among ourselves frequently, and also involve the MoH ad hoc, ask the Direction for Family Health for their opinion or approval of certain aspects of the programme.	
30	**Cameroun:** • MoH leadership at central and regional level has been strong since the beginning, and Minister of Health/ Secretary General frequently participate in annual review and planning meetings, or any other major event. For example, the Secretary General chaired one of the H4+ JPCS quarterly review and planning meetings. • The Director of Family Health (MoH) chairs the H4+ JPCS monthly coordination meetings and the regional health director chairs the weekly H4+ JPCS meetings. • In December 2016, they will organize a 3-day "Forum to review the results of H4+ JPCS". The Minister of health will invite other RMNCAH development partners to participate in this meeting. • At regional level, there is also strong MoH leadership: The regions organize a large RMNCAH every six months with the participation of all partners, including also *the "prefet", "sous-prefet"* and local leaders. • At district level, they lack funds to organize similar RMNCAH coordination meetings.	Interview. H4+ team member
31	**Cameroun:** The Ministry of Health (MOH) has major beneficiary of the project, chairs all the meetings and takes leads the implementation of activities.	Sida H4+ Donor Report 6 Cameroon, 2015 (H4+ SIDA 2015c)
32	**Côte d'Ivoire:** Côte d'Ivoire has established an effective coordination mechanism which is led by national health authorities and reaches to sub-national levels: • Inter-agency/internal meetings are held on a monthly basis. • Joint coordination meetings (MoH and H4+ members) also take place monthly: The MoH (General Director of Health, who delegated to Director of Community Health) convenes and chairs monthly H4+ JPCS and Muskoka meetings (combined into one meeting, as H4+ members implement both programmes jointly, but in different districts): "*We, the H4+ members, have to report on progress and works plan indicators to the MoH."*	Interview, H4+ country team member

	• H4+ JCPS funded these meetings (coffee break etc.) At sub-national level, H4+ JPCS coordination also seems effective: • The programme funds quarterly meetings to review H4+ JPCS progress and plan activities for the next period. The meetings take place at regional level (3 regions) with the participation of all 8 target districts. MoH representatives from central level participates in these meetings, and reports back to the H4+ members (and other relevant institutions) on progress, needs and issues/bottlenecks. • This facilitates ongoing needs identification, problem solving, and taking district level activities to national level.	
33	**Democratic Republic of the Congo:** Senior staff of the Division for Family Health raised several issues in the collaboration with the H4+ members: • The H4+ coordination worked well in the early years. Beginning of 2015, the joint coordination broke down. According to senior MoH officials, 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) o Only one *joint* annual review meeting was organized (in 2013) in DRC. o 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. o Different H4+ agencies had different disbursement procedures, and there is a need to harmonize (D10 called an individual meeting with each agency to discuss) o The D10 indicate that UNFPA in particular was not responsive to their needs (as coordination unit for H4+), whereas UNICEF and WHO were *"The programme was aligned – until it became "clandestine" in 2015-2016"*	Interviews, senior officials in MoH in Kinshasa
34	**Democratic Republic of the Congo:** • *« Pour le PNSR [Programme National de Santé de la Reproduction/ national reproductive health programme], le programme avait bénéficié d'un assistant technique [H4+coordinator] qui avait*	Interview, senior official in MoH in Kinshasa

	aussi le mandat de la coordination de H4+ et de la coordination des réunions des agences et bailleurs. » • *« Au début du programme, les réunions de coordination des activités étaient régulièrement tenues, le suivi et l'évaluation des activités étaient bien organisés (…) nous remarquons que durant les deux dernières années, les réunions ne se tiennent plus régulièrement. »* • Il y a eu quelques faiblesses au niveau de tenues réunions de coordination, car au début tout allait bien, mais 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 plans de travail annuel (PTA) du PNSR, la non production du bulletin, faible réalisation des missions conjointes sur terrain. »* • *« Les défis à surmonter ?* ***Que les agences H4+ jouent leur rôle d'accompagnement et non comme des ONG d'exécutions.*** *Le coordinateur de H4+ devrait vraiment aider le gouvernement à jouer son rôle de leadership. Aussi De plus, la faible motivation de la partie gouvernementale serait un facteur de relâchement de la tenue des réunions de coordination entre les Agences et Gouvernement »*	
35	**Democratic Republic of the Congo:** A H4+ focal point noted that the weak collaboration and lack of coordination meetings between the H4+ agencies and the government is a challenge to effective joint coordination and implementation of the programme because joint field supervision visits to monitor activities no longer take place.	Interview, H4+ country team member
36	**Democratic Republic of the Congo:** *« La coordination des intervenants constitue un deuxième défi et mérite d'être améliorée pour plus de résultats, ceci entre les agences et la partie gouvernementale dans la mise en œuvre. »*	DRC H4+ Annual Report 2014 (H4+ Canada 2015c: 27)
37	**Democratic Republic of the Congo:** The available meeting minutes indicate that most H4+ technical team meetings took place without the government counterpart.	Meeting minutes from 2012-2015 as they appear in Google Drive. See also bibliography for DRC country note
38	**Democratic Republic of the Congo:** 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	H4+ country team member H4+ Country Team (2015). (H4+ Country Team 2015a)

	the third day, the Representatives of the seven agencies (WHO, UNICEF, UNFPA, UNAIDS, UNWOMEN, World Bank, WFP) join.	H4+ Country Team (2016). *Rapport de la Retraite H6+ République Démocratique du Congo 2016. Du 06 au 08 Avril 2016* (H4+ Country Team 2016) H4+ Country Team (2015). *Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015* (H4+ Country Team 2015b)
39	**Democratic Republic of the Congo:** • Another reason for the "broken" relationship between the H4+ coordinator (UNFPA) and the Director of the Family Health Division 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. • The UNFPA H4+ coordinator indicates he 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 providing the Family Health Division a vehicle.	Interview, senior official in MoH in Kinshasa Interview, H4+ country team member.
40	**Democratic Republic of the Congo:** A Provincial Health Director noted that H4+ JPCS have made promises that they have not kept. For example, the 2015 work plan contains an activity to support the provincial RMNCH Task Force meetings, but the activity was never funded. Further, he states that H4+JPCS has not made any significant efforts to coordinate the implementing partner NGOs who have limited organizational capacity.	Interview, Provincial Health Director (Bandundu Province).
41	**Ethiopia:** H4+ contributed to on-going strategy and plan by FMOH – it not clear how it advanced strategy beyond contributing to accelerating outcomes through provision of resources.	Observation from H4+ Evaluation Team, Desk Study.

42	**Guinea Bissau:** Collaboration with other partners is identified as the lesson learned for Guinea Bissau in 2014. Coordination is considered "*strong*" and involves monthly technical meetings with participation of head of agency; Coordination meetings also "*between EU partners, Global Fund, SNLS, and H4+ every 2 months and extraordinary meetings held when necessary*."	H4+, Global 2013-2014 intermediary report to SIDA. 2014. (H4+ 2014a)
43	**Liberia:** **We have achieved ownership by the government**; The target population has taken ownership of the programme and we have built their capacity to take the lead; Collaboration with the ministry and other partners; The trust from the ministry has been built in the partnership.	H4+ Coordinator, KII, June 3, 2016.
44	**Sierra Leone:** Coordination of H4+ JPCS in 2013 took place under the: • Monthly Health Partners meeting chaired by the Chief Medical Officer and including NGOs and bilateral and multilateral development partners in health • Monthly health development partners meeting chaired by DFID • Monthly health sector steering committee meetings chaired by the Minister of Health • Monthly reproductive health commodity security meeting • Annual forecasting and quantification meeting and the • National annual district health planning mechanism	*H4+ Canada Annual Report 2013* (H4+ Canada 2013a)
45	**Sierra Leone:** Difficulty in implementing training related activities because of poor coordination between partners and also within the RCHD programme. **Agreed on the importance of reactivating the RCH technical working group between the MoH and the UN partners** as a way of improving communication and streamlining workplans. Also proposed to **open the developing partners forum** to include a high level MoH staff, this will ultimately provide an opportunity to discuss and exchange ideas on key issues affecting programme implementation.	*Minutes of the UN H4+ Heads of Agencies RMNCAH Meeting 21 October, 2016* (H4+ Agencies 2015a)
46	**Zambia:** **The H4+ was considered successful by MoH**: Ministry of Health senior staff said, *"H4+ has been the best in terms of coordination with the UN. It has also done well through its **promotion of government ownership** – starting at the central level and all the way to the districts. The districts where the H4+ is working are progressing very well.*" **Coordination needs the right kind of person**. Specialist technical skills are being used for project management and procedural jobs. "*As a government we are really feeling this is a gap. The technical*	Interview, Senior Officials, MoH

	assistance that senior UN technical advisers used to provide is missing because the people are running the H4+ project. A coordinator was appointed for a while, and now it is an existing UN staff member rather than a consultant or special appointment. The coordinator was already doing a senior post and now has added H4+ coordination to her portfolio. It is not possible to do everything and project management is not the best use of expertise."	
47	**Zambia:** "*Main weakness is in the use of the senior people. I expected them to work but not only to support the funding of H4+. I want us all to be thinking and working on another level, at a higher policy level so that the H4+ informs the national level*."	Interview, Senior Officials, MoH
48	**Zambia:** **Continued strengthening of the H4+ Coordination** "*The overall coordination of the H4+ programme is commendable, where nearly all the UN agencies (except the World Bank) are 100 percent involved and the leadership from the Ministry of Community Development and Mother and Child Health is committed. Nevertheless, there is always room for improvement and continued strengthening of the H4+ coordination, planning and implementation of the programme including M&E."* [To note: at the time this report was written, (a) UN Women was not present in Zambia and (b) responsibility for MNCH was located in the Ministry of Community Development and Mother and Child Health.]	H4+ Canada Supported Activities: Mid Term Review in Zambia, Country Report, Period: 2012-2013, 24th April, 2014. (H4+ 2014i: 12)
49	**Zimbabwe:** • This was the first meeting of the national H4+ Steering Committee set up after the review meeting in Victoria Falls in late 2013. At this meeting the Director of Family Health MoHCC and chair of the H4+ steering committee made it clear that: *"H4+ had poor recognition as an initiative in government circles, more specifically in the provinces and the districts, which was one of the reasons for provinces and districts to be not very responsive to H4+.*" P.1 • The meeting also highlighted: Poor national coordination mechanisms (p.2)	Minutes of the 1st National H4+ Steering Committee 18th June 2014 (H4+ Zimbabwe 2014a)
Theme: Role of implementing partners (IPs) in H4+ coordination		
50	**Democratic Republic of the Congo :** *« 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*	Interview, implementing partner (NGO)

	ensemble pour nous informer, par exemple, qu'ils vont financer ceci et cela. Il n'y a pas eu des réunions. »	
51	**Liberia:** **Implementing partners** referred to the lack of funding such that one meeting per facility (one group meeting per month) was insufficient. The team mentioned that implementation is done in the same area but due to the lack of coordination of the H4+ county coordination there is little or no information about who is working where. **The IPs have never met each other before in the context of the H4+ programme work. They could have been more coordinated on the ground if there had been better coordination at the national level.** Implementing partners mentioned that some of the activities that were successful under their programmes might be included in a forthcoming micro-planning process. This would be an example of continuity in that case but they are not sure whether they will be invited or how their experience will contribute. Also suggested that the H4+ should expand to all facilities in the county, not just a few.	Interview, implementing partners, June 3 2016.
52	**Zimbabwe:** The quarterly H4+ planning and review meetings include representation from MoHCC headquarters at the Director, Deputy Director and Programme Officer level as well as technical staff. They also include members of the H4+ country team (all partners). Most importantly they include Provincial Medical Directors and members of the District Health Executive and facilities staff from all six H4+ districts. Finally, implementing partner NGOs take part in these meetings with Katswe Sistahood and Women's Action Group (WAG) taking part in the June 2015 meeting.	MoHCC, *Report on Quarterly Provinces and Districts Review and Planning Meeting,* 11-12 September 2013 (MoHCC 2013a) MoHCC, *Report on H4+ Planning and Review Meeting,* 23-25 September 2014 (the Victoria Falls Meeting) (MoHCC 2014a) MoHCC, *Report in H4+ Planning and Review Meeting,* 01-03 June 2015 (MoHCC 2015c)

53	**Zimbabwe:** *"For Katswe Sistahood [implementing partner], being invited into the H4+ programme and its quarterly review and planning meetings was a big step in their organizational recognition and development."*	NGO Interview (Katswe lSistahood).
Theme: Contextual factors influence the effectiveness of the coordination of H4+ JCPS and RMNCAH in general		
54	**Cameroon:** Contextual factors influencing programme implementation: Outbreaks of epidemics (polio and cholera), polio vaccination weeks, lack of human resources, and general instability caused by Boko Haram slow down implementation, as health authorities and service providers are generally overstretched, and unavailable for programme implementation/monitoring during certain periods.	Interview, H4+ country team member
55	**Democratic Republic of the Congo :**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. Selon lui, 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 de ces derniers. Selon lui, 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 [de soumettre des requettes de financement], cependant la reforme a beaucoup perturbée son fonctionnement »*.	Interview, H4+ country team member.
56	**Democratic Republic of the Congo:** ***« 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 technique.»*	MoH (2016). *Plan national de développement sanitaire 2016-2020: vers la couverture sanitaire universelle.* Mars 2016. Ministère de la santé publique (MoH 2016b)
57	**Guinea Bissau:**	Evaluation Team observation

	Few donors/programmes make it easier for H4+ members to coordinate effectively among themselves and with other partners – and have a more effective voice/larger influence on overall health sector coordination	
58	**Burkina Faso:** *« Au cours de 2015, la gestion du programme a été perturbée par le putsch manqué des 16 et 17 septembre avec la grève générale lancée par les syndicats ayant abouti à une paralysie de tous les secteurs. A cela s'est ajoutée la menace de l'épidémie à virus Ebola avec une réduction d'espace budgétaire des autres programmes de santé. »*	*The H4+ partnership: Joint support to improve women's and children's health Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations*, BURKINA FASO report, 10 February 2016, p. 16.

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.

	Information/data:	**Information sources:**
Theme: The H4+ JPCS coordination mechanisms are inclusive of governmental and non-governmental stakeholders and reach to sub-national levels		
59	**Burkina Faso:** The planning and coordination of H4+ activities with other RMNCH interventions take place through a standard process institutionalized by the MoH since 1996, by which the **health districts/regions** develop and present consolidated annual work plans to the MoH and all partners/donors at national levels for funding during a "session to finance work plans". The annual work plans contain all activities (not just RMNCH) of the health districts and regions. Prior to work plan development, the H4+ provides guidelines to the districts and regions on what activities can be funded under H4+. According	Interview, H4+ team member, 23 June 2016.

	to interviewed stakeholder, duplication and overlap are prevented and activities well coordinated, as all partners participate in this MoH-led planning meeting.	
60	**Burkina Faso:** <u>Sub-national level:</u> • Bottom-up approach for annual work planning – districts submit their plans to regional → national level – a annual planning workshop taking place with the *Chef médicin des district sanitaire*, hospital directors, DRS and national level MoH institutions (p. 37) • H4+ supported a *« Atelier de planification opérationnelle des activités dans les plans d'action des districts du 28 au 30 mars 2012* » (p. 3) • H4+ supported *the « élaboration des plans d'action 2013 des directions régionales de la santé, des districts sanitaires et des Centres Hospitaliers Regionaux ; cela a permis d'obtenir des plans d'action consolidés de bonne qualité, prenant en compte les interventions prioritaires pour la santé maternelle et infantile »* (p. 2)	Rapport de la rencontre de planification des activites du programme H4+CIDA, Ministère de la Santé, date unknown ; and « Revue à mi-parcours des activités H4+ supportés par le Canada au Burikina Faso. Rapport pays. Période couverte: 2012-2013, Avril 2014 (Ministry of Health 2014: 37, Ministry of Health nd) MINUTES DE LA TC DU 29/02/2012 (H4+ 2012c: 3) 2012 Annual Narrative Progress Report. H4+/CIDA (H4+ SIDA 2012)
61	**Burkina Faso:** Coordination at regional and district levels – main challenges: • Challenges: Involvement, ownership and degree of understanding of the H4+ programme of decentralized structures has been an issue, and it was recommended during national coordination meetings to "strengthen the involvement of all actors" (p. 3)	Réunion de coordination inter agence du 29 septembre 2014, 10h à l'OMS

	• Request for funding (local implementing partners submitting applications to WHO/UNICEF/UNFPA) are often not aligned with the national H4+ work plan (p. 3) • A meeting was organized between the H4+ members (WHO and UNICEF) and the health structures at regional and district levels to "improve the ownership at all levels" and clarify "misunderstanding/lack of knowledge about the programme". • The 2013 Annual Progress Report Burkina Faso states that "an improved understanding of the H4+/Canada project and its ownership by all involved stakeholders is influencing the achievement of objectives, in a context of "high turn over of staff", and there is a need to regularly update/brief the new staff about the H4+ programme (p. 23)	(WHO, UNICEF et al. 2014: 3) Compte rendu de réunion OMS-UNICEF et l'équipe de mise en œuvre du programme H4+ Canada dans la Région du Nord (H4+ Canada 2015a) 2013 Annual Progress Report, Burkina Faso (H4+ 2013c)
62	**Cameroon:** • The H4+ coordinator (UNICEF) is based in UNICEF regional office in Maroua, in the Extreme North Region. This was decided to facilitate capacity development of regional and district health authorities and close monitoring and supervision of H4+ JPCS activities. The Extreme North Region is very far away from the Yaoundé and access can be difficult (e.g. flight schedule unreliable). o The coordinator frequently participates in ad hoc and quarterly review and planning meetings of district health team and regional health departments, which facilitates responsiveness to their needs, joint planning of activities, and communication. o The coordinator organizes **weekly H4+ coordinating meetings** with the regional health team and H4+ focal points (UN agencies) based in regional offices in the field. o He feels that being based in the field allows him to gain a better understanding of challenges/needs and to support RMNCAH in a more global/integrated way. • The H4+ coordinator also intervenes at national/strategic level. UNICEF put in place several strategies and mechanisms to work effectively at both national and sub-national level: o The coordinator travels to Yaoundé on a monthly basis, and has a substitute in the UNICEF office who participates in meetings at central level in case he cannot travel. o The coordinator has a direct counterpart in the MoH at central level with whom he works closely.	Interview, H4+ team member

	o Most importantly, they have established a "H4+ core team" composed of H4+ members and MoH representatives **from both the central and regional levels**, which organizes **monthly teleconference calls** to coordinate H4+ JPCS.	
63	**Cameroon:** Quarterly H4+ JPCS review meetings were frequently organised and included several governmental and non-governmental partners, as well as development partners, for example: • *«Les autorités administratives et Communales des DS/H4+ (5 Sous-préfets et 5 Maires) ;* • *Les représentants du Minsanté : Directeur de la Santé Familiale et Sous-directeur de la Coopération (DCOOP) ;* • *Les membres des Agences Sida/H4+ venus de Yaoundé, Garoua et Maroua (UNICEF, ONUSIDA, ONUFEMME, OMS, UNFPA).* • *Quelques intervenants en santé ayant une collaboration directe avec le projet Sida/H4+ dont GIZ, C2D, DR/MINPROFF, ALDEPA, Public Concern.* • *Responsables régionaux de la DRSP ;* • *Chefs de Service de Santé (SSD), Directeurs des HD et Chefs Bureau santé (CBS) de 5 DS /H4+ ;* • *Délégués régionaux des secteurs apparentés (MINPROFF et MINCOM).* • *10 Membres de la Communauté de 5 DS /H4+. »*	H4+ country team (2014). *Workshop Report, Biannual Review of H4+ JPCS Programme,* July 2014 (H4+ Country Team 2014b)
64	**Cameroon:** The coordination is strong, especially at sub-national level with 17 organized with MoH from January to September 2015. Other relevant meetings have been: two with the MoH at national level, three with other Ministries, one with bilateral actors, four with NGOs, two with the civil society. Furthermore, quarterly meetings of Sida H4 head of agencies are organized.	*Intermediary rapport, Sida* *H4+ Joint Programme Mid- year progress report - January to September 2015 – Cameroon* (H4+ 2015h)
65	**Democratic Republic of the Congo :** *« Oui au niveau des priorités des zones de santé (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, ensuite ce plan est validé par le conseil d'administration de la ZS, et le plan consolidé de la DPS est validé au niveau du CPP . (…) Les priorités de la PNDS dée coulent des engagements que le pays a pris vis-à-vis de la stratégie Globale en rapport avec la*	Interview, health zone team (Nsele)

	SRMNE de la santé de la mère comme le CAO 4-5 ; l'accessibilité universelle 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. »	
66	**Democratic Republic of the Congo:** According to representatives of the health zone team in Mbanza-Ngungu, in 2013-2014, the government was proactively 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, health zone team, Mbanza-Ngungu.
67	**Democratic Republic of the Congo :** *« La DPS [provincial health department] n'a pas vraiment joué un grand rôle là-dessus [dans l'identification des besoins]. 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 (…) Comme la cible a été adoptée dans le document du projet, la DPS a simplement récupéré ses informations pour les intégrer dans le PAO de la province, et chaque zone a intégré aussi dans le PAO de la zone, ce qui lui revenait en termes de formation, en termes d'appui aux médicaments et à l'équipement. »*	Interview, provincial health department (Kongo Central).
68	**Democratic Republic of the Congo :** Normally, the provincial health department (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 organised with the participation of some partners. Ad hoc meetings with 1-2 partners are frequently organized. The DPS of Kongo Central has never organised 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).
69	**Democratic Republic of the Congo:** *« L'appui [H4+ JPCS] s'amenuisait dans le sens qu'aucune réunion de Taskforce n'a été tenue au cours de cette année 2016 ; en 2015, nous avons eu une réunion sur quatre prévues ; et en 2014, il y 3 réunions sur quatre réunions prévues ».*	Interview, provincial health department (Bandundu).

70	**Democratic Republic of the Congo:** According to the Division for Family Health (MoH central level), **the provincial health departments (DPS) did not clearly understand what H4+JPSC is about**. They thought that H4+ was a project that would bring them a lot of money and they suspected that the D10 steals the money, as they only saw the agencies, not H4+, come to their provinces. They think that H4+ never happened. The Division for Family Health would have liked that the DPS come to Kinshasa to programme activities together. That meeting would have been very important [but did not take place].	Interview, senior official in MoH in Kinshasa.
71	**Liberia:** **Are the activities provided by the H4+ part of the county priorities?** The CHT acknowledged that the H4+ activities match their own priorities but during implementation the county was not fully involved. County operational plans (developed by the county) are kept at the central ministry and partners can access these. The operational plan guides each partner's implementation plans. The county specifically mentioned their appreciation to UNFPA for the level of involvement although some of the implementation is slow as is the case of the supply of the solar lights. Several people mentioned implementation partners of UN Women (Africare) and said they worked really well with them.	River Gee facility observations and record by the evaluation team, June 6-8 2016.
72	**Liberia:** **H4+ coordination at the county level and between county and national levels:** The Field Coordinator was contracted by one of the H4+ partners and reports to that partner on a monthly basis, submitting a quarterly report of activities. That partner then reports to the wider H4+ country team and to relevant implementing partners. Because of the way the contract has been structured, the Field Officer focuses mainly on the activities and bottlenecks associated with his H4+ contracting partner's component of the programme. He also reports on bottlenecks in other partners' components as he comes across them but does not automatically report on progress. **The Field Officer is not invited systematically to join the quarterly H4+ meetings in Monrovia and does not have direct contact with other H4+ member agencies. The Field Officer has no formal or specific role coordinating with implementing partners at the county level.**	Interview, H4+ Field Coordinator.
73	**Zambia:** "*H4+ is* ***delivered through the districts and the district health offices are the implementing partners.*** *Priories have come from the districts; they develop their action plans. H4+ has been very responsive to this* *from the start and very responsive to what the districts wanted*."	Interview, Senior Officials, MoH.

74 75	**Zambia:** **"Human Resources for Health** *"Reproductive Health Technical Committee meetings are held at the County and district levels in the three H4+ original counties by CHTs and CHVs and TTMs trained and are working with health facilities in the catchment communities in the three counties. At these meetings, RH issues such as maternal death in the community, neonatal death in the communities and awareness and distribution of FP commodities by CBD are discussed, and solutions to the problems are put in place.* ***Summary of RHTC Meetings held in the three H4+ Counties*** • *County Level: 36 county level RHTC meetings were held with 18 health facilities OICs and 192 DHOs in the three H4+ Counties* • *District level: 192 district level RHTC meetings held with 18 health facilities' OICs and midwives* • *Clinic level: 216 clinic level RHTC meetings held with staff from 18 health facilities in the three H4+ counties"*	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k).
76	**Zambia :** **Coordination** – suggestion: "*H4+ coordinators should look at the **county level.** They should also meet to help assist all with sharing of ideas – just the H4+ partners – so we can have an agreed agenda*." The most recent PCA that was signed wanted this. H4+ concerns should be shared with all the other partners.	Interview, implementing partners.
77	**Zambia:** **Procurement processes not responsive to government needs:** The way the H4+ buys equipment for the districts is not yet fully in line with Zambian needs. UNICEF decides on the make/ model of the motorcycles since they only procure from two suppliers. They are the wrong kind for the sand and the conditions in the west of the country according to the Director of MCH Services, but they were not procured with detailed specifications. The government could have tailored certain specifications, however they [UNICEF] bring their own preferred type according to officials. *"Yes, when we let UNICEF do it, they procure whatever they want.* *Resources go through the UNICEF procurement group in Copenhagen and they have an arrangement with Yamaha. But they should have three vendors who would offer equipment that is suitable and then the MoH can choose. The issue is mainly with the procurement of motorbikes. Most of the Yamahas are not working now in some areas of the country [the West]. In other places they are still working. There are no problems with solar panels or other equipment. But the outreach indicators are not very good in some areas because of the wrong motorbikes."*	Interview, senior officials, MoH.

78	**Zimbabwe:** • "*Coordination works right down to the district level and involves all partners in H4+. "* • *"All the districts take part a quarterly partner coordination forum which is chaired by the Provincial Medical Director. All the partners have to fit their work into the Provincial Work Plan. Discussions on how to match H4+ activities to needs take place at H4+ planning meetings which are joint with the MoHCC, the provincial team, district teams and implementing partners as well as H4+ agencies. It is important to recognise that all of this was done under the "Road Map for Accelerating Progress on Maternal, Newborn and Child Health*" • *"The annual planning meetings for H4+ are/were used to establish quarterly implementation targets and these were followed up in quarterly planning and review meetings."*	Interviews, Provincial Health Executive, Manicaland.
79	**Zimbabwe:** The DHE met to develop plans and identify needs then did a joint planning session with the DHE, PHE, MoHCC, MoGWCD, Education, Plan International, World Vision etc. to develop their overall plan before integrating H4+. In 2011, OPHID joined in this process and a representative of H4+ became involved in the planning (UNFPA). Plans were refined through later joint planning and review meetings, especially from 2014 onwards.	Interview, District Health Executive, Chipinge District
80	**Zimbabwe:** *"From the beginning, hospital staff were involved in planning how H4+ as a programme could support them. The H4+ planning committee met with the Hospital Board and Community Representatives to identify their needs and how the programme could best support them."*	Interviews, St. Peter's Mission Hospital, Chipinge.
Theme: Responding to changes and emerging needs		
81	**Burkina Faso:** • The parent-child dialogue approach did not exist in the beginning. The approach was presented by a local NGO during a quarterly MoH review meeting and the Director of Family Health found it interesting and suggested to the H4+ team that the H4+ programme funds this activity, as it lacked a focus and specific activities for adolescents. • The funding for the Husband's Schools approach was insufficient • The Global Steering Committee approved these two approaches.	Interview, H4+ country team member.
82	**Burkina Faso:** • There have not been any major changes of activities during the implementation period. The H4+ country team first planned to implement a midwifery curriculum at the universities, but we found	Interview, H4+ country team member.

	that it was too complicated and therefore implemented it at the National School of Public Health instead. • When the government announced the policy to abandon user fees and guarantee free RMNCH services, the H4+ team abandoned the support to the subsidy policy, i.e. the innovation "Cost sharing system". In May 2016, the programme allocated 80,000 USD to support the implementation of the free services policy instead**.**	
83	**Cameroon:** • Needs were initially identified through baseline studies and the national strategic plan. • The first two-year workplan (2013-2014) was developed by all key stakeholders during a 3-day planning workshop with all the target districts. • Needs are identified on a regular basis through the district review and planning meetings, during which their "micro-plans" are developed and submitted to the regional heath department and partners. The H4+ coordinator participates in these meetings and can provide feedback/responses to the district teams immediately, when they raise a need/request for support. • The programme has been flexible in responding to changing contexts and needs, as revisions/adaptations took place when the 2015-2016 workplan was developed. Several activities were reprogrammed based on uncovered needs and necessary modifications. There has been "a lot of flexibility" in the approach, also by the Global Technical Team which allowed for activities to be reprogrammed.	Interview, H4+ country team member.
84	**Cameroon:** With the bottleneck analysis done in 2013 identifying four main hindrances, including emergencies in the Far North region, insecurity and insufficiency of human resources, corrections for a closer alignment were made in the 2015-16 Action Plan.	Sida H4+ Donor Report 6 Cameroon, 2015 (H4+ SIDA 2015c)
85	**Cote d'Ivoire:** • The programme was able to respond to changing needs. For example, in 2015, UNAIDS had to re-programme activities together with the MoH to align to the new HIV/AIDS national strategic plan 2015 – 2017). This was discussed with and approved by the Global Technical Team in Douala in November 2015. • There were no particular changes or impact of the electoral crisis, as this happened in 2010-2011, and the programme only started in 2013. • Ebola affected implementation in districts close to the Liberian border (5/8 districts), as health authorities were busy preventing Ebola, which slowed down implementation of H4+ JCPS in 2014.	H4+ country team member.

86	**Ethiopia:** Mid-project shifts occurred in response to gaps in performance, i.e., midwives mentorship programme: The mentorship programme was established after post-training follow up of new midwife graduates revealed some knowledge and skill gaps. The AMTP (accelerated Midwifery Training Program) was initiated by the FMOH in 2011, and while it resulted in expanding capacity, a post-training assessment revealed gaps that were addressed by the mentorship programme funded by H4+.	Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program (H4+ 2015m)
87	**Guinea Bissau:** H4+ responsiveness to national changes: The H4+ had developed a three year operational workplan (2013-2015) and then got a six-month extension into 2016. Five planned activities were re-programmed in 2015-16 because they were no longer needed.	Approved activities in 2015-16 Annual Work Plan that need Reprogramming.
88	**Zambia:** *"There is some evidence that the H4+ was responsive to national needs. As described above, for example, the **H4+ JPCS became increasingly focused on reaching youth and adolescents over the lifetime of the programme**, particularly following the midterm review (conducted in early 2014). Similarly, as the programme developed, **more effort was placed on the role of men in supporting maternal health outcomes and the challenges of early marriage."***	Observation from H4+ Evaluation Team: Zambia Country Note
89	**Zimbabwe:** • Reports on the planning and review meetings provide examples of identified areas of need put forward by staff of provincial health executives, district health executives and health facilities staff. These needs are not always met due to resource constraints and issues of reach. For example, the call for more intensive work on demand promotion and community mobilization on the part of district health executives may exceed both the capacity of NGO implementing partners and the funds allocated to demand-side activities, especially by UN Women and UNAIDS • After each quarterly planning and review meeting, as reported in the minutes for the 2015 meeting (P.8) staff of each District Health Executive work together to prepare their workplan for H4+ for the coming quarter. • Comparing the district report segments of the reports over time illustrates a strong shift from (in the 2013 report) a simple listing of deficiencies and challenges facing each district, to (in the 2015 report) a reporting of achievements in each district including health care providers trained, clinical mentoring carried out, installation of machines and equipment, and availability or occasional stock outs of medicines and supplies.	• MoHCC, *Report on Quarterly Provinces and Districts Review and Planning Meeting,* 11-12 September 2013 (MoHCC 2013a) • MoHCC, *Report on H4+ Planning and Review Meeting,* 23-25 September 2014 (the Victoria Falls Meeting) (MoHCC 2014a)

	• In the 2013 report examples of deficiencies reported include: o Need for funds for the refurbishment of youth friendly service corners (Binga, p.2) o Challenges in securing fuel and transport for supportive supervision (Binga, p.2) o Lack of electricity for lighting in the delivery rooms (Chiredzi, p.2) o Shortages of midwives (Chiredzi, p.2) o No functional theatre at the hospital (Mbire, p.3) o Underutilisation of youth friendly corners and a shortage of health care providers trained in YFS (Hurungwe, p.3) o Human resource shortages generally (Hurungwe, p.3) o Shortages of midwives for quality maternal health services (Chipinge, p.4) • By the 2015 report, the Chitsungo District Hospital in Mbire reported (p.5) that it had a functional operating theatre commissioned in 2015 after receiving support by H4+ and was performing caesarean sections at the time of the review. • The 2015 report (p.7-9) includes a report by the H4+ partners on the activities funded for 2015 in response to earlier planning and review meetings. These included specific initiatives to address deficiencies raised in early planning meeting reports. For example: o Training of doctors and nurses in treatment of obstetric fistula at Mutare hospital in response to districts identifying the lack of capacity as an issue (UNFPA) o Training of Trainers in MVA (UNFPA) o Training health workers on how to deal with young people living with HIV (UNICEF) o Improved reporting on male mobilizer activities (UNICEF) o Focus on improved support to peer mother support groups (UNICEF) o Training on IMNCI and training of managers of MNCH programmes (WHO) o Training of more facilitators to respond to success of community dialogue forums facilitated by Katswe Sistahood (UN Women)	• MoHCC, *Report in H4+ Planning and Review Meeting,* 01-03 June, 2015 (MoHCC 2015c)
Theme: Responsiveness to the Ebola Virus Disease (EVD)		
90	**Liberia:** Expansion to include **three additional counties after EVD**, use of resources to support EVD, training in IPC for health staff etc. all part of the H4+ agencies' ability to support national priorities. However, H4+ was largely put on hold while EVD outbreak was at its worst and River Gee was shut down completely as there was no personal protective equipment at the facilities.	H4+ Annual Report 2015 (H4+ 2015k).

91	**Liberia:** The list of attendees shows that the H4+ Coordinator participated in EVD meetings indicating that due to the Ebola emergency the coordinators attention was diverted away from H4+ activity during the month of September 2014.	Infection Prevention and Control coordination meeting.
92	**Liberia:** Counties at risk of EVD got most attention and H4+ was practically suspended during EVD	UNFPA Country Team, KII, May 30 2016.
93	**Liberia:** Before the H4+, **Cape Mount County** did not have district health teams. Ebola revealed the need to constitute a team in every district. Therefore, through the H4+ grant there was surveillance team training. They also empowered the surveillance team through the provision of computers and motorbikes for collection of reports and information. The H4+ has supported the county in addressing issues associated with fear from community members about accessing health services due to Ebola. *"They blame health workers and think they are the major cause of the Ebola outbreak."*	Interview, Cape Mount County Health Team.
94	**Sierra Leone:** • *"The implementation of 2015 activities was geared toward reaching the programme strategic objectives towards the end of the year: the objectives were aiming at achieving the goal by the end of the programme in 2016. However, due to the continuous spread of the Ebola outbreak in 2015, following the state of emergency declaration in July 2014, all the routine activities of the programme were put on hold, while the country concentrated on fighting the Ebola outbreak, averting some funds to respond to needs."* (p.14) • DHMTs were mainly engaged with the Ebola response, making it difficult for them to conduct supportive supervision of activities which were not Ebola related. (p.15) • H4+ continued to focus on two districts out of 13, covering 16% of the population. • At policy level H4+ provided support to the Development of the National Health Recovery Plan, 2015-2017 in response to the Ebola Viral Disease (EVD) crisis. • The programme clearly continued to provide some national level policy engagement and advocacy during the national EVD crisis and response: o Advocated for high level political commitment by the president as part of Every Women, Every Child, Every Adolescent Global Strategy to expand number of midwives by four fold by 2020 and to scale up EmONC (but it is not clear from what base, presumably a very diminished base following the EVD emergency) o Development of post-abortion care guidelines	*Sierra Leone Submission (Feb 2016) for the 2015 H4+ Annual Report* (H4+ 2016f: 7-15)

	o Development of national MDSR guidelines to focus on the response to maternal deaths (since data on maternal deaths was already available (p.7) • *"Following the peak of the EVD outbreak the government revitalized its commitment to reducing maternal and child deaths, and as part of this, increasing the number of trained midwives. The H4+ supported technical cooperation between Sierra Leone and Malalwi which included a study tour to Malawi focusing on service delivery as well as education, regulation, accreditation of nurses / midwives and other health cadres. The delegation to Malawi that including the Chief Nursing and Midwifery Officer, the heads midwifery and nursing schools, the Registrar of the Nursing and Midwifery Board and the Director of Training MoHS. "* p.8 • The H4+ partnership supported the MoHS develop a process to review the Reproductive and Child Health Policy and Strategy. (p.8)	
95	**Sierra Leone:** • As early as March 2014, H4+ agencies began to advocate for the need to ensure safe delivery during the EVD crisis. As a result, they reprogrammed 2014 funding to provide commodities and equipment for safe delivery. This was highly appreciated by the MOHS • Only external funds available to support non-Ebola health interventions • Supplied medicines, equipment and supplies such as elbow gloves for delivery services. • Did provide infection prevention training and commodities.	Interview, H4+ Country Team (UNFPA).
96	**Sierra Leone:** In March 2015, UNFPA supported development and publication of a study of the impact of Ebola on use of RMNCAH health services in Sierra Leone which identified severe reductions in the use of services and some of the reasons why (fear of health care workers in Personal Protective Equipment (PPE), attitudes of health workers, myths regarding intentions of health care workers etc. (p.1-3).	*Rapid assessment of Ebola impact on reproductive health services and service seeking behaviour in Sierra Leone*. March 2015, UNFPA (UNFPA 2015b)
97	**Sierra Leone:** • 22 facilities being upgraded in 2015/16 by UNFPA and UNICEF working jointly (51 identified in needs assessment for 6 to 9 month recovery plan of MOHS but the workplan for the 6-9 month recovery targets 34. Accounts for a good part of the recovery plan. • In Sept. 2015 UNFPA to deploy 5 international midwives to regional hospitals to support quality service delivery, mentoring and supportive supervision.	*Minutes of UN Heads of Agencies H4+ Meeting September 2015.* (H4+ Agencies 2015b)

Theme: Setting up parallel H4+ JPCS system for data collection		
98	**Zambia:** **Improve the HMIS and quality data collection:** The Ministry of Community Development and Maternal and Child Health, the MoH, the UN H4+ agencies and monitoring and evaluation partner (INESOR) should ensure that appropriate data are being collected to establish evidence of best RMNCH implementation practices in H4+ districts. There were some inconsistencies found in the data collected, where some were missing data while for other indicators, these were inconsistently recorded casting doubts on the reliability of the data. **For example, in the H4+ districts there were two streams of data recorded; (i) the regular HMIS data for the ministry, and (ii) a separate form completed for the H4+ indicators only.** When these two data were compared, there were some inconsistencies found. There will be a need to identify what are the main gaps in the health management information system and how they should be best addressed during the post-mid-term review period.	H4+ Canada Supported Activities: Mid Term Review in Zambia, Country Report, Period: 2012-2013, 24 April 2014. (H4+ Canada 2014c: 55)
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.***		
	Information/data:	**Information sources:**
Theme: H4+JPCS coordinating mechanisms *do not duplicate or overlap* with other structures for coordinating activities in RMNCAH		
99	**Democratic Republic of the Congo:** • 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 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	DRC H4+ proposal (H4+ Canada 2010b: 11-12)

	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 • 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.	
100	**Democratic Republic of the Congo:** • The H4+ JPSC work plans includes activities to strengthen country-led coordination of RMNCAH interventions at all levels, including: o 2015-2016 work plan: ▪ Support the organisation of national and provincial RMNCH Task Force meetings ▪ Support the organisation of Board of Director meetings at HZ level ▪ Support the organisation of CNP-SS meetings ▪ Support the functioning of the H4+ coordination based at the MoH (Division for Family Health, *Direction 10*) o 2014-2015 work plan: ▪ Support the organisation of quarterly national and provincial RMNCH Task Force meetings ▪ Support the 2015 annual planning process (analysis, needs identification, prioritisation) ▪ Provide TA and support the organisation of monthly meetings of CNP-SS technical committees ▪ 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 DRC H4+ annual work plan 2014-2015 (H4+ Canada 2013c: 2, H4+ Canada 2014b: 1)
101	**Democratic Republic of the Congo:** In 2014, H4+ JPCS coordination with the government counterpart was effective and H4+JCPS supported national and provincial RMCNH Task Force meetings: • *« 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.* • *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*	DRC H4+ Annual Report 2014 (H4+ Canada 2015c: 9-10)

	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. • *Renforcement de la Task-Force SMNE (Santé de la Mère, du Nouveau-né et de l'Enfant) à 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 identifié les lacunes et formuler des directives et interventions correctrices. »*	
102	**Democratic Republic of the Congo:** Early 2016, the MoH finally agreed that the RMNCAH Task Force, and thus the coordination of the H4+ initiative, will be integrated into the Service Delivery Sub-Committee of the National Health Sector Coordinating Committee (CNP-SS) to streamline and integrate coordination of RMNCAH within broader health sector coordination structures. Until now, the RMNCAH was an independent organ (i.e. not accountable to any formal structure), although it was chaired by the Director of the Division for Family Health of the MoH.	Interview, RMNCAH development partner (international NGO supporting the RMNCH Task Force together with WHO)
103	**Democratic Republic of the Congo:** • Meeting minutes indicate that coordination of RMNCH interventions **at decentralised levels** 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. »* • 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) [et] la partie décentralisée (au niveau DPS et Bureau central de la ZS) pour une meilleure analyse et coordination des intervenants. »*	H4+ meeting minutes : *Compte rendu de la réunion H4+ 10/12/2014* (H4+ Agencies 2014: 3)
104	**Democratic Republic of the Congo:** ***« 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 (MoH 2016b)

105	**Zambia:** **National coordination mechanisms and processes** The health sector is coordinated through the Joint Assistance Strategy for Zambia (JASZ) and the Health Sector Memorandum of Understanding. There is an active cooperating partners group in Zambia, and CPs coordinate their participation in the support through their own coordination mechanism managed by a troika of partners (currently DFID, USAID and Sida). The coordination meetings include: (i) the annual consultative meeting; (ii) sector advisory group meetings (SAG); (iii) MoH/ CP policy meetings; (iv) monitoring and evaluation (M&E) sub-committee; (v) health sector joint annual review, and (vi) various technical working groups (TWGs) on key thematic areas, such as health care financing, human resources for health and reproductive health. UN health agencies participate in the sector-wide approach (SWAp) meetings. Other stakeholders include the MoH (as leader and convenor), other multilateral and bilateral partners, civil society organisations (CSOs) and non-governmental organisations (NGOs).	Interviews, senior ministry officials and donor representatives, Lusaka, Zambia.
106	**Zimbabwe:** Interviews with members of the H4+ country team did point to the **interlocking set of coordinating and planning committees and technical working groups** involved in coordination of the health sector in Zimbabwe but they did not note significant levels of duplication or overlap. Specifically, they agreed that the establishment of an effective National H4+ Steering Committee in 2014 was necessary to achieve coherence in UN support to RMNCAH. They also pointed to the expressed intention of the MoHCC to continue some form of national coordinating committee for MNCH within the structure of the HDF.	Interviews, H4+ country team (UNFPA, UNICEF, WHO, UN Women, UNAIDS.
107	**Zimbabwe:** *"What H4+ has brought to the situation that is new is a new era of coordination. The government (MoHCC) has recognised how effective the H4+ coordination has been and wants to use the model in the coordination of the new Health Development Fund."*	Interview, H4+ country team (UNICEF).
108	**Zimbabwe:** • *The new Health Development Fund which is coming out of the experience of the older Health Transition Fund will build on the work of H4+. For example, it includes many outcome indicators in RMNCAH and supports all the pillars of the WHO health systems building blocks.* • *However, H4+ targets innovation in RMNCAH and the Permanent Secretary is worried that, in the absence of dedicated funding for RMNCAH innovation will this dimension be lost. There is a risk that the HDF will provide funding at a big picture level and will not prioritize innovation in MNCAH. The unique focus of H4+ could be lost.*	Interviews, MoHCC staff at Director and Deputy Director Level at Headquarters.

Theme: H4+ JPCS coordination *provides a strong RMNCAH focus to national and sub-national health sector coordinating platforms.*		
109	**Cameroon:** As a result of joint advocacy efforts by the H4+ members, the presidency established a multisectoral **National Committee to Fight Maternal Neonatal and Infant Mortality** which convenes biannually. There are strong linkages between this national committee and the H4+ JPCS as: • The permanent secretary of the national committee is also member of the H4+ core group. • H4+ JPCS funds allowed the H4+ members to help establish this committee (development of statutory texts etc.) and organise the first meeting. • The H4+ JPCS team is the technical arm of this national committee, by acting as the technical secretariat. • The coordinator feels that this joint advocacy would not have been possible without the coordination of H4+ JPCS.	Interview, H4+ country team member
110	**Democratic Republic of the Congo:** 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)
111	**Democratic Republic of the Congo:** Staff of Canada Global Affairs in DRC expressed a concern that H4+ members have not effectively played a leadership role in bringing the experiences of H4+ JPCS (institutional and operational levels) into the broader policy dialogue and health sector coordinating platforms. Their participation in the Health Partners' Forum (GIBS) has diminished significantly since UNICEF no longer chairs the group (since mid 2014). Bilateral donors, most of them members of GIBS, would like to see H4+ members become a more effective convener of RMNCAH and to provide high-level strategic and technical assistance to the government.	Interview, staff members of Canada Global Affairs, Embassy of Canada in DRC
112	**Ethiopia:** H4+ supported the 2013-14 annual health sector review meeting (ARM) at national and regional levels. ARM is a forum to assess the progress towards the achievement of the strategic objectives of the health sector.	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Programme.* (H4+ 2015m)

113	**Liberia:** Although H4+ members speak in a more unified, coherent way on maternal health policy, the H4+ JPCS programme has had little discernible influence on shaping or establishing new national coordination platforms.	Observation from H4+ Evaluation Team, Liberia Country Note.
114	**Liberia:** The president pronounced the death of any woman as an emergency. Reports of maternal deaths were to be on her desk within 48 hours after the death. A steering committee was set up in 2013 and it was recommended that all line ministries be part of the committee. The line ministries were not regular at the meetings. The committee meetings were later dormant. Under the H4+ programme, a national and county process was developed to revitalize the national committee. A maternal death protocol was developed and approved. Through the use of the protocol 52 maternal deaths were reported. The Ministry requested an assessment with support from WHO and the H4+ supported this assessment. The assessment report is being review for which the Ministry has requested the development of an action plan which are yet to be developed. The H4+, through both funding and the impact of six agencies working together, speaking with one voice, etc., has managed to revitalise the maternal death review process.	Interview, H4+ Coordinator.
115	**Guinea Bissau:** • JANS: Support the JANS process (the joint assessment of the national strategy) a process in which all partners work together to do a combined assessment of the national strategy every year rather than each partner doing their own. • HMIS review**:** The H4+ partnership helped the MoH launch a full revision of the national health information indicators (SNIS). Particular attention in the national process was paid to the integration of gender equality and equity in data collection and analysis approaches.	H4+ Annual Workplan Guinea Bissau 2013-2015. (H4+ 2012a)
116	**Zambia:** WHO commissioned report on health expenditure which shows there is a US$ 93 spending per capita in Zambia but it must be very inefficiently spent as there is still such poor results. The UN has gone into service delivery but in doing so has left the national policy field wide open. The experience of working with the H4+ (and the UN health agencies in general) has therefore been a little disappointing and there is still an absence of consistent quality policy leadership and support**.** The existence of the H4+ TWG was news and although a technical group, "*there is a much needed interface with the larger policy processes*." Major NGOs need to be folded in to build a common approach. To do this, the H4+ could start with producing more information and proactively share the results and gains from the JPCS, communicating evidence, experience or even anecdotes that would enable others to build on it	Interview, DFID

	or adopt a similar approach. Some UN agencies are weaker than others, for example, in collaboration with government or in communications. Little is done in writing; all very verbal and the institutional memory, the visibility of the policy process is weak. Thus, the H4+ has little impact on others and gains little traction.	
117	**Zambia:** **USAID officials said they invited H4+ to collaborate** and share their advice when they developed their Saving Mothers Giving Life programme. Saving Mothers Giving Lives is in 19 districts shared between CDC and USAID. However, they said it was difficult to get a contribution from the H4+ even when directly approached. Also, USAID has not seen much evidence of H4+ coordinating, sharing products, reaching out to donors or providing much assistance to the Ministry of Health. USAID would like to see H4+ to be an effective convener of RMNCAH and to provide high-level strategic and technical assistance to the government. The Ministry of Health has not taken advantage of opportunities to convene all agencies together on RMNCAH**.**	Interview, USAID

Innovation

4. 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+ Joint Programme Canada Sweden (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:
Theme: Identification of potential, high impact innovations		
1	**DRC** Several activities were identified as H4+ JPCS-supported innovations: • **Competency-based Emergency Obstetric and Newborn Care (EmONC) training of service providers:** Based on experiences from other countries, H4+ JPCS supported the introduction of competency-based EmONC training in the DRC using mannequins.	Interviews with national, provincial and health zone health officials and facility staff.

	• **Family kit approach and engagement of community health workers:** The family kit approach aims to improve home-based Integrated Management of Newborn and Child Illnesses (IMCNI) and safe deliveries through the distribution of kits and vouchers for subsidised curative care, antenatal care (ANC) and assisted deliveries in health facilities. • **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 health zones (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.	
2	**DRC** An 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. The Ministry of Health (MoH) played a leadership role in selecting competency-based EmONC training as an innovation to be developed and piloted under H4+JPCS.	UNFPA DRC Office (2016). UNFPA Good Practices - EmONC Training Revised. (unpublished). (UNFPA 2016c)
3	**DRC** 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.	Interviews with H4+ staff.
4	**DRC** The family kit approach aims to improve home-based IMCNI and safe deliveries at community and health facility level. Different kits are distributed, including (1) essential medicines to households to enable families to treat simple diarrhoea and fever; an ANC kit to pregnant women; and a delivery	Silene Martino Almeras (2015). Les Kits Familiaux, un pas important vers la

	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 Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) and essential family practices by community health workers (CHWs) is an important component of the family kit approach.	couverture universelle en soins de santé. 12 mai 2015. (Almeras 2015)
5	**Liberia** There was evidence that H4+JPCS supported the implementation of several innovations in service delivery: • Chlorhexidine gel for cord care • Non pneumatic anti-shock garment (NASG), a first-aid device to treat postpartum haemorrhage • Installation of solar suitcase, a portable solar power system set up in several clinics to ensure power for delivery rooms • Implementation of Kangaroo Mother Care (KMC), a method of providing neonatal care (skin-to-skin contact, breastfeeding) • Repurposing traditional birth attendants into Trained Traditional Midwives (TTMs) to refer women for antenatal care and to accompany women to the clinic for delivery. • Mama-baby kits used as an incentive to deliver in facilities rather than at home.	Observations from Evaluation Team in River Gee, Libera June 6-8, 2016.
6	**Liberia** KMC services were set up at four county hospitals. Eleven babies were admitted to the units. All gained weight and were discharged. When the KMC method was introduced, the reception by the caregivers was poor and they viewed it as an added responsibility. However, with continuous supervision, these caregivers and service providers have become KMC friendly.	Save the Children, Standard Progress Report, September 2014. (Save the Children 2014c)
7	**Liberia** The anti-shock garments are a real innovation and having rolled them out in the south east counties they will start introducing them in the north west as well. They are both an innovation and a success from the H4+ programme. They do not solve maternal haemorrhage but they are one more way of supporting EmONC in a context where you need three, four or five different ways of addressing maternal emergencies in case some do not work.	Interviews, UNFPA Country Team.

8	**Liberia** UN Women Installed a solar panel in the health centre and linked it to a TV. In communities where there is no electricity, this attracted a lot of people to the clinic especially for an evening antenatal session and people could watch a TV programme they liked during the ANC clinic. UN Women provides the solar panels to the smaller facilities.	H4+ Quarterly Report, 1st Quarter, 2014. (H4+ 2014d)
9	**Liberia** Save the Children (SCF) procured 60 NASG at 300 USD per item (total 18,000 USD) and 20,000 doses of chlorhexidine at 1 USD per dose (total 20,000 USD). Fuel and freight charges for clearance and delivery were 5,000 USD. 15,000 USD to KMC units in 4 hospitals and 8 health centres. 100 health facility staff trained in EmONC including the use of the non-pneumatic anti-shock garment (NASG), KMC and post abortion care with stepdown training in 4 hospitals and 15 primary and secondary health facilities. SCF support included helping to **re-purpose TTMs** to accompany women to deliver in the health facility. They provided a transport allowance to TTMs at 10 USD per time. Funds were also set aside in this plan to document best practice (1000 USD).	Save the Children 2014 Annual Work plan Output 2.1 Liberia, 1 Jan to 31 Dec 2014. (Save the Children 2014b)
10	**Zambia** An innovative practice introduced by H4+ included a postnatal check for mother and baby at 48 hours after delivery. They have about 26 deliveries a month on average. During the postnatal care (PNC) period they give oral polio vaccine to the baby and Vitamin A and post-natal family planning for the mother. They watch for post-partum haemorrhage and ensure the baby is latching on correctly. They also assess the baby for congenital malformation and show the mother how to do cord care, infection control, educating her about nutrition, exclusive breast feeding, and the importance of immunisation etc.	Interviews with Health Staff, Tafelansoni Rural Heath Centre.
11	**Zambia** "*The scaling up plan for the mobile phone technology (mHealth) to remind pregnant women and newborn babies for follow-up services through community workers is completed and includes the five project districts. Discussions are ongoing to define the roll-out of mHealth including the training plan*."	Progress Report for April 2011 – June 2012 , *Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia,* (2012). (INESOR 2012: 3)

12	The SMS (Short message service or text message) intervention is facing challenges as there is no telephone network in some areas -- e.g. Chipundu RHC in Serenje districts. The community is generally active and involved in health programmes. (Example of tried and tested innovation).	Minutes, Debrief of the CIDA UN H4+ MNCH initiative 2013 to MCDMCH (undated). (H4+ nd-b)
13	**Zambia** "Mama packs" include a few items for mother and baby (blanket, nappy, hat, wrapper) and are provided to mothers when they have attended four ANC, delivered and had the postnatal check. Successful mama packs study outcomes: Increased demand and utilisation of delivery services has resulted in national policy formation for institutional deliveries.	H4+ 2014 Annual Narrative Progress Report, H4+ Foreign Affairs, Trade and Development, Canada (January 1 – 31st December, 2014). (UNICEF Zambia 2015: 15)
14	**Zambia** *"Provision of scholarships for midwifery training has increased the workforce for skills birth attendants at birth."* Enrolled nurses were taken from their posts and sent for one-year midwifery training. While away being trained, their posts were filled by retired midwives, enabling continuity of care while upgrading existing staff skills.	H4+ 2014 Annual Narrative Progress Report, H4+ Foreign Affairs, Trade and Development, Canada (January 1 – 31st December, 2014) (UNICEF Zambia 2015: 15)
15	**Zimbabwe** Three innovations were identified during the mid-term review of H4+ in Zimbabwe: Point of Care (PoC) CD4 Machines to support rapid diagnosis of HIV in Prevention of Mother to Child Transmission (PMTCT) services, mentorship programmes to support provider capacity development and maternal death surveillance and response. Of these three innovations, the reviewers determined that the Point of Care CD4 machine was the only intervention that had clear documentation regarding how it was identified and started. PoC CD4 machines were first introduced in Zimbabwe in 2009 in a VCT centre in Harare. The Clinton Health Access Initiative (CHAI) and Elizabeth Glazer Paediatric AIDS Foundation (EGPAF) used US Government Pepfar funding to expand the initiative. Under H4+, UNICEF further rolled out this innovation.	H4+ Mid-term Country Report, Zimbabwe July 2014. (H4+ 2014c)

16	**Zimbabwe** UNICEF and MoHCW commissioned an evaluation to generate evidence in order to improve understanding of the effectiveness of the POC CD4 count machines in maternal and new-born child health (MNCH) settings in country; document best practices, lessons learnt, challenges and recommendations related to scale up of this new technology. It was largely acknowledged that patient management had improved due to reliable clinical assessments, and also patient retention had improved due to less referrals. There was a general consensus that most HIV positive pregnant women and their families were now able to be assessed for ART eligibility on time. US Government (USG) Pepfar supported EGPAF to initiate and scale-up PoC CD4 testing in PMTCT sites and USG partners led the scale up and early infant diagnoses using these machines.	Mtapuri-Zinyowera, S. and Edward T. Chiyaka (2012). *An Evaluation of the Use of Point of Care PIMA CD4 Cell Count Machines for HIV Positive Women and their Families in Maternal Newborn And Child Health (MNCH) Settings in Seven Districts in Zimbabwe, 2012*. Harare, Ministry of Health and Child Care, Government of Zimbabwe and UNICEF. (Mtapuri-Zinyowera and Chiyaka 2012) Pepfar (2010). *Zimbabwe Operational Plan Report FY 2010*. (PEPFAR 2010)
17	**Zimbabwe** In discussions with national, provincial and district health officials, clinical mentorship and supportive supervision were cited as key innovations for Zimbabwe. Although these were not considered "new," H4+ funding was instrumental in the revitalization of these practices so that they were performed routinely and at scale in the H4+ selected districts.	Interviews with National, Provincial and District health personnel.
18	**Zimbabwe** The MoH prioritized strengthening the capacity of human resources in order to achieve the national health and millennium development goals (MDGs). The Zimbabwean health delivery system was affected by a massive loss of experienced, qualified health professionals during the economic crisis in the last decade.	Sibanda, T P Goverwa (2014). *Preliminary Report for the Provincial Maternal and Neonatal Health Clinical Mentorship Program for*

		Matebeleland North Province. Unpublished. Harare, Provincial Maternal and Child Health Officer. (Sibanda 2014)
19	**Burkina Faso** Three innovations identified: 1) IFC approach *(Individus, Familles, Communautés)*, 2) Cost sharing system (SPC) in the Northern Region, 3) Husbands' School *("L'école des maris")*.	Rapport de l'atelier de réflexion sur le rapport de la revue à mi-parcours H4+ Canada: Burkina Faso (H4+ 2014j: 4)
20	**Burkina Faso** "The implementation of the husbands' school is based on the experience of the Zinder Region in Niger" (Ref. 2a); The Niger approach was developed with initial support from UNFPA and the European Union (EU) " The strategy is being implemented in Zinder Region, via the Reproductive Health Programme co-financed by the European Union and UNFPA between 2004 and 2008, and from 2009 in partnership with the Spanish Agency for International Development"	H4+ Innovative Approaches – Burkina Faso – Schools for Husbands; "Niger – Husbands' schools seek to get men actively involved in reproductive health" (UNFPA 2010)
21	**Cameroon** The H4+ innovations identified are: 1) Obstetric kits, 2) priceless phone network, 3) Maternal and perinatal death surveillance and audits, and 4) provision of integrated health package at community level by community health workers.	H4+ Joint Programme Mid-year progress report - January to September 2015 - Cameroon. (H4+ 2015h)
22	**Cameroon** The project is implementing some innovative approaches in selected health districts. Some are adapted from previous experiences in country (community referral system, community self-assessment of action plan, introduction of Essential Family Practice Kits in communities, recognition award for performing health districts) and others are initiated in the region (obstetrical kits strategy, utilisation of priceless phone network for health information system and surveillance).	SIDA H4+ Donor Report 6 Cameroon, 2015. (H4+ SIDA 2015c)

23	**Cote D'Ivoire** In 2014, Review of the tools and documents related to the "husbands' schools" strategy in order to reinforce the engagement of the participants in the strategy. District and regional health authorities are actively involved in the implementation of innovative interventions such mobile medical consultations and "husbands' schools" interventions.	*Rapport standard de progrès annuel de la mise en oeuvre de la 6e programme 2009-2015 prolongé à 2015.* (H4+ SIDA 2015d)
24	**Ethiopia** Innovations identified (and documented) by Ethiopia H4+ include: • Task shifting to Emergency Surgical Officers (ESO) as part of a larger Government of Ethiopia (GOE) effort to ensure that a trained clinician is in each district. H4+ supported training of Integrated ESOs (IESO) • Mother-Baby Cohort PMTCT register to ensure continued follow up and treatment for HIV positive mothers and their children. H4+ supported this as a promising practice. H4+ designed training manuals and supported TOT for 226 individuals and supported the distribution of the innovative electronic training package and tools to 1,000 PMTCT sites across the country. • The H4+ team supported an innovation in which polio campaign workers were provided with simple case identification tools to identify women with suspected fistula during household visits conducted as part of the polio campaign. Through this campaign alone, 2,450 women were identified and linked to fistula treatment centres for screening and, if needed, treatment.	*H4+, Task-shifting Procedures to Non-Physician Clinicians to Save Lives, October 29, 2015.* (H4+ SIDA 2015f) *H4+, Mother-Baby Cohort PMTCT Register – An H4+ Innovation to Achieve the 90-90-90 Targets, October 29, 2015.* (H4+ SIDA 2015a) *H4+, Polio Campaign as an opportunity to Identify Fistula Cases, October 29, 2015.* (H4+ SIDA 2015b)
25	**Guinea Bissau** Maternity waiting homes were the leading innovation in Guinea Bissau. The installation of two homes in Quinara and Tombali regions using H4+ resources resulted in increased attendance and utilisation of delivery services. Food was provided to waiting mothers.	H4+, Global 2013-2014 intermediary report to SIDA. 2014. (H4+ 2014a)
26	**Sierra Leone** Joint Programme Document (p.17) of 2011, identified five inter-linked innovations: • Barrier analysis methodology used for identifying and prioritizing interventions	Joint *Programme Document (2011).*

	• A focus on scaling up post-natal care in the country by strengthening supportive supervision • A focus on community level integrated action and reaching the hard to reach and vulnerable population • Performance based financing to be used to improve maternal and newborn child health treatment based on a strengthened referral system • Use of m-health to facilitate both referrals and MDRS systems. • The proposal does not speak to the use of a voucher system to allow adolescents and pregnant women and newborns to access RMNCAH services although this became a key programme innovation and goal in 2013/14	(Ministry of Health and H4+ Canada 2011)
27	**Sierra Leone** The original plan for the programme developed in 2011 included an innovation to develop and implement a voucher system for free provision of in-kind services in RMNCAH to pregnant and lactating mothers, and marginalized adolescents but this had still not been implemented by the end of 2015. The 2015/16 Results Framework and Plan indicated the system would be implemented in the two target districts (programme focus since 2014) in the first quarter of 2016.	H4+ Results Framework 2015-2016. (H4+ 2016e)
28	**Sierra Leone** • In 2012: o H4+ supported MoHS in development of operational guidelines for a national voucher system and in-kind package of services for vulnerable pregnant girls and women and hard to reach groups in 2011 and 12. Operational guidelines completed in 2012 o Voucher system and package to cover ANC, delivery, PNC and family planning including conditional transfers to beneficiaries (vulnerable, pregnant teenage girls and women) o Proposal and budget for using mobile phone technology (m-health) for real time monitoring of maternal and peri-natal deaths and stock outs of contraceptives and life-saving medicines. • In 2013: o Processes were developed for the implementation of the voucher system and in-kind packages for vulnerable, pregnant girls and women in remote areas to commence in 2014 in two pilot districts of Port Loko and Pujehun.	H4+ Canada Annual Report, 2012. (H4+ Canada 2012a) H4+ Canada Annual Report, 2013. (H4+ Canada 2013a)
Theme: Link to global policies and guidelines		
29	**DRC**	UNFPA DRC Office (2016). UNFPA Good

	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.	Practices - EmONC Training Revised. (UNFPA 2016c)
30	**DRC** The introduction of Maternal Death Surveillance & Response (20 percent of health zones 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)
31	**DRC** Maternal Death Surveillance and Response: In 2014, maternal deaths were officially included in the list of weekly mandatory notifications. A workshop was organised to review the list and subsequently, meetings were organised to develop necessary tools. At health facility level, the database was reviewed to integrate maternal deaths, and trainings were organised across the country. UNFPA and WHO supported the activities. According to a MoH senior official, the MDSR system works and 100% of health zones notify maternal deaths, as it is now mandatory.	Interview, senior official in MoH in Kinshasa.
32	**Liberia** Protocols on KMC have been distributed to the four Hospital KMC Units.	Save the Children, Standard Progress Report, September 2014. (Save the Children 2014c)
33	**Zimbabwe** In November 2012, a stakeholder meeting was held to discuss the need to support clinical mentorship, based on WHO definitions of the practice and with support from UNFPA.	WHO, *Agenda for Clinical Mentorship*, September 2013. (WHO 2013a)
34	**Zimbabwe** H4+ participated in, and supported, the mid-term review of the Adolescent Sexual and Reproductive Health (ASRH) strategy (although there is no mention of which UN or other agency organised the review). This resulted in an age-appropriate breakdown of interventions as well as the introduction of innovations using new technologies to reach out to larger numbers of young	H4+, *2013 Annual Narrative Progress Report*, Final, 2014. (H4+ Global Technical Team 2014a)

	people. In addition, it resulted in advocacy to ensure that interventions are evidence-based and should draw on documented on good practices good practices from within the region.	
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*		
	Information/data:	**Information sources:**
Theme: Global and/or regional technical assistance in support of innovation		
35	**DRC** The National School of Public Health of the University of Kinshasa received technical support from Columbia University Averting Death and Disability (AMDD) programme in USA to conduct the EmONC baseline survey ("Enquete de Besoin en Soinds Obstétricaux et Néonatal d'Urgence (ESONU) 2012)"	H4+ Country Team (2012). Annual Progress Report 2012. (H4+ Country Team 2012b)
36	**DRC** *"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 2016c)
37	**DRC** UNICEF and WHO have mobilized regional/international experts to provide technical assistance to implement H4+ JPCS activities	Interview, senior official in MoH in Kinshasa.
38	**DRC** 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, UNICEF.
39	**DRC** UNFPA participated in a regional MDSR workshop organized by UNFPA and WHO with technical support of University of Pretoria	Consolidated comments from UNPFA, WFP and UN Women on Zero Draft

		DRC Country Note, 8 November 2016.
40	**Liberia** Training was provided for KMC. SCF provided training for 100 health facility staff (certified midwives, registered nurses, physician assistants and licensed practical nurses) – on EmONC, including NASG and KMC (in four hospitals and fifteen secondary health facilities).	Annual Workplan, Save the Children, December 31, 2014 (Save the Children 2014a: 9).
41	**Liberia** Teams of women, including illiterate women, were trained to set up solar suitcases in the health facility and health teams were trained to do the maintenance.	Interview with UN Women Country Team.
42	**Liberia** Save the Children Fund (SCF) provided training for 100 health facility staff (certified midwives, registered nurses, physician assistants and licensed practical nurses) – on EmONC, including NASG and KMC (in four hospitals and fifteen secondary health facilities).	Annual Workplan, Save the Children, December 31, 2014. (Save the Children 2014a)
43	**Liberia** Technical support was handled in-country by reproductive health supervisors together with the County Health Team. Joint quarterly supportive supervision, and coaching of service providers was conducted at 18 project facilities of health care providers trained in KMC, partograph, and other key EmONC skills including postpartum and method-mix family planning in the three counties. The outcome of the supervision was that health staff did not enter information correctly in the reproductive health ledgers in three of the eighteen health facilities supervised. As part of their support to the clinics, corrections were made and the ledgers were updated.	H4+ Draft Annual Report, H4+, 2015. (H4+ 2015d)
44	**Zambia** An innovative strategy being supported by the project is the re-engagement of retired midwives to increase the number of trained healthcare workers available to the sector. Ten contracts have so far been singled out of the planned 25. Funds for remuneration packages for these retired midwives will be disbursed to the provincial health offices on a quarterly basis). Technical support for this effort came from within the country H4+ partners.]	INESOR (2012) Progress Report for April 2011 – June 2012, *Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia,* Lusaka. (INESOR 2012: 3)
45	**Zimbabwe**	Interviews with H4+ Country Team and

	Each H4+ partner draws on the regional technical focal points in MNCAH in its own agency and they see little or no need for duplicating technical expertise at regional level since they already have it. Each agency reports to its own agency and there was no felt need to duplicate a major regional role for H4+ beyond the on-going technical support that each partner already gets. With regard to the expertise needed to support the design, implementation and monitoring of interventions, H4+ agencies have relied on internal expertise within their organisations and the MoHCC for monitoring and evaluation (M&E) activities, plus they have access to, and have used, consultants and national institutions to supplement expertise. H4+ agencies have a reasonable level of technical capacity in-house with experienced advisers with a long history of involvement with H4+, especially in the case of UNFPA, UNICEF and WHO. There are highly competent senior and middle managers in MoHCC who are solid technical counterparts for the UN agencies in the area of RMNCAH as well as in the routine aspects of M&E. However, there is less evidence of expertise in the specific area of building a case to more systematically manage the process of innovation, including the capacity to document a practice or tool as an innovative approach worthy of scaling up.	MoHCC representatives in Harare.
46	**Zimbabwe** The MoHCC and H4+ country team members travelled to Ethiopia in June 2013 to develop country action plans for H4+ activities. Country teams were oriented to the SIDA H4+ proposal and areas for financial and technical assistance were identified. (No specific mention of innovation; but is a good example of country exchange).	WHO, *Report on H4+ Addis* 2013. (WHO 2013c)
47	**Burkina Faso** A study tour was organized to visit the "husband's school" approach in Niger	UNFPA, 2012 Annual Narrative Progress Report – Burkina Faso. (WHO 2013b: 3)
48	**DRC and Cameroon** Regional advisors were actively involved in JPCS proposal development and provided technical assistance for specific technical approaches. While these activities were part of the regional office's normal duties, H4+ JPCS funds allowed countries to participate and implement approaches. Examples include participating in joint H4+JPCS missions. The Regional Office, however, was not actively involved in the process of innovation programming. While they "received documentation" and were "informed," this was the extent of involvement. Innovations noted by regional staff include: • The LOFT electronic system to collect data on maternal deaths (and other HMIS indicators as well). The regional office indirectly contributed to this, as they organised the first regional workshop on MDSR and the MDSR training in Cameroon, which encouraged the MoH to initiate	Interview with WHO Africa region staff.

	this electronic system. The MoH sends the weekly reports to the regional office, and there is an ongoing dialogue about the system and the data. • DRC created "centres of excellency" for EmONC training using mannequins	
49	**West and Central Africa Region** When it comes to technical assistance (TA), and disseminating new guidelines and innovations to country offices, the TA should come from the regional office (RO) and be consistent with what the different roles are for each of the levels (global, regional, country). H4+ didn't engage ROs meaningfully; therefore, it is difficult to identify areas where regional support was provided.	Interview with West and Central Africa Region staff (UNICEF).
50	**West and Central Africa Region** The regional office engagement in H4+ was considered an afterthought. Most interactions happened between Geneva and UNFPA/NY and between headquarters (HQs) and countries; however, at some point it was realized that it would be easier to support the countries from the region than from Geneva. Joint missions between HQs and regional staff were useful, and H6 should include this going forward.	Interview with West and Central Africa Region staff (UNAIDS).
51	**Global level** There is active support to countries – planning meetings each year, then put teams together for joint missions. H4+ is even more organized now to support countries than before, especially when countries request assistance. The example of Mauritania was provided: All agencies are involved in talking with the country team, a joint mission is planned for November. All the agencies are supporting this financially. (Other countries that have requested support include SRC, Sierra Leone, Guinea Bissau, and Burkina Faso). However, this comment was general and not specific regarding innovations.	Interview with Global Team (UNFPA).
52	**Global level** • Little evidence of engagement at and by the regional level. The global and country level teams came together in a much more meaningful way. They have a regional office in Dakar that oversees the work in the Muskoka countries but that is not very well (if at all) integrated into the Muskoka work. • Innovation was more in terms of common sense approaches and adopting good practices from other jurisdictions or revitalizing practices which had worked before. Could have been better communicated across countries but you don't need a really heavy handed approach to documenting these "innovations".	Interview with H4+ Global team (UN Women).

53	**Global level** Regarding the role of global and regional staff in H4+ (generally, not just for innovations): • Not a lot of regional involvement in this but there has been a global community of interest with 20 different global organizations taking part. • The regional level was engaged at a much later date than the country offices and headquarters and perhaps has not yet found its role even though they do have a focal point in the UNAIDS regional office. • They should and could have had a larger role as they are closer to the country offices and do regular country visits. The regional level is a missing link and not much is happening at that level. • It's also not engaging the higher level decision makers, especially the Regional Directors in the H6 agencies. The main global (and country level) innovations have been: • Transforming the perceived role and legitimacy of community engagement in the provision of health services • Making human rights engagement an integral part of RMCH • Difficulty has been in communicating this effectively to clinicians and public health practitioners	Interview with H4+ Global team (UNAIDS).
54	**Global level** • The H4+ partners were not able to put the regional offices in a strong position and to reach a working relationship with them. • The HQ and country levels of H4+ JPCS were able to work together. • The Regional Directors of the H4+ partners showed little interest in becoming engaged and working together. • Innovation was explicitly part of UNICEF's mandate, especially for the documentation of the results of innovation so it's a bit striking to hear that documentation was generally poor. • Innovation is not so much new technology but sharing good practices across countries and introducing or re-introducing good methods for program development, implementation, management and supervision. It can be re-vitalizing a good practice which has gone dormant or introducing new, common sense ways of doing things. • May not require the full gamut of testing, costing, documenting we would expect of innovations in a private sector setting. It can include, for example, arriving at a good mix of distant education and in-class or on the job upgrading of skills.	Interview with former H4+ global team member (UNFPA).

55	**Global level** Regarding the role of the global/regional teams in assisting country teams on innovation: • On innovating they at the central level (the global steering group) pushed for documentation of anything that looks like a new way of doing things in the country where it is applied – not limited to or even highlighting technological innovations • Documentation really amounts to identifying and sharing what is a good practice, then it becomes more a narrative, a story of what works rather than a fully, evidence based documentation of an experiment with quantified results and costs • Doing things differently in a common sense kind of way is what these narratives mostly highlight not "innovation" in a business or private sector sense • Nonetheless, even with this limited definition of innovation, they are missing a step which they could have insisted on from the global perspective. Say at the beginning of each year they could have asked the countries to document what had been their big innovation the year before and then take that collection of innovative ideas as a group to see what they should do with them – perhaps referring them to existing research programmes at WHO for example to see if they tested out. • They did not link these narratives on new ways of doing things to systems for knowledge generation which go beyond reporting on stories of achievements to share them as identified good practices.	Interview with H4+ Global Team (WHO).

56

Innovation: To your knowledge, has the H4+country team provided support to innovative measures to strengthen the supply of – and demand for – services in RMNCAH in the period from 2011 to the present?		
Answer Options	**Response Percent**	**Response Count**
Yes	77.6%	38
No	10.2%	5
Don't Know	12.2%	6
	Skipped question	28
	Answered question	49
Total		**77**

Innovation: Did the innovation result in changes to national programmes or policies? Please specify.		
Answer Options	**Response Percent**	**Response Count**
Yes	84.4%	27
No	15.6%	5
If yes, please specify		24
	Skipped question	45
	Answered question	32
Total		**77**

Responses from H4+ Partners and Stakeholders Survey, Questions 24 and 25.

Theme: Application of practical tools to support innovation programming

57	**DRC** 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 (UNFPA).

58	**DRC** A joint mission led to the development and submission of the **RMNCH Trust Fund Proposal** which was funded. The 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 MDG 4&5 and "leverage resources from all these partners in an aligned, focused approach." 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 (2014). Recommendations de la Mission H4+ & RMNCH en RDC, 3-7 Février, 2014. (GIBS 2014) 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) Interview, H4+ country team member.
59	**DRC** 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. H4+helped accelerate the progress in RMNCH by training the Eglise du Christ au Congo (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.
60	**Liberia** The NASG introduction is based on WHO guidance on the prevention and treatment of postpartum haemorrhage and is listed in the interagency compendium of essential equipment for managing maternal and newborn emergencies published by WHO, UNICEF and UNFPA in 2015 (as a Global Programme Product).	WHO 2012. Recommendations for the Prevention and Treatment of Postpartum Haemorrhage. (WHO 2012)

61	**Zimbabwe** HQ-produced guidelines are used in the development of national level guidelines, for example WHO-produced guidance was the basis for clinical mentoring guidelines produced in 2015. These guidelines are an important tool for the on-the-job mentoring for practicing health professionals in reproductive, maternal, neonatal, child and adolescent health. The purpose of the guidelines is to provide guidance at all levels of care, national, provincial, district health management teams and central hospitals in developing and/or integrating a clinical mentorship programme, to ensure quality healthcare service delivery in all health facilities.	Interviews: H4+ Country Team, UNFPA and WHO
62	**Zimbabwe** The H4+ country team was unaware of several of the key global knowledge products developed globally nor or the expectation that they should be used/replicated within the programme. The global knowledge products with the clearest link to Zimbabwe 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) • Final version of Rapid Assessment of RMNCH Interventions and Commodities (UNICEF, 2013) • Development of the list of essential life-saving commodities/equipment for MCH/FP 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 CHW RMNCH training guidelines (UNFPA 2014) • RMNCH training guidelines developed. A mapping of existing training tools for Community Health Workers (CHW) 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).	Interviews with H4+ Global and Country Team.
63	**Burkina Faso** Burkina consulted the available documentation (“Guide”) for implementing the Husband’s School approach (the “guide” was later adapted/revised)	Interviews with UNFPA Burkina Faso.

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.*

	Information/data	Information sources
Theme: Information on success or failure of innovation		
64	**Global level** This report mentions a compendium of case studies on innovative approaches to MNH. It was finalised and published in print and electronically. Copies were also provided to all H4+ countries at the annual Canada H4+ meeting. The ultimate purpose of the compendium is to inform countries about existing innovative approaches to MNH and highlight some key considerations for bringing MNH innovations to scale. In addition, a guidance note for documenting innovative approaches to MNH was developed and shared with H4+ countries to enhance active documentation of best practices. (Refer to evidence in Line 41).	H4+, *Annual Narrative Progress Report for 2013 (Canada) Final*. May 2014. (H4+ Global Technical Team 2014a)
65	**Global level** 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"* (p. 3). It should be innovative in the country context and can be identified at any one of the planning, implementation or evaluation/programme stages. Practical guidance was offered for documenting as either a description summary (using case study format), as a report or working paper, or as an academic/peer review journal article. A template was offered for documentation of innovations, with key sections noted below: • Justification of innovation (why is the intervention considered innovative; what is new about this approach compared to previous approach) • Strategy (a description of the strategy used, where it came from how is it implemented, at what scale)	H4+, *Guidance for Documenting Innovative Approaches.* November 2013. (H4+ 2013d)

	• Results (including progress, coverage and verified results and whether it is being replicated elsewhere) • Lessons learned (including enabling and constraining factors, and how these were respectively leveraged or overcome).	
66	**DRC** UNFPA country office used the global guidelines for documenting innovations and submitted two documented innovations: • Competency-based Emergency Obstetric and Newborn Training of service providers; and • Participation of midwives in the fight against maternal mortality in Bandundu town.	UNFPA (2016). *Bonne pratique de l'UNAAC Bandundu.* (UNFPA 2016a)
67	**DRC** UNFPA country office responded to a request from headquarters to document good practices in July 2016 by documenting the following innovations: • Institutionalization of maternal death surveillance and response • Improving the quality of pre-service midwife training • Operationalising Basic Emergency Obstetric and Newborn Care (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) 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 2016e) H4+ JCPS Global Technical Team (2016) Opérationnalisation des services de SONU-B dans les dix pays du H6 Programme Conjoint (H4+ Global Technical Team 2016f)
68	**DRC** UNICEF documented and shared the family kit approach through a video which is accessible on YouTube.	UNICEF (2016). Des kits familiaux pour la santé des enfants? Une innovation réussie! (video film) (UNICEF 2016)
69	**DRC** DRC experiences with EmONC trainings and other key H4+ JCPS interventions was selected (together with Sierra Leone) as good practice to be documented, and a brochure and a video were produced in 2014.	H4+ (2014). Stories from Democratic Republic of the Congo and Sierra Leone. May 2014 (H4+ 2014o). H4+ (year unknown). Saving Mothers' and Babies' Lives (video film) (H4+ nd-c)
70	**Liberia** The introduction and piloting of tricycles in the programme (and in Liberia) has been well documented. In order to support and strengthen county-level supply chain management systems, three tricycles were supplied to the three County Health Teams (CHTs). These tricycles are currently	H4+ Draft Annual Report, H4+, 2015. (H4+ 2015k)

	being used to move reproductive health commodities, family planning commodities and other supplies to more than six health facilities in the three counties that were identified and selected by the CHTs and Save the Children. However, the use of tricycles in rural Liberia is not effective and is very challenging due to the bad road conditions. The tricycles are not used during the wet/ rainy season as roads are not easily accessible even by a strong four-wheel drive.	
71	**Liberia** Evidence was found related to learning and documentation of review / lessons learned from an innovation (in this case, in the use of chlorhexidine). Since the introduction of the chlorhexidine gel in the 18 health facilities for core care, there has been a big reduction in neonatal death as a result of neonatal sepsis. Only a few cases were reported from four other non H4+ counties where mothers applied chlorhexidine gel in the eyes of the infant thereby leading to blindness of five children. At present, a nationwide awareness exercise is due to take place before chlorhexidine can again be given the mothers to take home as it is currently being applied ONLY at health facilities by skilled attendants and by trained general Community Health Volunteers (gCHVs) in the 18 H4+ health facilities.	H4+ Draft Annual Report, H4+, 2015. (H4+ 2015k)
72	**Liberia** Innovations, such as KMC, NASG and Chlorhexidine 7.1% can be showcased to inform of efforts being made by the UN Agencies to address the issues of maternal mortality and to stimulate others to adapt or scale up such innovations.	H4+ Heads of Agencies Meeting, Minutes of meeting, April 16 2015. (H4+ 2015g)
73	**Zambia** The terms of reference (ToR) include the requirement to conduct research, document progress, including innovation, and to write and prepare all of the H4+ JPCS material. There is also reference made to the lack of funds for the whole contract. Key activities the H4+ has done to support results and to document according to INESOR included: increasing space for the 48-hour postnatal check; midwifery training/ contracting retired midwives; community involvement (community workers); bringing health services closer to the community (to do ANC); building maternity waiting shelters. One impact reported was that more men escort partners to the facility and there is more family engagement.	Institute for Economic and Social Research (INESOR), KII, 14th July 2016.
74	**Zambia** INESOR has done human interest stories to document innovation. WHO asked for more human interest stories, and they are documenting innovations according to UNICEF. UNICEF innovations originated with some funding from H4+. As an example, early infant diagnosis for neonates (H4+	Interview, UNICEF, 2016.

	districts with H4+ funds plus additional UNICEF money) was first identified in a UNICEF-funded programme in Zambia. INESOR might be duplicating the national health system, because some of the indicators are outside of the national system and INESOR travels to the districts to collect the data. Then they go to the MoH and compare the data with the DHIS 2 system. But they also do quality reviews (which show the quality is good). Some of the indicators that H4+ had were not in the Health Management Information System (HMIS). The so-called 'Global Indicators' as proposed by the UN at HQ level were not consistent with Zambia Health System indicators. As an example, the Zambian Government insists on measurement of postnatal at six hours, six days, and six weeks. But the H4+ is 48-hours. Another difference is with institutional deliveries rather than births.	
75	**Zimbabwe** The key indicator on innovation is under Output 8: Communication and H4+ visibility: Number of documentations produced (human interest stories and innovations). Two documents have been produced: • The POC PIMA CD4 story summarises the assessment noted in Assumption 4.1 of the POC machines in 7 districts, but does not discuss the process of scaling this up through H4+ • The document describing the use of social media in addressing teenage pregnancy in Hurungwe is a human-interest story. It indicates that UNFPA and its partners in the National ASRH Network identified this "emerging strategy". It is intended to "exploit social media to empower adolescent girls to make healthy reproductive health choices and act on them. The document briefly describes the inputs, but does not present outputs. • The documents appear to have been written to satisfy the requirement of reporting on two innovations. The POC CD4 document includes information on scalability; however, neither follows the guidance on documentation (refer to evidence in Line 20), nor includes information on the results of testing or scaling them up within H4+.	H4+Zimbabwe, H4+ M&E Logframe revised May 2014. H4+ Zimbabwe, 2014 The use of Point of Care PIMA CD4 Cell Count Machines for HIV Positive Women and their Families in Maternal Newborn and Child Health Settings in Seven Districts in Zimbabwe. (H4+ Zimbabwe 2014c) Hurungwe Youth User of Social Media to Fight Teenage Pregnancies. Interviews with H4+ Country Team.
76	**Burkina Faso**	The H4+ partnership: Joint support to improve

	"The husbands' school" approach and the "cost sharing system" were documented and 2 two-pagers ("H4+ Innovative Approaches") were produced (print and electronic) – "innovation completed"	women's and children's health. Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations. (WHO 2014: 27) Compte rendu réunion de coordination H4+ Canada, Jeudi 25 Juin 2015. (H4+ Canada 2015b: 2) Two-pagers: « H4+ Innovative Approaches – Burkina Faso – Schools for Husbands »; « H4+ Innovative Approaches – Burkina Faso – Le système de partage des coûts. »
77	**Cameroon** A draft of a protocol to document community-based activities was shared with the focal point and the draft for two other activities is awaited (for utilization of priceless phone network and maternal death and surveillance).	SIDA H4+ Donor Report Cameroon, 2015. (H4+ SIDA 2015e)
78	**Cote D'Ivoire** Developing 5 strategic documents to support "husbands' Schools" are part UNFPA's output 7 (demand including community ownership and participation). Nevertheless, the implementation rate was only 20.3% in 2014.	*Rapport de la mise en oeuvre des activités de l'initiative H4+ Sida en Cote d'Ivoire (August 2013-April 2014).* (H4+ 2014k)

79	**Cote D'Ivoire** A survey was conducted in 2014 to assess the implications and effect of the "Husbands Schools" strategy. • "Lot Quality Assurance Sampling" was conducted in the regions covered by the intervention "Husbands' Schools" to explore the populations' knowledge, the perceptions and the practices related to (PNC/FP/sexually transmitted infection/HIV/gender-based violence). • Four surveillance missions were conducted in 3 different regions covered by the intervention Husband School: 2 missions in Toumodi, 1 mission in 2 villages EDM H4+ and 1 mission in 5 villages of Bouflé). • Two central supervision missions were conducted in the 22 old Toumodi schools to assess the performance of the participants (model husbands) and their coaches. Two other district supervision missions were conducted for the same purpose. These different missions revealed some deficiencies in the availability of the necessary equipment and in the use of the management tools.	*Rapport standard de progrès annuel de la mise en oeuvre de la 6e programme 2009-2015 prolongé à 2015.* (H4+ SIDA 2015d)
80	**Guinea Bissau** H4+ working on documenting the experience of the maternity waiting homes and might do a case study of it. Other case studies include midwifery training, gender equality tracking and others.	Interview: H4+ Country Team.
81	**Global** The innovation component of H4+ was not well documented or highlighted. In the Global Financing Facility (GFF) they want to look at innovation in two ways: • Innovative financing mechanisms and sources, especially innovative financing through the private sector • Engaging with other stakeholders, such as civil society – examples include the kangaroo mother care experiment in Cameroon and social impact funds in other countries. • They hope to have more systematic attention to documentation of innovation as countries work with the GFF.	Interview with Global H6 DED (World Bank).
Theme: Knowledge sharing of innovations for decision-makers		
82	**DRC** *"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*	Interview, senior official in MoH in Kinshasa.

	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."	
83	**DRC** 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 2014)
84	**Liberia** H4+ country partners mentioned innovations and their interest in documenting them and sharing experience with other H4+ countries. However, it is difficult to find time.	H4+ Evaluation reference Group presentation to the evaluation team, 31 May 2016. (H4+ 2016b)
85	**Liberia** There appears to be no process of systematic documentation to assess information that would help others to generalize lessons learned. For example despite its excellent promise, an assessment of the costs, logistics and training needed to roll out the NASG was not conducted. Documentation is primarily done for reporting purposes and for regional meetings. Although the H4+ country team indicated that the approach taken by H4+ wold be rolled out beyond the JPCS, there was no clear documentation of this.	Observations and interviews from Evaluation Team, Liberia, May 30-June 15, 2016.
86	**Zambia** DFID officials said they looked to the H4+ agencies to strengthen cooperation with development partners more broadly and "t*ake their place*" in the development process. They appear to work privately with government and don't appear to invest time in supporting the broader partner processes. Regarding their collaboration, the H4+ agencies have their jobs to do and may even do their jobs well but there isn't evidence of collective thinking at least not through their expression, documentation, or presentation of their H4+ work at the level of the cooperating partners' forum.	Interviews with DFID representatives, Lusaka.
87	**Zambia** This randomised evaluation of results from implementing the Mama Packs revealed that "*a modestly priced non-monetary Mama Pack incentive was a cost-effective intervention to improve rural facility delivery rates in Africa. Our primary analysis estimated a USD4 mama kit increased facility deliveries by 44 percent (statistically significant at the one percent level) in poor, remote areas of Zambia. Cost-effectiveness modelling estimates the mama kits cost effectiveness at USD*	Measuring the Impact of Mama Kits on Facility Delivery Rates in Rural Chadiza and Serenje Districts in Zambia. End of project

	3,490 per death averted, a figure that is comparable to other public health interventions, such as insecticide-treated bed net distribution, anti-retroviral drugs for HIV, and other established maternal and child health interventions."	technological report, 28th April, 2014.
88	**Zambia** According to the MoH, several of the innovations implemented by H4+ are under discussion. They face some structural barriers, such as contracting retired midwives due to budget regulations. There is also some confusion about the policy process associated with making innovation (such as the mama pack) into national policy. Some cooperating partners had not heard about the policy shift to ensure every mother and baby received a postnatal check within 48 hours.	Observations and interviews from Evaluation Team, Zambia.
89	**Zimbabwe** At UN H4+ review meetings, agenda item on "sharing the progress" allows the different UN agencies to showcase what is working – e.g. UNFPA identified its "Parent to Child Communication" as a potential strategy to reduce teenage pregnancy, although there is no evidence of how it was received/ used.	Minutes, UN Agencies meeting, 20th August 2015. (na 2015)
90	**Zimbabwe** Refer to line 78; neither of the stories produced to document innovative interventions in Zimbabwe included information that would be useful to decision-makers.	
91	**Zimbabwe** This report contains documentation about the results of clinical mentorship, even though it was not written for the purpose of documenting an innovation. Doctors and nurses were mentored on surgical and aesthetic management of PPH, ruptured uterus, eclampsia, and ectopic pregnancy and the report included feedback from mentees: • According to all the doctors and nurses who have gone through the mentorship "attachments", the programme is very useful for their professional development with respect to management of obstetric emergencies as they are now able to perform complicated C-Sections. The doctors are also now able to perform manual vacuum assisted deliveries (MVAs), which they were not able to do before the programme. • However, there are some procedures that the mentees were not able to do, because caseload was inadequate.	MoHCC (2013). *Summary Report for the Clinical Mentorship Meeting held at Holiday Inn Harare. 24-25 September 2013*. (MoHCC 2013b)
92	**Zimbabwe** Consultations by national health and programme officials with provincial and district stakeholders have been an effective mechanism for rolling out innovative practices, such as clinical mentorship. However, without greater emphasis by the global and national teams on documenting both the	Observations by the Evaluation Team, Zimbabwe, June 6-22, 2016.

	content and process of innovation, H4+ misses an opportunity to influence other programmes with evidence and results of its experience.	
93	**Zimbabwe** While innovation was highlighted as a priority aspect of the programme at its inception, it appears that the routine and intensive acts of programme coordination take precedence to investing in the implementation of the full cycle of programme innovation. Apart from exchanges at meeting, there is little evidence to support a strong effort at knowledge management within and across programmes. Despite having an M&E resources in place and access to technical expertise in country, the limited attention by H4+ to documenting the results of testing and scaling up of innovative practices is attributed to placing greater emphasis and importance on the communication of results to increase public awareness of H4+ activities.	Observations by the Evaluation Team, Zimbabwe, June 6-22, 2016.
94	**Burkina Faso** There are several indications in annual progress reports and meeting minutes of coordination meetings that *documenting* the possible innovations should be a priority, although there is no discussion or record of how to document results, failures or success.	Observation by Evaluation Team Desk Review.
95	**Ethiopia** *"The programme contributed to the development of new PMTCT M&E tools and supported the TOT for MNCH providers and programme managers.The H4+/SIDA collaboration through UNAIDS provided support for the preparation and distribution of an electronic training package prepared in the form of a DVD. The electronic training packages was distributed to 1,000 PMTCT sites across the country"* (p. 29-30).	Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program, Ethiopia. (H4+ 2015m)
Assumption 4.4 *National health authorities are willing and able to **adopt proven innovations** supported by H$+ JPCS and to **take them to scale.** They have **access to required sources of financing** (internal and external).*		
Information/data:		**Information sources:**
Theme: Replication and scaling of innovation within countries		

96	**DRC** The family health kit approach was first piloted in implemented 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.	Rie Takesue (2014). Des kits familiaux pour l'amélioration de la santé des mères et des enfants. (Takesue 2014)
97	**DRC** *"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 the Global Alliance for Vaccines and Immunization (GAVI)."*	UNICEF (2015). A nurse and a family kit help save children's lives. By Yves Willemot. (UNICEF 2015b)
98	**DRC** 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.	MoH (2016). La stratégie de développement de la participation communautaire en RDC. DRAFT. Kinshasa, June 2016. (MoH 2016a)
99	**DRC** The approach engaging CHW in community-based RMNCH supported by H4+ JPCS has been extended to other health zones.	DRC H4+ JPCS annual report 2015. (H4+ 2015k)
100	**DRC** *"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.* (H4+ Global Technical Team 2014a)

101	**DRC** 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. *"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.
102	**DRC** • H4+JPCS funds were used to create a national 3-year midwife education curriculum with direct entry after the baccalaureat, 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. • H4+ JPCS funds allowed: (1) integration of the new midwife curriculum in 38 Higher Medical Technology 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. • 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. • 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.	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 2016e)
103	**Liberia** The use of the anti-shock garment has become wide-spread in the H4+ health facilities in the three counties as staff have been trained to use the garments to save lives of mothers experiencing bleeding. The garments are effectively being used by our trained staff for referring of pregnant women and postpartum mothers with obstetric haemorrhage. For the periods under review, there were a total of 34 mothers who were placed into the NASG garment and then transferred to hospital by ambulance; five in Maryland county, fifteen in Grand Kru and fourteen in River Gee county. The compliance and results were good as all of these mothers' lives were saved with usage of the garments.	H4+ Draft Annual Report, H4+, 2015. (H4+ 2015d)

104	**Liberia** The ERG presented the NASG as an innovation and planned to take the NASG to scale. The first stage would be to roll it out to the next three H4+ counties (Grand Kru, Cape Mount and Gbarpolu Counties) with an ultimate ambition to integrate NASG into national policy.	H4+ Evaluation reference Group presentation, 30 May 2016. (H4+ 2016c)
105	**Liberia** Heads of agencies encourage showcasing innovations such as KMC, anti-shock garment, and CHX 1.7% (chlorhexidine) in order to "*stimulate others to adapt or scale up such innovations*". The H4+ team plans to hold a meeting with parliamentarians to brief them on progress made and challenges. The note refers to a desire to be "*looking for synergies with neighbouring counties*" and the possibility of organising an opportunity to explore and learn from the Sierra Leone adolescent sexual and reproductive health ASRH programme. Extension of innovation to other locations has been opportunistic and inconsistent rather than structured: UNICEF provided 15 ambulances – 1 for each county – for maternal health support. Reference made to dire state of blood banks and roads and commodity shortfalls. Also noted that motorbikes are better than tricycles. Reference to WHO working on funding blood banks and neonatal units. Programme to consider supplying AG-100 motorbikes. As with previous HOAs meeting, no MoH or World Bank (WB) members in attendance.	H4+ Heads of agencies, minutes of meeting, April 16 2015 (H4+ 2015l).
106	**Liberia** The provision of the solar suitcase is viewed as an innovative intervention and can be used in different terrains. The devise can be used in an emergency (for example, to provide light for a caesarean section) and also at night time for deliveries. The solar suitcase is simple to install and use. An assessment was completed which identified a widespread need for electricity in health facilities and linked electricity (and lights) to a higher likelihood that women would attend the clinic in the evening/ after dark. As a local team can be trained to install and maintain the equipment, sustainability is more promising. 'We Care Solar' installed two solar units after training a local team (including all women, some of whom are illiterate) who can now –theoretically – train others. Plan to monitor how the solar units change effect attendance at the health facility. It remains unclear whether a systematic assessment of impact is planned. There are plans to link up with GIZ to do an additional programme proposal to install solar suitcases in a wider number of health facilities.	Interview with UN Women Country Team.
107	**Zambia** "*The EU Millennium Development Goals Initiative (MDGi) programme has adopted the Mama kits and the government will also incorporate into the next budget it says."*	Interview with Senior Ministry of Health Officials.

108	**Zambia** Regarding innovation and new ideas in H4+ JPCS and what was new or really memorable, the senior officials at the provincial medical office said: (1) the mama packs were really appreciated; (2) involvement of the community in upgrading the facility such as through the training of SMAGs, the construction of the maternity waiting shelter, the new equipment, etc.; (3) 'Talking Walls' at the clinics (posted dashboards developed through self-assessment process) and working with communities to engage them; transmission and discussion of information in an open way to promote decision making; (4) retired midwives contracted to fill the place of nurses gone for training.	Interviews with Provincial Medical Office, Western Province.
109	**Zambia** There is no funding allocated in the public budget to hire retired midwives while the nurses are in training (public funds cannot be used to pay salaries for *ad hoc* or temporary staff according to statements made by UNFPA and confirmed also by the district health authorities), but the government has extended the retirement age to 62 instead of 55 years. So all those who reach 55 years are not going to retire. If they opt to retire the package will come later. In the Eastern Province, Sida is beginning to fund the same kind of H4+ package of RMNCAH interventions, and through the districts. They recently advertised contracts for retired midwives. The midwives are invited to apply and Sida will provide the funding to support the contracts for five years. Government will continue training one new midwife per district (so H4+ will carry on in the East Province at least). In years to come there will be less need for the retired midwives. The Government looked at the model of H4+ and knew the impact and achievements so far.	Interviews with UNFPA staff.
110	**Zambia** Successful innovations in the view of UNFPA include: training of midwives; contracting retired midwives; training teachers alongside health workers in sexuality and reproductive health so they can support adolescents together. UNFPA trained teachers on their own to take adolescents through sexual education. But then the training of teachers was combined with training health workers in pairs based on district or location (rather than separately). It was apparent their roles reinforced one another so teachers call upon health providers when needed. The impact was significantly better. They got to know each other and teachers could refer the pupils to the healthcare provider. UNFPA had supported this in the North Western districts prior to H4+. Then, they started doing this in the H4+ on a wider scale (i.e. the five H4+ districts) and it has now been extended to other parts of the county. It is not as yet national policy but this may happen ("*they are starting to look into it*"). In addition, they are working together with UNESCO on an initiative to support a curriculum development centre for trainers. Asked if there were any data on it or whether and how is success	Interviews with UNFPA staff.

	monitored, UNFPA said they go back to schools to monitor outcomes. They are also monitoring the number of pupils visiting the health facility for family planning. Also monitor how many girls drop out of school as a result of early pregnancy.	
111	**Zimbabwe** The Global Fund and PEPFAR are scaling up the use of CD4 machines at point of care nationally, based on the approach developed by H4+. Documentary evidence indicates that EGPAF was the initial driver of introducing and testing this innovative approach in Zimbabwe, which was not mentioned or acknowledged in interviews with H4+ team members.	Interviews with H4+ country team members. Zimbabwe PEPFAR Operational Plan Report, 2010. (na 2010)
112	**Zimbabwe** The coordinators of the new Health Development Fund (HDF) programme (UNFPA and UNICEF) intend to carry forward some of the innovations "introduced" by H4+, including clinical mentorship and supportive supervision. However, funds pledged for this programme are well below the needs identified, so it is not clear whether and how these innovations will be prioritised within HDF. Government resources for health are allocated mainly for personnel costs, therefore, unless additional donors funding is identified, the future is not clear for scale up of these (and other aspects) of the H4+ programme.	• Interviews with H4+ country team members. • Interviews with donor representatives.
113	**Zimbabwe** H4+ is recognised as a vehicle for programme innovation. During the Victoria Falls review meeting in 2013, innovation was introduced as an important topic and area of focus. Prior to this, the individual agencies did not have a common view or vision of innovation within the programme. Before the Steering Committee became operational, most programme activities were focused on training and the supply of commodities. However, are major concerns that resources for innovation will be limited after H4+ ends and this will translate to less interest and focus on innovation in RMNCAH. The HDF is the main resource vehicle for RMNCAH going forward, and there is a risk it will not prioritize innovation and the unique focus within H4+ could be lost.	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
114	**Burkina Faso** The "cost sharing system" was extended to cover 7 out of 9 districts (78% coverage in the two target regions) (as of 2015) (p. 9)	The H4+ partnership: Joint support to improve women's and children's health. Annual report 2015 of the H4+ joint

		programme with Canada and Sweden collaborations. (H4+ Global Technical Team 2016d)
115	**Burkina Faso** The H4+ team wanted to adapt and pilot the Husbands' School approach based on the Nigeria experience before scaling up which is the reason why it was only implemented in two districts. Covering all districts would also have been financially challenging. The Husbands' School approach has now been included in the WB-funded project « *Projet autonomisation des femmes et dividende démographique au Sahel* » 2016-2019. It was the Direction of Family Health that made this decision, and the approach will be implemented in 6 districts. The parent-child dialogue approach was developed and piloted by a local NGO, Initiative Privée Communautaire, in the Centre East Region, and was presented to the MoH and partners during a review meeting. The available funds only allowed the H4+ team to implement the parent-child dialogues in two districts. UNFPA has submitted a proposal to Belgium to fund the approach in two regions.	Interview with UNFPA staff.
116	**Burkina Faso** The "husband's school" approach started in Kaya district, and there are plans to extend it to the North region in the near future. A *« Guide pour le passage à l'échelle de l'approche IFC »* was elaborated and approved in May which will support the scale up of the IFC approach.	Interview with WHO staff.
117	**Guinea Bissau** Among the priorities for 2016 is to *"fill infrastructures and logistics gaps (rehabilitation, transport, equipment and devices delivery; Maternity Waiting Homes"* and *"reinforce communication, advocacy and best practices dissemination actions."*	H4+ Presentation to the Global Mission in Guinea-Bissau, 20-24 July 2015, Implementation Review & Way Forward, Powerpoint presentation, Bissau, 2015 (H4+ 2015i)
118	**Sierra Leone**	Interview with H4+ Country Team, UNFPA.

	When the programme was revitalised in 2015 following the Ebola crisis, the decision was taken to continue with the combined in-kind kit and voucher system for free access because it was worth testing in the two districts of concentration and would have direct benefits for women and adolescent girls. Indications are, however, that the national government is not able to fund the national roll-out of the voucher system. Resources for its testing in two districts were provided by Irish Aid.	
119	**Sierra Leone** Because of the Ebola crisis, plans to scale up the voucher system and m-Health innovations were revised. The voucher system was to be implemented in two target districts which were the focus of programme attention in 2014 and the m-health activity was discontinued and resources were reallocated to support the revitalisation of MDSR.	H4+ Results Framework 2014-2016. (H4+ 2016e) Interview with H4+ Country Team, UNFPA.
Assumption 4.5 *H4+ JPCS **mechanisms for promoting successful innovations** across the team programme countries and among non-programme countdown countries are effective.*		
	Information/data:	**Information sources:**
Theme: Replication of innovations across country programmes		
120	**DRC** The office for innovation at UNICEF in New York supported the UNICEF country team in documentation innovations. There 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.
121	**Liberia** NASG was used in H4+ supported facilities with good results. It was presented at regional meetings as an innovation. The NASG was recommended as a useful device for PPH management while awaiting transfer to the hospital but the need for more and better evidence was specifically	Observations and interviews from Evaluation Team,

	identified. H4+JPCS supported global knowledge documents include the NASG; however, there is no documented evidence from the Liberia experience and certainly no baseline. Thus, the experience in Liberia does not appear to have influenced other H4+ JPCS countries to explore the use of NASG.	Liberia, May 30-June 15, 2016.
122	**Liberia** H4+JPCS annual reports and other communications material highlight successful innovations for use by non-programme countries. The report is silent on whether innovations are shared and how. The report identifies innovations but not how they can be scaled up or transferred to other countries.	H4+ Annual Reports, 2015 and 2014. (H4+ 2014g, H4+ 2015k)
123	**See Lines 76 and 79 for replication of Husbands Schools (piloted in Niger) in Burkina Faso and Côte D'Ivoire**	
Assumption 4.6 *Global knowledge projects produced with support of H4+ JPCS incorporate examples of successful innovations for strengthening RMNCAH that can be adopted in non-programme countries.*		
124	**Africa region:** The WHO regional office actively shares/distributes global knowledge products to the country offices, including: • Tool for evaluation of quality of care • Guidelines for PMTCT/Option B+ • IMNCI training modules • EmONC guidelines The regional office typically also organises a regional workshop on a new approach/guideline in which MoH representatives and UN agencies from different countries participate. Based on this general orientation, the MoH or country office makes a request to the regional office to provide TA. This process was also followed in the context of the H4+ JCPS, which indicates that there was not a particularly active "push" or promotion of the global knowledge products supported by H4+ JPCS other than "business as usual".	Interview with Africa regional staff (WHO).
125	**West and Central Africa region** There was no recall regarding any specific documents, although said that at the meetings H4+ shared tools for monitoring and evaluation and discussed information on how to use them, how	Interview with WCA regional staff (UNAIDS).

	they can be utilized. Best practices were also shared from country-to-country, such as how to support more effective training and curricula development.	
126	**Global level** The gender equality framework for action is an example of a global knowledge product, led by UN Women and developed jointly with the other agencies to provide practical, "how to" guidance on ensuring that women and girls needs and priorities are fully taken into account within RMNCH programs. (This work is still under development.) This effort was a result of a "ground-up" request from country programmes for more guidance on how to operationalize gender in RMNCAH programmes. It is seen as useful to the other agencies, and it is expected that each agency will have its logo on this global knowledge product.	Interview with Global staff (UN Women).

Division of Labour

5. 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:**
Theme: Coordination as the basis for division of labour		
1	**Democratic Republic of the Congo** A 2014 H4+ Representatives Meeting discussed how to harmonize approaches (e.g. Results Based Financing (RBF) and avoid duplication of activities (e.g. evaluation of community health insurances) and how to coordinate H4+ activities with the RMNCH Trust Fund. • *« Evaluation des mutuelles : L'évaluation à mi-parcours a recommandé une évaluation des mutuelles. La Banque Mondiale prépare une étude/évaluation sur les mutuelles. Donc, il est plus indiqué de faire une seule évaluation des mutuelles en mettant les ressources ensemble. »* • *« Briefing sur la mission du consultant du processus d'engagement Reproductive Maternal, Newborn and Child Health (RMNCH) Trust Fund (…) Financement de 15 millions de US Dollars pour 2 volets retenus : les intrants (12.3m USD) et la coordination (1.5m USD). L'UNICEF est responsable*	*Note de la Réunion de Chefs d'agences H4+* du 07 juillet 2014 (H4+ 2014e: 2-4).

	des intrants et (World Health Organization) l'OMS de la coordination, l'UNFPA n'a pas reçu des fonds RMNCH. »	
2	**Democratic Republic of the Congo** How has the H4+ Canadian funds contributed to improved coordination? • *"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."* • *"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."* With the H4+ Canadian funds, it was decided to implement activities in the same health zones (HZ), which enabled the H4+ agencies to create synergies and plan activities jointly based on each agency's comparative advantage. 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."* The H4+ approach was ahead of other UN joint platforms and the H4+ dynamic inspired other UN coordinating platforms, such as the Monitoring and Evaluation team, the communications team, One Place One, and One UN Gender Team.	Interview: H4+ country team member.
3	**Liberia** **Coordination with the national authority** (government). The H4+ country team has good relations with the Ministry of Health (MoH) at a senior level. The team reports close coordination and a high level of collaboration. National health authorities report that the process of consultation and coordination of H4+ JPCS programming **was effective in avoiding or eliminating overlap and duplication of efforts.**	Presentation: Evaluation Reference Group, May 31 2016 (H4+ 2016b).
4	**Liberia** **What are the issues related to coordination among the agencies of the H4+?**	Interview: H4+ Country Team, WHO.

	• Agency regulations differ, making integration and reconciliation of finances a challenge • Pulling together reports from several implementing partners and with different internal reporting structures for the different agencies • Agencies' regulation for the release of funding at the different levels • Competing priorities by Government, such that it can be difficult to choose what to do • M&E: project management tool provided by headquarters is not user friendly even with training. It will probably be abandoned or completely revised.	
5	**Zambia** **Process of collaborative planning:** *"The government made the Maternal Health Plan, and the UN and all agencies together identified joint programming opportunities. We mobilised resources together. This resulted in the building of H4+. Together we undertake joint monitoring missions."* Key informants could not identify challenges to working together, though neither could they specify what was unique/ better about working together.	Interview: H4+ Evaluation Reference Group.
6	**Zambia** The Evaluation Reference group provided the evaluation team with minutes of the various Heads of Agency and Technical Working Group meetings and annual review planning meeting documentation. The documentation provided shows that 21 meetings in total took place between 16/07/2012 and 15/10/2015. For example: • Heads of Agency Meeting at Protea Chisamba, 11, October, 2012 • Mother and Child Health Intervention Discussion Meeting, 13th March, 2013 • H4+ Heads of Agency Meeting, June, 2013 • H4+ Heads of Agency Meeting, 19th August, 2013 • Heads of Agency Meeting, 4th February, 2014 • UN Technical Monthly Meeting, 4th March, 2014 • Heads of Agency Quarterly Meeting, 6th May, 2015	Assembled from minutes of meetings and other documentary evidence.
7	**Zambia** Experience of coordinated delivery • The UN agencies have always worked together since the first United Nations Development Assistance Framework (UNDAF) of 2011-2015 • The H4+ project was commissioned at the same time as the first UNDAF, therefore, there was combined effort to develop the H4+ proposal together. Initially some agencies wanted to be more visible.	Interview, H4+ Country Team, WHO.

	• Recently, the H4+ agencies came together to support the development of the Global Vaccine Initiative (GAVI) proposal.	
8	**Zimbabwe** The process of setting a new direction for H4+ began with the first quarterly joint planning and review meeting of all stakeholders (Ministry of Health and Child Care (MoHCC), H4+ partners and provincial and district health facilities staff as well as participating NGOs) in September 2013.[5] This first step was followed up by the H4+ partners and the MoHCC during the global H4+ inter-country planning and review meeting held in Victoria Falls, Zimbabwe from May 26 to 30, 2014 (and subsequently referred to in key informant interviews as the Victoria Falls meeting). One outcome of this meeting was the establishment of the national H4+ steering committee under the chair of the Director of Family Planning of MoHCC, with its first meeting held in June 2014.	Joint Interview: H4+ country team. Interviews: MoHCC staff at Director and Deputy Director Level at Headquarters.
9	**Zimbabwe** • Enhanced coordination has been the major positive improvement due to H4+ JPCS. The programme collaborated first on the needs assessment to underpin a coordinated response • They focused on the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best).	Interview, H4+ country team, WHO.
10	**Cameroon** The project is coordinating efforts with key stakeholders present in the field to generate synergies. An example is the coordination at district level of the project with UNICEF Nutrition program and UNICEF Japanese Fund project in Far North Region.	*Sida H4+Donor Report 6* Cameroon, 2015.
11	**Côte d'Ivoire** • A joint mission including Ministry of Health, UNFPA, WHO, UNICEF, UNAIDS, UN Women to launch the implementation and coordinate the stakeholders' activities of H4+ (Swedish International Development Agency (SIDA) in three regions covered by this programme • The MoH is the main partner of the Coordination Committee and leads all its meetings. • Monthly meetings between the different national bodies and agencies involved in the implementation of H4+ activities	*Rapport de mise en oeuvre des activités des intiatives H4+ Sida (August-December 2013.*
12	**Guinea Bissau**	*The H4+ partnership: Joint support to improve*

[5] (H4+ Zimbabwe 2013). While joint planning and review meetings were planned on a quarterly basis they sometimes occurred less frequently due to scheduling difficulties. At a minimum, they occur twice each calendar year.

	After a gap since the beginning of the year 2015, H4+ Guinea Bissau team regained a full time coordinator in July 2015. Several coordination meetings, working sessions, field missions and public presentations on H4+ SIDA have taken place since then (7 coordination meetings, including 1 enlarged meeting; 3 public presentations; field missions to all 7 H4+ regions).	*women's and children's health. Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations, Guinea Bissau 10 Feb 2016.*
13	**Ethiopia** Coordination forums include: • Participation Annual Review Meetings (ARM) of the Health Sector Development Plan (HSDP) • H4+ Technical Working Group meetings of UN agency representatives and Federal Ministry of Health (FMOH); once a month meetings plus additional meetings when the need for joint work arises • Individual H4+ member agencies coordinating with implementing partners • Participation in Joint Integrated Supervision meetings organized by FMOH (2x a year) • Joint monitoring visits • H4+ meeting for six countries participating in H4+ in Victoria Falls 2014	*Final Report, Mid-term review of the H4+/SIDA Collaboration on RMNCH Program.*
14	**Sierra Leone** • There is no new coordinating mechanism established for the Canada initiative of H4+ in Sierra Leone, Rather the programme will rely on existing mechanisms as follows: o Implementation will be under the leadership of the Ministry of Health and Sanitation (MOHS) which provides guidance for identifying priority interventions o Implementation is the responsibility of the director of Reproductive and Child Health and the Manager of Reproductive Health/Family Planning and MOHS o Overall coordination is under the existing Reproductive and Child Health (RCH) committee which reports to the National Health Steering Group chaired by MOHS and with the heads of the H4+ agencies participating o The working coordination of the country programme will be done under the existing Technical Working Group on the Joint UN Programme in Health - no special working group will be formed for the Canada grant (p.14) however o The three executing agencies (WHO/UNICEF/UNFPA) to present annual budgets to the Local Steering Group composed of the five H4+ participating agencies (UNFPA, WHO, UNICEF, UN Women, UNAIDS and the Director of Reproductive and Child Health (RCH) and only on approval will the proposed budget be submitted to the global level. (p.14)	*Joint Programme Document* (2011).

15	**Online Survey of H4+ Partners and Key Stakeholders:** 85 percent of respondents indicate that national health authorities take part in sector coordinating meetings, while 94 percent indicate H4+ partners do as well.	On-Line Survey of H4+ partners and key stakeholders: Question 35.
16	**Online Survey of H4+ Partners and Key Stakeholders:** 76 percent of respondents agree that health partners work together effectively to ensure national priorities are met.	On-Line Survey of H4+ partners and key stakeholders: Question 35.
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.*		
	Information/data:	**Information sources:**
Theme: Partner roles reflect capacities and advantages matched to national contexts		
17	**Democratic Republic of the Congo** The original H4+ JPCS proposal clearly outlines the distinct roles and responsibilities of the H4+ agencies in the draft 2011-2012 work plan: • **UNFPA:** Introduction of Emergency Obstetric and Newborn Care (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/Family Planning 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. • **UNICEF:** provision of drugs, supplies and equipment to Health Zone (HZ) health facilities; strengthening referral system (referral tools and involving communities); engage communities in RMNCH through Community Health Workers (CHW); advocate for improved HRH management	*DRC H4+ JPCS proposal* (H4+ Canada 2010b: 17ff)

	• **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	
18	**Democratic Republic of the Congo** 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 HZs, the target groups, operational strategies, which activities of the minimum service package each agency supports, and the links to the National Health Development Programme (*PNDS* 2011-2015) and the Millennium Development Goals (*CAO*) 4 and 5.	H4+ agencies (year unknown). *Cartographie des interventions des agences H4+ en RD Congo.*
19	**Democratic Republic of the Congo** • Division of labour among the agencies is effective, for example: UNFPA – training; WHO – equipment/ mannequins; UNICEF – medicines and equipment. • H4+ Canada funds led to improved division of labour and has created a "culture of coordination" *"We have other joint initiatives, for example: UNICEF: Family Kits, WHO: strengthening coordination; UNFPA: medicines."*	Interview: H4+ country team member.
20	**Democratic Republic of the Congo** 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 Country Office to UN Women Country Office. However, only 90.000 USD of 150.000 USD were disbursed and there is no evidence of the reason. Both UNFPA and UN Women were inquired about this, but no clear answer obtained. This had a negative impact at community level, as it caused certain activities in the approved work plan not to be implemented.	Interview: H4+ country team member. Interview: H4+ Global Technical Team Member.
21	**Liberia** What do you do differently with the H4+? Allows concentrated effort in particular areas by all partners; each agency does different things in the same location; coordination, activities are not duplicated. UNICEF activities include: Prevention of Mother to Child Transmission (PMTCT), adolescent health, and Water, Sanitation and Hygiene (WASH).	Interview: H4+ Country Team, UNICEF.

22	**Zambia** How has the division of tasks and funding been affected by H4+? • According to the WHO, the division of labour between H4+ members has been crystallised and more organised. WHO said there are templates for H4+ to draw upon that can help mobilise resources. At the start of the H4+ programme, funding was a challenge as 'there was one pot'. Also, now, the H4+ members are sharing tasks based on the comparative advantage of each agency. UNFPA said the proposal writing process for the RMNCH Trust Fund is a good example of how the agencies are working together. They received 7 million USD (from the RMNCH Trust Fund) for one year. • UNAIDS has had limited engagement and does not receive any funding from H4+. Therefore, the agencies that have been most active in H4+ are WHO, UNICEF and UNFPA. These agencies have received funding from the JPCS. • According to the group, the agencies see funding as critical to their ability to "do H4+ work". They are unable to hire people without it because of the way funds are managed in the UN now. The group also believes that the H4+ mechanism forces them to come together. H4+ partners said they would still be doing what they do now without H4+ funding but it would take more time and would not deliver the same product and would not be shared as easily.	Interview: H4+ Heads of Agencies, 7th July 2016.
23	**Zimbabwe** • **UN Women** became part of the programme in 2013 when Swedish (Sida) funding was provide for Zimbabwe. It concentrated on efforts to engage and empower girls and boys, men and women to effectively demand access to services in SRH, MNCH and HIV. • **WHO** is part of the original H4+ team and Zimbabwe was one of the original countries with an H4+ country team. The H4+ team (and especially WHO) worked with the MoHCC to develop a set of priorities and prepare the original proposal for Canada funding. • **UNICEF** was part of the original H4+ Canada programme way back in 2011 and acted as the coordinator then. Priority in the early days was to ensure HIV was integrated into MNCH. H4+ worked with MoHCC on HIV integration. • **UNAIDS** began to receive funding under the programme in 2012 (Sida) but only became operational in 2013. Their focus (within H4+) was having HIV services leveraged out to other MNCH services. They integrated their work into the harmonized H4+ JCPS work plan of 2013 and their mandate (within the programme) was to mobilize support at the community level.	Joint Interview: H4+ country team (WHO, UNICEF, UNFPA, UNAIDS, UN Women).

	• In particular, **UNAIDS** focused on stimulating demand for, and access to, contraceptives and to demonstrate need and value to traditional community leaders. Their NGO implementing partner developed a tool kit for traditional leaders.	
24	**Burkina Faso** The 4-year work plan assigns activities to each agency (UNFPA, WHO, UNFPA) according to their mandate and technical expertise (p. 14-18). WB and UNAIDS are mentioned as "participating" partners in the proposal (p. 19), but not assigned any activities in the work plan.	*Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011,* Ministère de la Santé (Proposal to H4+ CIDA). (Ministry of Health 2011b)
25	**Cameroon** The main role of H4+ partners is to set and/ or enhance the following: *I) prepositioning obstetric kits in the Far North region (Government and UNFPA funding);* *II) strengthening the availability of RMNCH supplies and equipment, including contraceptives, antiretroviral and antimalarial drugs and tests, at health facility level (Government, UNFPA, UNICEF);* *III) putting in place maternal and new-born death surveillance, audits and reviews (Government, WHO, UNFPA);* *IV) setting up a community based health services delivery and community involvement (Government, UNICEF, UN Women , UNFPA, UNAIDS);* *V) strengthening the health system through advocacy and integrated supervision (EPI, IMCI/SR) of health districts and health areas (Government, UNICEF, WHO, UNAIDS);* *VI) organising in-service EmONC and PMTCT training of service providers (Government, UNFPA,UNICEF, UNAIDS and UNWOMEN);* *VII) supporting initial and continuous training of midwives in RMNCH (Government, UNFPA);* VIII) *ensuring case management of severe, moderate and acute malnutrition of children under-five years (Government, UNICEF).*	*Sida H4+Donor Report 6* Cameroon, 2015. (H4+ SIDA 2015c)
26	**Côte d'Ivoire** • UNFPA is the coordinator of H4+ activities • UN women leads the development of a common UNH4+ approach to address community empowerment, women empowerment, and mobilization towards addressing barriers to access and utilize RMNCAH services	*H4+ SIDA mid-term report*. (H4+ 2015m)

	• WHO leads developing tools to assess and plan community engagement in improving quality of RMNCAH services • UNCEF leads the development of a guidance note to document innovative approaches to Maternal and Newborn Health (MNH) as part of enhancing active documentation of best practices.	
27	**Côte d'Ivoire** The report indicates clearly the role of each agency in the activities/interventions planned for 2013-2014 i.e. each agency had to perform clearly defined tasks.	*Rapport d'etape de la mise en oeuvre des activités de l'intiative H4+ Sida en Cote d'ivoire August 2013-April 2014*. (H4+ 2013f)
28	**Guinea Bissau** Each agency is identified in all the documents. Although some documents have H4+ headers, where a funder is identified it is usually a specific H4+ partner rather than "the H4+". For example, in the list of all the partners supporting the free-of-charge programme, there is a column entitled H4+ next to an European Union column and so on. But the specific agencies are then assigned roles and responsibilities according to the resources they bring (UNICEF, UNFPA, WHO, etc). Thus the H4+ is a funding source rather than a collaborative instrument. The agencies remain separate within the programme. However, what is really good about this particular document is that it shows how the different financing instruments used to fund the gratuity programme were coordinated and managed to build coherence.	*Anexo 4: Projetos para a Gratuidade* (No date).
29	**Ethiopia** The following activities were delegated as follows in the proposal/initial workplan for the H4+ partnership in Ethiopia: <u>UNFPA:</u> • Accelerated Midwives Programme • Mentorship for newly graduated midwives • Training of midwifery tutors • Masters level training in Integrated Emergency Obstetric Care • Training of Anaesthetists • Monitoring and supervision of training institutions (anaesthesia and IESO) <u>WHO:</u> • Integrated supportive supervision	*United Nations and SIDA Collaboration in Reproductive Maternal, Newborn and Child Health in Ethiopia, Work Plan 2013-2015.* (UN and SIDA 2012)

	• Refresher training on data management systems • Assessments of service availability and readiness • Assessment of quality of care • Training in paediatric HIV • Development of job aids/guidelines for PMTCT and paediatric HIV • Training for district and health facility managers on MNH program management • Document and share best practices related to RMNCH (every year) • Annual Program Review Meeting • Regular performance review meetings of technical team (every 2 months) <u>UNICEF:</u> • Train health workers on Basic EmONC (including procurement of training aids and supportive supervision to Basic EmONC sites) • Train health workers in New Born Care • Support Annual safe motherhood campaign • Train Health Extension Workers (HEW) on clean and safe delivery <u>UN Women:</u> • Organize national consultation based on findings of multi-country study on maternal death audit system (not clear why this was assigned to UN Women and not WHO). • Train health workers on Gender Based Violence (GBV) clinical management and gender-responsive service delivery in RHNCH • Gender mainstreaming skill training for Provincial Medical Directorates (PMD) and regional health bureaus • Train regional associations to play active role in ensuring women participation and benefit in health services and outcomes <u>UNAIDS:</u> • Support Monitoring and Evaluation efforts for PMTCT	
30	**Sierra Leone** • Original Programme proposal assigned specific roles to H4+ agencies: o UNFPA designated lead agency and focused on Family Planning, Community Advocacy, Referral Systems, skilled birth attendance and Basic Emergency Obstetric and Newborn Care (BeMONC) (p.14) o WHO with overall responsibility for Quality of Care (QoC) across the continuum of care and development and updating of protocols, guidelines and procedures.	Joint *Programme Document (2011).* (Ministry of Health and H4+ Canada 2011)

	o UNICEF given responsibility for community level integrated actions including outreach, strengthening capacity of MCH aides and BeMONC. o Government's role to include HR management for implementation, providing `supporting supervision, monitoring and evaluation and, the District Health Management Information System (DHMIS). (p.14) No mention of role of UN Women and UNAIDS.	
31	**Online Survey of H4+ partners and key stakeholders:** 76 percent of respondents agreed very much or considerably that future funding to RMNCAH programmes of the UN agencies at country level should be provided through the H4+/H6 partnership approach.	Online Survey of H4+ partners and stakeholders. Question 43.
Theme: A more effective collaboration		
32	**Democratic Republic of the Congo** • UNICEF, UNFPA and WHO received two grants from the RMNCH Trust Fund to implement a joint RMNCH programme: • Phase 1 grant « Augmenter l'accès, la demande et l'utilisation des 13 produits d'importance vitale et améliorer la santé des enfants et des interventions de santé reproductive », 3.4 million US Dollars (USD), October 2013-December 2015 • Phase 2 & 3 grant : « Fonds catalytiques pour améliorer la disponibilité des intrants et accouchement (Delivery kits) », 22.8 million USD, Septembre 2014-Juillet 2016	RMNCH Task Force meeting minutes. *La revue du rapport annuel 2015. République Démocratique du Congo* (RMNCH Trust Fund 2016).
33	**Democratic Republic of the Congo** "*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 (*'chacun faisait de son côté').* 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.*	Interview: Senior Ministry of Health Staff.
34	**Liberia** One H4+ representative said, "*working together is harder but better. It takes more time to work together but it is appreciated*."	Interview, H4+ Country Team, UNFPA.
35	**Liberia**	Interview, H4+ Country Team, UN Women.

	Collaboration between H4+ partners: UN Women has received excellent support from other members in developing and implementing their programmes including UNFPA chairing their procurement process for the solar suitcases and UNAIDS sitting on the committee to select their implementing partners (Africare, etc.). WHO helped them identify the solar suitcases as an alternative to panels while other agencies helped them develop their proposals.	
36	**Zambia** H4+ achievements as a result of working together? They are transitioning from the mode of delivering projects individually to working together on the H4+ programme. According to the group, they have begun to see the results of working together [under H4+] over the past one year. "*The H4+ is [a] wonderful concept in terms of bringing UN organisations together – each one of us bringing our own comparative advantage*." UN Women will soon be joining H4+ in Zambia. The World Bank works directly with the government and "*is not directly engaged with H4+*."	Interview: H4+ Country Team Heads of Agency Meeting.
37	**Zimbabwe** The partners focused on where is the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best).	Interview: H4+ country team, WHO.
38	**Burkina Faso** According to stakeholder interviews, the H4+ has enabled the three H4+ agencies to work much closer together, to share information about which activities they fund and where, and to better coordinate their activities at national and district level, even beyond the H4+ activities (so it has had a spill-over/generalized effect of the coordination of the three agencies contributions in Burkina Faso) *« Avant H4+, chacun travaillait de façon isolé dans son coin… on ne savait pas ce que l'autre faisait. Depuis ce programme (H4+) a été financé, on travaille plus directement » (Dr Belemvire, UNFPA)* «*Ca a permit aux agences de travailler ensemble, ca nous permets d'avoir une aperçue globale de nos programmes, éviter des doublons (pas financer la même activité deux fois), rapports et sorties conjointes, et amélioration de la communication » (Dr ZAN, H4+ coordinator, WHO).*	Interview notes, Dr Belemvire, UNFPA, Burkina Faso, 23 June 2016. Interview notes, Dr ZAN, WHO, H4+ coordinator, Burkina Faso, 26 June 2016.

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.

Theme: Coordinating to avoid duplication and overlap		
39	**Democratic Republic of the Congo** H4+ collaboration within the larger donor landscape in the Health Development Partners' Forum (*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 Materrnal and Child Mortality.*"	Email with H4+ coordinator (UNFPA), 4 August 2016.
40	**Democratic Republic of the Congo** 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.
41	**Liberia** **H4+ coordination:** Overall, coordination could be improved. In 2015, UN Women recognised "*potential duplication of activities (i.e.: overlap between UN Women and UNAIDS community engagement activities in the H4+ counties). This issue was resolved in a technical working group meeting but only by UN Women leaving out some of its community engagement activities rather than by expanding the scope of activities to a larger area".*	Interview, H4+ country team, UN Women.
42	**Liberia** Activities of each **H4+ partners identified and itemised**. Thus, the H4+ gathers together a consolidated plan with operating principles/ code of conduct around good partnership behaviour (avoiding duplication, joint travel, joint meetings etc.). [Code of Conduct not seen]	*Notes on H4+ retreat,* March 17-24 2014.
43	**Liberia** This UNFPA report presents achievements against the six major outputs. It provides some quantitative detail. Coordination strengthened at all levels through logistical and technical support to central MOH, County Health Teams and community levels. For example, Reproductive Health (RH) coordination meetings have been decentralised from central to county and downwards. Efforts are ongoing to cascade this initiative down to the community level to empower the health facility officer-in-charge to take charge of issues in maternal and newborn healthcare.	*Substantiating the Gains in Maternal and Newborn Health in Liberia H4+ Annual Report 2015*.

	• Supported RH meetings, 30 at county level (10 in each county) and 4 at central level through provision of fuel, communication cards and motivational incentives • Donation of two trucks, 4x4 Toyota Land Cruisers, to support monitoring and supervision as well as trainings at various levels • Supported advocacy on MNH at county, district and community levels.	
44	**Zimbabwe** • During the Review Missions MoHCC have noted different positive results linked to more common approaches to support by H4+ partners: o There is less emphasis on pre-service and more emphasis on on-the-job training o While there is more follow up and assessment required for training H4+ partners are providing support for it o They have standardized their approach to mentorship and supportive supervision o EmONC training is now scaled down with more emphasis on support and supervision. o IMNCI training is mainly now done through on-line distance training and needs to be supported by better supervision.	Interviews: MoHCC staff at Director and Deputy Director Level at Headquarters.
45	**Burkina Faso** The annually updated joint work plan shows no sign of duplication and overlap in support.	*Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011, Ministère de la Santé* (Proposal to H4+ CIDA). (Ministry of Health 2011b: 14-15) 2013, 2014 and 2015 H4+ workplans Burkina Faso
46	**Cameroon** The level of coordination is strong with clear division of tasks according to the different expertise of the UN agencies. The World Bank is not involved yet, but will be as the WB is extending strategy PBF to Northern regions.	*Intermediary rapport*, Sida.
47	**Ethiopia** There does not appear to be duplication of effort across the activities assigned to the different partners.	*United Nations and SIDA Collaboration in Reproductive Maternal, Newborn and Child*

		Health in Ethiopia, Work Plan 2013-2015. (UN and SIDA 2012)
48	**Sierra Leone** Difficulty in implementing training related activities because of poor coordination between partners and also within the RCHD programme. Agreed on the importance of reactivating the Reproductive and Child Health technical working group between the MoH and the UN partners as a way of improving communication and streamlining workplans. Also proposed to open the developing partners forum to include a high level MoH staff, this will ultimately provide an opportunity to discuss and exchange ideas on key issues affecting programme implementation.	*Minutes of the UN H4+ Heads of Agencies RMNCAH Meeting 21 October, 2016.* (H4+ Agencies 2015a)
Assumption 5.4 ***Global*** *structures, systems and processes for* ***identifying needs and opportunities and for planning, budgeting, approving and monitoring and reporting on H4+JPCS initiatives*** *recognise and encourage agencies' distinct advantages and contribute to* **an effective division of labour.**		
Theme: Effective coordination for strategic action at global level		
49	**UNAIDS** **Coordination at Global Level** • Yes, it has improved significantly but it is always a challenging task. • At both global and country level they have been able to proceed jointly but it was very difficult in the beginning to see how they could work together • The solution has been a kind of task force approach, working together as a global and a country task force and, at global level, working in nodes on specific tasks with inter-agency groups • At country level it is challenging for UNAIDS because they are not the lead technical agency ever and they are not the coordinating partner in any of the ten countries.	Interview: H6 Global Team, UNAIDS.
50	**UNAIDS** At a global level, UNAIDS works as a joint system and an agency task force.	Interview: H6 Global Team, UNAIDS.
51	**UNAIDS** *"The initiative is an 'eye opener' for me. It can solve many, many issues in country."* The joint missions are the most useful activity. Lala was invited to participate in three missions (Guinea Bissau, Cote	Interview; H6 Regional Team, UNAIDS.

	D'Ivoire and the DRC) and each one was very valuable in terms of communication, collaboration and unified program advice and support to the countries.	
52	**UNFPA** We coordinated approaches, strategies and support for countries. In having the maternal health and child health communities work together, we saved resources, mitigated vertical strategies, which in the past would have come at different moments. Work in the context of the EWEC is another example where together, we have supported countries making commitments (which would have been more difficult if each agency pursued this on its own).	Interview: H6 Global Team, UNFPA.
53	**UNFPA** There is active support to countries – planning meetings each year, then put teams together for joint missions. We are even more organized now to support countries than before, especially when countries request assistance.	Interview: H6 Global Team, UNFPA.
54	**UNFPA** Global Programmatic Action • Broadly speaking yes, but it took time to really figure out how to work together at global level and to move beyond just adding to what they already wanted to do to funding genuinely collaborative activities. • The Global and Country level H4+ teams were able to work together well (although it took time to develop a strong working relationship) but this was never achieved at regional level. • Even at global level, his view is that the good working relationship developed only at the technical level (in the global steering committee for example). The senior leadership of the H4+ partner agencies (Deputy Executive Directors and Executive Directors) still focused overly on advancing their individual mandates. • So, they were able to demonstrate the spirit of "one UN" at global level but only among the technical team. Disappointed with the engagement by senior leadership. • At both global and local level, it was hard to get the WB to engage. At global level, basically they come and listen but always reserve the right to act totally independently. Even now they (The WB) are not convinced that H6 should be and can be an important implementing arm of the GFF. • At country level the relative exclusion of the WB and lack of discussion on what is H6 (if its more than a vehicle for the Canada/Sweden funds) may result from the frustration of the H4+ partners with having no dedicated resources for MNCH so that when the grants came along, they dove in with both feet to really engage in programming real resources – and perhaps neglected the more intangible aspects of partnership.	Interview: H6 Global Team, UNFPA.

55	**UN Women** H4+ did bring real value added at Global Level. The Global Strategy 2.0 and the way that the new strategy was able to pull together and draw on new material was strengthened by the work of H4+ partners.	Interview: H6 Global Team, UN Women.
56	**UN Women** • It was useful partly because it was one of the first joint programmes they (UN Women) were involved in working together with other agencies – specifically aimed at the demand side. • The structures and processes worked will at global and country level to create space for UN Women to advocate for a Gender Equality (GE) perspective. • The value added was in bringing UN Women into the global dialogue so it could come in and take part in the conversation and consistently bring the gender equality dimension • Many of the other H4+ partners have small GE units or divisions that do not always have the resources to take part in discussions, consultations, workshops, dialogues on MNCH, even within their own organizations so having UN Women at the global table on RMNCH was only really possible through and H4+/H6 type structure and they were able to use that platform for GE within the programme and for advocacy.	Interview: H6 Global Team, UN Women.
57	**UNICEF** • At the global level, the Canada and Sida funds allowed them to do more joint programming and to have common, global level funding to programme • A key example is the global "Newborn Action Plan" which is not always branded as H4+ but which came out of H4+ collaboration and funding • Development of the Newborn Action Plan was supported jointly by WHO/UNICEF/UNFPA and helped to scale up RMNCH • At the global level, they work on global policies, strategies, guidelines. The beauty of all this was that the agencies came together in a coordinated way.	Interview: H6 Global Team, UNICEF.
58	**UN Women** • The global work plan was done in accordance with the ongoing work of larger coalitions and not based on what was happening at country level in H4+ JPCS	Interviews: H6 Global Team, UN Women.
59	**WHO** • You have to keep separate H4+ as a partnership and collaboration at global, regional and country level.	Interview: H6 Global Team, WHO.

	• There seems to be more separation at the global than the country level.	
60	**WHO** • The global coordination and collaboration was often around a task force structure working together on specific products. • An important question is how did this structure and operational framework work for all the H6 partners. Clearly there was an issue with how it engaged the WB. The most you can say is they did get the bank involved and ready to recognize their global role as the technical arm of the EWEC and to at least agree that they have a role to play in the Global Financing Facility (GFF). They also demonstrated to the WB that there is a value and an investment case for investing in women and children's health. The Bank for instance participated at global level in the workshops on building an investment case.	Interview: H6 Global Team, WHO.
61	**WHO** • Global technical team/global steering group did add value to the overall work of the programme but from the regional perspective it was most evident that this occurred in the country programmes through the approval of policies and participation in joint field review missions.	Interview: Regional H4+/H6 Coordinating Office, WHO.
62	**WHO** • The global coordination and collaboration was often around a task force structure working together on specific products. • An important question is how did this structure and operational framework work for all the H6 partners. Clearly there was an issue with how it engaged the WB. The most you can say is they did get the bank involved and ready to recognize their global role as the technical arm of the EWEC and to at least agree that they have a role to play in the GFF. They also demonstrated to the WB that there is a value and an investment case for investing in women and children's health. The Bank for instance participated at global level in the workshops on building an investment case.	Interview: H6 Global Team, WHO.
63	**WHO** *On global collaboration for innovation* • Even with this limited definition of innovation, they are missing a step which they could have insisted on from the global perspective. Say at the beginning of each year they could have asked the countries to document what had been their big innovation the year before and then take that collection of innovative ideas as a group to see what they should do with them – perhaps referring them to existing research programmes at WHO for example to see if they tested out.	Interview: H6 Global Team, WHO.

	• They did not link these narratives on new ways of doing things to systems for knowledge generation which go beyond reporting on stories of achievements to share them as identified good practices.	
64	**World Bank** • The real missed, strategic opportunity, was not working out and coming up with a clear send of roles and responsibilities (regardless of the funding source) at the country level. • For example, health financing for RMNCAH could have been the role of the Bank and WHO working together in their combined areas of expertise • WHO and the Bank should also take the lead globally and at country level on health systems strengthening where they have a real comparative advantage in technical expertise	Interview: H6 Global Team, World Bank.
65	**World Bank** • The Deputy Executive Director (DED) committee itself was even technical in subject matter and did not seem to grapple with strategy and how H4+ could really accelerate progress. • A key factor in H4+ meetings being diluted was the fact they became very technical and focused on supply side clinical practices and approaches rather than dealing with strategies • A limiting factor at the global level was the poor communications links within H4+ partner organizations. It seemed they spent a huge amount of time in meetings and discussions so that UNFPA (just as an example) at global level could find out what was happening in UNFPA programmes at country level	Interview: H6 Global Team, World Bank.
66	**Sida** • H4+ partners, especially WHO, argued that they needed the funding to activate and energize the partnership globally • Sida was sceptical at first and still finds it difficult to see how the funds were spent at a global level (6 million USD) and to see what the value added has been at global level. • They did work out a specific global level work plan but it took a very long time to get one global work plan – Sida are interested in seeing what the value added has been at global level.	Interview: Donor Representative.
67	**Results for Development** Collaboration among the partners has much improved. There is a much greater expectation that the partners will develop elements in common rather than separately. There is now and assumption of collaboration that did not exist eight years ago (when H4 was originally founded). A key example of this is all major donors sitting on the board of GFF to bring together decide how to use this additional funding.	Interview: Global Stakeholders, Results for Development (former World Bank).

Assumption 5.5

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 sources:
Theme: More effective advocacy at country and global level		
68	**Democratic Republic of the Congo** 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.
69	**Democratic Republic of the Congo** The Department for Planning and Studies (DEP) views on coordination - strengths: • Before, each agency operated independently: *"Chacun faisait de son coté."* Now, the partners (H4+ agencies) speak with the same voice. • 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.
70	**Liberia** This UNFPA report presents achievements against the six major outputs. It provides some quantitative detail. **Coordination strengthened at all levels** through logistical and technical support to central MOH, CHTs and community levels. Supported advocacy on MNH at county, district and community levels.	*Substantiating the Gains in Maternal and Newborn Health in Liberia* H4+ Annual Report 2015. (H4+ 2015o)

71	**Zambia** "*Agencies worked together to develop Trust Fund Proposal Power point presentation with HoA included: (a) a proposal for UNFPA to be the lead facilitating agency for the RMNCH trust funds, (b) the use of the H4+ Model of implementation given its successes in Zambia*. *HoAs committed themselves to make available staff and resources if need be for proposal writing and submission by end of Feb 28.*" Regarding the division of labour amongst UN Agencies, this should be spelt out in terms of reference of the working group and reflect technical expertise needed for the proposal development, including communication and M&E experts.	*H4+ (2015) Minutes of H4+ Heads of Agency Quarterly Meeting*, Lusaka, 6th May 2015. (H4+ 2015n)
72	**Zambia** ***Advocacy and Health financing***: "*In Zambia, the RMNCAH Roadmap was disseminated to ensure prioritisation of public financing for high impact RMNCAH interventions in the five supported districts. In addition, as part of the fiftieth independence anniversary of Zambia (24 October 2014), a local fund raising initiative coined 50-4-50 was undertaken to raise additional funds for rehabilitation of a labour ward at Kalabo district hospital*."	*H4+ (2014) Annual Narrative Progress Report 2013*, H4+ Canada Initiative, Accelerating Progress in Maternal and Newborn Health, Reporting period: 1 January-31 December 2014, Zambia. (H4+ Global Technical Team 2014a: 6)
73	**Zimbabwe** MoHCC has recognised how improved coordination has made H4+ partner policy engagement and advocacy more coherent and effective and wants to use this as a model for coordinating the new Health Development Fund.	Interviews: H4+ country team, UNFPA.
74	**Zimbabwe** Examples of areas where strong common agreement was reached and supported by H4+ at national level based on their (MoHCC and H4+) joint recognition of the problem and need for action): (not a comprehensive list but indicative of priorities) • Targeting the hardest to reach districts and the under-served populations, particularly adolescents and youth • The need to strengthen Maternal Death Surveillance and Response (MDSR**)** systems (for example by establishing a national MDSR committee) to improve accountability for results • The need to deal effectively with obstetric fistula	Interviews: MoHCC staff at director and deputy director level.

	• The need for improved clinical mentoring (now taken to scale as a national programme after trials in the H4+ district) • The need for better supportive supervision and training follow up • The emphasis on innovations in how to support MNCAH programming including: electronic MNDSR, Point of Care (PoC) use of CD4 machines in PMTCT and the revitalization of clinical mentoring.	
75	**Burkina Faso** The programme also conducted advocacy activities to maintain a national budget line for Reproductive Health products; and funded the new national strategy to provide services free of charge (80,000 USD for commodities), thus contributing to removing financial barriers to access.	Interview: H4+ Coordinator, Burkina Faso.
76	**Sierra Leone** The experience of the partners in H4+ JPCS allowed them to work together effectively on supporting the national application and programme for accessing the GFF.	Interviews: H4+ Country Team, UNFPA
77	**Sierra Leone** H4+ Canada supported advocacy helped civil society lobby for increased financial support to SRMNACH, especially procurement of contraceptives and maternal death reporting. Between 2011 and 2014, government budget allocations for the Directorate of SRMNCH more than doubled from USD 2.689 million to USD 5.757 million.	*H4+ Canada Annual Report*, 2013 (H4+ Canada 2013a)
78	**UNAIDS** As noted by WHO, the development of the new Global Strategy 2.0 was really driven by H6 and not by the individual agencies acting on their own mandates Back before the H4+ JPCS each partner sent their own policy and advocacy pieces to the countries but this is much more powerful now that they work together.	Interview: H6 Global Team, UNAIDS.
79	**UNFPA** Yes, contributed strongly to the development of the Global Strategy 2.0 because it helped them take a leadership role that they did not have in Global Strategy 1.0	Interview: H6 Global Team, UNFPA.
80	**WHO** H4+ JPCS allowed the H4+ agencies to take a leadership role in the development of global knowledge products and driving the development of the Global Strategy 2.0 and a central part in the Every Women, Every Child (EWEC) movement and, potentially, the GFF.	Interview: H6 Global Team, WHO.
81	**WHO**	Interview: WHO Regional Office, Libreville.

	Moreover, now H4+ agencies speak with one voice vis-à-vis the government and are thus **more efficient in their advocacy and policy efforts**. She highlights the DRC where the H4+ JPCS created a strong platform for inter-agency collaboration, strengthened advocacy for RMNCAH with other partners, and ultimately helped the government mobilise additional funds, such as the Muskoka Initiative funds in 2013 (Muskoka in DRC focused on broader health systems strengthening issues, including development of the health zones, human resources for health, and reform of the pharmaceutical sector).	
82	**UN Women** It helped immensely that the pieces produced by H4+ could speak together, especially when working with governments. UN Women had more legitimacy in both global and country level forums when bringing its demand side and rights perspective to the table along with the other H4+ partners.	Interview: H6 Global Team, UN Women.
Assumption 5.6 *Working from an integrated work programme at global level, H4+JPCS partners produce technically sound and operationally useful knowledge products for strengthening national systems and practices in RMNCAH in collaboration or through consultations with other H4+ partners.*		
	Information/data:	**Information sources:**
Theme: Joint Contribution to produce useful global knowledge products		
83	**UNAIDS** H4+ JPCS did support some critically important joint work. For example, They worked with WHO on addressing root causes of discrimination in health care services including: i. Increasing political support for addressing discrimination ii. Scaling up and iii. Accountability The global public good here is a global community of interest on addressing discrimination in provision of health services – all developed with H4+ JPCS support.	Interview: H6 Global Team, UNAIDS.

84	**UNAIDS** Another example of a valuable global knowledge product was the development of the Stigma Index reporting tool which is being used by civil society organizations to develop an index of stigma against PLWHIV for advocacy with national governments, including around, specifically, RMNCAH – it includes a costing tool for measures to address HIV.	Interview: H6 Global Team, UNAIDS.
85	**UNFPA** • A good example of the H4+ partners working together on global knowledge products has been the WHO-led work on IFC (Individuals, Families, Communities) and their role in MNCH, and caring for children. Would be worth looking more closely at. Again, strong emphasis on IFC as a good example of WHO undertaking activities encouraged by UNFPA and even funded by it. Focuses on competencies and the roles of community based agents. • Also State of the Worlds Midwives Report which was a strong collaboration between WHO, UNFPA and the International Confederation of Midwives. • One failing in the system was that they (H4+JPCS) were not so good at getting the messages developed in the global knowledge products back down to country level (including for use in the H4+ JPCS country programmes). UNFPA used to fund a programme to introduce and promote new tools, guidelines, but then decided to drop the funding and the programme has disappeared although WHO still does its best. • One exception, has been around **MDSR** where UNFPA and WHO have worked hard and sponsored many workshops, funded translations, provided technical advice ets. It is not accident that one area of the global work that does seem to be well reflected in the H4+ JPCS at country level is MDSR.	Interview: H6 Global Team, UNFPA.
86	**UNFPA** • They still should have done more work on "thinking" about how best to work together on really new things they could not otherwise do. Also, should have given more attention to the partnership (as argued by the WB) independent of the Canada and Sweden grants. • A good example of the H4+ partners working together on global knowledge products has been the **WHO led work on IFC (Individuals, Families, Communities)** and their role in MNCH, and caring for children. Would be worth looking more closely at. Again, strong emphasis on IFC as a good example of WHO undertaking activities encouraged by UNFPA and even funded by it. Focuses on competencies and the roles of community based agents. • Also **State of the Worlds Midwives Report** which was a strong collaboration between WHO, UNFPA and the International Confederation of Midwives.	Interview: H6 Global Team, UNFPA.

87	**UN Women** • There needs to be more consolidation of country level knowledge so it bubbles up into global guidance – they don't see much evidence of that from UN Women's perspective • Global guidance is not well informed by experience at the country level and innovation needs to be pulled up from the country level to the global level to inform different kinds of programming – just getting a report and publishing it is not enough.	Interview: H6 Global Team UN Women.
88	**WHO** • It is important to note that the budget allocations and even the results reports of H4+ don't capture the larger picture of how important the global knowledge products are. • Its not strange that UNFPA, UNICEF and WHO seem to dominate the production of global knowledge products as they all have elements of their core mandate focused on MNCH. UNAIDS/UN Women have a different perspective. UN Women, for example, works specifically on gender and human rights at the normative, operational and coordination levels. • UN Women and UNAIDS engagement is much more important on the Sida grant and came later. UN Women as a new organization took time to find its place and niche in H4+ • UN Women is a real factor now in the areas beyond the health system – it engages with the communities, especially in non-health sector situations.	Interview: H6 Global Team, WHO.
89	**World Bank** • The real missed, strategic opportunity, was not working out and coming up with a clear send of roles and responsibilities (regardless of the funding source) at the country level. • For example, health financing for RMNCAH could have been the role of the Bank and WHO working together in their combined areas of expertise • WHO and the Bank should also take the lead globally and at country level on health systems strengthening where they have a real comparative advantage in technical expertise	Interview: H6 Global Team, World Bank.
Assumption 5.7 *H4+JPCS agencies cooperate effectively to communicate the content of global knowledge products produced with H4+JPCS support and to advocate jointly for their use by programme and non-programme countdown countries.*		
Information/data:		**Information sources:**

90	**UNFPA** One failing in the system was that they (H4+JPCS) were not so good at getting the messages developed in the global knowledge products back down to country level (including for use in the H4+ JPCS country programmes). UNFPA used to fund a programme to introduce and promote new tools, guidelines, but then decided to drop the funding and the programme has disappeared although WHO still does its best. One exception has been around **MDSR** where UNFPA and WHO have worked hard and sponsored many workshops, funded translations, provided technical advice etc. It is not accident that one area of the global work that does seem to be well reflected in the H4+ JPCS at country level is MDSR.	Interview: H6 Global Team UNFPA.
91	**UN Women** • "*The problem was getting these knowledge products effectively shared and used at country level in H4+. This was stronger when there was a dedicated resource person working on communications in the secretariat but they could have done much better on feeding back to the country teams*." • The development of the global work plan and the selection of which global knowledge products to support seemed to take part very much in parallel with the development of country work plans, with little crossover. • The global work plan was done in accordance with the ongoing work of larger coalitions and not based on what was happening at country level in H4+ JPCS • A couple of good examples of where this worked well (communicating things to the country teams) were the Quality of Care standards for training midwives and the MDSR tools, guidelines and approaches.	Interview: H6 Global Team, UN Women.
92	**WHO** • Experience at country level could be fed back into the global programme if the global/regional participation in country to country meetings (annual) led to messaging getting into the global programme but no real evidence of that. • There was scope for more information from the country level to flow upward and into the global knowledge products	Interview: Regional H4+ Coordinator, WHO.
93	**WHO** • The **extent that the global knowledge products and public goods get transmitted to and used by the country level** (especially the H4+ country teams) varies from one public good to the next. For example:	Interview: H6 Global Team, WHO.

	• **MDSR** is the most readily communicated product area and gets the most recognition and use at country level perhaps because it is very operational and technical and is relatively easy to communicate and build into programmes.	

Value Added in Support of the Global Strategy

6. 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 Reproductive Maternal Newborn and Child Health (RMNCAH) investments and systems?

b. During the life of the programme, how well did the H4+ partners support existing global structures (for example, the Partnership for Maternal Newborn and Child Health (PMNH), 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/date:	Information source:
	For evidence of increased levels and effectiveness in advocacy at country level see Assumption 5.5	
Theme: H4+ JPCS Overall Contributions to Value Added at Global Level		
1	**UNAIDS** The Sweden Grant built on the H4+ Canada grant by adding value in three key areas: a. Human rights focus b. Community engagement c. A focus on adolescents UNAIDS works mainly on these three dimensions, especially at country level. H4+/H6 has an important value added in overcoming silos within the H4+ partners. There are lots of different departments within the different partners dealing with, for example HIV AIDS and	Interview: H6 Global Team, UNAIDS.

	Maternal Newborn and Child Health (MNCH). They were able to bring to the partnership the lessons of UNAIDS on who to bridge those divides.	
2	**UNAIDS** The main global (and country level) innovation has been around transforming the perceived role and legitimacy of community engagement in the provision of health services	Interview: H6 Global Team, UNAIDS.
3	**UNAIDS** Regional meetings were good. The sharing of best practices and results has been a good learning experience that would not have happened without H4+ • There is the attempt now to manage H6 even though this is no direct funding. Mauritania has requested support from H6 and this is the one country where there will be a joint mission to pull partners together for the planning without dedicated funding. This was done at the request of the country itself, but is unlikely to be requested from other countries. • It is unrealistic to expect this level of coordination and communication to continue – especially the joint missions and reporting – **without some monetary investment** for at least coverage for a country focal point (to do the heavy lifting re coordination/write common reports) since everyone already has a full-time job. It will fall apart without some commitment. • It is definitely worth trying to keep this going. It's wonderful – it makes the agencies talk together, share results and support country programs in a more efficient and coordinated manner. "But without money, let's see how it works."	Interview: H6 Regional Team, UNAIDS.
4	**UNFPA** Yes, H4+JPCS contributed strongly to the development of the Global Strategy 2.0 because it helped them take a leadership role that they did not have in Global Strategy 1.0	Interview: H6 Global Team, UNFPA.
5	**UN Women** • The value added was in bringing UN Women into the global dialogue so it could come in and take part in the conversation and consistently bring the gender equality dimension • Many of the other H4+ partners have small Gender Equality (GE) units or divisions that do not always have the resources to take part in discussions, consultations, workshops, dialogues on MNCH, even within their own organizations so having UN Women at the global table on RMNCH was only really possible through and H4+/H6 type structure and they were able to use that platform for GE within the programme and for advocacy.	Interview: H6 Global Team, UN Women.

6	**UN Women** H4+ JPCS has helped them to work together in a much more collaborative way, really considering each other's mandates but also how they can collectively contribute to RMNCAH	Interview: H6 Global Team, UN Women.
7	**WHO** The apex of collaborative work at a global level was the finalization of the new Global Strategy 2.0 and EWEC	Interview: H6 Global Team, UN Women.
8	**WHO** The **main value added** of H4+ JPCS was the improved collaboration between the agencies. The H4+ JPCS funds helped the agencies better coordinate interventions, develop a harmonized joint work plan and budget, and reduce competition between the agencies. The H4+ JPCS funds are seen as catalysis for this change.	Interview: H6, Regional Office, WHO.
9	**WHO** As the technical arm of the Global Strategy for Every Women's Every Child and Every Adolescent's Health (2016-20130) (GS2), H6 has had added value. WHO mandate is quite restrictive (the way it works, its ability to do implementation etc.) so working with other partners enables WHO to focus on what it does best while others can take forward implementation efforts (like UNICEF). At country level the H6 can help compensate for challenges like piecemeal investments or progress across the country, strengthen coverage in underserved areas. At country level, H6 agencies can work in their own niche (adolescence, humanitarian). The heads of the agencies meet regularly and their delegated representatives meet weekly by phone.	Interview: Senior Management Level, WHO Headquarters.
10	**WHO** The H4+/H6 approach enables a harmonised message to go to country governments and other stakeholders. Coordination varies by country and is better in places where personal relationships among the main interlocutors are strong. The H6 will help develop messaging on GS2 to support country engagement. The main role of the H6 now as supporting member states to understand, plan for and implement the Global Strategy 2.0 (GS2). There is a toolkit for the GS2 and all H6 agencies should be encouraging and supporting member states to make commitments.	Interview: Senior Management Level, WHO Headquarters.
11	**WHO** • Global technical team/global steering group did add value to the overall work of the programme but from the regional perspective it was most evident that this occurred in the country programmes through the approval of policies and participation in joint field review missions. • The relationships among the H4+/H6 partners were strengthened over time (with the exception of the World Bank)	Interview, H4+ Regional Coordinator, WHO.

12	**World Bank** The transition to the H6 and the Global Financing Facility represents a good chance to take a hard look at what each partner is contributing regarding the achievement of results and what they want to be accountable for • What they want to avoid is that they found it very difficult to see how H4+ was supposed to work at a global level how do you get beyond the narrow focus. • The GFF has a big advantage as the countries can then bring in the technical expertise of the UN agencies on an as needed basis. Some, such as UNICEF for instance, do have experiences with multi-sectoral approaches with, for example, the education and sports ministries around reaching youth but that did not seem to come into H4+ much. • A very important tool for them (and for H6) will be the investment case element of the GFF. This will go beyond government into private sector resources and will also be multi-sectoral so it gives them a wider perspective and a chance to address some of the missed opportunities noted in the evaluation's presentation to the Evaluation Reference Group. • "*The point is you need to get beyond the health sector in some cases to address, for example, teenage pregnancy and early marriage*."	Interview: H6 Global Team, World Bank.
13	**Results for Development** The key purpose of the H4+ was to provide a forum where all the agencies collaborating around the same goal could leave it all behind and cooperate. It should be "A group of people coming together to solve problems, not to point fingers and to make sure that at the country level, H4+ agencies help coordinate and make things happen."	Interview: Global Stakeholders, Results for Development.
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****.*		
Information/date:		**Information source:**

Theme: Incremental impact on global knowledge products and other global initiatives		
14	**UNFPA** Did encourage them to work together collaboratively in new ways but it took some time. UNFPA advocated strongly in the global steering committee to have the global work plan include activities that were truly collaborative and would not have been done without H4+ JPCS. The point was to eliminate "additions" of small pieces of work that would have been done any way and concentrate on the things they could do best together.	Interview: H6 Global Team, UNFPA.
15	**UNICEF** It is not clear what global activities would have not taken pace in the absence of H4+JPCS.	Interview: H6 Regional coordination office, UNICEF.
16	**UN Women** The global level really has been working in a collaborative way and a big worry is how will this be sustained in the absence of the Canada and Sweden grants. This is also a challenge for how to interact with the GFF – how do we provide technical support to countries engaging with the GFF without earmarked resources.	Interview: H6 Global Team, UN Women.
17	**WHO** • The availability of H4+ JPCS funds meant that the H4+ partners could come together and be the driver of the process leading to GS 2.0 and, most importantly, recognized as the technical arm of the EWEC • H4+ JPCS allowed them to participate in this process of developing SDGs, GS 2.0 and EWEC from inception through to recommendations. It also joined up with the accountability initiative. • To be very clear, without the grant they could not have assemble the teams and put in the effort necessary to pull everyone together. They might perhaps have found some funding for some of the products but they could not have come together to really drive the agenda forward and keep it focused on MNCH. They also would probably have lost the leadership role.	Interview: H6 Global Team, WHO.
18	**World Bank** • As for the global knowledge products, it seems to them that a lot of it consisted of assigning the H4+ logo to work that was ongoing or would have been done anyway. • This spilled over into the global knowledge products where each agency talked about its "flagship" publications.	Interview: H6 Global Team, World Bank.

19	**World Bank** • We know that the H6 partners have a lot to contribute individual but we are not really clear on what the "collective" H6 is able to bring to the table that is different. • They did not see this real difference in what was being done at the global level, it seemed to be more an exercise in labelling products with H4+ than identifying critically important projects which needed to be done together at global level.	Interview: H6 Global Team, World Bank.
20	**RMNCH** H4+ as a body or a group was not particularly present in the global arena for RMNCH over the last five years. As a collective entity, the H4+ did not lead or convene or fund or brand any of the major policy pieces in MNCH. To give examples: • The Every Newborn Action Plan (ENAP): this was co-chaired by UNICEF and WHO. While UNFPA was on the advisory committee they were not really part of the process or deliverables. • State of the World's Midwives: This was chaired by UNFPA and UNICEF/ WHO were engaged but not prominently. • The Global Strategy 2.0, this was a UN Secretary General's office led initiative. • Family Planning 2020 was led by the UNFPA, UK and Gates. • The 12 Technical Working Groups that produced the evidence base of the Global Strategy 2.0 (as published in the British Medical Journal) in 2015, was convened, chaired and driven by WHO. None of these processes engaged UN Women, UNAIDS or the World Bank in any meaningful way although UNFPA sat on the advisory committee of the ENAP process. The H4+ was that aimed to do more and better at country level. If it was intended to support global efforts, it was not clear which they would be. It is difficult to identify a H4+ funded, motivated, championed global product.	Interview: Global Stakeholders, RMNCH.
21	**Results for Development** Another example is the way that the key agencies participated in the development of the Global Strategy 2.0. There were regular (monthly/ sometimes bi-monthly) meetings and all contributed jointly (of course with others). The first Global Strategy was produced by a small group in a room in WHO.	Interview: Global stakeholders, Results for Development.

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/date:		**Information source:**
For evidence on assumption 6.3 refer to Area of Investigation 5, Assumption 5.5		
22	**WHO** • The apex of collaborative work at a global level was the finalization of the new Global Strategy 2.0 and EWEC • The availability of H4+ JPCS funds meant that the H4+ partners could come together and be the driver of the process leading to GS 2.0 and, most importantly, recognized as the technical arm of the EWEC • H4+ JPCS allowed them to participate in this process of developing Sustainable Development Goals, GS 2.0 and EWEC from inception through to recommendations. It also joined up with the accountability initiative.	Interview: H6 Global Team, UN Women.
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:**

For evidence on contributions to positive outcomes in RMNCAH by H4+JPCS see Assumption 1.5, 2.4 and 5.5		
23	**WHO** **H4+ JPCS contribution to health and health outcomes in general?** • Yes, H4+ JPCS most likely contributed to improving outcomes in RMNCAH, but we need to finalise the ongoing country level reviews of RMNCAH data (2011 baseline against 2015 data) to have more certitude on the improvement of key indicators. • H4+ JPCS most likely helped increase the coverage of services, planning and M&E capacities • Capacity development of service providers is highlighted as a key achievement, particularly EmONC and IMNCI.	Interview: H4+ Regional Coordination Office.

ANNEX 2 METHODOLOGY AND DATA LIMITATIONS

Challenges and limitations arising from analytical approach and data collection methodologies	Implication for the evaluation and/or validity of findings
Addressing causal assumptions in the theory of change The use of contribution analysis as the core analytical approach of the evaluation means that considerable effort is devoted to assessing the key causal assumptions which may result in the use of mainly qualitative evaluation evidence.	The purpose of testing the causal assumptions (using a mix of quantitative and qualitative evidence) as noted in the Inception Report is to **determine the plausibility of programme claims to contributing to verifiable results**. The results themselves have been documented in the report primarily but not exclusively in qualitative terms. Field and desk country notes provide more **quantitative material** on results.
Linking quantitative data on outputs and outcomes at local and national level to qualitative evidence • While quantitative data at national level show progress in RMNCAH indicators, it is difficult to link this directly to H4+JPCS activities at national and local level. • H4+JPCS programme reports at global and country level often focus on activities and immediate output. • Data on service use and quality at local level are often contradictory or of limited quality and reliability	The strength of contribution analysis as a method is its ability to assess the programme as **one factor in a complex institutional and programmatic set-up**. The key question becomes not the quantitative impact of the programme **but its fit (complementarity) in the overall framework of support at country level**. Data on activities and immediate outputs are assessed in light of the plausibility of the key causal linkages in the programme model and interpreted in light of the roles and actions of other programmes and institutions throughout the report.
The relationship between field and desk country case studies • The four field country case studies allow for more in-depth examination of issues and more robust triangulation of evidence because of their range of key informant interviews, focus group discussions and site visits as well as access to an extensive body of documentation and data • The six countries chosen for desk studies may have different characteristics (and different results) from the field studies.	While the field country case studies provide much more detail and a more robust process of triangulation to validate evidence and findings, **the results of the field country case studies are consistent with the results of desk studies** which increases confidence in desk studies. Generally, the body of documents for desk studies was reasonably complete **and results were triangulated with telephone interviews**.
Online survey – Countries with operational H4+ teams • The sample frame of persons contacted may vary from country to country. • At 33 percent, response rates were not at expected levels (50 percent)	Survey outcomes are compared with other data sources for triangulation, such as interviews and documents. **Survey results were also consistent with the findings from interviews and document reviews**.
Online survey – Other countdown countries • The sample frame of persons contacted may vary from country to country. • At 33 percent, response rates were not at expected levels (50 percent)	The results of the "other countdown countries" survey were consistent with the survey of countries with operational H4+ teams. **Results were also consistent with findings from key informant interviews and document reviews at country level in all ten case study countries**.

ANNEX 3 VOCABULARY OF MEDICAL TERMS USED IN THE REPORT

Medical terms frequently used in the report	
Ampicillin	An inexpensive, stable broad-spectrum penicillin-based antibiotic used to treat a range of infections in adults and children including pneumonia, bronchitis, urinary tract infections, and others.
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.
CD4 Count	A CD4 count is a lab test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of your blood. In people with HIV, it is the most important laboratory indicator of how well the immune system is working and the strongest predictor of HIV progression.
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.
Chlorhexidine Gel	An antiseptic with a broad spectrum of activity against gram-negative and gram-positive bacteria. It is used for cord care in neonates and has been shown to dramatically reduce infections.
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.
Gentamycin solution	An anti-infective solution to prevent or treat eye infections in newborns.
Infant mortality	The death of a child between one and twelve completed months of life.
Kangaroo Mother Care (KMC)	An approach to nurturing small and sick babies using skin to skin contact usually between mother and baby.
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.
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.
Non-pneumatic anti-shock garment (NASG)	The non-pneumatic anti shock garment is used to manage post-partum haemorrhage.
Option B+ management	An approach taken to treating HIV infected mothers, which incorporates a commitment to provide lifelong ART for all HIV-positive pregnant and breastfeeding women regardless of CD4 count.
Oxytocin	A medication given to a woman to cause contraction of the uterus in order to strart labour, to increase the speed of labour, and/ or to stop bleeding following delivery
Perinatal death	The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. Perinatal mortality refers to the number of stillbirths and deaths in the first week of life (early neonatal mortality).
Stillbirth	Stillbirth is the death of foetus before birth. A macerated stillbirth is one where the foetus has died in utero some hours or days before the delivery. Fresh stillbirths are those where the foetus was alive going into labour but died in the course of the delivery. Both types of stillbirth are largely preventable. Numbering about 2.5 million annually across the world, stillbirths have only recently begun to be counted systematically and data is difficult to interpret as a result. A declining number of stillbirths is the direct result of better maternity care (both antenatal and during delivery).

ANNEX 4 H4+ INTERVENTIONS AND INNOVATIONS BY COUNTRY

Table 1:H4+JPCS Investments in Support of Health Systems Strengthening

	DRC	LIB	Zam	Zim	BF	Cam	CDI	ETH	GBI	SL
National Level										
Technical support and policy advice in RMNCAH	X	X	X	X	X	X	X	X	X	X
Technical support to national MNDSR processes	X	X	X	X	X	X	X	X	X	X
Support to EmONC policies, plans, guidelines, curricula	X	X	X	X	X	X	X	X	X	X
Support to national training facilities and to curricula	X	X		X	X	X	X	X	X	X
Support to HMIS and M&E systems for RMNCAH	X			X	X	X	X	X	X	X
Provincial and District Level[6]										
Support to pre-service training institutions	X	X		X	X					X
Support to supervision of health facilities and staff		X	X	X	X	X	X	X		X
Support to training and mentoring of staff		X		X	X	X	X	X		X
Support to financing mechanisms (RBF, vouchers for access and/or income generating activities)	X				X	X	X			X
Support to MNDSR Reviews	X	X		X	X	X	X	X		X
Facilities Level										
Support to training and supervision:										
• MNDSR		X	X	X	X	X	X	X		X
• EmONC	X	X	X	X	X	X	X	X	X	X
• IMNCI/Helping babies breath			X	X	X	X		X	X	
• Infant and young child feeding (IYCF)		X		X	X					
• Early Infant Diagnosis (EID) and Paediatric ART		X	X	X				X	X	X
• HIV including PMTCT	X	X	X	X	X	X	X	X	X	X
• Family planning services	X	X	X		X	X	X		X	X
• Obstetric Fistula		X		X	X		X	X	X	X
• Youth friendly service provision	X	X	X	X			X	X		X
Equipment, Technology, Infrastructure										
• Ambulances	X	X	X		X	X	X		X	
• Motorbikes, Bicycles	X	X	X	X	X	X	X		X	
• Radios/mobile phones/tablets (for MDSR)		X	X	X	X					
• Operating theatre/ maternity ward equipment		X	X	X			X		X	X
• Point of Care CD4 Machines				X						
• Maternity Waiting Shelters	X	X	X	X					X	
• Infrastructure upgrades (including power, water supply, sanitation)		X	X						X	X
Commodities and Supplies										
• Essential medicines for RMNCAH	X	X	X	X	X	X	X	X	X	X
• Surgical instruments				X	X	X	X	X		

[6] The terms provincial and district are used here generically. In some countries, the terms region and country or health zone are used to designate the two levels of decentralization outside the capital region.

Table 2: H4+ partners and their approach to engaging communities in different H4+ JPCS focus countries[7]

UNAIDS	UNFPA	UNICEF	UN Women	WHO
- Media engagement - Mass communication - Print material - Radio discussion programmes aimed at engaging men on gender issues including childbirth, childcare, gender based violence, HIV/ AIDS prevention, male circumcision etc. - HMIS support and tracking indicators - Support to information management.	- Support to adolescent engagement and training peer educators; support to weekly talks by the midwife and after school clubs - Supply of Mama kits; Family kits to encourage skilled birth attendance for delivery. - Training of CHWs - Engaging community, religious and traditional leaders around RMNCAH issues - Training police, health staff, teachers and others about GBV, rape - Training health workers to respond to community demand - Building maternity waiting shelters.	- Equipment & supplies procurement including Mama kits & Family kits to encourage skilled birth attendance for delivery. - Training CHWs and health committees - Community engagement to support girls, and to reduce violence against girls, early and forced marriage, and to increase education outcomes. - Building and equipping maternity waiting shelters - Engaging community, traditional, religious leaders.	- Supporting the formation of community groups to discuss gender and RMNCAH issues including violence and HIV and AIDS through support to regular meetings convened by peer educators including groups for men, young mothers, and adolescents - Research, data collection and analysis in the community.	- Support to adolescent engagement and training peer educators - Support to training and mentoring CHWs - Specific support to adolescent peer educators, and community leaders - Strengthened referral systems. - Engaging communities in maternal death surveillance and response processes. - Support to the supply of Mama kits to encourage demand for skilled birth attendance.

Table 3: Details of H4+ innovations related to capacity, supply and demand considerations

Innovation (Country)	Description of Intervention/Rationale	Genesis of innovation
	Capacity-related innovations	
DRC	**Competency-based EmONC training:** An EmONC needs assessment conducted in 2012 revealed that less than one percent of service providers working in maternity wards knew how to correctly manage obstetric complications. The MoH played a leadership role in selecting competency-based EmONC training with mannequins as an innovation to be developed and piloted under H4+. Competency-based training using mannequins to simulate real-life situations had proven successful in other countries and helped to shorten the duration of training while allowing trainees to develop full competency in the management of each obstetric complication.	Global best practice
Liberia	**Trained Traditional Midwives**: Traditional birth attendants were given the new designation Trained Traditional Midwives (TTMs) and were trained and deployed to refer women for antenatal care and to accompany women to the clinic for delivery, enabling this cadre of community-based volunteers to retain an important function while upgrading the quality of care available. TTMs represented an important strategy for encouraging women to delivery in a health facility.	Country-based innovation

[7] This table is not exhaustive and aims to illustrate the wide range of community engagement activities.

Zambia	**Retired Midwives approach**: H4+ contracted qualified retired midwives to fill the places of nurses at the health facility for a year while they went for training. Quality of care in maternity units increased immediately as these retired midwives were on hand and solved the usual problem related to interruption of services that occurs when providers are sent out of the facility for training.	Country-based innovation
Zimbabwe	**Clinical Mentorship:** Over the last decade, the Zimbabwean health system experienced a massive loss of qualified health professionals during the severe economic crisis. As a result, human resources capacity development has been a major priority of the MoHCC. H4+ supported the revitalization of a past practice of clinical mentorship by providing a reliable allocation of resources to support supervision, identification of provider needs and the opportunity for mentorship either in the provider's own facility or at a facility where there is opportunity for practice. While not new, mentorship practice is an innovation to the current generation of health providers and has contributed to increased capacity of skilled personnel to address emergencies at the district and health facility level.	Country-based innovation, based on WHO guidelines
	Supply-related innovations	
DRC and Guinea Bissau	**Maternity Waiting Homes**: There are many documented examples of maternity waiting homes,[8] residential facilities sited near a qualified medical facility where women can await their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier, if a complication arises. However, in DRC a waiting home was introduced in a remote and rural area of Mosango where they were credited for reducing geographic barriers to access for women at risk of obstetric complications. In Guinea Bissau, although there is little documentation about the process or results, anecdotal evidence suggests that the homes were valued and led to increased attendance. (Note: H4+ supported waiting homes in Zimbabwe, although these were not identified as an innovation in that context.)	Global best practice
Liberia	**Non-pneumatic anti-shock garment (NASG):** The NASG is a practical innovation that helps stabilise a haemorrhaging woman preventing shock while she is taken to more specialized care. Introduced by H4+ along with efforts to strengthen referrals, the NASG is effective as it enables affected women to be transferred for urgent care. Implementation also requires community engagement to mobilise support for clinical-based deliveries and referral in emergencies.	Emerging global best practice, under study and WHO guidance
Liberia	**Solar Suitcase**: The solar suitcase is a portable solar power system set up in several clinics to ensure power for delivery rooms. H4+ JPCS installed these in several clinics and supported training for health workers and community members to give them the skills to undertake the modest amount of maintenance required during their lifespan (five years), contributing to their potential sustainability.	Unknown
Zambia	**Postnatal checks at 48 hours after delivery**: H4+ introduced an innovative practice that included a postnatal check for both mother and baby at 48 hours after delivery. During this visit, they provide oral polio vaccine and Vitamin A to the baby and FP counselling. They watch for postpartum haemorrhage and support proper breastfeeding practices, cord care, infection control, nutrition and the importance of immunization.	Country-based innovation

[8] Andina, M and Figa-Talamanca, I, 1996. Maternity Waiting Homes: A review of experiences. Geneva: WHO. Accessed on 11/28/16 from http://apps.who.int/iris/bitstream/10665/63432/1/WHO_RHT_MSM_96.21.pdf

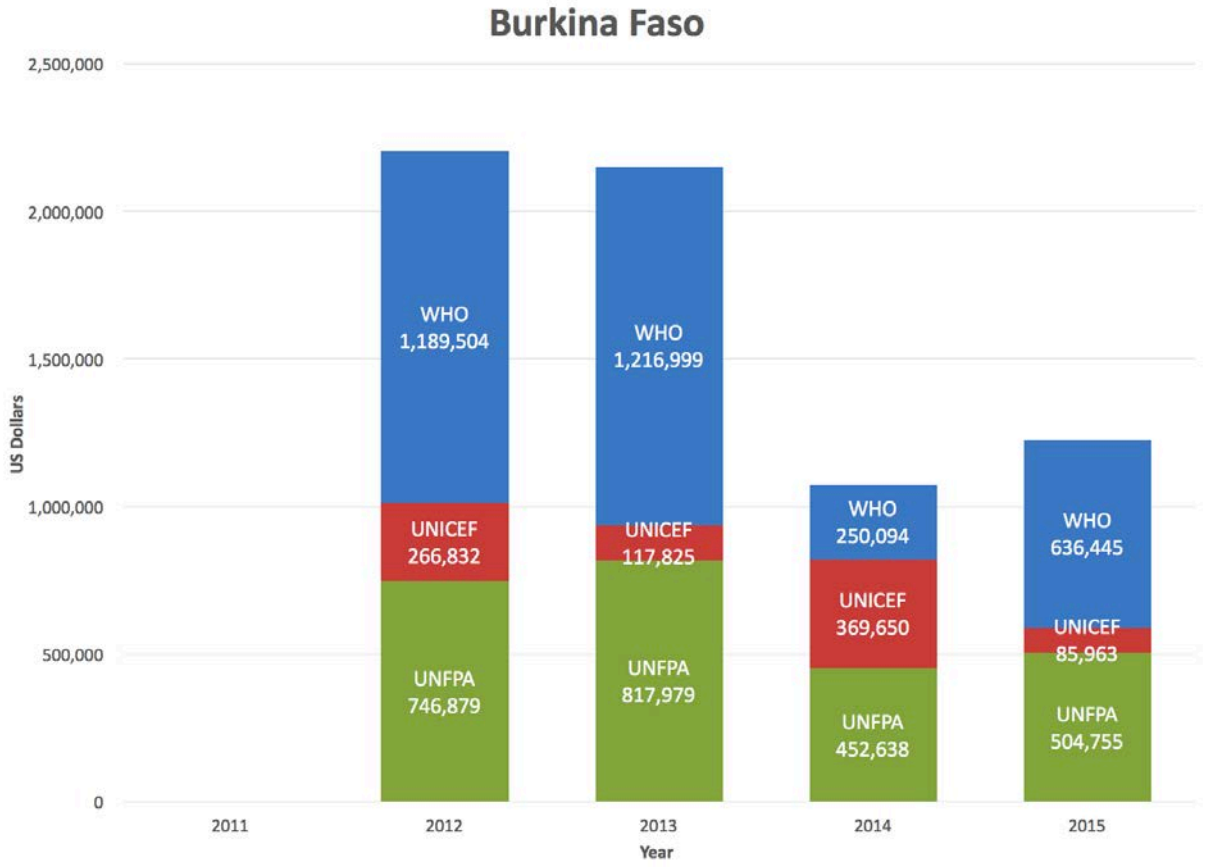
Zimbabwe	**Point of Care (PoC) CD4 Machines**: PoC CD4 machines support rapid diagnosis of HIV in PMTCT service settings. These were first introduced in 2009 by other development partners. H4+ JPCS (UNICEF) supported an evaluation to generate evidence on the effectiveness in MNCH setting in seven districts and make recommendations for scale-up more widely. ~~Patient~~	Global innovation
	Demand-related innovations	
DRC	**Family Kit Approach with vouchers:** The family kit approach aims to improve home-based IMCI and safe deliveries at community and health facility level. Kits include: essential medicines for households to treat diarrhoea and fever, an ANC kit for pregnant women, and a delivery kit with essential supplies and commodities for safe deliveries.	Country-based innovation
DRC	**Flat rate pricing of EmONC services:** H4+ piloted flat-rate pricing of key EmONC services to reduce financial barriers to access and to strengthen referrals in Mbanza-Ngungu and Mosango. The family kit includes vouchers that women can use to access services at a subsidized flat-rate, such as antenatal care, pre-school consultations and c-sections. (Regarding the latter, a woman must be referred by a first line health centre in order to benefit from the subsidised price.)	Country-based innovation
Zambia and Liberia	**Mama Packs:** The mama pack is a kit of useful baby gear including a diaper, receiving blanket, wrapper and other essential products that are not easily afforded by pregnant mothers. The kits were highly desired and resulted in increased attendance at ANC clinics. The mama packs were provided after women attended ANC services, delivered in a facility and attended the postnatal check.	Global practice

ANNEX 5 FINANCIAL PROFILE OF H4+ JPCS IN PROGRAMME COUNTRIES

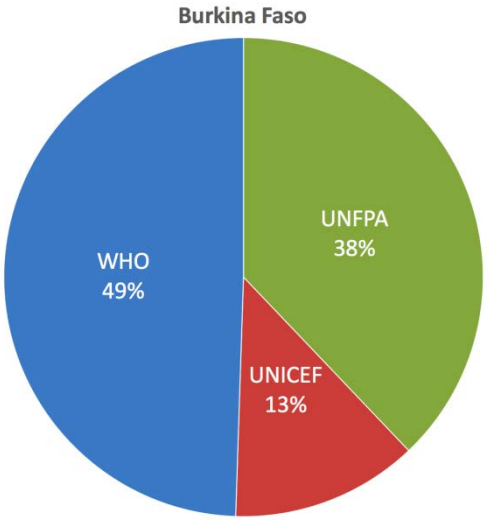
H4+JPCS Expenditures in Burkina Faso

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	746,879	817,979	452,638	504,755	2,522,251	38%
UNICEF	0	266,832	117,825	369,650	85,963	840,270	13%
WHO	0	1,189,504	1,216,999	250,094	636,445	3,293,042	49%
TOTAL US$	**0**	**2,203,215**	**2,152,803**	**1,072,381**	**1,227,163**	**6,655,563**	**100%**

H4+JPCS Expenditures by Year and Agency in Burkina Faso



H4+JPCS Expenditures in Burkina Faso: 2011-2015



Source: (UNFPA 2016b)

H4+JPCS Expenditures in Cameroon

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	26,162	1,076,559	500,430	1,603,151	33%
UNICEF	0	0	462,345	685,300	830,619	1,978,264	41%
WHO	0	0	0	174,274	210,791	385,065	8%
UNWOMEN	0	0	80,469	235,156	161,281	476,906	10%
UNAIDS	0	0	115,112	110,067	131,433	356,612	8%
TOTAL US$	**0**	**0**	**684,088**	**2,281,356**	**1,834,554**	**4,799,998**	**100%**

H4+JPCS Expenditures by Year and Agency in Cameroon

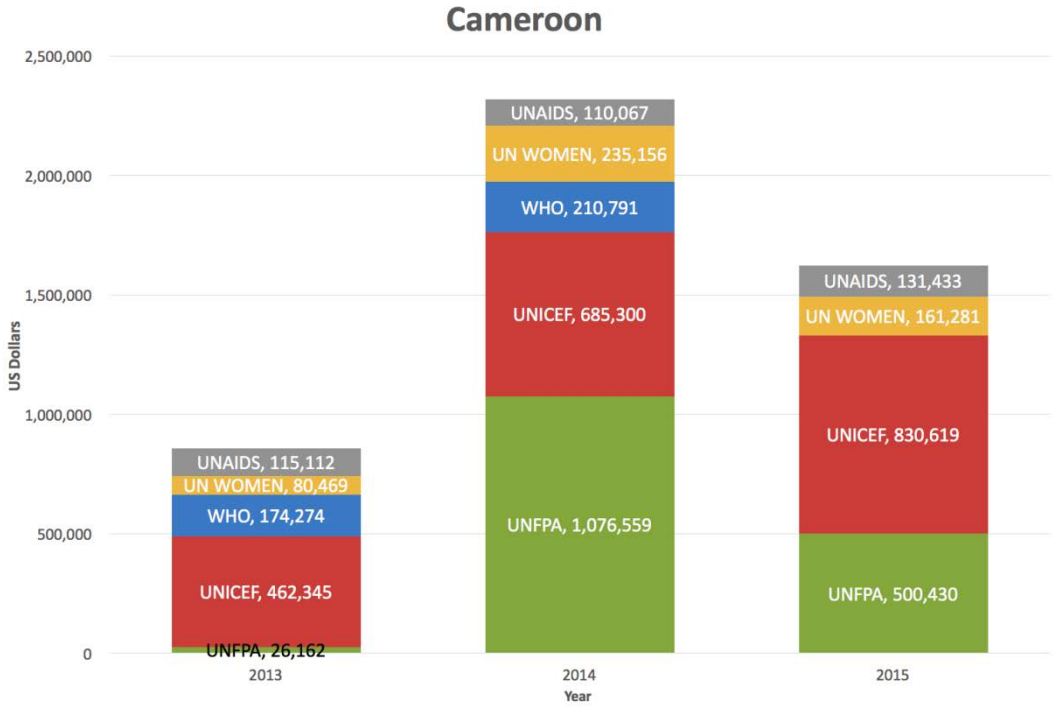
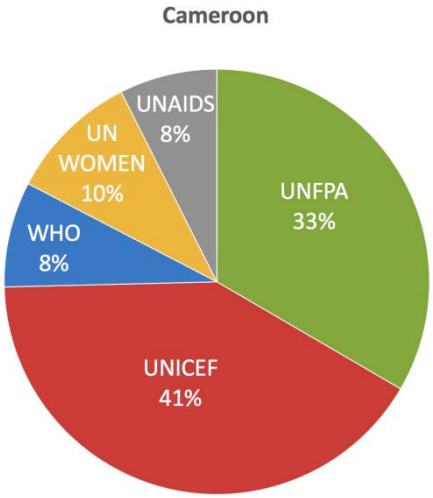


Figure 2: H4+JPCS Expenditures in Cameroon: 2011-2015

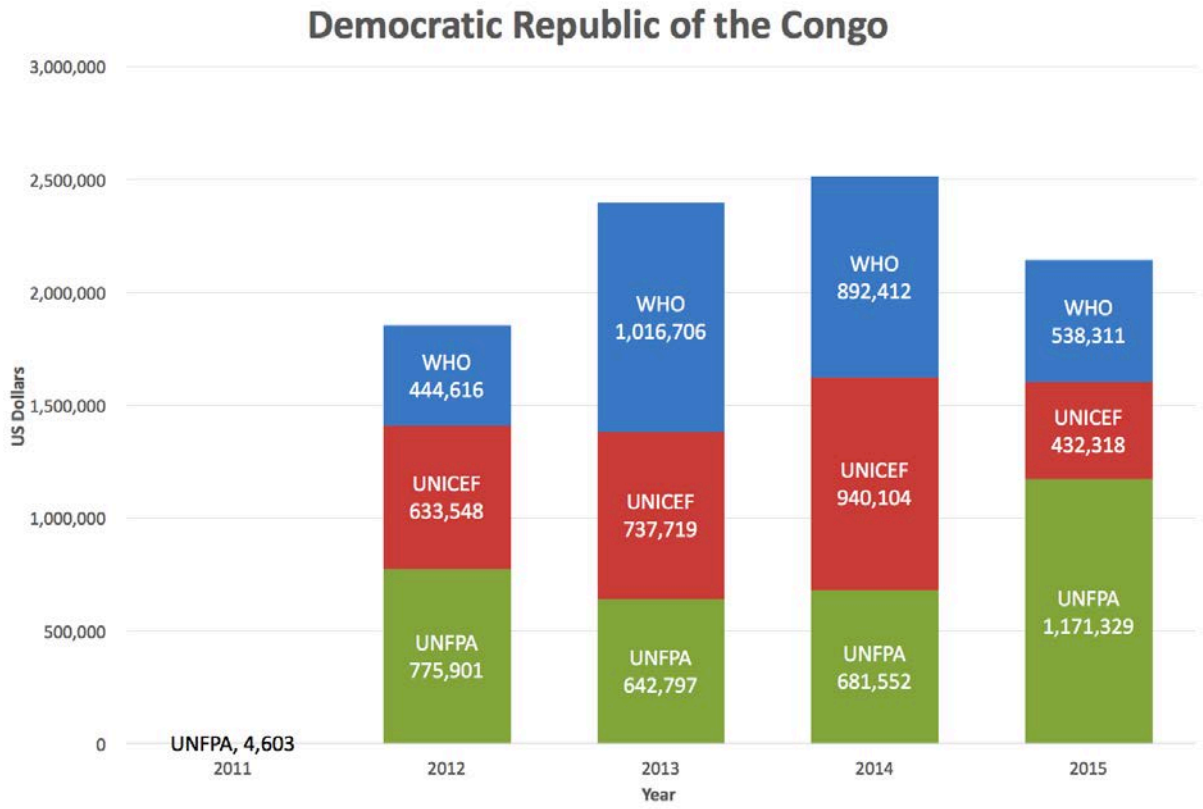


Source: (UNFPA 2016b)

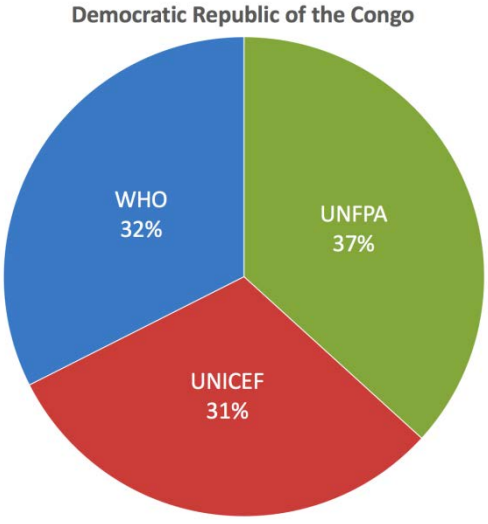
H4+JPCS Expenditures in Democratic Republic of the Congo

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%**

H4+JPCS Expenditures by Year and Agency in Democratic Republic of the Congo



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

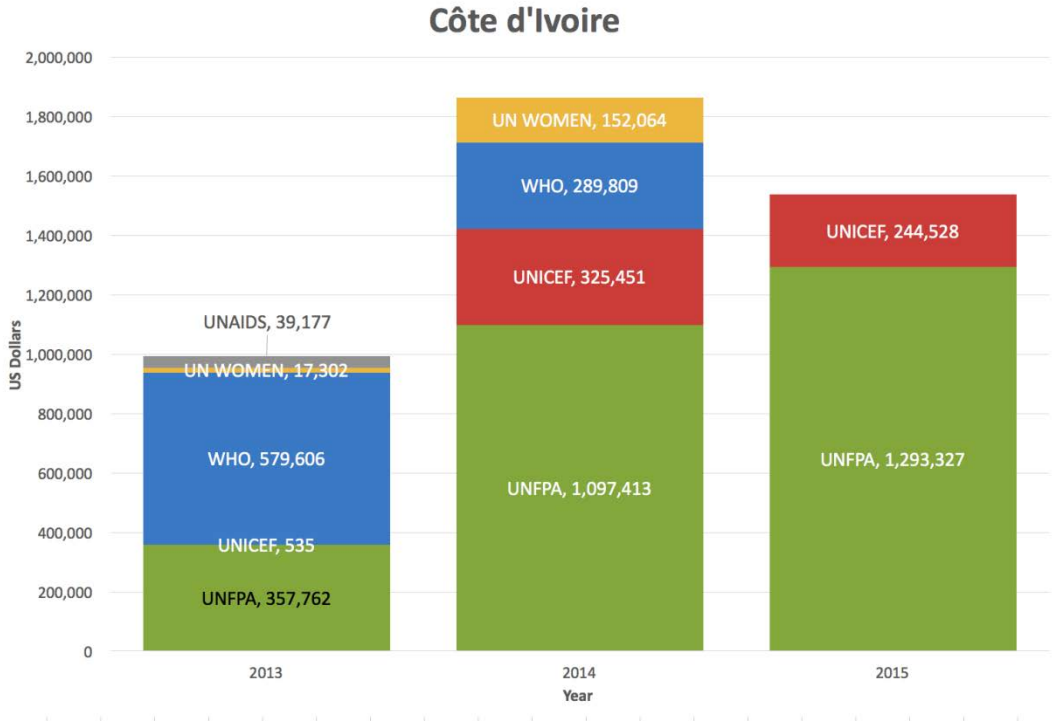


Source: (UNFPA 2016b)

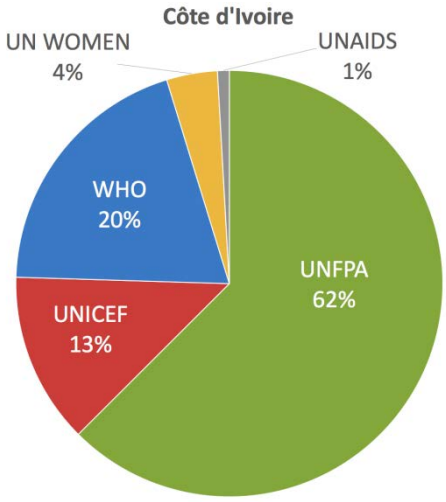
H4+JPCS Expenditures in Côte d'Ivoire

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	357,762	1,097,413	1,293,327	2,748,502	62%
UNICEF	0	0	535	325,451	244,528	570,514	13%
WHO	0	0	0	579,606	289,809	869,415	20%
UNWOMEN	0	0	0	17,302	152,064	169,366	4%
UNAIDS	0	0	0	0	39,177	39,177	1%
TOTAL US$	**0**	**0**	**358,297**	**2,019,772**	**2,018,904**	**4,396,974**	**100%**

H4+JPCS Expenditures by Year and Agency in Côte d'Ivoire



H4+JPCS Expenditures in Côte d'Ivoire: 2011-2015

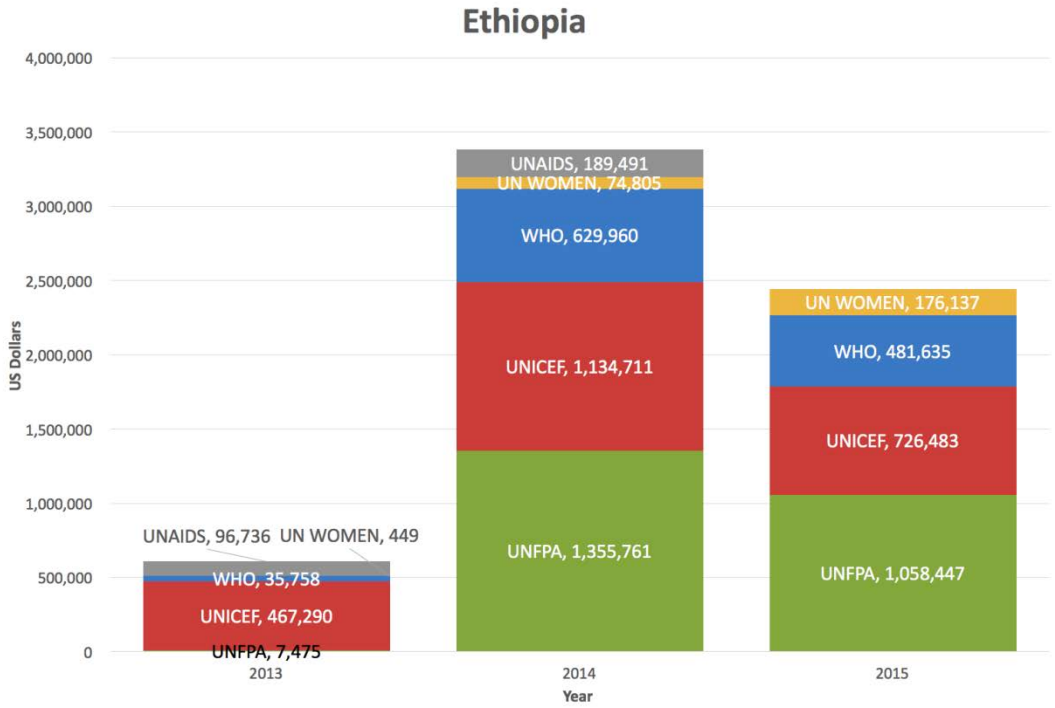


Source: (UNFPA 2016b)

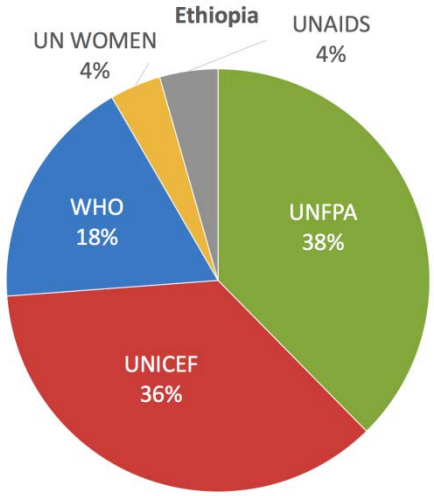
H4+JPCS Expenditures in Ethiopia

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	7,475	1,355,761	1,058,447	2,421,683	38%
UNICEF	0	0	467,290	1,134,711	726,483	2,328,484	36%
WHO	0	0	35,758	629,960	481,635	1,147,353	18%
UNWOMEN	0	0	449	74,805	176,137	251,391	4%
UNAIDS	0	0	0	96,736	189,491	286,227	4%
TOTAL US$	**0**	**0**	**510,973**	**3,291,973**	**2,632,193**	**6,435,138**	**100%**

H4+JPCS Expenditures by Year and Agency in Ethiopia



H4+JPCS Expenditures in Ethiopia: 2011-2015

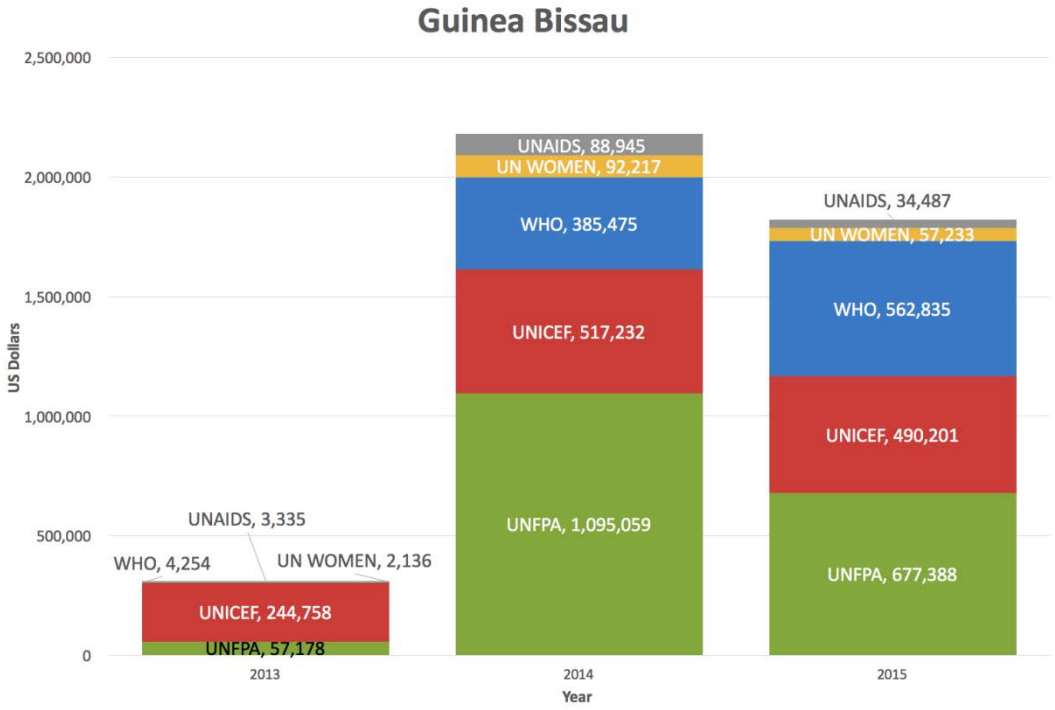


Source: (UNFPA 2016b)

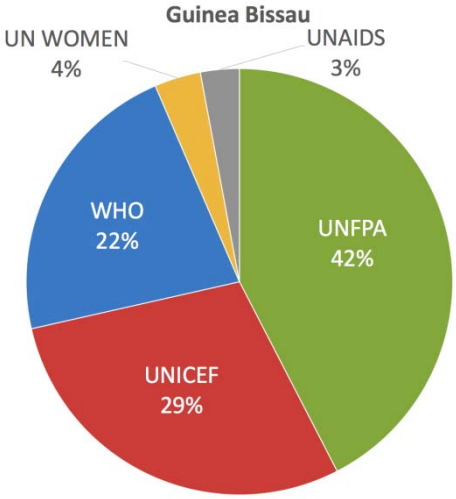
H4+JPCS Expenditures in Guinea Bissau

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	57,178	1,095,059	677,388	1,829,625	42%
UNICEF	0	0	244,758	517,232	490,201	1,252,191	29%
WHO	0	0	4,254	385,475	562,835	952,564	22%
UNWOMEN	0	0	2,136	92,217	57,233	151,586	4%
UNAIDS	0	0	3,335	88,945	34,487	126,767	3%
TOTAL US$	**0**	**0**	**311,661**	**2,178,928**	**1,822,143**	**4,312,733**	**100%**

H4+JPCS Expenditures by Year and Agency in Guinea Bissau



H4+JPCS Expenditures in Guinea Bissau: 2011-2015

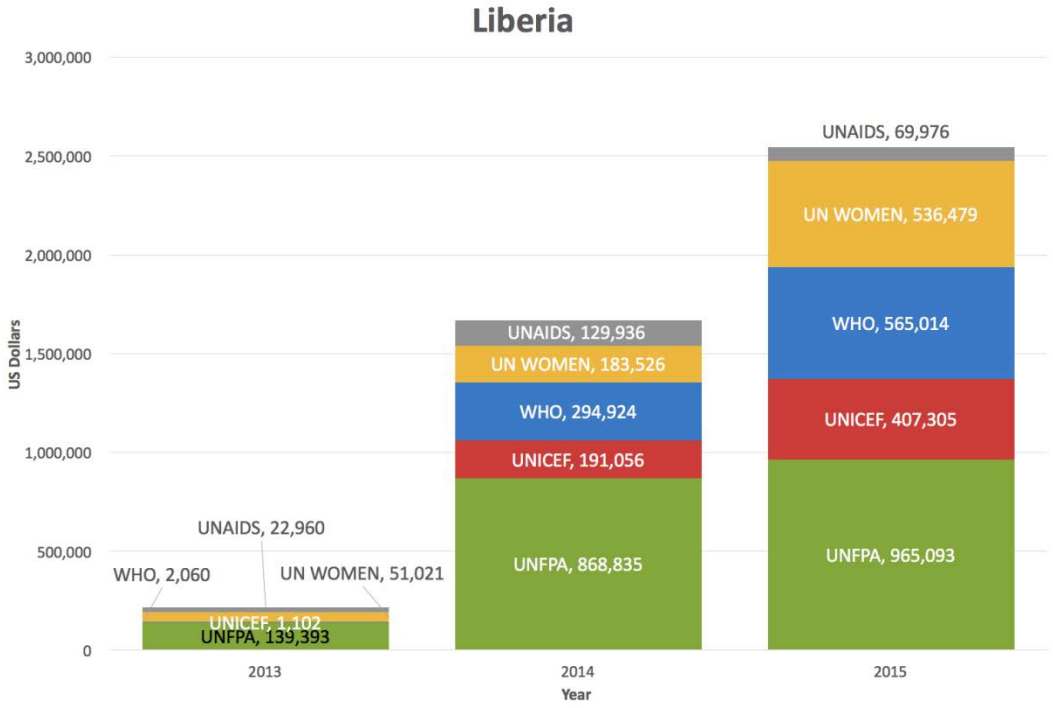


Source: (UNFPA 2016b)

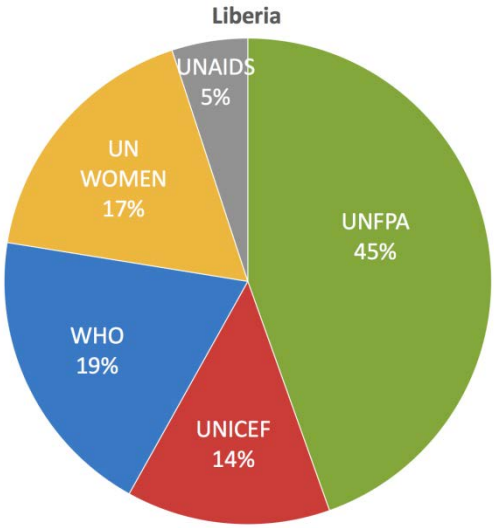
H4+JPCS Expenditures in Liberia

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	139,393	868,835	965,093	1,973,321	45%
UNICEF	0	0	1,102	191,056	407,305	599,463	14%
WHO	0	0	2,060	294,924	565,014	861,998	19%
UNWOMEN	0	0	51,021	183,526	536,479	771,026	17%
UNAIDS	0	0	22,960	129,936	69,976	222,872	5%
TOTAL US$	**0**	**0**	**216,536**	**1,668,278**	**2,543,867**	**4,428,680**	**100%**

H4+JPCS Expenditures by Year and Agency in Liberia



H4+JPCS Expenditures in Liberia: 2011-2015

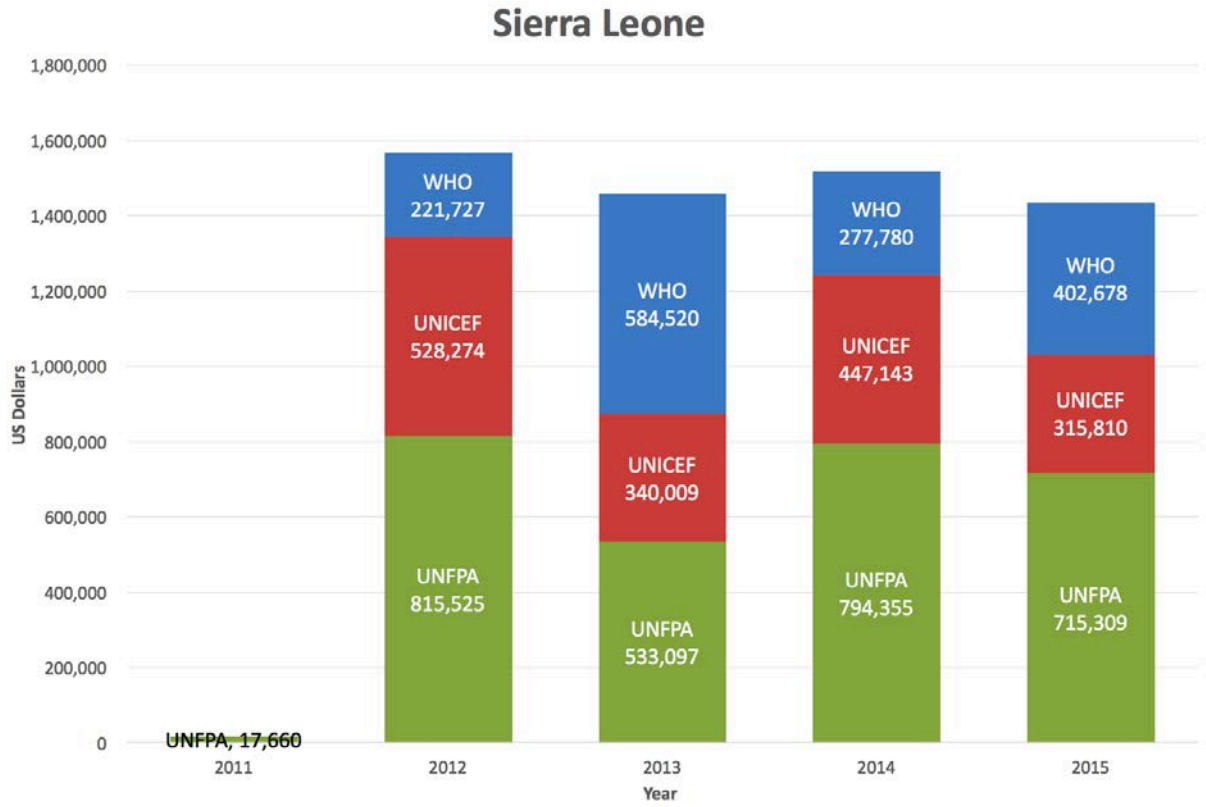


Source: (UNFPA 2016b)

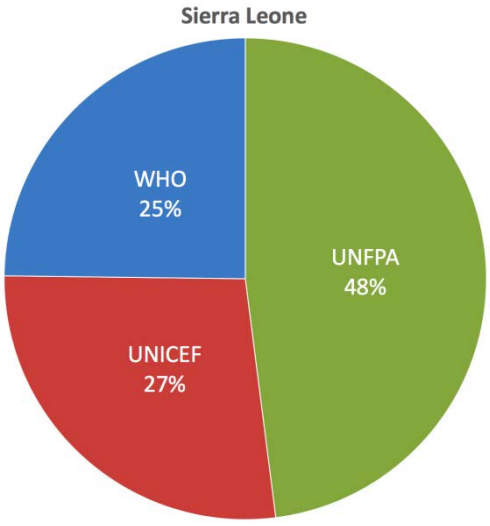
H4+JPCS Expenditures in Sierra Leone

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	17,660	815,525	533,097	794,355	715,309	2,875,946	48%
UNICEF	0	528,274	340,009	447,143	315,810	1,631,236	27%
WHO	0	221,727	584,520	277,780	402,678	1,486,705	25%
TOTAL US$	**17,660**	**1,565,526**	**1,457,626**	**1,519,278**	**1,433,797**	**5,993,887**	**100%**

H4+JPCS Expenditures by Year and Agency in Sierra Leone



H4+JPCS Expenditures in Sierra Leone: 2011-2015

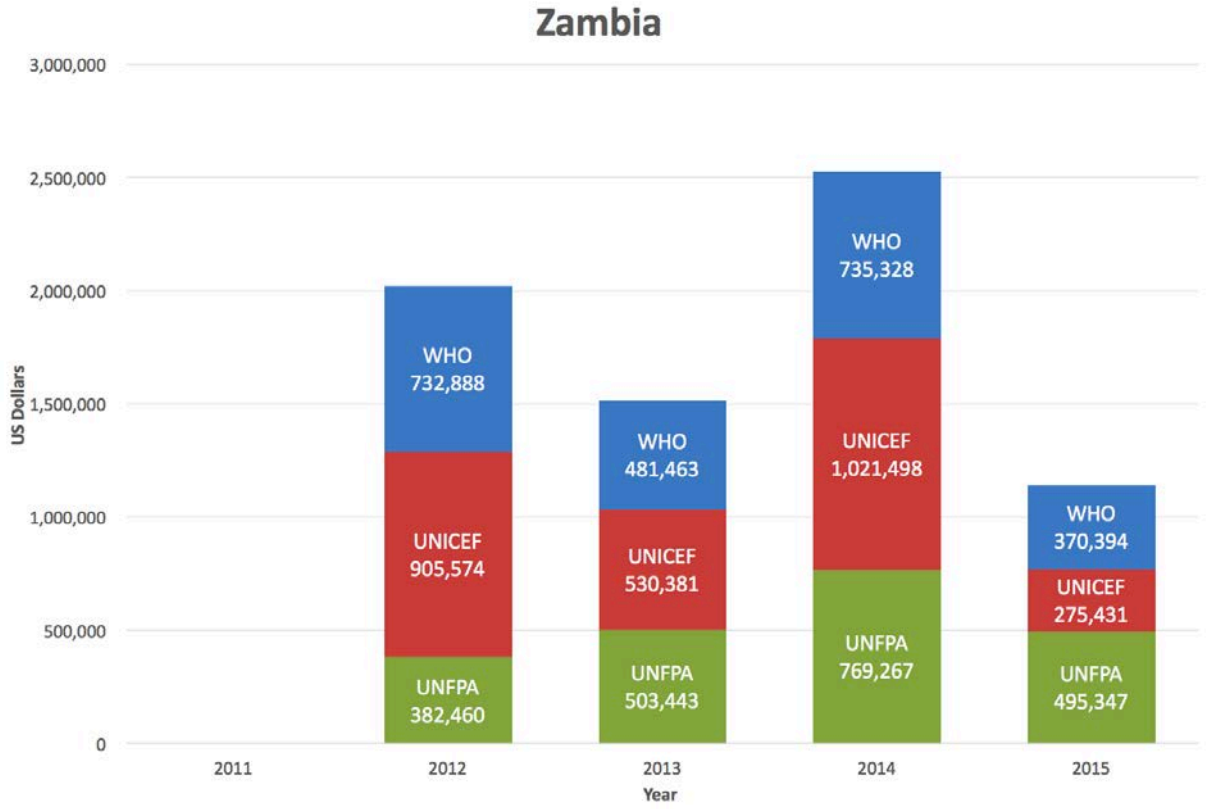


Source: (UNFPA 2016b)

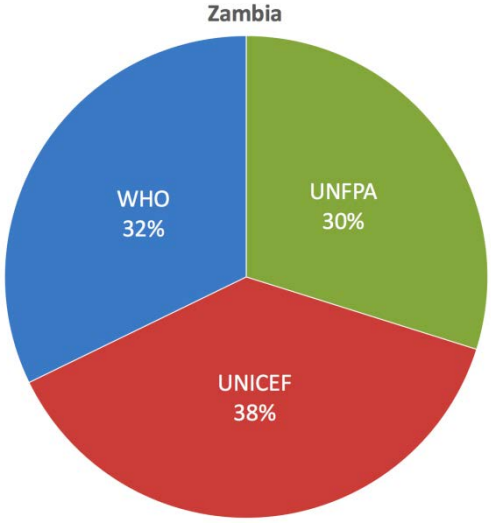
H4+JPCS Expenditures in Zambia

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	382,460	503,443	769,267	495,347	2,150,517	30%
UNICEF	0	905,574	530,381	1,021,498	275,431	2,732,884	38%
WHO	0	732,888	481,463	735,328	370,394	2,320,073	32%
TOTAL US$	**0**	**2,020,922**	**1,515,287**	**2,526,094**	**1,141,172**	**7,203,474**	**100%**

H4+JPCS Expenditures by Year and Agency in Zambia



H4+JPCS Expenditures in Zambia: 2011-2015

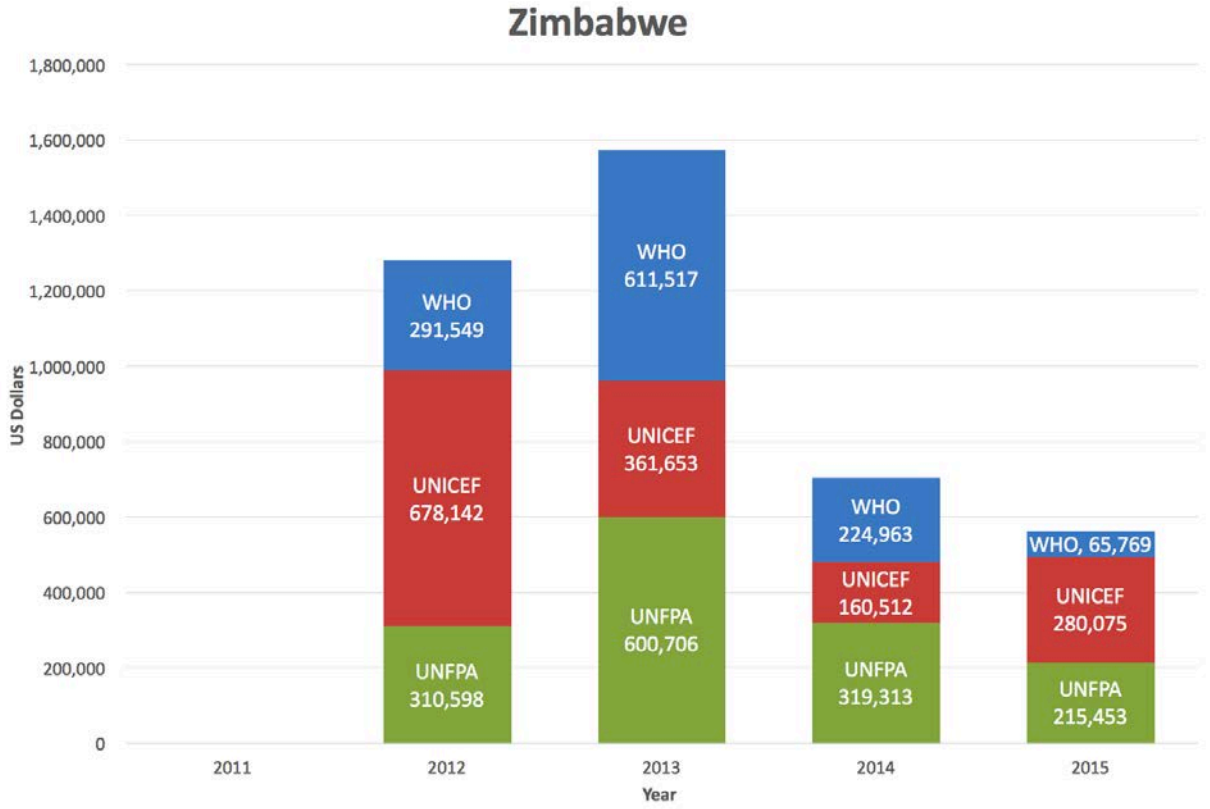


Source: (UNFPA 2016b)

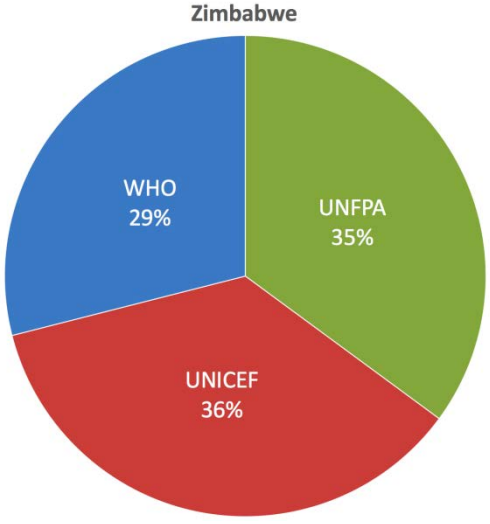
H4+JPCS Expenditures in Zimbabwe, Canada

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	310,598	600,706	319,313	215,453	1,446,070	35%
UNICEF	0	678,142	361,653	160,512	280,075	1,480,382	36%
WHO	0	291,549	611,517	224,963	65,769	1,193,798	29%
TOTAL US$	**0**	**1,280,288**	**1,573,876**	**704,788**	**561,297**	**4,120,250**	**100%**

H4+JPCS Expenditures by Year and Agency in Zimbabwe, Canada



H4+JPCS Expenditures in Zimbabwe: 2011-2015, Canada

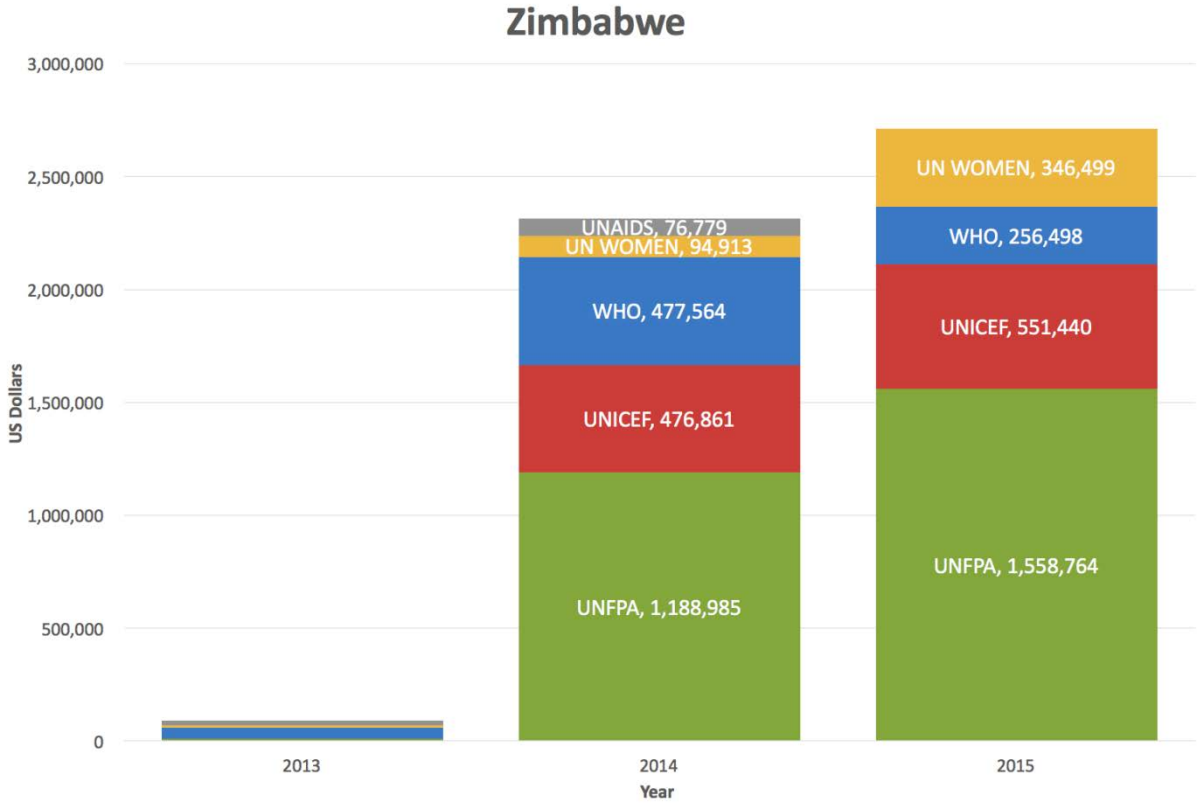


Source: (UNFPA 2016b)

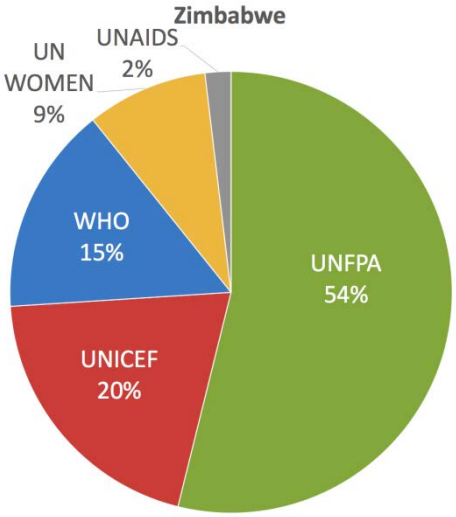
H4+JPCS Expenditures in Zimbabwe, SIDA

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	9,055	1,188,985	1,558,764	2,756,804	54%
UNICEF	0	0	1,364	476,861	551,440	1,029,665	20%
WHO	0	0	47,499	477,564	256,498	781,561	15%
UNWOMEN	0	0	11,754	94,913	346,499	453,166	9%
UNAIDS	0	0	0	20,000	76,779	96,779	2%
TOTAL US$	**0**	**0**	**69,672**	**2,258,323**	**2,789,980**	**5,117,975**	**100%**

H4+JPCS Expenditures by Year and Agency in Zimbabwe, SIDA



H4+JPCS Expenditures in Zimbabwe: 2011-2015, SIDA

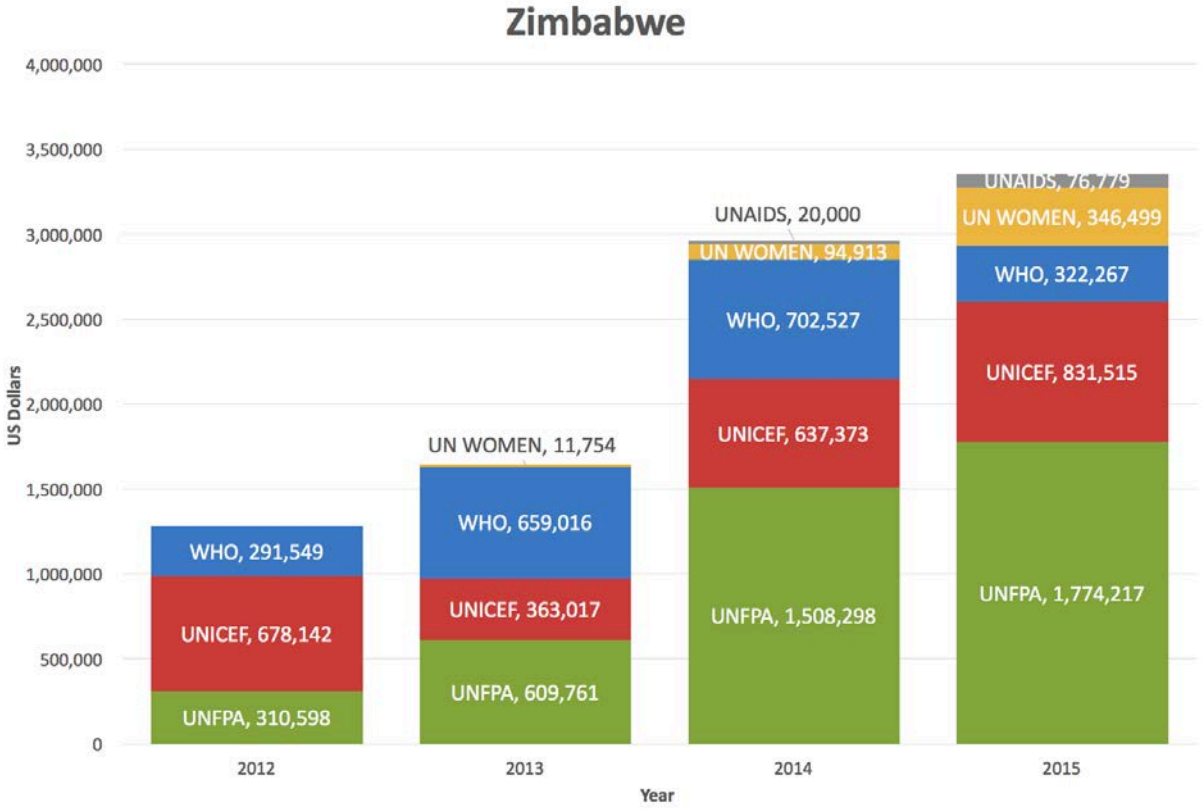


Source: (UNFPA 2016b)

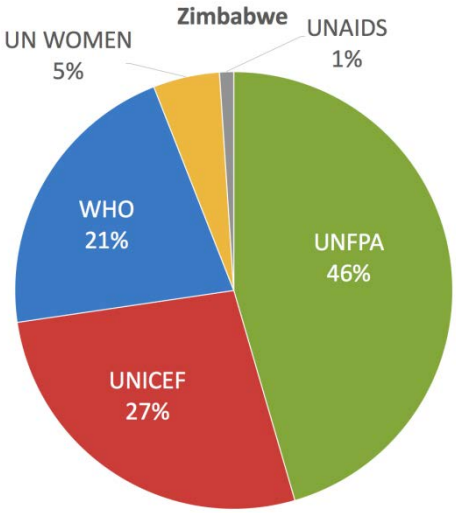
H4+JPCS Expenditures in Zimbabwe, Canada and SIDA

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	310,598	609,761	1,508,298	1,774,217	4,202,874	46%
UNICEF	0	678,142	363,017	637,373	831,515	2,510,047	27%
WHO	0	291,549	659,016	702,527	322,267	1,975,359	21%
UNWOMEN	0		11,754	94,913	346,499	453,166	5%
UNAIDS	0			20,000	76,779	96,779	1%
TOTAL US$	**0**	**1,280,288**	**1,643,548**	**2,963,111**	**3,351,277**	**9,238,225**	**100%**

H4+JPCS Expenditures by Year and Agency in Zimbabwe, Canada and SIDA



H4+JPCS Expenditures in Zimbabwe: 2011-2015, Canada and SIDA



Source: (UNFPA 2016b)

ANNEX 6 TRENDS IN INDICATORS OF RMNCAH

Burkina Faso

Table 1: Basic info

Country income level	Low-income	
Population 2014	17.6 million	(World Bank 2016i)
Literacy rate 2007	28.7%	(World Bank 2016a)
Political/administrative system	13 administrative regions, 45 provinces, 301 departments	

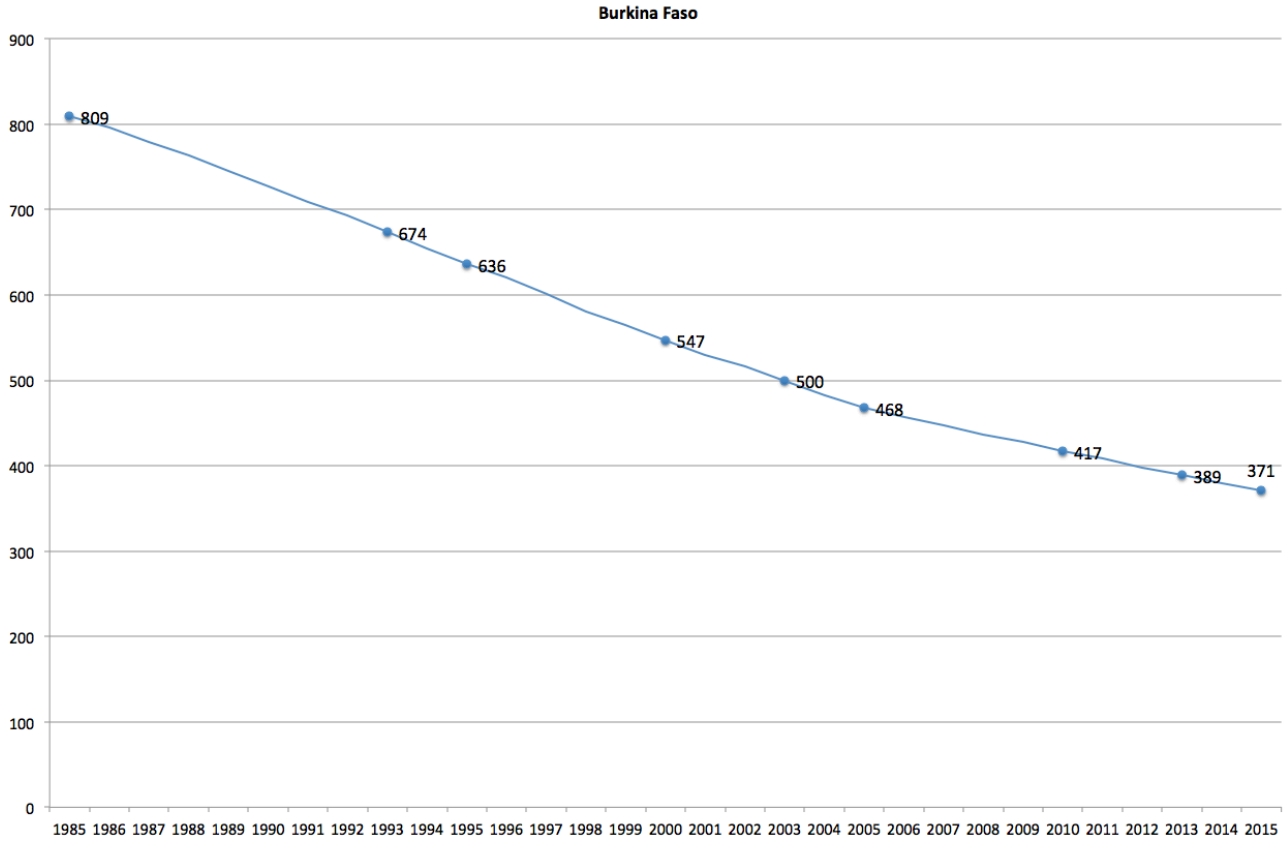
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.8%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	3.4%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	36.4%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	79.6%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

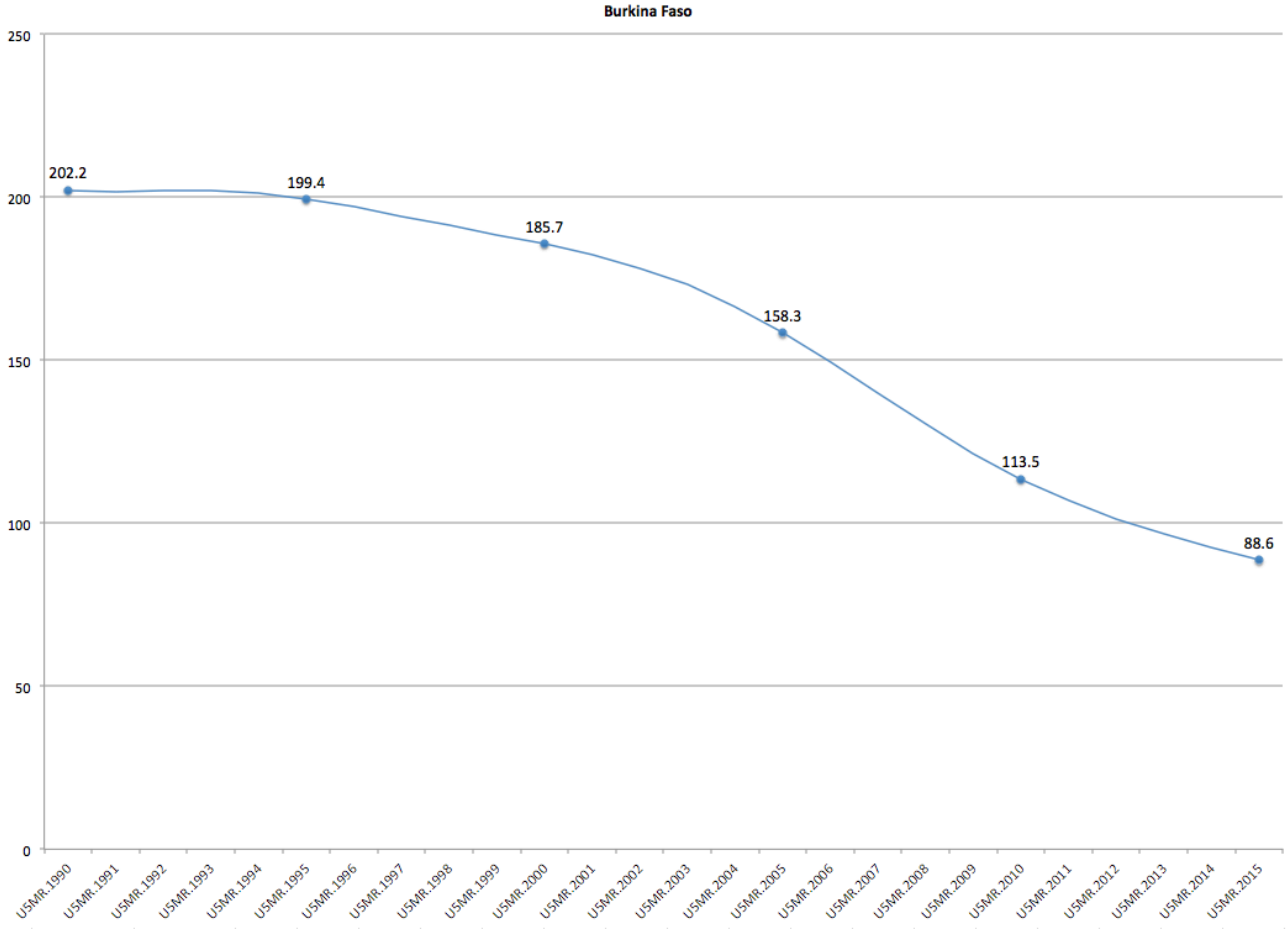
Indicator	1993	1999	2003	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	50%	28%	32%	40%	32%	(Countdown 2015a)
Indicator	**1996**	**2001**	**2006**	**2008**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	144	131	128	136	-	(Countdown 2015a)
Indicator	**1993**	**1999**	**2003**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	31.1%	25.4%	23.2%	23.6%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	636	547	468	417	371	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	27	(Countdown 2015b)
Infant Mortality, per 1,000 live births	...	...	...	...	61	(Countdown 2015b)
Under Five Mortality, per 1,000	199.4	185.7	158.3	113.5	88.6	(Countdown 2015a)
Indicator	**1993**	**1999**	**2006**	**2010**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	7.9	11.9%	17.4%	16.2%	...	(World Bank 2016c)
Indicator	**1993**	**1999**	**2003**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	24.6%	30.3%	29.8%	24.5%	...	(World Bank 2016k)
Indicator	**1993**	**1999**	**2003**	**2010**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	23%	23%	18%	34%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	42.8%	50.7%	57.8%	75.5%	(Countdown 2015a)
Lower bound	<1%	35.9%	42.8%	48.5%	63.0%	
Upper bound	<1%	50.9%	60.4%	68.8%	90.2%	
Indicator	**1999**	**2003**	**2006**	**2010**	**2014**	**Source**
Skilled attendant at delivery, %	31%	38%	54%	66%	...	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	26%	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	72%	...	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	6%	19%	7%	25%	50%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	1%	1%	1%	2%	...	(Countdown 2015a)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.09	0.13	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2008**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.73	0.57	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Burkina Faso



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Burkina Faso



Source: (Countdown 2015a)

Cameroon

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	22.8 million	(World Bank 2016i)
Literacy rate 2010	71.29%	(World Bank 2016a)
Political/administrative system	10 regions, 58 divisions	

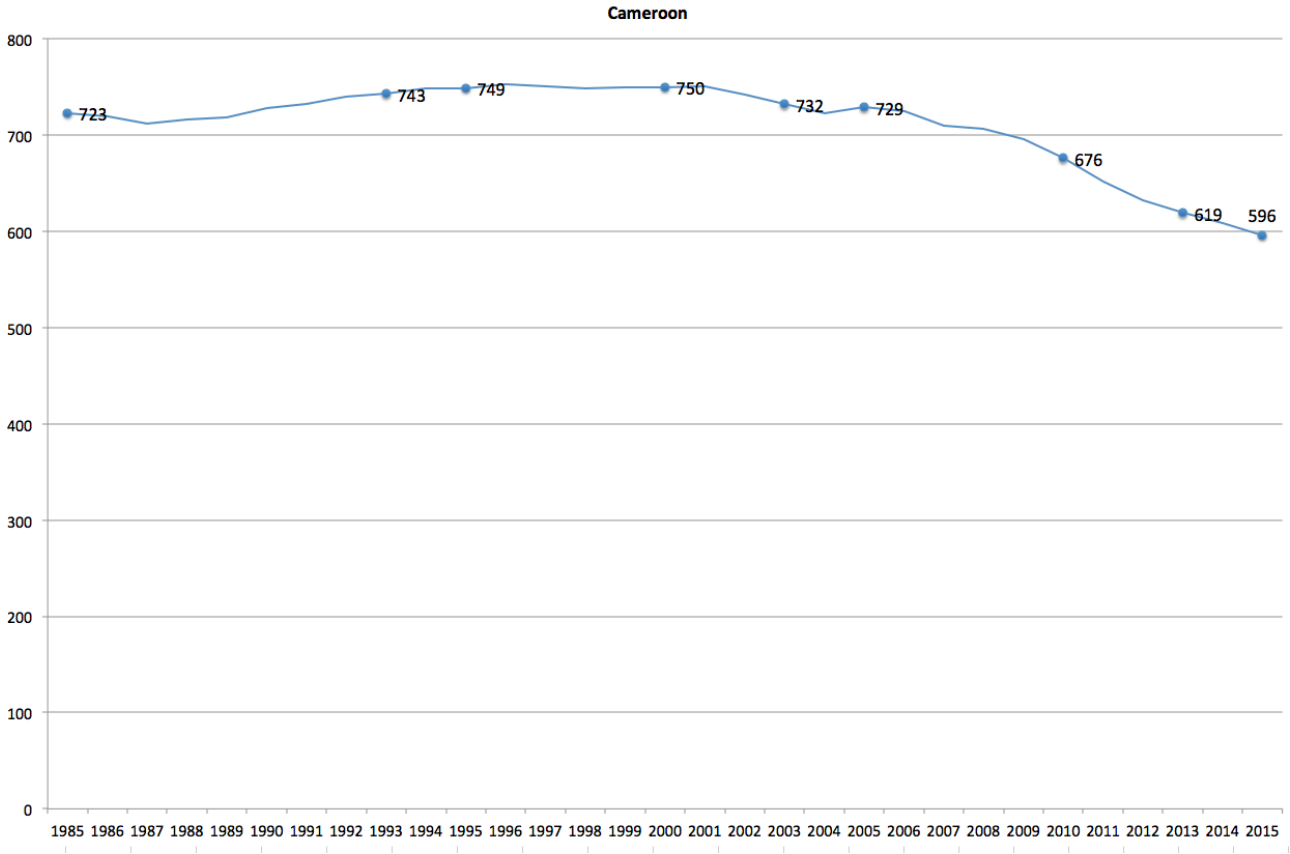
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

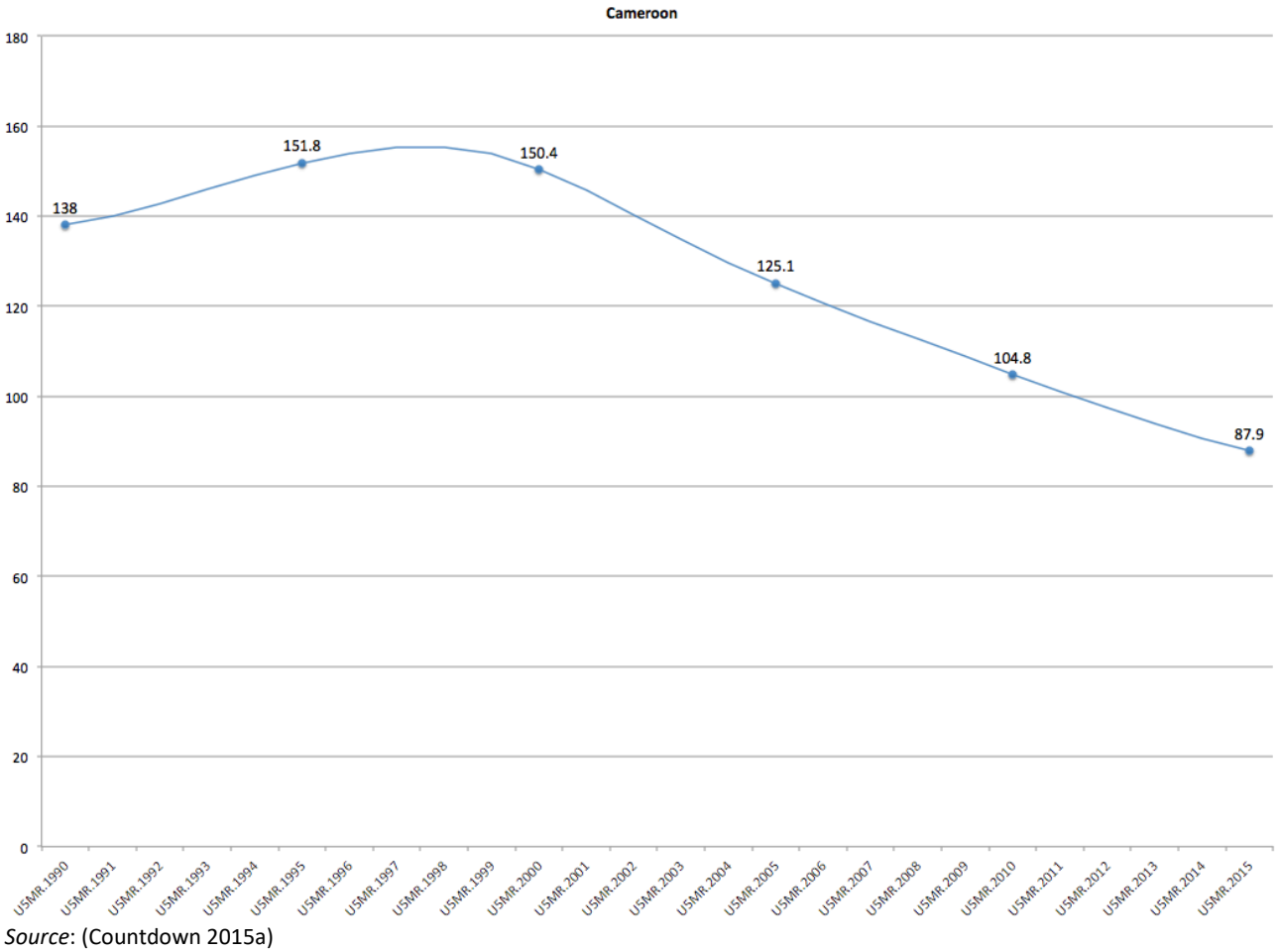
Indicator	1991	1998	2004	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	42%	48%	56%	50%	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2001**	**2005**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	142	136	141	128	-	(Countdown 2015a)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Teenage mothers, % women age 15-19	35%	31.2	28.4%	25.2%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	749	750	729	676	596	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	26	(Countdown 2015b)
Infant Mortality, per 1,000 live births	...	...	...	...	57	(Countdown 2015b)
Under Five Mortality, per 1,000	151.8	150.4	125.1	104.8	87.9	(Countdown 2015a)
Indicator	**1991**	**1998**	**2006**	**2011**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	16.1%	19.3%	29.2%	23.4%	...	(World Bank 2016c)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	22.3%	20.7%	20.5%	23.5%	...	(World Bank 2016k)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	49%	52%	60%	62%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	18.6%	41.3%	53.0%	65.6%	(Countdown 2015a)
Lower bound	<1%	16.8%	37.3%	47.8%	59.5%	
Upper bound	<1%	20.6%	45.8%	58.8%	73.0%	
Indicator	**1998**	**2000**	**2004**	**2006**	**2011**	**Source**
Skilled attendant at delivery, %	58%	60%	62%	63%	64%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	37%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	12%	...	24%	21%	20%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	3%	...	2%	...	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	...	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2009**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	1.6	0.44	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Cameroon



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Cameroon



Source: (Countdown 2015a)

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)

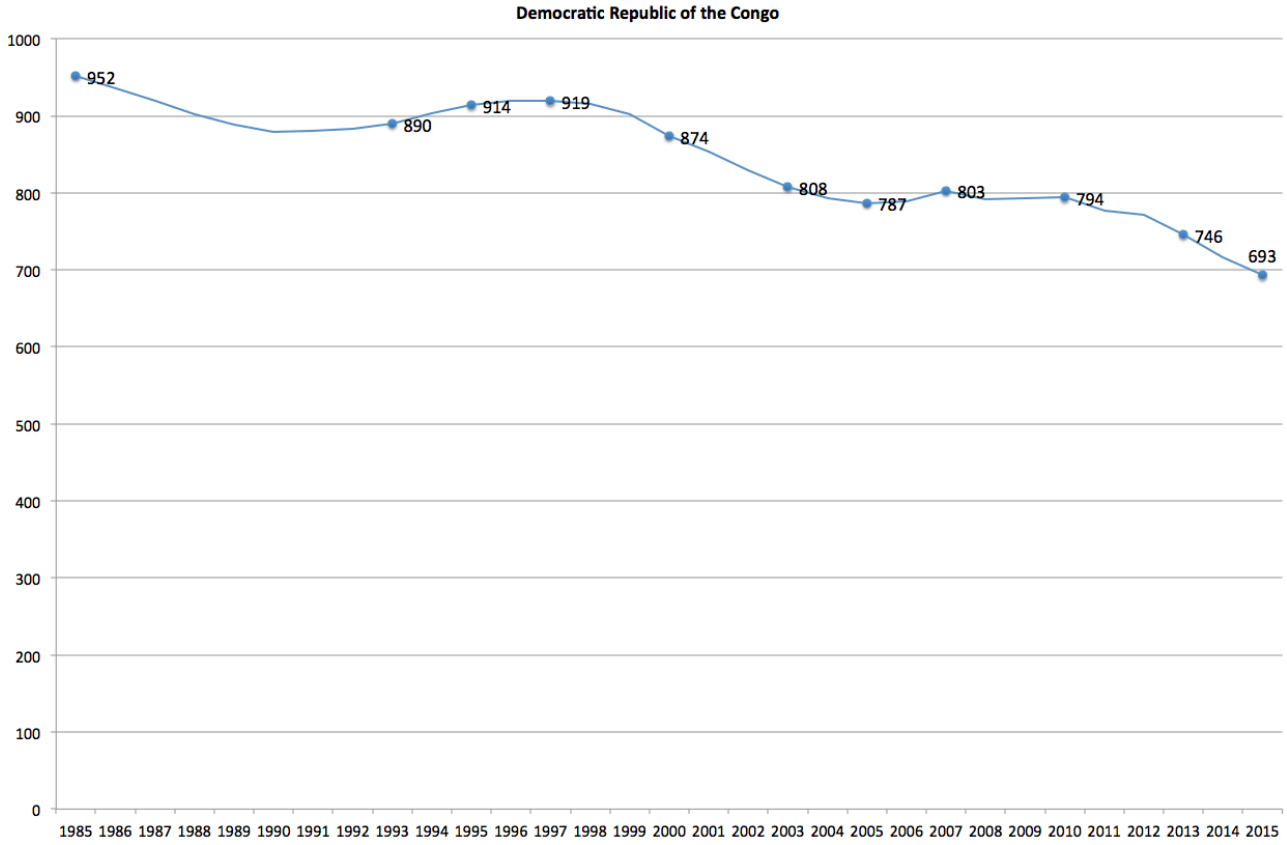
Table 3: H4+JPCS Profiling Indicators 1990-2015

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 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	75	(Countdown 2015b)
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]	(MoH 2015b: 67)
Facilities providing CEMoNC, number	…	…	…	…	47[b]	(MoH 2015b: 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

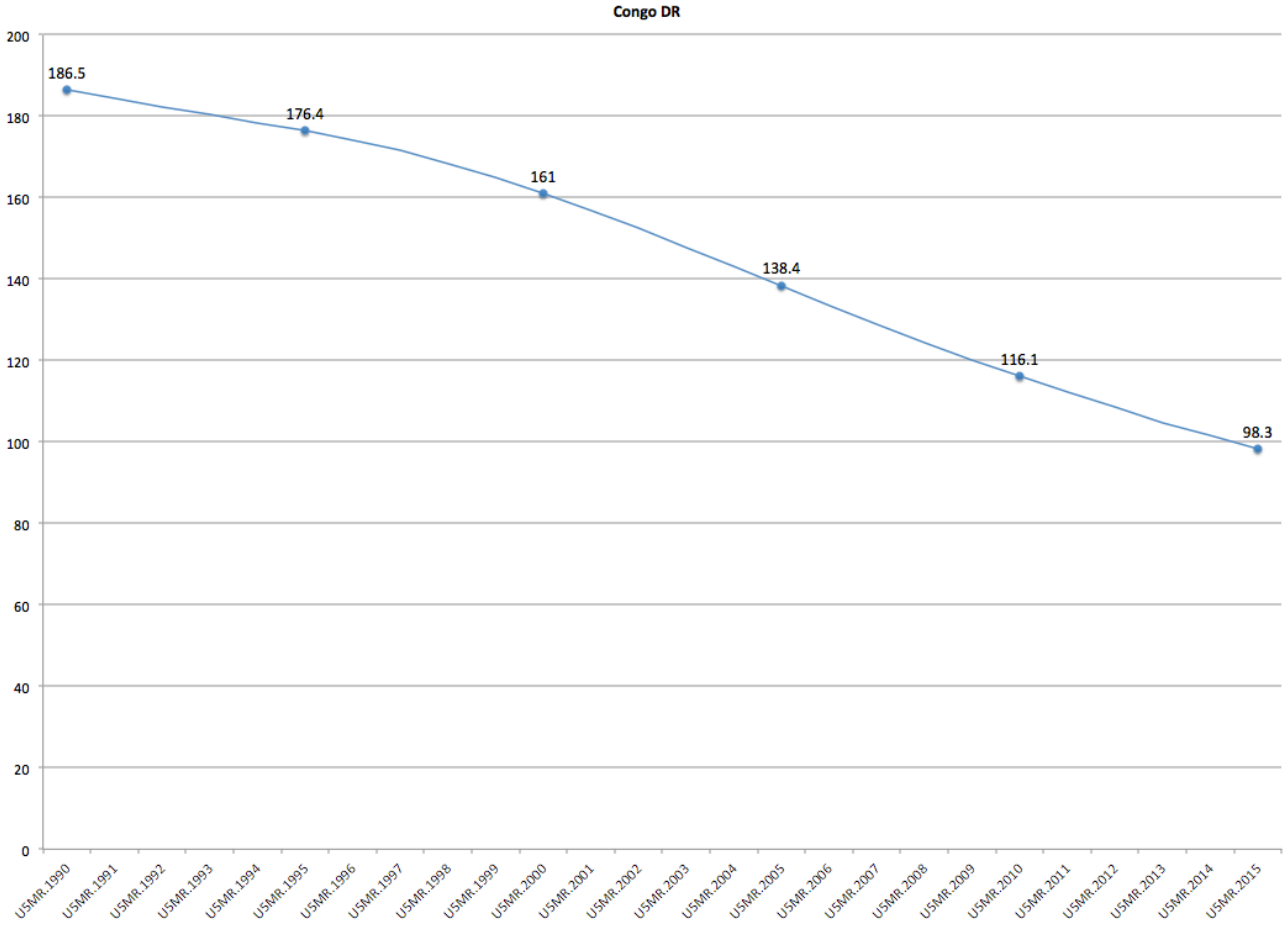
[b] 47 *soins obstétricaux complets* (SOUC) (3%) of 1,555 health facilities in total

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Democratic Republic of the Congo



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Democratic Republic of the Congo



Source: (Countdown 2015a)

Côte d'Ivoire

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	22.2 million	(World Bank 2016i)
Literacy rate 2012	40.98%	(World Bank 2016a)
Political/administrative system	14 districts, 31 regions	

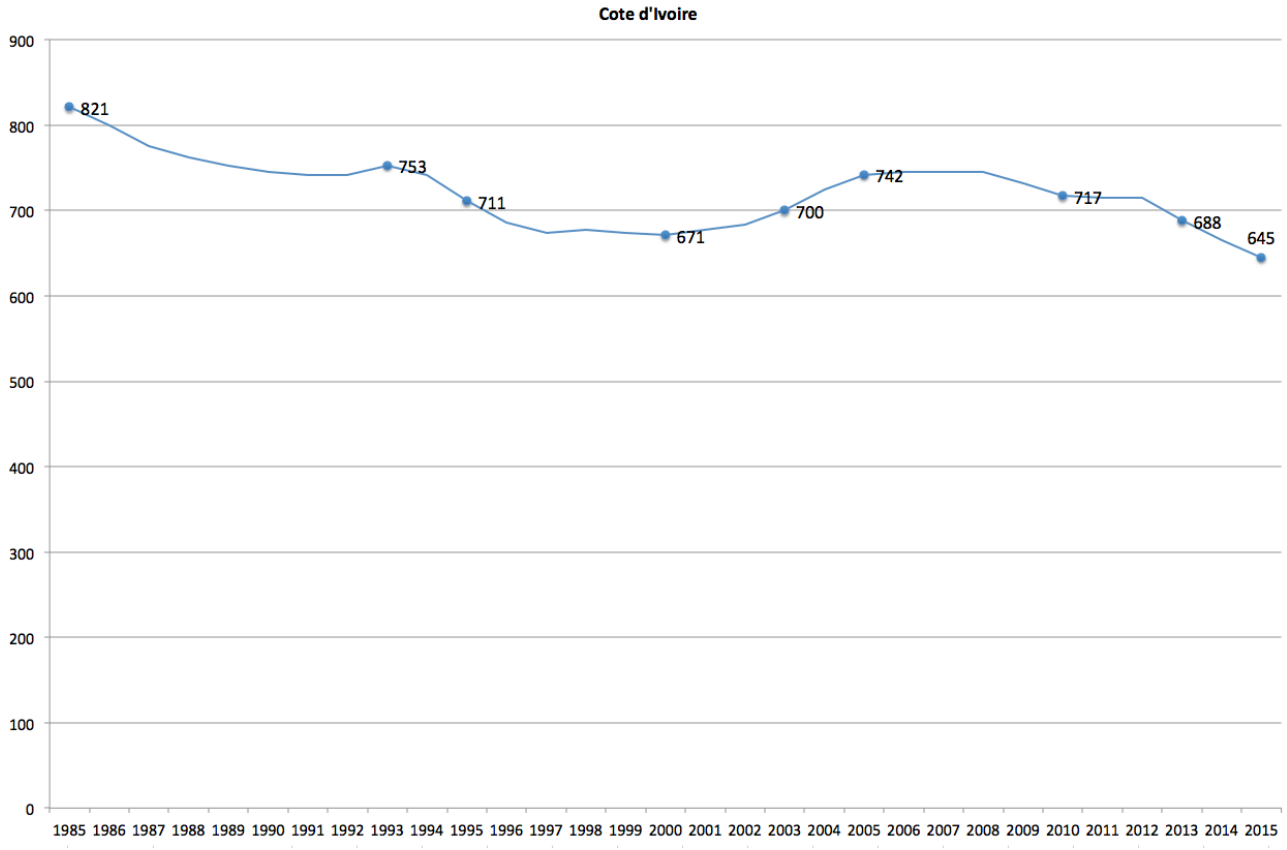
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

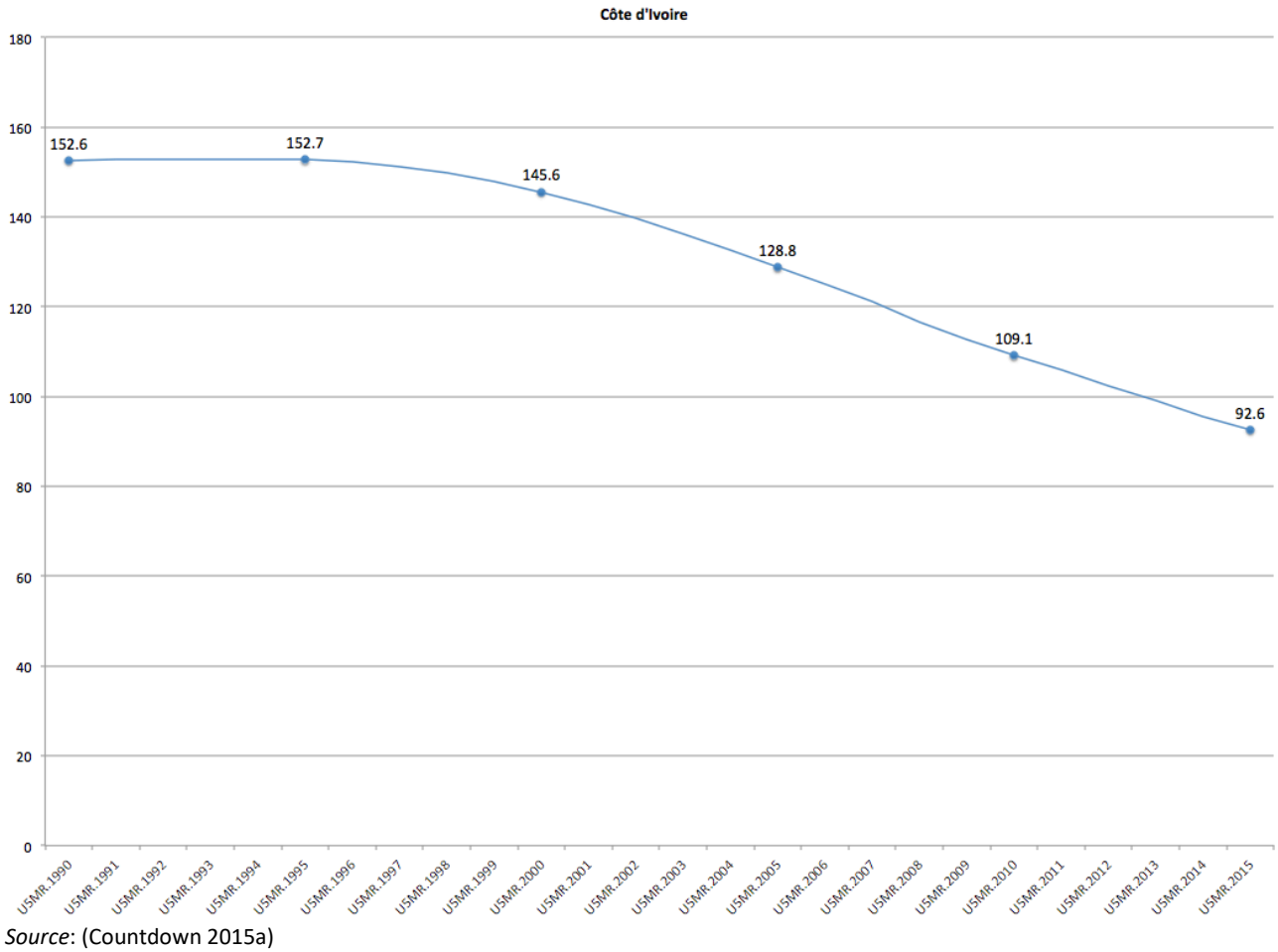
Indicator	1994	1999	2006	2012	2014	Source
Demand for family planning satisfied, % women age 15-49	27%	34%	-	45%	-	(Countdown 2015a)
Indicator	**1992**	**1996**	**2003**	**2006**	**2009**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	151	126	132	111	125	(Countdown 2015a)
Indicator	**1994**	**1999**	**2005**	**2012**	**2015**	**Source**
Teenage mothers, % women age 15-19	35%	31%	...	29.6%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	711	671	742	717	645	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	38	(Countdown 2015b)
Infant Mortality, per 1,000 live births	...	...	...	...	67	(Countdown 2015b)
Under Five Mortality, per 1,000						
Indicator	**1994**	**1999**	**2006**	**2012**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	11.4%	15%	12.9%	18.2%	...	(World Bank 2016c)
Indicator	**1994**	**1999**	**2006**	**2012**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	30.4%	28.9%	...	27.1%	...	(World Bank 2016k)
Indicator	**1994**	**1999**	**2005**	**2012**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	29%	36%	45%	44%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	...	...	...	...	...	(Countdown 2015a)
Lower bound						
Upper bound						
Indicator	**1994**	**1999**	**2000**	**2006**	**2012**	**Source**
Skilled attendant at delivery, %	45%	47%	63%	57%	59%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	34%	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	70%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	3%	4%	10%	4%	12%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	2%	3%	...	6%	3%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	...	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2014**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.6	0.48		(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Côte d'Ivoire



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Côte d'Ivoire



Source: (Countdown 2015a)

Ethiopia

Table 1: Basic info

Country income level	Low-income	
Population 2014	97 million	(World Bank 2016i)
Literacy rate 2007	39.0%	(World Bank 2016a)
Political/administrative system	9 regional states	

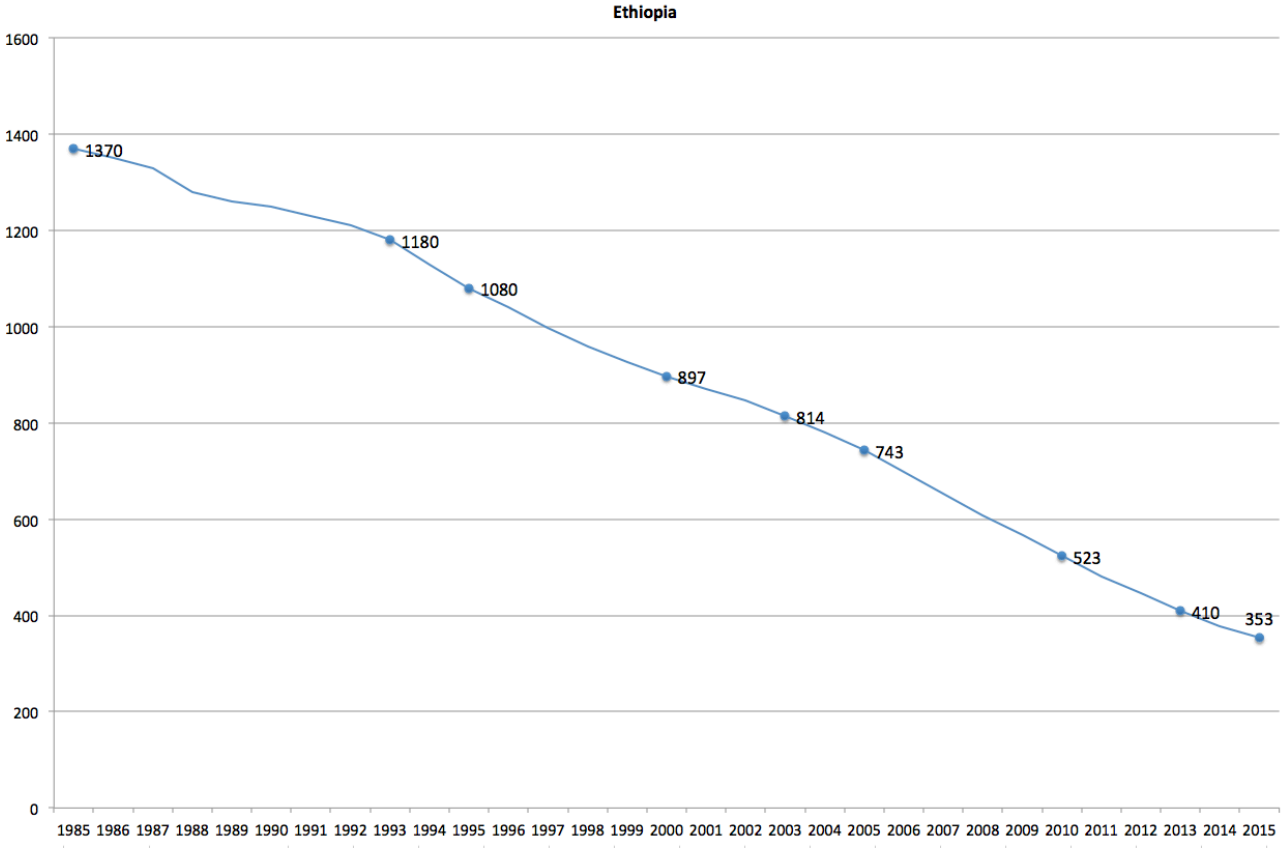
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.0%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	1.9%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	41.2%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	79.9%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

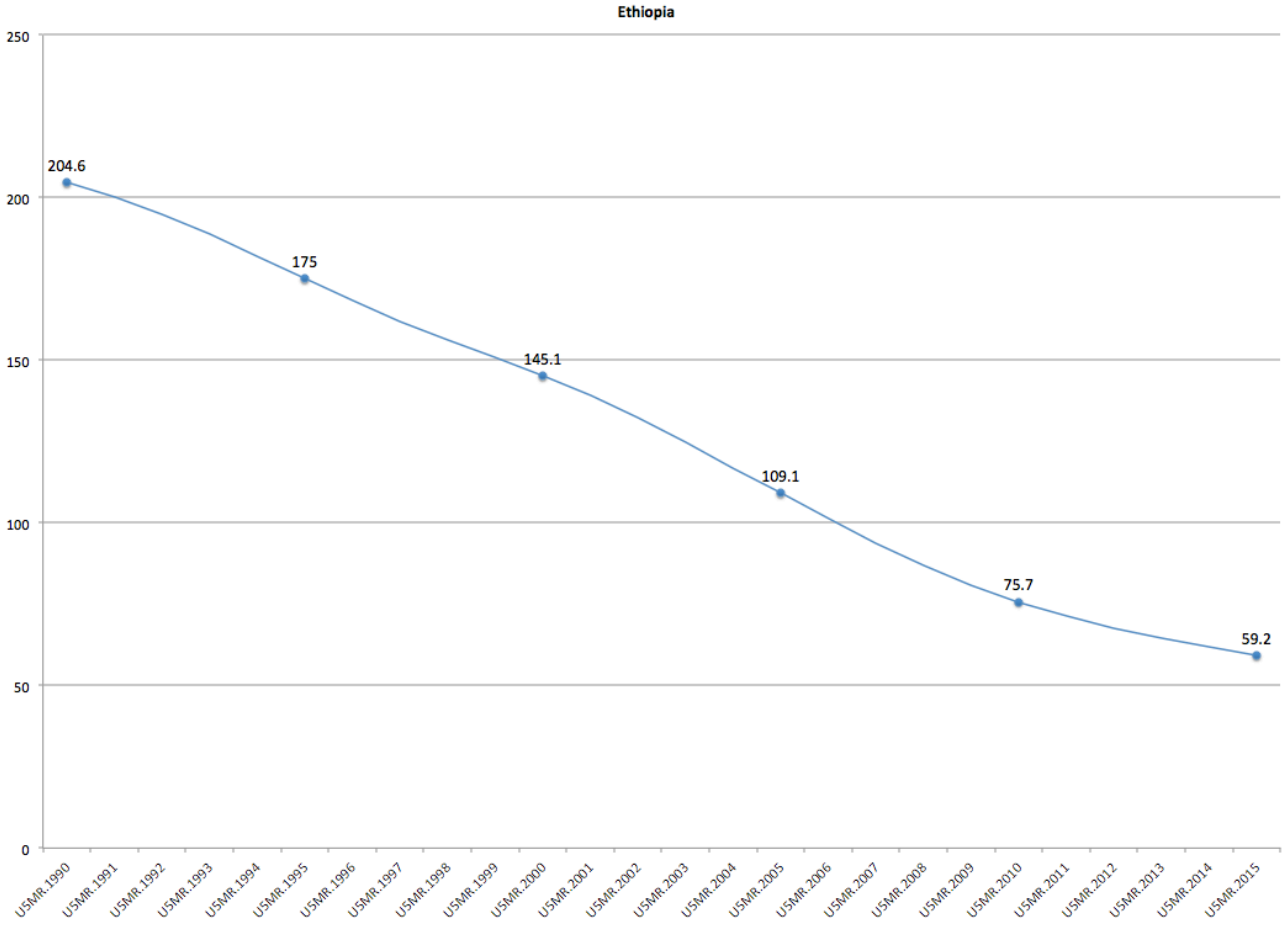
Indicator	1995	2000	2005	2008	2014	Source
Demand for family planning satisfied, % women age 15-49	70%	80%	83%	84%	82%	(Countdown 2015a)
Indicator	**1994**	**1997**	**2002**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	99	110	109	87	71	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	…	16.3%	16.6%	12.4%	…	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	1,080	897	743	523	353	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	28	(Countdown 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	41	(Countdown 2015b)
Under Five Mortality, per 1,000	175	145.1	109.1	75.7	59.2	(Countdown 2015a)
Indicator	**1997**	**2000**	**2005**	**2011**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	3.3%	8.1%	14.7%	28.6%	…	(World Bank 2016c)
Indicator	**1995**	**2000**	**2005**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	…	36.6%	36.1%	26.3%	…	(World Bank 2016k)
Indicator	**1994**	**2000**	**2005**	**2011**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	10%	12%	19%	32%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	11.9%	20.3%	52.3%	72.8%	(Countdown 2015a)
Lower bound	<1%	10.1%	17.4%	44.5%	60.7%	
Upper bound	<1%	14.0%	24.0%	61.8%	89.6%	
Indicator	**1994**	**2000**	**2005**	**2011**	**2014**	**Source**
Skilled attendant at delivery, %	…	6%	6%	10%	16%	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	…	…	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	…	12%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	…	54.2%	49%	52%	…	(Countdown 2015a)
Facilities providing BEMoNC, number	…	…	…	…	…	
Facilities providing CEMoNC, number	…	…	…	…	…	
C Section Rate, % of live births, women age 15-49	…	1%	1%	2%	2%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2009**	**2015**	**Source**
Community Health Workers, per 1,000 people	…	…	0.22	0.36	…	(World Bank 2016b)
Indicator	**1995**	**2003**	**2007**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	…	0.22	0.24	0.24	…	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Ethiopia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Ethiopia



Source: (Countdown 2015a)

Guinea Bissau

Table 1: Basic info

Country income level	Low-income	
Population 2014	1.8 million	(World Bank 2016i)
Literacy rate 2013	57.8%	(World Bank 2016a)
Political/administrative system	8 regions, 37 sectors	

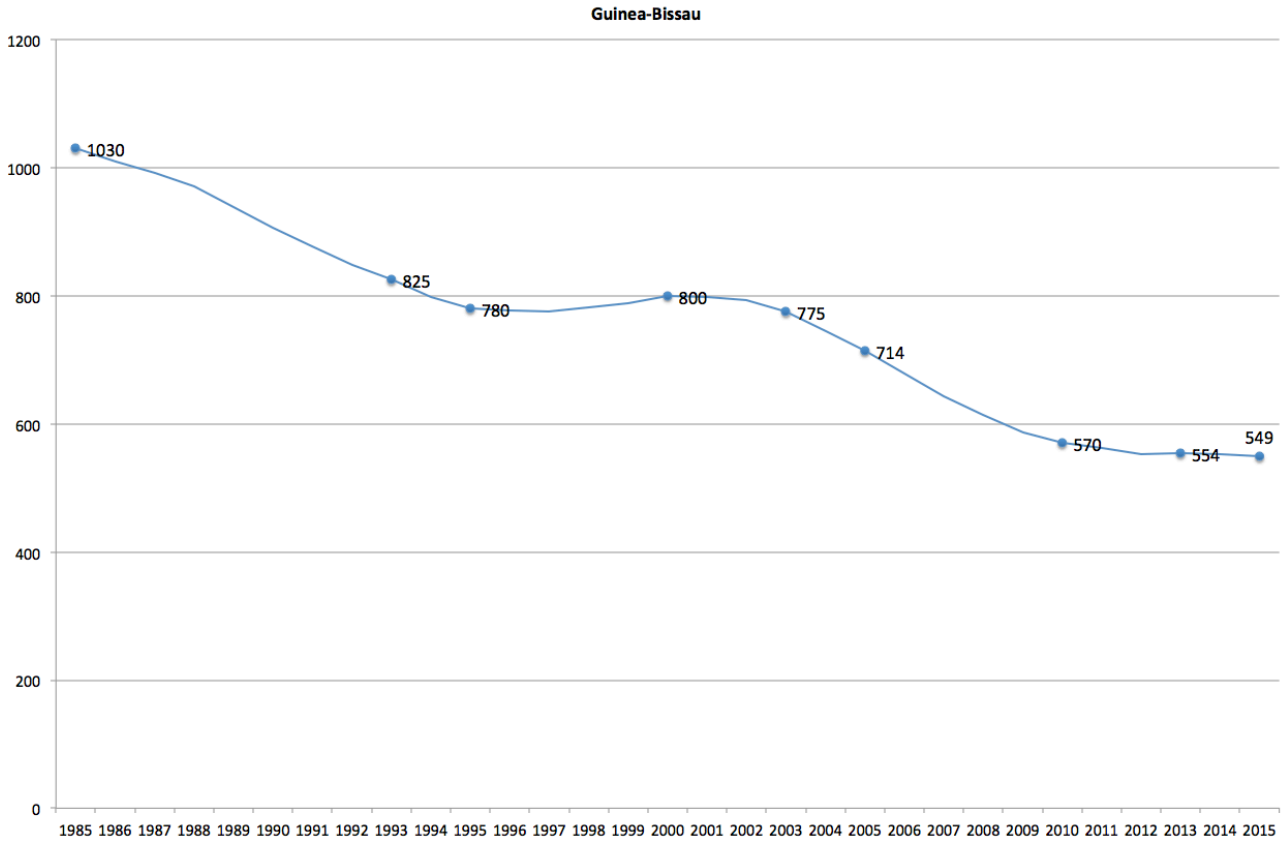
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

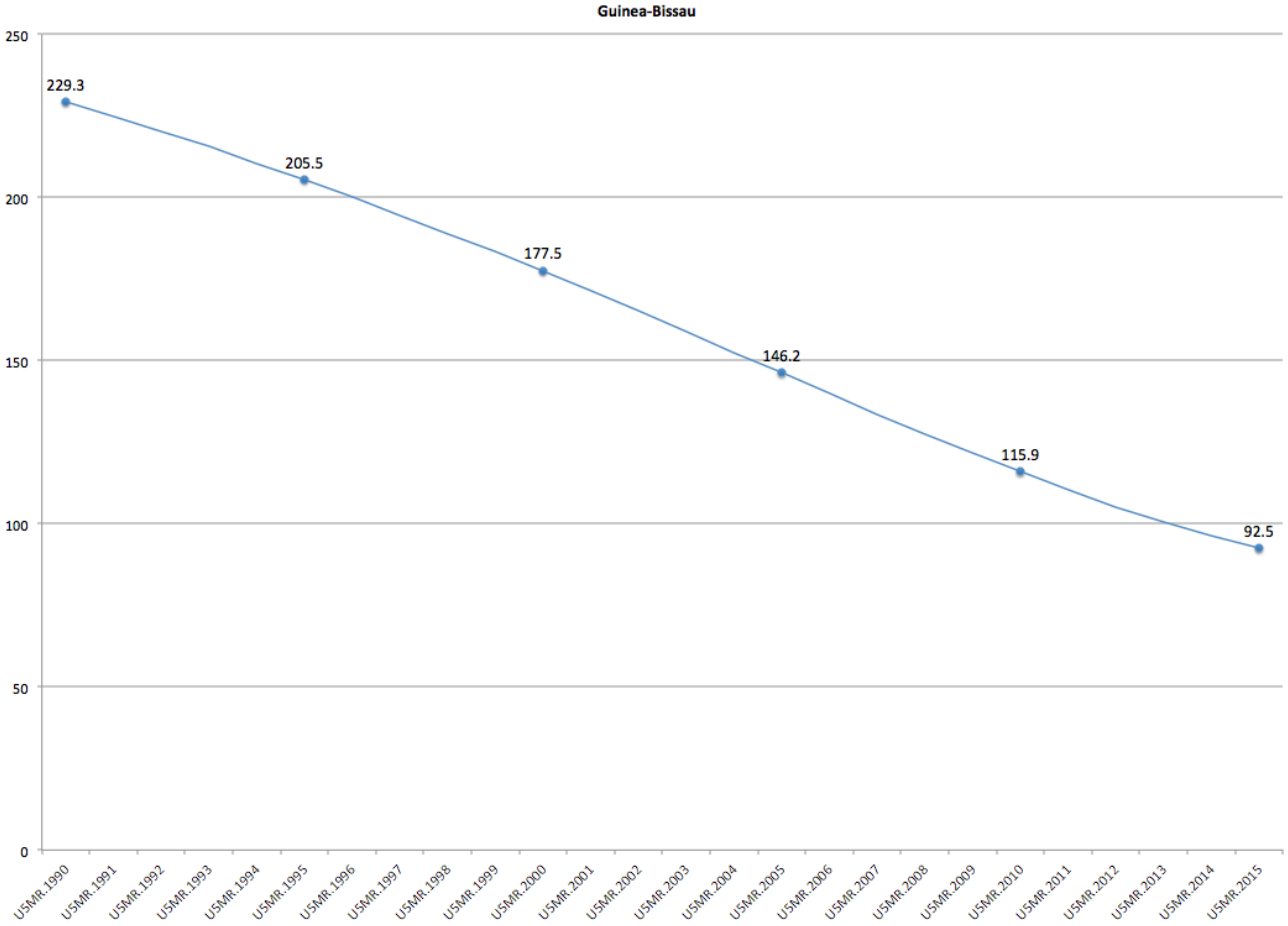
Indicator	1994	1999	2006	2010	2014	Source
Demand for family planning satisfied, % women age 15-49	-	-	-	70%	-	(Countdown 2015a)
Indicator	**1997**	**2000**	**2005**	**2009**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	-	170	-	137	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	…	…	…	…	…	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	780	800	714	570	549	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	40	(Countdown 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	60	(Countdown 2015b)
Under Five Mortality, per 1,000	205.5	177.5	146.2	115.9	92.5	(Countdown 2015a)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	…	7.6%	10.3%	14.2%	…	(World Bank 2016c)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	…	…	…	6%	…	(World Bank 2016k)
Indicator	**1994**	**1999**	**2006**	**2010**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	-	-	68%	65%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	10.8%	15.3%	32.4%	83.5%	(Countdown 2015a)
Lower bound	<1%	9.5%	13.5%	28.7%	74.1%	
Upper bound	<1%	12.5%	17.4%	36.6%	94.2%	
Indicator	**1995**	**2000**	**2006**	**2010**	**2014**	**Source**
Skilled attendant at delivery, %	25%	35%	39%	43%	45%	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	…	…	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	…	…	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	…	36.5%	16.1%	38.3%	52.5%	(Countdown 2015a)
Facilities providing BEMoNC, number	…	…	…	…	…	
Facilities providing CEMoNC, number	…	…	…	…	…	
C Section Rate, % of live births, women age 15-49	…	…	…	2%	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	…	…	2.9	…	…	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	…	…	0.7	0.55	…	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Guinea Bissau



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Guinea Bissau



Source: (Countdown 2015a)

Liberia

Table 1: Basic info

Country income level	Low-income	
Population 2014	4.4 million	(World Bank 2016i)
Literacy rate 2007	42.94%	(World Bank 2016a)
Political/administrative system	15 counties, 90 districts	

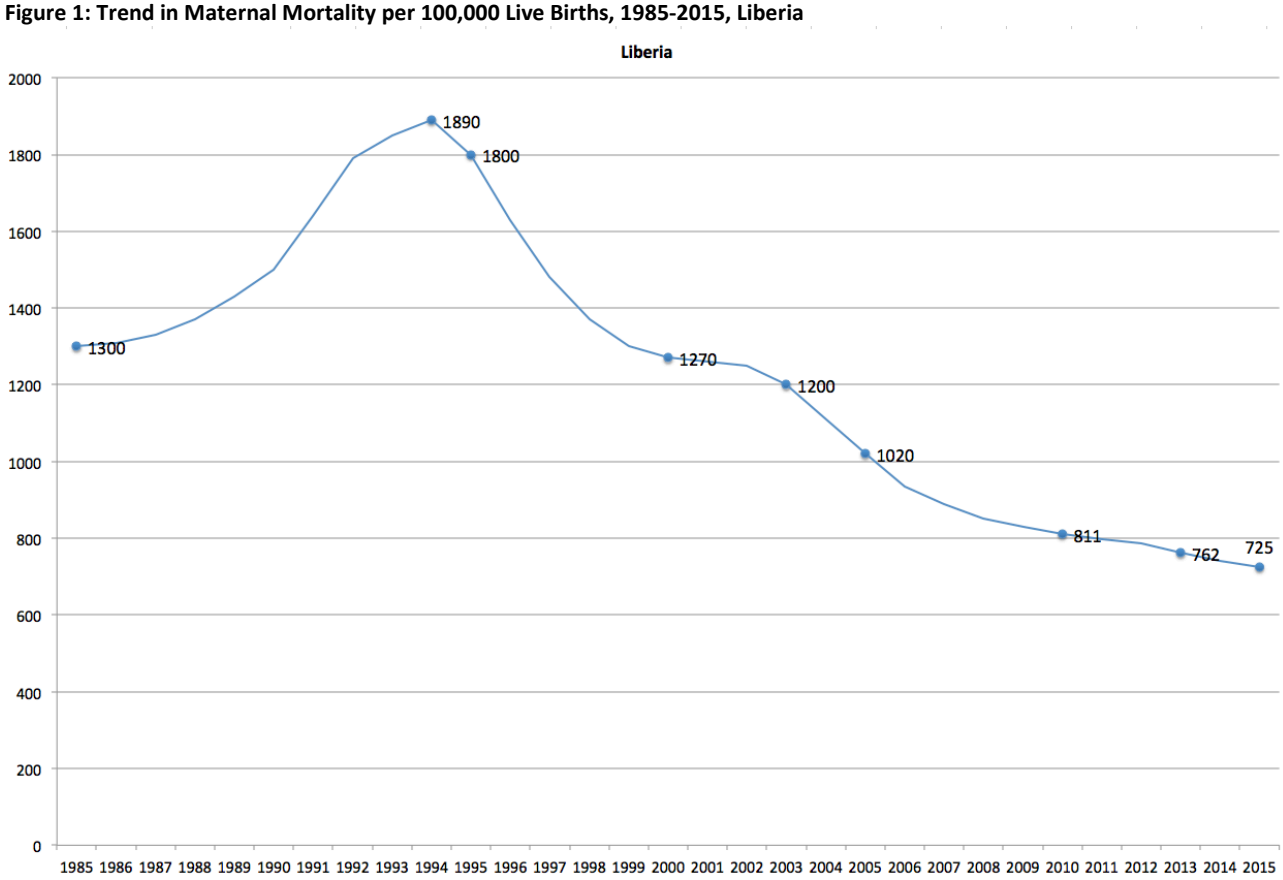
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

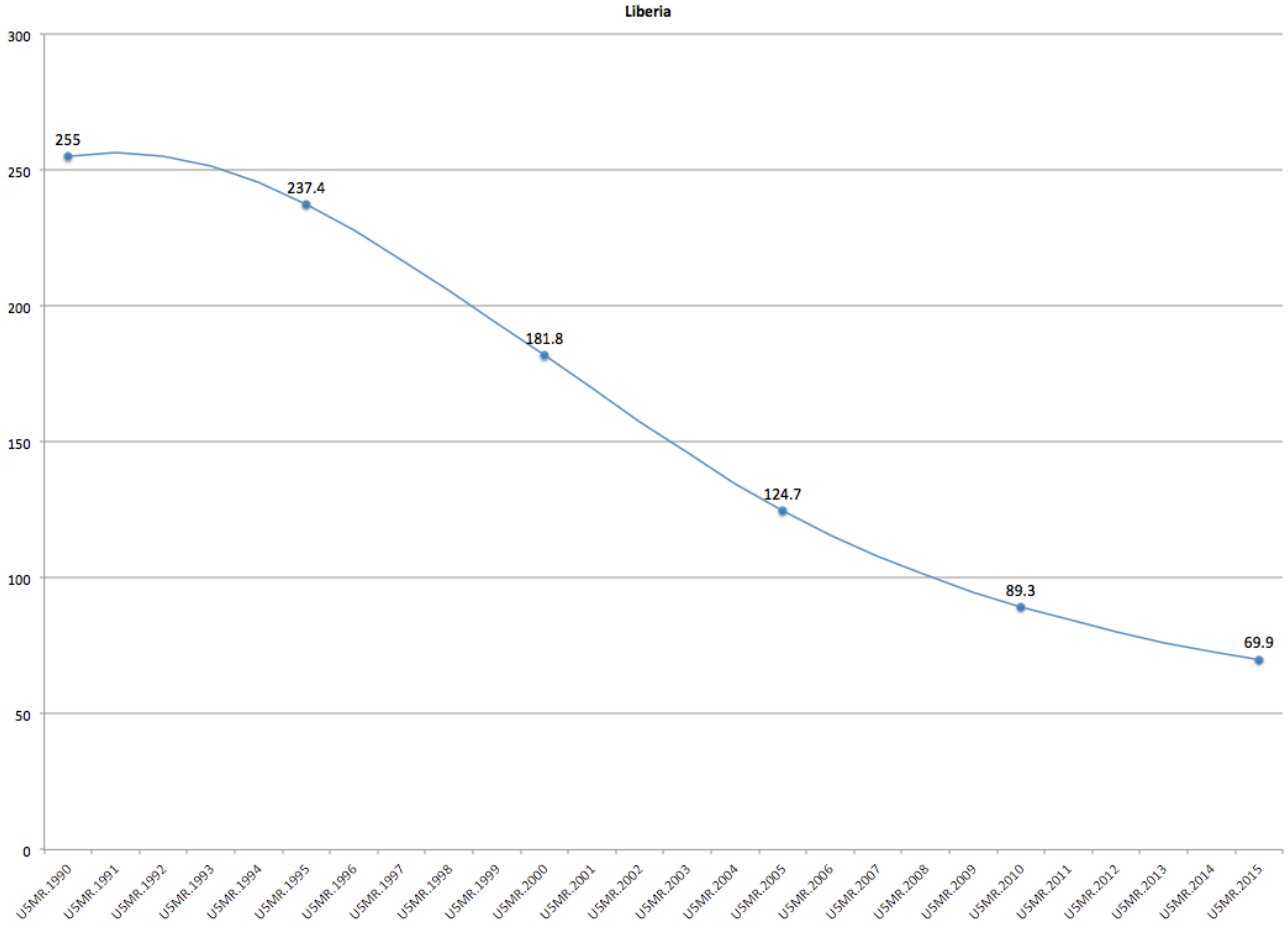
Indicator	1994	1999	2007	2011	2013	Source
Demand for family planning satisfied, % women age 15-49	-	-	24%	-	39%	(Countdown 2015a)
Indicator	**1998**	**2004**	**2006**	**2010**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	135	137	177	147	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Teenage mothers, % women age 15-19	…	…	32.1%	37.6%	31.3%	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	1,800	1,270	1,020	811	725	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	24	(Countdown 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	53	(Countdown 2015b)
Under Five Mortality, per 1,000	237.4	181.8	124.7	89.3	69.9	(Countdown 2015a)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	…	10%	11.4%	…	20.2%	(World Bank 2016c)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Unmet need for contraception, % aged 15-49	…	…	35.7%	…	31.1%	(World Bank 2016k)
Indicator	**1995**	**2000**	**2005**	**2007**	**2013**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	-	-	66%	78%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	18.7%	31.5%	52.8%	52.0%	(Countdown 2015a)
Lower bound	<1%	16.4%	27.4%	45.8%	45.0%	
Upper bound	<1%	21.6%	35.8%	60.5%	59.9%	
Indicator	**1994**	**2000**	**2007**	**2013**	**2015**	**Source**
Skilled attendant at delivery, %	…	51%	46%	61%	…	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	35%	…	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	71%	…	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	…	35.4%	29.1%	55.2%	…	(Countdown 2015a)
Facilities providing BEMoNC, number	…	…	…	…	…	
Facilities providing CEMoNC, number	…	…	…	…	…	
C Section Rate, % of live births, women age 15-49	…	…	4%	4%	…	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	…	…	0.04	…	…	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	…	…	0.3	0.27	…	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Liberia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Liberia



Source: (Countdown 2015a)

Sierra Leone

Table 1: Basic info

Country income level	Low-income	
Population 2014	6.3 million	(World Bank 2016i)
Literacy rate 2013	45.7%	(World Bank 2016a)
Political/administrative system	4 regions, 14 districts	

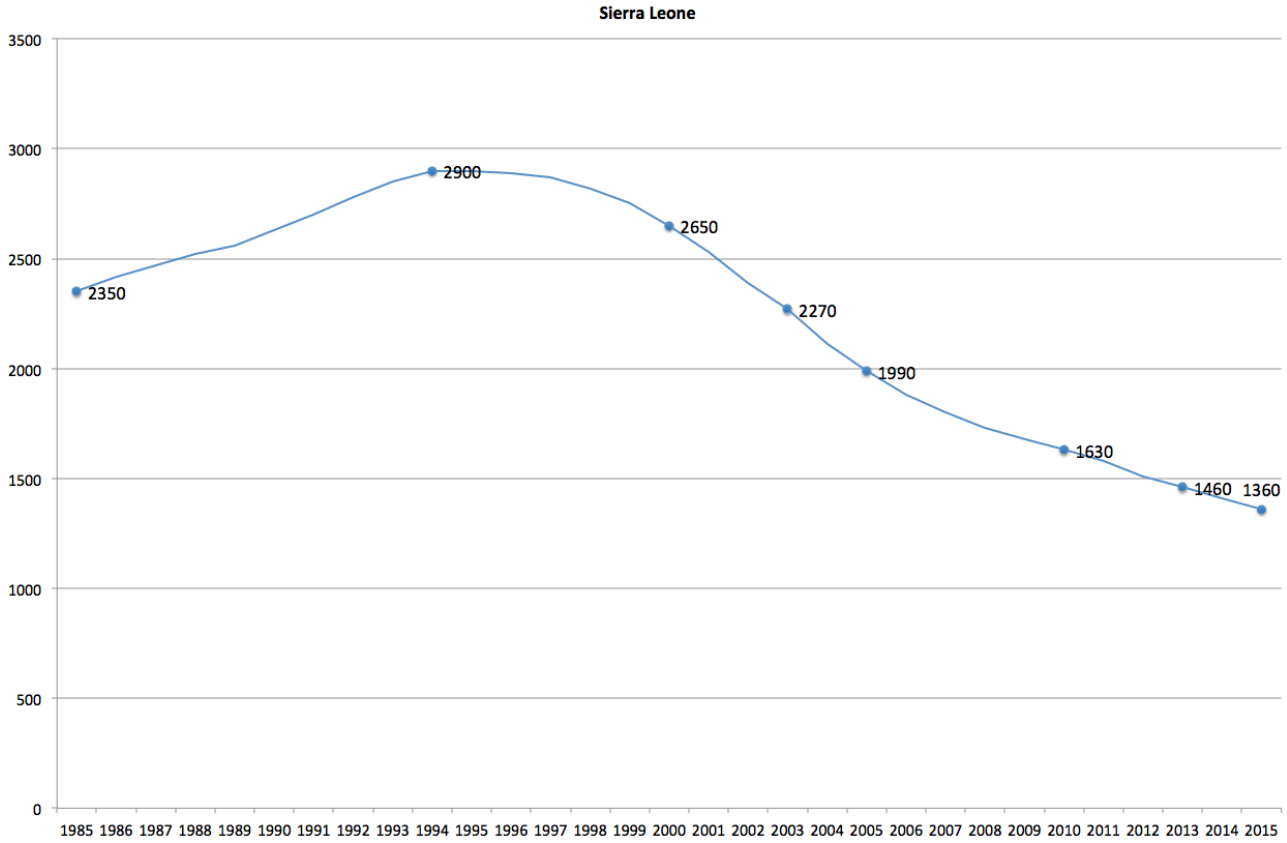
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

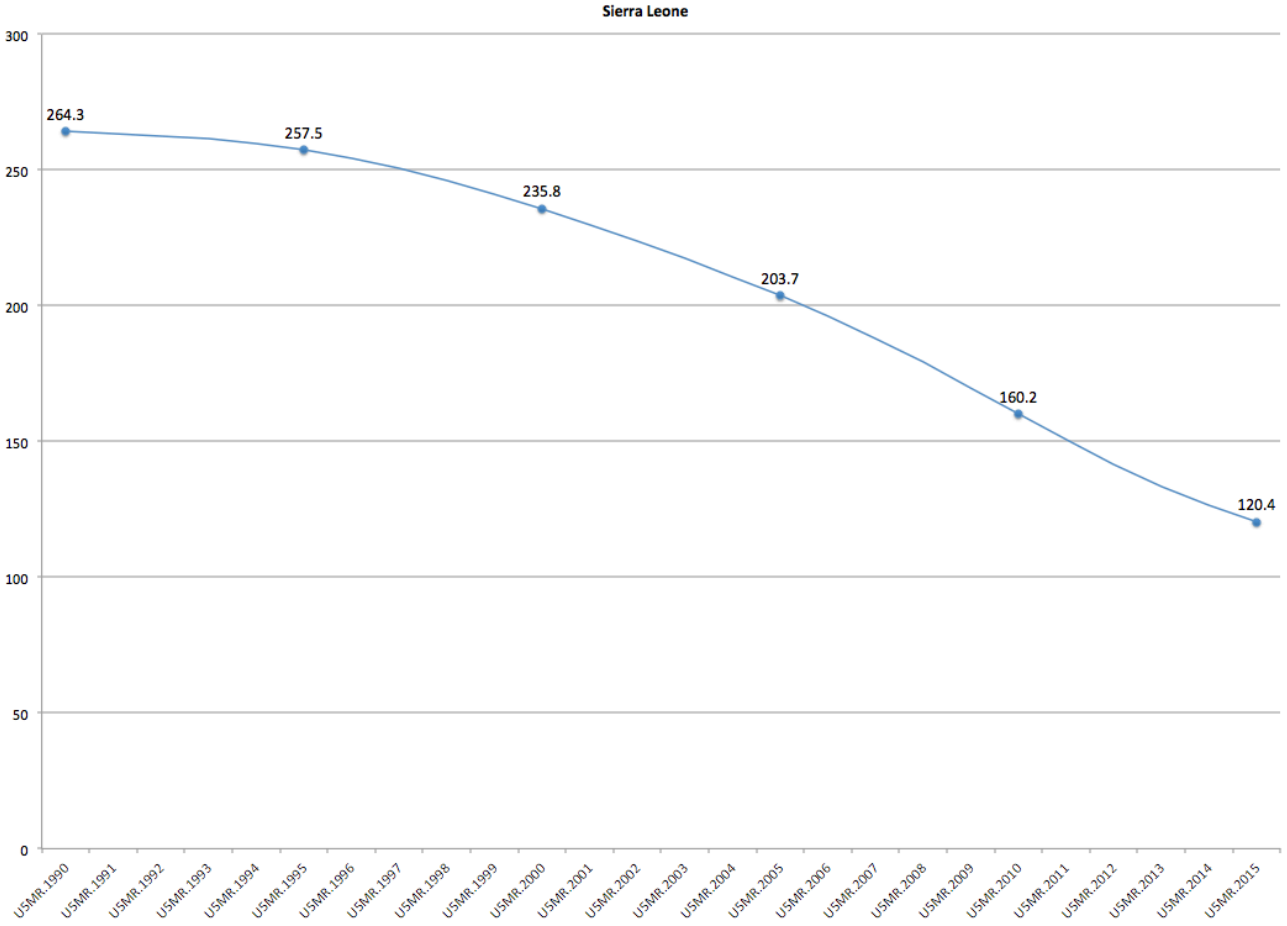
Indicator	1994	1999	2008	2010	2013	Source
Demand for family planning satisfied, % women age 15-49	-	-	22%	29%	40%	(Countdown 2015a)
Indicator	**2000**	**2003**	**2005**	**2009**	**2011**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	150	113	143	122	131	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2011**	**2013**	**Source**
Teenage mothers, % women age 15-19	…	…	…	34%	27.9%	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	2,900	2,650	1,990	1,630	1,360	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	35	(Countdown 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	87	(Countdown 2015b)
Under Five Mortality, per 1,000	257.5	235.8	203.7	160.2	120.4	(Countdown 2015a)
Indicator	**1992**	**2000**	**2005**	**2010**	**2013**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	2.6%	4.3%	5.3%	11%	16.6%	(World Bank 2016c)
Indicator	**1995**	**2000**	**2008**	**2010**	**2013**	**Source**
Unmet need for contraception, % aged 15-49	…	…	28.4%	27.4%	25%	(World Bank 2016k)
Indicator	**1993**	**1997**	**2005**	**2011**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	13%	17%	40%	50%	48%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	…	…	…	…	…	(Countdown 2015a)
Lower bound						
Upper bound						
Indicator	**2000**	**2005**	**2008**	**2010**	**2013**	**Source**
Skilled attendant at delivery, %	42%	43%	42%	63%	60%	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	39%	…	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	…	73%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	4.1%	7.9%	11.2%	31.6%	32%	(Countdown 2015a)
Facilities providing BEMoNC, number	…	…	…	…	…	
Facilities providing CEMoNC, number	…	…	…	…	…	
C Section Rate, % of live births, women age 15-49	…	…	2%	5%	3%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	…	…	0.12	0.02	…	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	…	…	0.49	0.17	…	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Sierra Leone



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Sierra Leone



Source: (Countdown 2015a)

Zambia

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	14.5 million	(World Bank 2016i)
Literacy rate 2007	61.4	(World Bank 2016a)
Political/administrative system	10 provinces, 89 districts	

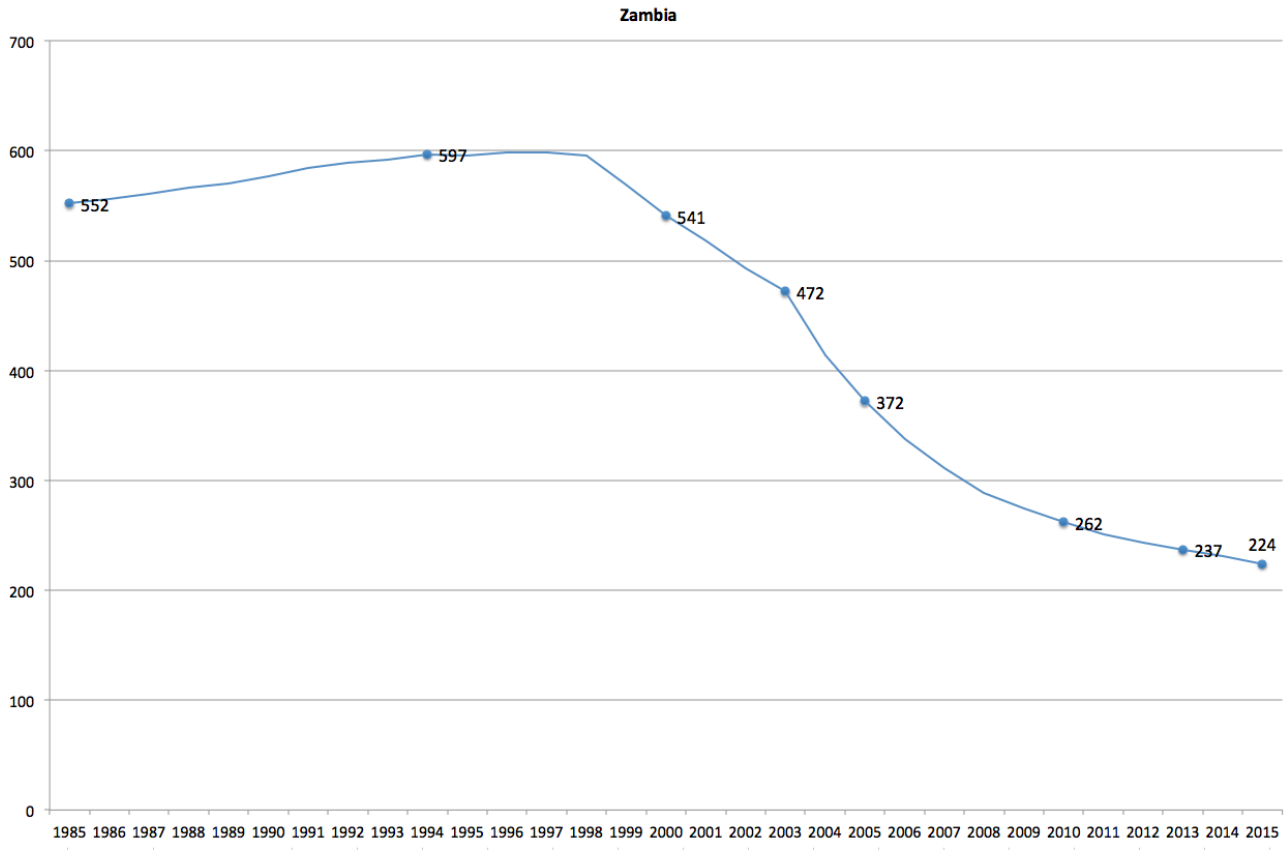
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.3%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	4.2%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	23.9%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	66.7%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

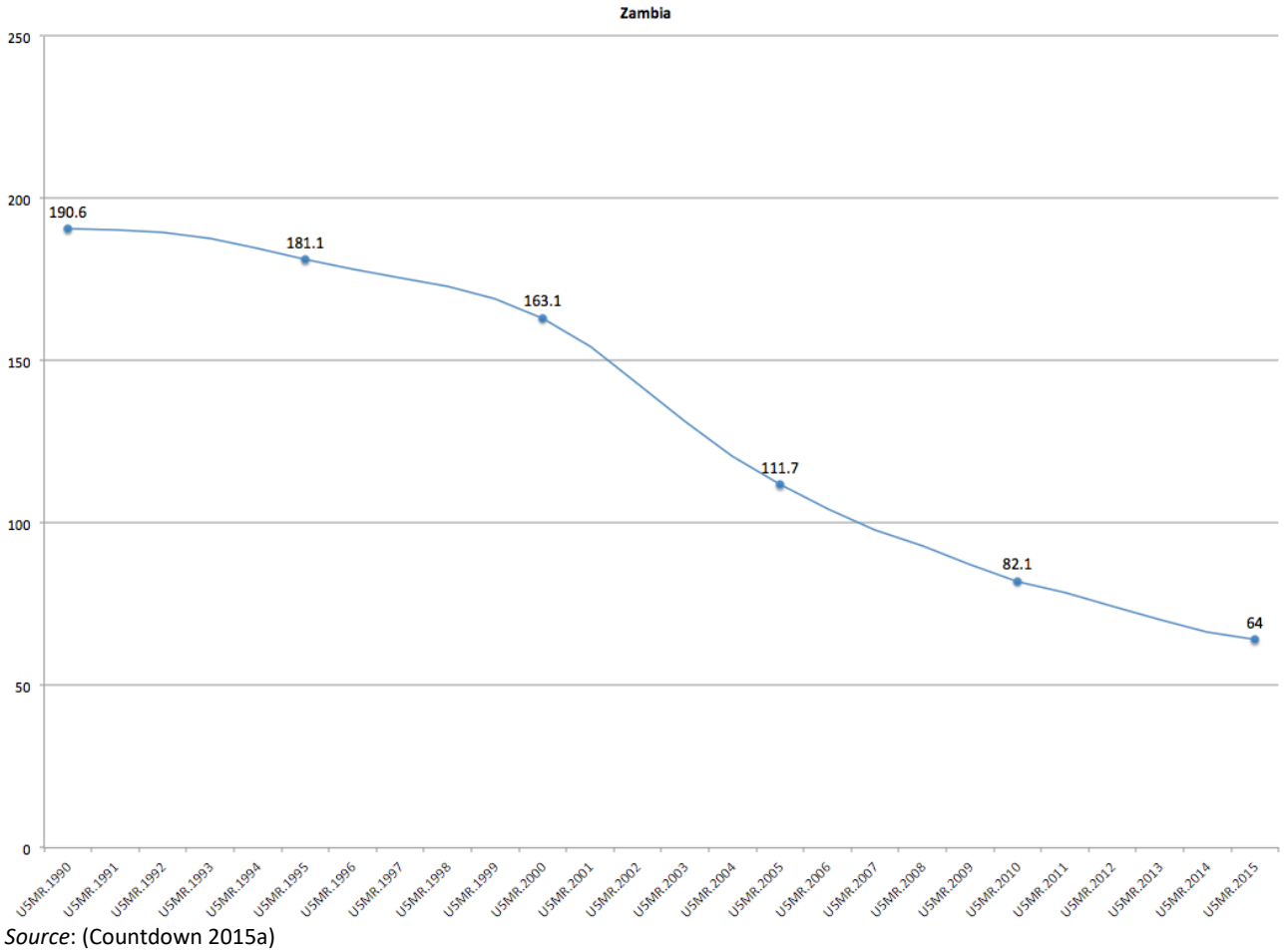
Indicator	1994	1999	2006	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	72%	76%	80%	80%	87%	(Countdown 2015a)
Indicator	**1997**	**2002**	**2003**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	108	103	101	112	120	(Countdown 2015a)
Indicator	**1996**	**2002**	**2007**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	30.7%	31.6	27.9%	...	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000	596	541	372	262	224	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000	...	...	...	...	21	(Countdown 2015b)
Infant Mortality, per 1,000 live births	...	...	...	...	43	(Countdown 2015b)
Under Five Mortality, per 1,000	181.1	163.1	111.7	82.1	64	(Countdown 2015a)
Indicator	**1995**	**1999**	**2002**	**2007**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	...	22%	34.2%	40.8%	...	(World Bank 2016c)
Indicator	**1997**	**2002**	**2007**	**2010**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	25.2%	27.5%	26.6%	...	...	(World Bank 2016k)
Indicator	**1992**	**1996**	**2002**	**2007**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	69%	71%	72%	60%	56%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	62.9%	>95%	>95%	85.8%	(Countdown 2015a)
Lower bound	<1%	57.5%	>95%	>95%	79.8%	
Upper bound	<1%	68.8%	>95%	>95%	92.1	
Indicator	**1996**	**1999**	**2002**	**2007**	**2014**	**Source**
Skilled attendant at delivery, %	47%	47%	43%	47%	64%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	16%	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	63%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	19.3%	26.7%	40.1%	60.9%	72.5%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	2%	...	2%	3%	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2008**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.84	0.73	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.71	0.78	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Zambia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Zambia



Source: (Countdown 2015a)

Zimbabwe

Table 1: Basic info

Country income level	Low-income	
Population 2014	15.2 million	(World Bank 2016i)
Literacy rate 2011	83.6	(World Bank 2016a)
Political/administrative system	8 provinces, 59 districts	

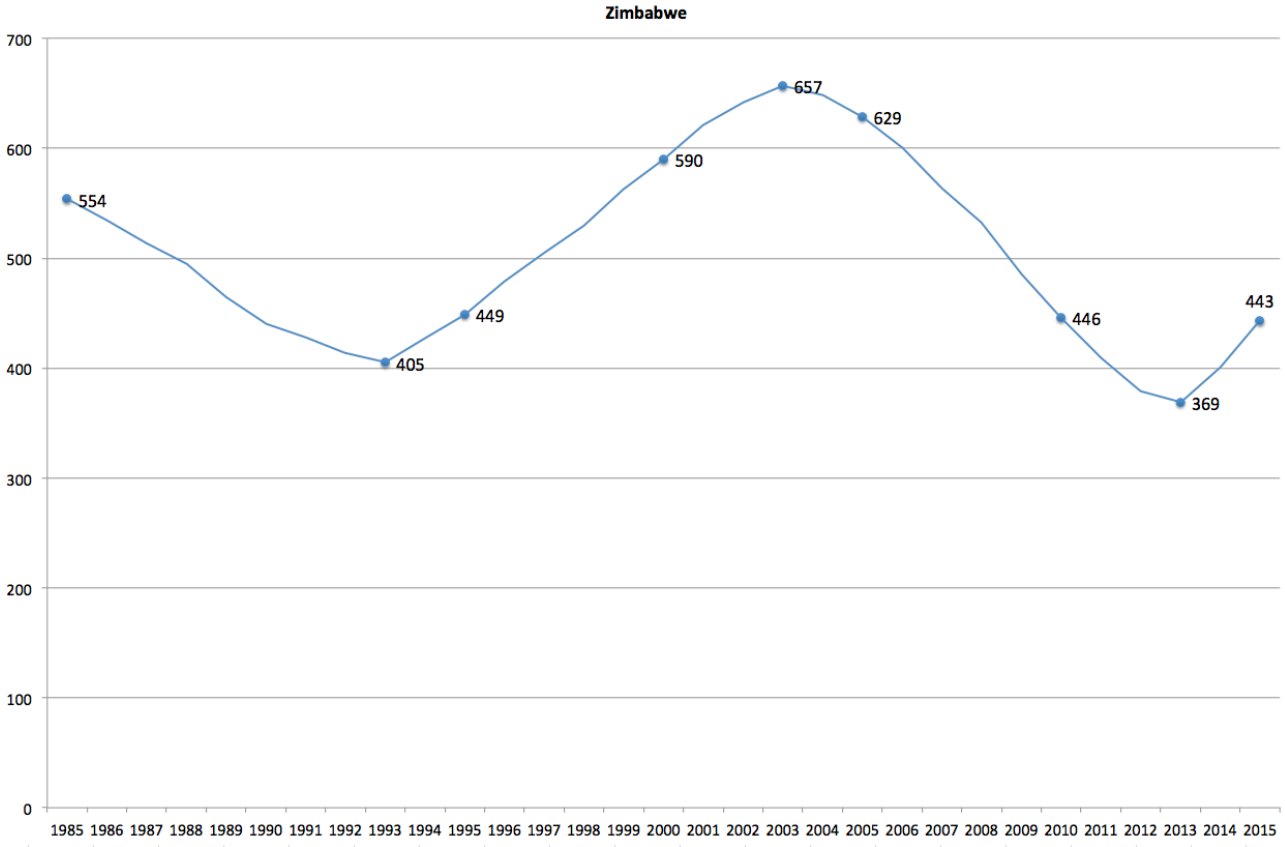
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.3%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	4.2%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	23.9%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	66.7%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

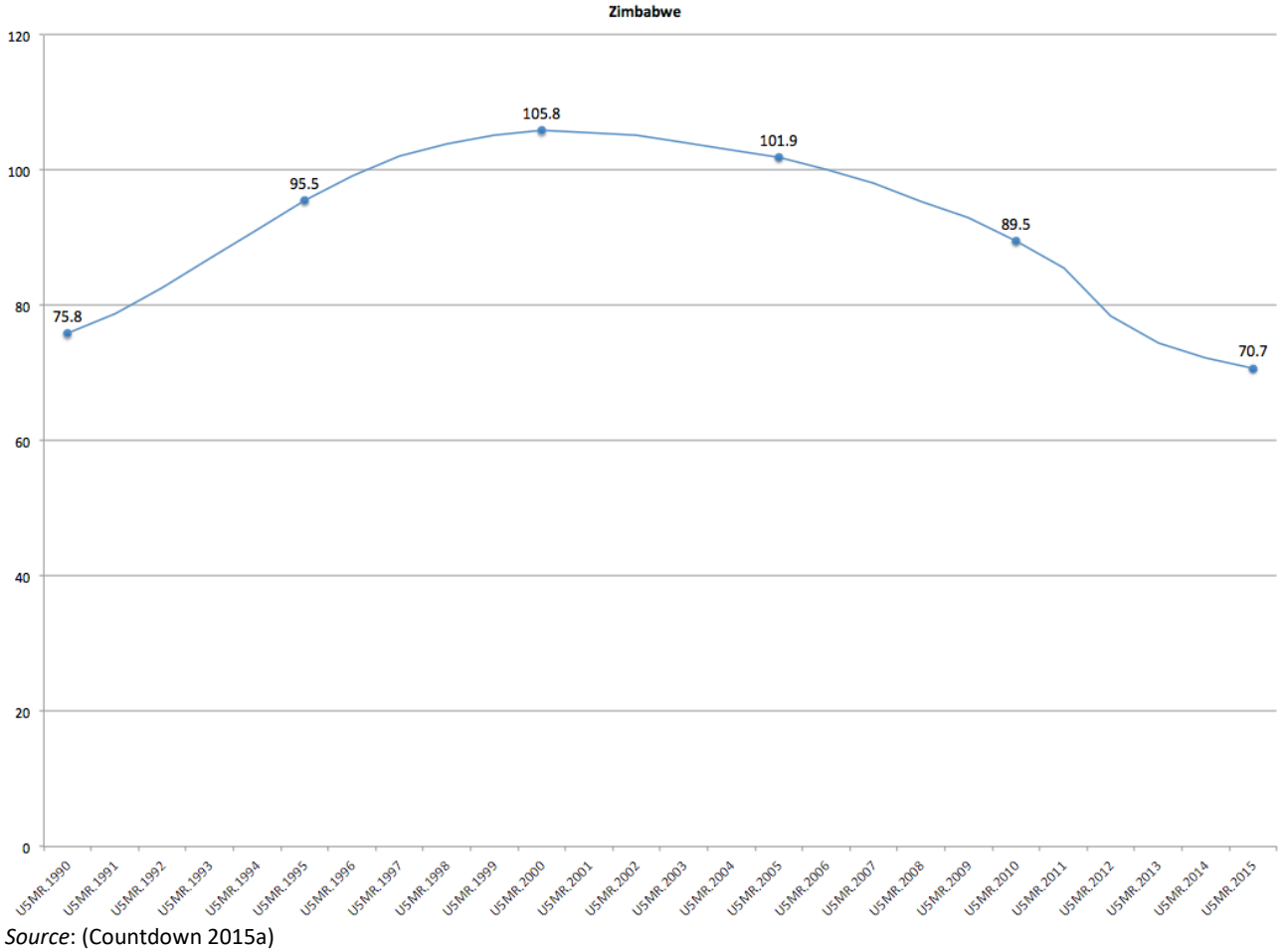
Indicator	1994	1999	2006	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	72%	76%	80%	80%	87%	(Countdown 2015a)
Indicator	**1997**	**2002**	**2003**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	108	103	101	112	120	(Countdown 2015a)
Indicator	**1994**	**1999**	**2006**	**2011**	**2013**	**Source**
Teenage mothers, % women age 15-19	19.7%	20.5%	21.2%	23.5%	…	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	449	590	629	446	443	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	24	(Countdown 2015b)
Infant Mortality, per 1,000	…	…	…	…	47	(Countdown 2015b)
Under Five Mortality, per 1,000	95.5	105.8	101.9	89.5	70.7	(Countdown 2015a)
Indicator	**1994**	**1999**	**2005**	**2011**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	48.1%	53.5%	60.2%	58.5%	…	(World Bank 2016c)
Indicator	**1994**	**1999**	**2006**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	19.1%	16.7%	15.5%	14.6%	…	(World Bank 2016k)
Indicator	**1994**	**1999**	**2006**	**2011**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	74%	64%	71%	65%	70%	(Countdown 2015a)
Indicator	**2006**	**2009**	**2010**	**2011**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	9.4%	31.0%	50.1%	78.2%	(Countdown 2015a)
Lower bound	<1%	8.7%	28.7%	46.2%	72.4%	
Upper bound	<1%	10.2%	33.5%	54.1%	84.6%	
Indicator	**1994**	**1999**	**2006**	**2011**	**2014**	**Source**
Skilled attendant at delivery, %	69%	73%	69%	66%	80%	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	…	85%	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	…	77%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	11.2%	31.7%	22.2%	31.4%	41%	(Countdown 2015a)
Facilities providing BEMoNC, number	…	…	…	…	…	
Facilities providing CEMoNC, number	…	…	…	…	…	
C Section Rate, % of live births, women age 15-49	6%	7%	5%	5%	6%	(Countdown 2015a)
Indicator	**1994**	**1999**	**2004**	**2011**	**2014**	**Source**
Community Health Workers, per 1,000 people	…	…	0.04	…	…	(World Bank 2016b)
Indicator	**1994**	**2004**	**2009**	**2011**	**2014**	**Source**
Nurses and/or midwives, per 1,000 people	…	1,485	1,251	1,335	…	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Zimbabwe



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Zimbabwe



Source: (Countdown 2015a)

ANNEX 7 LIST OF "COUNTDOWN COUNTRIES" INCLUDING H4+ JPCS

	75 Countdown Countries Where More Than 95% Of All Maternal And Child Deaths Occur	38 Countries Reporting Either Having A Dedicated H4+ Country Team Or Having H4+ As Part of A UN Coordinating Team	10 Countries Participating In The H4+ Joint Programme -Canada And Sweden (H4+ JPCS)
1	Burkina Faso	Burkina Faso	**Burkina Faso**
2	Cameroon	Cameroon	**Cameroon**
3	Congo, Democratic Republic of the	Democratic Republic of the Congo	**Democratic Republic of the Congo**
4	Guinea-Bissau	Guinea-Bissau	**Guinea-Bissau**
5	Liberia	Liberia	**Liberia**
6	Sierra Leone	Sierra Leone	**Sierra Leone**
7	Zambia	Zambia	**Zambia**
8	Zimbabwe	Zimbabwe	**Zimbabwe**
9	Ethiopia	Ethiopia	**Ethiopia**
10	Cote d'Ivoire	Cote d'Ivoire	**Cote d'Ivoire**
11	Botswana	Botswana	
12	Burundi	Burundi	
13	Central African Republic	Central African republic	
14	Congo	Congo	
15	Benin	Benin	
16	Guinea	Guinea	
17	Haiti	Haiti	
18	India	India	
19	Indonesia	Indonesia	
20	Kenya	Kenya	
21	Korea, Democratic People's Republic of	Korea, Democratic People's Republic of	
22	Kyrgyzstan	Kyrgyzstan	
23	Lao People's Democratic Republic	Lao People's Democratic Republic	
24	Lesotho	Lesotho	
25	Madagascar	Madagascar	
26	Malawi	Malawi	
27	Mauritania	Mauritania	
28	Morocco	Morocco	
29	Mozambique	Mozambique	
30	Nigeria	Nigeria	
31	Papua New Guinea	Papua New Guinea	
32	Philippines	The Philippines	
33	Senegal	Senegal	
34	~~Sierra Leone~~	~~Sierra Leone~~	Already among the top 10
35	Somalia	Somalia	
36	Tajikistan	Tajikistan	
37	Uganda	Uganda	
38	Vietnam	Viet Nam	
39	Afghanistan		
40	Angola		
41	Azerbaijan		

42	Bangladesh		
43	Bolivia		
44	Brazil		
45	Cambodia		
46	Chad		
47	China		
48	Comoros		
49	Djibouti		
50	Egypt		
51	Equatorial Guinea		
52	Eritrea		
53	Gabon		
54	Gambia		
55	Ghana		
56	Guatemala		
57	Iraq		
58	Mali		
59	Mexico		
60	Nepal		
61	Niger		
62	Pakistan		
63	Peru		
64	Rwanda		
65	Sao Tome and Principe		
66	Solomon Islands		
67	South Africa		
68	South Sudan		
69	Sudan		
70	Swaziland		
71	Tanzania, United Republic of		
72	Togo		
73	Turkmenistan		
74	Uzbekistan		
75	Yemen		

ANNEX 8 PERSONS MET AND INTERVIEWED

PERSONS INTERVIEWED AT GLOBAL AND REGIONAL LEVEL		
Name	**Position**	**Institution**
Name	Position	Organisation
Adeboyega, Ayotunde	Regional H4+ Focal Point	WHO
Bannerjee, Anshu	Senior Adviser, Department of Reproductive Health and Research	WHO
Black, Geoff	Senior Analyst, Foreign and Defence Policy	Privy Council Office of Canada
Chaliban, Ted	Director of Program Division	UNICEF
Charpentier, Louis	Senior Adviser Evaluation Office	UNFPA
Conombo, Ghislaine	MNCH Specialist, Libraville	WHO
Cook, Andrea	Director, Evaluation Office	UNFPA
Damji, Nazneen	Policy Adviser, HIV and AIDS	UN Women
De Bernis, Luc	Private Consultant	UNFPA (retired)
Dixon, Kim	Senior, Adviser, Maternal and Newborn Health	UNICEF
Dwevadi, Hemant	Global Coordinator, H4+ Joint Programme	UNFPA
Evans, Tim	Deputy Executive Director	World Bank
Glenmarec, Yannick	Deputy Executive Director	UN Women
Hertel, Ulrika	Senior Programme Manager, Health and Education	Sida
Iovita, Alexandrina	Human Rights Adviser	UNAIDS
Lakshminaryanan, Rama	H4+ Focal Point	World Bank
Laski, Laura	Chief, Sexual and Reproductive Health Branch	UNFPA
Loyer, Adam	Development Officer, Nigeria Program	Global Affairs Canada
MacCormack, Julie	Global Affairs Canada	Senior Program Officer, Maternal Newborn and Child Health and Nutrition
Maliqi, Blerta	Technical Advisor, MNCH	WHO
McDougall,Lori	Senior Advocacy Officer	Partnership for Maternal Newborn and Child Health (PMNCH)
Milroy, Emilie	Global Affairs Canada	H4+ Officer
Monet, Jean Pierre	H6 and Maternal Thematic Fund Officer	UNFPA
Nicholls, Sara	Deputy Director, Nutrition Programmes and Immunization	Global Affairs Canada
Ostergren, Mikael	Programme Manager, MNCAH	WHO
Park, Michelle	H4+ Communications Coordinator	UNFPA
Prual, Alain	Senior Health Specialist	UNICEF
Preshant, Menon	Evaluation Officer	UNICEF
Schweitzer, Julian	Consultant	Results for Development (R4D)
Smith, Sally	Community Engagement Adviser	UNAIDS
Toure, Lala Haidara	Regional H4+ Focal Point	UNAIDS

Tremblay, Pierre J.	Global Affairs Canada	Deputy Director, Development Evaluation Division
Van Hove, Dirk	Senior Programme Adviser	UNAIDS

PERSONS MET DURING FIELD COUNTRY CASE STUDIES

DRC		
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
Dr Michel Muvudi	Chargé de RBF	Banque Mondiale
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	Societé Congolaise de G.O.
Mukumpani, Guy, Dr	Chef de division MSP	PNSR
Mulimbi, Jules, Dr	Programme Officer/SGBV	UN Women
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 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
Keba, Cher	Logisticien	COULIBALY
Mbulambo, Elodie	Présidente du collège de jeunes	COULIBALY
Mutombo, Gaiton, Mr.	Directeur du Centre	COULIBALY
Nkwasa, Jeef, Dr	Médecin	COULIBALY
Ntoya, Michel, Mr	Financier	COULIBALY
Tuwila, Gaby, Mr	Représentant des P.E	COULIBALY
ENTRETIEN AVEC LES ONG LOCAUX (ABEF, BOMOTO, RACOJ) A KINSHASA		
Biyanga, Eugene, Mr	Suivi et evaluation	ABEF-ND
Dibinga, Freddy, Mr	Ass. C.P	BOMOTO
Elima, Carine, Ms	DAF	ABEF-ND
Mbila, Moïse, Dr	DE	ABEF-ND
Mpanzi, Mongo	Logisticien	ABEF-ND
Ndaya, Rachel, Ms	Coordonnatrice Nationale	RACOJ
ZONE DE SANTE DE N'SELE A KINSHASA		
Beya, Jean, Marie, Ms	A C	BCZS NSELE
Bukara, Kantole	AG	BCZS NSELE
Cinkobu, Israël, Mr	I S	BCZS NSELE
Dumandje, Rachel, Ms	A C	BCZS NSELE
Kabemba, Kalenda, Dr	MCZ	BCZS
Kaka, Nsenga	Commis	BCZS NSELE
Kakule, Pius, Dr	MDH/HGR	HGR/KINKOLE NSLE
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
ENTRETIEN PERSONNELS CENTRE DE SANTE KASAY		
Fumulungu, René	Infirmier	CS KASAY
Kileri, Bosco	Précodesa	CS KASAY
Kilonga, Chantal, Ms	Infirmière	CS KASAY
Kipulu, Claver	T.L	CS KASAY
Mafuta, Josée	Accoucheuse	CS KASAY
Muke, Kafuti	I.T	CS KASAY
Mupopo, Sylvie, Ms	Accoucheuse	CS KASAY
Ngombe-Empue, Silas,	Infirmière	CS KASAY
Pweba, Omer	T.O	CS KASAY
FOCUS GROUPE DES JEUNNES GARCONS A HGR MUSANGO		

Butela, Dieu	JOUEUR	FONAMES
Butele, Fide	ELEVE	FONAMES
Gabula, Gabriel, Mr	JOUEUR	FONAMES
Gabula, Olivier, Mr	ELEVE	FONAMES
Kapita	ELEVE	FONAMES
Kapita, Ngotie	JOUEUR	FONAMES
Kasongo Ngonzi, Patrick, Mr	ELEVE	FONAMES
Kasongo, Pierre	ELEVE	KALINA
Katika, Tonton	ELEVE	FONAMES
Kazaka, Chadrack, Mr	ELEVE	FONAMES
Kibala, Gede	ELEVE	FONAMES
Kimwanza, Fils	ELEVE	FONAMES
Kipilu, Uliriche	ELEVE	FONAMES
Kitoko, Serge	ELEVE	FONAMES
Kukembila, Timothée, Mr	ELEVE	MAJORITE
Mabaya, Serge	JOUEUR	FONAMES
Madibu, Mboma	JOUEUR	FONAMES
Mala, Jean, Ms	ELEVE	FONAMES
Masangi, Jures	JOUEUR	FONAMES
Masangila, Rodrick, Mr	ELEVE	MAJORITE
Mavula, Aldo	JOUEUR	FONAMES
Mboma, Odon	ELEVE	FONAMES
Mizenga, Musuma	ELEVE	MAJORITE
Mwanazori, Jeancy, Ms	JOUEUR	FONAMES
Mwanazori, Mafundu	JOUEUR	FONAMES
Ndanga, John, Mr	ELEVE	MAJORITE
Ngenzi, Pabert	ELEVE	MAJORITE
Ngogo, Teo	JOUEUR	FONAMES
Ngwakamatondo	JOUEUR	FONAMES
Nzumbu, Laurent, Ms	ELEVE	FONAMES
Pwanga, Merveille	JOUEUR	FONAMES
Tenga Tenga, Jean Marie, Ms	ELEVE	MAJORITE
MUTUEL DE SANTE MUSAMOS AMUSANGU		
Bungu, Carine, Ms	2èconseillé	MUSAMOS
Kapangala, Pasino	Secrétaire	MUSAMOS
Kingulu, Philemon, Mr	Secrétaire Adjoint	MUSAMOS
Lungoy, Martin, Mr	V/P	MUSAMOS
Mbiki Kalu, Bastin, Mr	Président	MUSAMOS
Mizinga, Paulin, Mr	1èrconseillé	MUSAMOS
PROVINCIAL HEALTH DIRECTORATE – KONGO CENTRAL BCZS ECZS		
Bambote, Zimana	Point Focal MLT	BCZS
Diantoma, Benjamin, Mr	AC/ZS	BCZS
Geba, Malongo,	DN/HGR	ECZS
Kinfuetete, Mbuaki	IS SSP	BCZS
Kinu, Olivier, Ms		
Leka, Genevieve, Ms	Journaliste	R.T.MB
Levo, Leon	AG/ZS	ECZS
Makuendi, JP	IS SR	ECZS
Muaka, Maonda	PHARMACIEN	ECZS

Ntete, Masiuming,	NUTRITIONISTE	ECZS
Pululu, Philippe, Dr	MCZS	ECZS
Semdeni, Nzita	MDH/HGR	ECZS
GROUPE DES FEMMES DE MBANZA-NGUNGU- FOCUS GROUPE DES FEMMES CIBLE SONU ET SMNE		
Levi, Diakanua, Ms		KUSKUSU
Lofofo, Dondomi, Ms		NSONA NKULU
Luzolo, Thythy, Ms		NOUVELLE CITE
Mafuala, Mvutu, Ms		NSONA NKULU
Mbengu, Diluadian, Ms		PRISON
Ndala, Marie, Ms		ONATRA
Nkusu, Kitenge, Ms		ONATRA
Nsimba, Tarya, Ms		KIMUINGU
Nsimba, Leko, Ms		NDOMBELE
Nzuzi, Massamba, Ms		NSONA NKULU
GROUPE DES RELAIS COMMUNAUTAIRES DE MBANZA-NGUNGU- FOCUS GROUPE DES FEMMES CIBLE SONU ET SMNE		
Anuv, Mabanga	Community Health Worker	NSONA NKULU
Bawele, Kisafu	Community Health Worker	NSONA NKULU
Kiangala, Masisa	Community Health Worker	X- ROI
Kitenge, Anny	Community Health Worker	NSONANKULU
Kiveni, Bavuidi	Community Health Worker	NSONA NKULU
Lusakibanza, Hort	Community Health Worker	NSONANKULU
Makuntuala, WE	Community Health Worker	NSONA NKULU
Mawete, Manza	Community Health Worker	NSONA NKULUU
Muimba, Kalemba	Community Health Worker	NSONA NKULU
Nsimba, Ndogesi	Community Health Worker	NSONA NKULU
FOCUS GROUPE DES FILLES A LOMA		
Bakonkila, Lusakweno, Ms	JARDINIERE	LOMA
Katondi, N'kombo, Ms	ELEVE	LOMA
Kinsumba, Diakiese, Ms	ELEVE	LOMA
Kundimba, Pauline, Ms	ELEVE	LOMA
Landu, Makaya, Ms	ELEVE	LOMA
Mananga, Makonko, Ms	COUTURIERE	LOMA
Mateka, Ntemo, Ms	ELEVE	LOMA
Ngobola, Matukio, Ms	ELEVE	LOMA
Nsimba, Nsenga, Ms	ELEVE	LOMA
Tutala, Nsimba, Ms	ELEVE	LOMA
FOCUS GROUPE DES GARCONS A LOMA		
Diluaka, Valeur, Mr	ELEVE	LOMA
Kiavanga, Marcel, Mr	ELEVE	LOMA
Mabasa, Andre, Mr	ELEVE	LOMA
Mandanda, Dinganga, Mr	ELEVE	LOMA
Mbala, Christophe, Mr	ELEVE	LOMA
Mvutu, Diluaka, Mr	ELEVE	LOMA
Nkafu, Melo, Mr	ELEVE	LOMA
Nseka, Mavata, Mr	ELEVE	LOMA
Nsimba, Kiamana, Mr	ELEVE	LOMA
Wankaya, Munzemba, Mr	ELEVE	LOMA

FOCUS GROUPE DES HOMMES DE KUMBI		
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
Nsimba, Mr	Community member	KUMBI
Sakananu, Mr	Community member	KUMBI
GROUPE DES HOMMES A CS NGUNGU TERRITOIRE DE MBANZA-NGUNGU		
Kazayimbote, Mr	Community member	NGUNGU
Kinkendo, Matomena, Mr	Community member	NGUNGU
Kukiele, Xavier, Mr	Community member	NGUNGU
Mampuya, Faustin, Mr	Community member	NGUNGU
Mantuila, Mr	Community member	NGUNGU
Massamba, Mr	Community member	NGUNGU
Mbende, Mr	Community member	NGUNGU
Munima, Mr	Community member	NGUNGU
Munzila, Jean, Mr	Community member	NGUNGU
Nsoki, Mr	Community member	NGUNGU
GROUPE DES HOMMES A NSONA NKULU		
Dylan, Mpuati, Mr	Community member	NSONA NKULU
Kwobwo, Ekiay, Mr	Community member	NSONA NKULU
Ma-boki, Manza, Mr	Community member	NSONA NKULU
Makiese, Paulin, Mr	Community member	NSONA NKULU
Mandiangu, Nkaba, Mr	Community member	NSONA NKULU
Matondo, Joseph, Mr	Community member	NSONA NKULU
Mbala-Zi-Suengi, Mr	Community member	NSONA NKULU
Tiamuna, Etienne, Mr	Community member	NSONA NKULU
ENTRETIEN EQUIPE DE L'HOPITAL GENERALE DE REFERENCE NSONA NKULU		
Batsema, Solila, Ms	INF. SAGE FEMME	HGR.NS-NK
Diwamteba, Nzebanga, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
Gaziala, Bethy, Ms	MEDECIN	HGR.NS-NK
Kitantu, Mukawu, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
Kitemoko, Ms	INF. MATRI	HGR.NS-NK
Lumfuankenda, Serafine, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
Mapangula, Watanda, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
Nkiambi, Matozi, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
Wumba, Bulisi, Ms	INF. ACCOUCHEUSE	HGR.NS-NK
ENTRETIEN EQUIPE AU CSR MATERNITE CITE		
Bibiche, Ndona, Lele, Ms	ACCOUCHEUSE	CSR MAT CITE
Dikitele, Mawete, Ms	ACCOUCHEUSE	CSR MAT CITE
Ikua, Vatu, Mr	INF.TRAIT.	CSR MAT CITE
Malanga, Mr	INF. TRAIT.	CSR MAT CITE
Matondo, Pap, Dr.	MEDECIN DIR.	CSR MAT CITE
Ndundu, Luyanga Thethe, Ms	ACCOUCHEUSE	CSR MAT CITE
Nkula, Matondo, Ms	ACCOUCHEUSE	CSR MAT CITE

Nzuzi, Pambu, Ms	ACCOUCHEUSE	CSR MAT CITE
Wabiya, Tony, Mr	DIRECTEUR DE NURSING	CSR MAT CITE
FOCUS DES FEMMES		
Bafuanisa, Dianzenza, Ms	MENAGERE	KONGO CENTRAL
Mado, Diambu, Ms	MENAGERE	KONGO CENTRAL
Makiese, Ms	MENAGERE	KONGO CENTRAL
Masamba, Ms	MENAGERE	KONGO CENTRAL
Matondo, Mati, Ms	MENAGERE	KONGO CENTRAL
Nsimba, Nkiadiambu, Ms	MENAGERE	KONGO CENTRAL
Nzuzi, Mbongo, Ms	MENAGERE	KONGO CENTRAL
Opes, Mwes, Ms	MENAGERE	KONGO CENTRAL
Tambi, Luzolo, Ms	MENAGERE	KONGO CENTRAL
Tsasa, Mabiala, Ms	MENAGERE	KONGO CENTRAL
FOCUS GROUPE		
Bafuanisa, Dianzenza, Ms		
Mado, Diambu, Ms		
Makiese, Ms		
Masamba, Fany, Ms		
Matondo, Matondo, Ms		
Nsimba, Nkiadiama, Ms		
Nzuzi, Mbongo, Ms		
Opes, Mwes, Ms		
Tambi, Luzala, Ms		
Tsasa, Mabiala, Ms		
BCZS ENTRETIEN		
Diantema, Benjamin, Mr	AC/ZS	ECZS
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
Zimana, Bambote, Mr	POINT FOCUS MTN ET ENREGISTREMENT	ECZS
FOCUS FEMME KINTAMBO		
Bizema, Catherine, Ms		
Kahunda, Cathe, Ms		
Kambamba, Agnes, Ms		
Kipulu, Mukaba, Ms		
Kitoko, Florence, Ms		
Lukela, Chaïda, Ms		
Maniema, Micheline, Ms		
Mboma, Patience, Ms		
Mbuku, Heleinne, Ms		
Sona, Florence, Ms		
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		
Zenga, Christine, Ms		
FOCUS GROUPE AVEC LES JEUNES FILLES DE 14-19 ANS		
Bafuidi, Nsoni-Nki, Ms	ELEVE	KONGO CENTRAL
Diasanza, Mbikiwulu, Ms	ELEVE	KONGO CENTRAL
Kitemoko, Niclette, Ms	ELEVE	KONGO CENTRAL
Muntaka, Lali, Ms	ELEVE	KONGO CENTRAL
Ndiekono, Cecile, Ms	ELEVE	KONGO CENTRAL
Nkenge, Nsumbu, Ms	ELEVE	KONGO CENTRAL
Nsona , Nsumbu, Ms	ELEVE	KONGO CENTRAL
Nzongo, Marie, Ms	ELEVE	KONGO CENTRAL
ENTRETIEN AVEC LES PRESTATAIRES		
Diasonama, Ms	INF. TRAITANT	CS. KUMBI
Diyab, Nsingi, Edo, Mr	IT	CS. KUMBI
Lufuankenda, Matu, Ms	INF. TRAITANT	CS. KUMBI
Lumba, Dikiladio, Ms	CHEF. MATERNITE	CS. KUMBI
Nsenga, Makangala, Ms	RECEPTIONNISTE	CS. KUMBI
Nsimba, Mavangi, Mr	ITA	CS. KUMBI

LIBERIA		
Name	**Position**	**Institution**
H4+ Partners		
Asije, O. Anthony, Mr	Child survival specialist	UNICEF
Asye, Toni, Mr	CSD Specialist	UNICEF
Duworkor, Musu, Mr	Reproductive Health Technical Advisor	WHO
Gobeh, Woseh , Mr	National Program Officer RH	UNFPA
Karloweah, Ghoma, Mr	Focal Person	UN Women
Kollie, Robert, Mr	Communication Officer	WHO
Korvah, Z. Steven, Mr	PMTCT Specialist	UNICEF
Lincoln, King Esther, Ms	H6 Focal Point	UNFPA
Livingstone, Maybe, Mr	National Program Officer SRH	UNFPA
Mabanda, Dhogba, Mr	Programme Officer	UN Women
Mambu, AZ. Andrew, Mr	FP Program Associate	UNFPA
Ogunlayi, Munirat, Mr	Health Specialist	World Bank
Page, Hawa, Ms	Adolescent & RH Program	UNICEF
Rogers, Edwin, Mr	WASH	UNICEF
Sogunro, Oluremi, Mr	Country Representative	UNFPA
Suwo, T. Woibah, Mr	M&E Officer	UNFPA
Tehoungue, Z. Bentoe, Mr	H6 National Coordinator	H6/WHO
Wei, Morris, Mr	H6 Focal Person	UNAIDS
Widiati Yolia Dr.	UNICEF	UNICEF
Ministry of Health (MoH)		
Clarke , T. Adolphus, Mr	Expanded Program on Immunisation	MoH

Dahn, YS. Emmanuel, Mr	Planning/ Monitoring and Evaluation	MoH
Gayson,J. Naney, Ms	Family Health Department	MoH
Gbanyan, Miatta	Pool Fund Manager	MoH
Jallah , Y. P. Mandainl, Mr	Family Health Department	MoH
Katakpal, Emma, Ms	Family Health Department	MoH
Katteh, Francis, Dr	Chief Medical Officer	MoH
Kerkula , S. Jre, Sr	Monitoring and Evaluation,	MoH
Kerkula, L. Joseph, Mr	Director/Family Health Department	MoH
Marpleh, Louise, Mr	FARA Manager	MoH
Walker, Ruth, Ms	Family Health Department	MoH
Washington, Musu, Mr	Nursing Department	MoH
Wesseh , C Stanford, Mr	Planning Department	MoH

National Implementing Partners	
Name	**Institution**
Alladin , Janneh, Ms	Liberia Women's Empowerment Network
Andrewe, M. Necus, Mr	Anti-AIDS Media Network
Barh, W. Lucy, Ms	Liberia Medical Association
Brown, Celestine, Ms	Africare
Bundor , W. Tamba	CODES
Cooper , Stephen, Mr	Africare
Dukuly , Abrahim, Mr	Global Fund for the fight against AIDS, TB and Malaria
Ewing , Helen , Ms	Clinton Health Access Initiative
Flomo, C.K. Cecelia, Ms	Liberia Board of Nursing and Midwifery
Gonleh, Cynthia, Ms	Liberia Women's Empowerment Network
Kanneh, Foday, Mr	Clinton Health Access Initiative
Korkpor , K. Maigaet, Ms	Africare
Mulbah, T. Zubah, Mr	National AIDS Commission
Nuahn , L. Helena, Ms	Jhpiego
Quiqui, K. Kula,	Jhpiego
Seh , Z. Momo, Mr	Planned Parenthood Association of Liberia
Watkins, Solomon, Mr	Anti-AIDS Media Network
Weah , Aaron, Mr	Search for Common Ground
Zoegar, ZM. Edith, MS	Liberia Women's Empowerment Network

Grand Cape Mount County		
Name	**Title**	**Organization**
Briggs, T. Simeon, Mr	Logistician	Grand Cape Mount County Health Team (GCMCHT)
Bropleh, B. Wokle, Mr	TB/HIV Focal Person	GCMCHT
Cooper , LC, Dr	County Health Officer	GCMCHT
Godeon, K. James, Mr	Community Health Services Administrator (CHSA)	GCMCHT
Jallah, K. Massayan, Mr	Community Health Department Director (CHDD)	GCMCHT
Kaba, M. Mark, Mr	CP	GCMCHT
Kallah, S. Timothy, Mr	Infection Prevention Control Focal Person (IPC-FP)	GCMCHT
Kamara, L. Patrick, Mr	Medical Director	GCMCHT

Kortee, PT. Zoe	DMC	UNICEF
Kpedebah, S. Tenneh, Mr	Superintendent	G. Cape Munt County
Kromah, K. Hawa	CCS	GCMCHT
Karva, K. Hawa,	Reproductive Health Supervisor	GCMCHT
Massaquoi , Janneh ,	Mid-Wife	GCMCHT
Mewa, Marry, Ms	Mid-wife	GCMCHT
OSI , Michel , Mr	Coordinator	WHO
Sao, Sheriff , Mr	Mid-wife	GCMCHT
Shilling , E. Weedor	RN/MHC	GCMCHT
Snch , N. Teta	OIC/SHC	GCMCHT
Tuma, Agustine, Mr	CSO	GCMCHT
Wile, T. Abraham, Mr	HR	GCMCHT
Zarbay, K. Gladys, Ms	Program Officer	Jhpiego
Sinje Health Center		
Aerson,L. Naomi, Ms	Registered Nurse (R/N)	
Kallah, S. Timothy, Mr	Physician Assistant	
Kamara,L. Patrick, Dr	Physician	
Snch, N. Teta, Mr	Officer In Charge (OIC)	
Tokpa, Gbolu, Mr	Certified Mid-Wife (CM)	
Turay, H. Musuline, Mr	Vaccinator	
Zawoo, T. Melvina, Ms	Nurse Assistant	
Sinje Community		
Armah, Zolduah	Imam	
Canah, Mohammed, Mr	Pastor	
Kiadii, B. Lawrence, Mr	Youth Leader	
Kiadii, Kason, Mr	District Commissioner	
Mulielu, Sonii	Town Elder	
Queye , Mary, Ms	TTM	
Safula, Sonii	Leader of Women's Group	
Sanko, Mary, Ms	TTM	
Seaku, Kiazolu	Elder	
Siafa, Sonii	Elder	
Siata, J. Perry, Mr	Town Chief	
Toe, Dekey	TTM	
River Gee County		
River Gee County Health Office Meeting		
Name	**Position**	**Organization**
Benson, G. Hinneh	Human Resource Manager (HRM)	River Gee County Health Team (RGCHT)
Boley , , N. David, Sr	M&E	RGCHT
Cassel, M. Evelyn, Ms	County Coordinator	Medica Liberia
Dwehswen, Bolton, Hon.	Commissioner	Ministry of Internal Affairs (MIA)
Gbanlon, M. Ellen, Ms	ED	TAI
Geleplay, , T. Marthalyin, Ms	Reproductive Health Supervisor	RGCHT
Gramoe , D. Moses,Mr	Assistant Health Coordinator	IRC
Haluane, W. Nathaniel, Mr	Officer In Charge (OIC)	RGCHT
Huntington, T.Q. Eugema	Community Health Services Administrator (CHSA)	RGCHT

Jackson, W. Hokie, Mr	DON	RGCHT
Kancemey, G. Komah, Mr	Lep, FP	RGCHT
Karlea , W. Charles, Mr	Administrator	Fish Town Hospital
Kenda, S. John, Mr	EHT Coordinator	RGCHT
King, T . Detoh, Dr	Medical Director	Fish Town Hospital
Leoma, Kon Martor Jah, Mr	HR	RGCHT
Malee, Y. Morris, Mr	ON	RGCHT
Mooe, B. John, Mr	District Health Officer (DHO)	RGCHT
Parker, Roger, Mr	CDO	RGCHT
Pharm, S. Dokie Jr, George, Mr	HFSCC	RGCHT
Quayeton, N. Terry, Mr	BCGFP	RGCHT
Quenneh, Benjamin, Mr	HIV/TB FP	RGCHT
Sawo, J. Koiyan, Mr	Community Health Services Supervisor (CHSS)	RGCHT
Sayee, Farley, Mr	CC TECH	RGCHT
Sayee, P. James, Chief	PC	MIA
Seakor , S. George, Mr	CSFP	RGCHT
Shilue , C.M. Moses, Sr	DHO	RGCHT
Sinatue, Haevodotus	CHSS	RGCHT
Swen , Saylee , Hon.	Commissioner	MIA
Teh, W. Henry, Mr	DHO / Act CS	RGCHT
Toe, W. Moses, Mr	DHO	RGCHT
Toe,S. Taryee, Mr	President	NTAL-River Gee
Tulay, T. Anna, Ms	CHSS	RGCHT
Washington, Trokon, Dr.	County Health Officer (CHO)	RGCHT
Wesseh, Q. Macfred, Mr	OIC	RGCHT
Gbepo Health Center		
Florma, W. Geraldine, Ms	R/N Screener	
Haluane, W.Nathaniel, Mr	R/N OIC	
Sumoku, V. Deddeh, Mr	R/N Screener	
Tanyon , N. Bennim, Mr	R/N Screener	
Tartue, G. Emily, Ms	C/N Screener	
Wrueh, Y. Vanessa , Ms	RHCS/NYV	
Jarkaken Clinic		
Brown , Gary, Mr	Registrar	
Choloplay , Curtis, Mr	Nurse Aid	
Doe, B. Robert , Mr	Security	
Musus , Augustine, Mr	Lab/Aid	
Weah , Joseph, Mr	Dispenser	
Wesseh, Macfred, Mr	Officer In Charge (OIC)	
Yamah, Harris, Mr	Certified Mid-Wife (C/M)	
Yangbie , James , Mr	Volunteer	
River Gbeh		
Konneh, Abu, Mr	Lab Technician	
Mason , Mary, Ms	Mid-wife	
Massaquoi, Gbondo, Mr	Officer In Charge (OIC)	
Yetal, Augustin	Dispenser	
Cheboken Clinic		
Doe , Victoria, Ms	Nurse Aid	

Grace, Ms	Registered Nurse (R/N)
Mandia , Solomon, Mr	Officer In Charge (OIC)
Socro, Lynch, Mr	Dispenser
Thomas, Samuel, Mr	Mid-Wife
River Gee Communities	
Jarkaken	
Barfeh, Aasia,	Community member
Briggsford, N. Dwel	Clerk
Chea, B. Prince	Student
Chebo, Waypo	Township Chief
Chenakan, B. Easter Ms	Student
Chenakan, G . Easter	Student
Cholopary , Deseyne	Youth Leader
Davis , N. Jewel	Student
Davis, N . Henry	Student
Davis, N . Jewel	Student
Davis, N. Henry	Student
Davis, Patience	TTM
Deagba, T . Esther	Teacher
Deayba, T. Esther, Ms	Teacher
Doe, Patience	TTM
Dweh Edwina,	Women's Group Member
Dweh, William,	Community member
Dweh, Margretta	TTM
Dweh, Morris	Farmer
Emmanuel, N. Collins, Mr	Club Member
Freeman , Adam	Peer Educator
Geegba, Abigail	Student
Geegba, Abigirl, Ms	Student
Gibson, T. Joe	Student
Gibson, T. Joe	Student
Harris, Florence	Women's Group Member
Jackson, Agnes	Student
Jackson, Agnies	Student
Jebleh , M. Caroline	Peer Educator
Jerbo , B Mclhdseleh	Disk Clerk
Johnson, Myerlyn	Student
Johnson, Myerlyn	Student
Jowah Cynthia,	TTM
Keh, Daniel	Clan Chief
Kenta , Jackie	Student
Kenta, Jackie	Student
Martin, Blessing	TTM
Moore, Ahday	Student
Moore, J. Oretha, Ms	Peer Educator
Noring, Evon	Women's Group Member
Nyaun , J. Mercy	Peer Educator
Nyefor, Sam	Community member
Nyenah, Sarah	TTM

Parse, S. Fulton	Township Commissioner
Paye, Comfort, Ms	Student
Quayee, Mark	Student
Quie , P. Paul	Peer Educator
Sagbeh, Amos	Community member
Saibo, George	Community member
Sam, W. Harris, Mr	Club Member
Sankon, T. Mary, Ms	Student
Sartee, Alice, Ms	Club Member
Seabo Willie ,	Farmer
Tarwreh, Philomena , Ms	Student
Terah, T. Wesseh, Mr	Club Member
Toe , T. Jeremiah	Teacher
Toe, B . Robert	Farmer
Toe, Dekey	Student
Toe, Jeremiah	School Health Teacher
Toe, Jerryline	TTM
Toe, N . Otis	Student
Toe, N. Otis,	Student
Toe, P. Joseph	Farmer
Toe, Pbebe,	TTM
Toe, Rita	TTM
Toe, Sylvester	Farmer
Toe, W. Joseph	Community member
Waka , S. Louis	Peer Educator
Weah , T. Joe	Chief Elder
Weah, T. Joe	Chairman
Weah, Verorica	TTM
Weal, Q. Lawrence	Pastor
Wesseh, Phillip	Community member
Wesseh, W. Peter	Peer Educator
Wilson, Yegbh, Mr	Club Member
Winn, S Kpadeh	Township Clerk
Winn, Tina	TTM
Woart, Patience, Ms	Peer Educator
Wolee, TG	Community member
Wreh, Jebleh Kelvin	Peer Educator
Zedebee, Elliott, Mr	Peer Educator
Cheboken	
Batchea, Shad	Community Leadership
Billy, J. Dartyea	Chairman
Chenakah, Albert	gCHV
Chorkosr, C. Patrick	Community Leadership
Johnson, Sankon	gCHV
Marthe, Martin	TTM
Noring, Alice,	Community Member
Noring, Victoria	Community Member
Nyenmah, Sophia	Community Member
Parley, Evon	Community Member

Quayee, Mancy,	Community Member
Sackie, Esie	Community Leadership
Sweh, Regina	Community Member
Swen, Diana	gCHV
Teh, Elizabeth	Community Member
Teh, Felecral	TTM
Toe, Rachel	Community Member
Toe, Rachel	TTM
Trullah, Oretha	Community Member
Wah, Harrison	Community Leadership
Weah, Ellen	TTM
Weah, Ruth	Community Member
Wesseh, Emily	Community Member
Wesseh, Mabel,	Community Member
Winn, Elizabeth,	Community Member
Yougba, Perry	Community Leadership
Yassaken (River Gbeh)	
Barehe,a K. Moses	Community Leadership
Bolee,G. Thomas	Community Leadership
Charles Betty,	Women's Group
Chelor, Elizabeh	Women's Group
Cooper, Elizabeh	Women's Group
Desuwah, Oretha	Community Leadership
Dweh, Janet	Women's Group
Fameh, Healen	Community Leadership
Freeman, Martha	Women's Group
Gbeh, Dorris	Women's Group
Hamilton, S. Weleplay	Community Leadership
Hanwea, W.S. Timothy	Community Leadership
Kesseh, Alice	Women's Group
Koffa, Felecia	Community Leadership
Morris, James	Community Leadership
Nagbe, S . Mark,	Community Leadership
Nungba , Brown	Community Leadership
Pah, Mary	Women's Group
Pawoo, Esther	Women's Group
Quayee, Lucy	Women's Group
Sampson , G.Ellen	Community Leadership
Sampson, Lucy	Community Leadership
Smith, Theresa	Community Leadership
Swen, D. Ezekiel	Community Leadership
Tarkor, C. Paul	Community Leadership
Tarpeh, K. Josephus	Community Leadership
Togbo, Betty	Women's Group
Tolh, Victor	Chairman
Wesny,Y. Robert	Community Leadership
Wesseh, Dorris	Women's Group
Winstom, Pan	Community Leadership
Wobogbo, Janet	Women's Group

Wongbaye, Moses	Community Leadership
Youlo, T. Annie	Community Leadership
Youmeh , MB. Mark Hon.	Community Leadership

ZAMBIA		
Name	**Position**	**Institution**
	H4+ Technical Working Group	
Bvulani, Sarai Malumo, Dr	National Programme Offier,	World Health Organisation
Chizuni Warmundile, Caren, Dr	Chief Safe Motherhood Officer	Ministry of Health
Kalunga, Elizabeth, Ms	Programme Officer	UNFPA
Kampekete, Gertrude, Dr	Principal IMCI Newborn	Child Health Unit, Ministry of Health
Kibassa, Colleta, Dr	Maternal & Child Health Specialist (MNCH/HIV&AIDS)	UNICEF
Maswenyeho, Sitali, Dr	Maternal and Newborn Health/ PMTCT Specialist	UNICEF
MBwalya, Mary, Katepa, Dr	National Programme Officer	Worth Health Organisation
Mijere, Jenipher, Dr	National Programme Officer	UNFPA
Munthali, Lois, Ms	Family Planning Officer	USAID
Mwaba, Angela, Dr	Principal Safe Motherhood Officer	Ministry of Health
Mwemba, Mable, Ms	Chief Adolescent Health Officer,	Ministry of Health
Mwiche, Angel, Dr.	Deputy Director	Ministry of Health
Shamambo, Daphne, Dr	Principal Family Planning Officer	Ministry of Health
Vichael, Silavwe, Dr	Chief IMCI Officer	Ministry of Health
	Ministry of Health	
Namboa, Mary, Dr	Deputy Director, Mother and Child Health	Ministry of Health
Phiri, Caroline, Dr	Director, Mother and Child Health	Ministry of Health
	Institute of National Economic and Social Research	
Mubiana Machwangi Prof	Director	Institute of Economic and Social Research, University of Zambia
Mulambia, Chisimba, Dr	Research Fellow	Institute of Economic and Social Research, University of Zambia
Richard Bwalya, Dr	Research Fellow	Institute of Economic and Social Research, University of Zambia
	H4+ Heads of H4+ Agencies	
Damisoni, Henry, Mr	Senior Strategic Information Advisor	UNAIDS
El-Bashire, Hamid Ibrahim, Dr.	Country Representative	UNICEF
Mufunda, Jacob, Dr.	WHO Representative	WHO
Mupeta, Stephen, Dr.	NPO Reproductive Health	UNFPA
Otieno, Mary, Dr.	Country Representative	UNFPA
	Cooperating Partners	
Forrest Healey, Jessica Ms	Deputy Health Office Chief	USAID

Gilpin, Uzoamaka Ms	Health Adviser	DFID
World Bank		
Chansa, Collins Mr	Health Specialist	World Bank
Makumba, B. John Mr	Senior Operations Officer (HNP Global Practice)	World Bank
Eastern Province, Provincial Health Office		
Matuyola, Catherine, Dr	Maternal and Child Health Coordinator	Provincial Health Office, Mongu
District Commissioner's Office, Lukulu		
Mandjolo, Kaumba	District Commissioner	Lukulu District Administration Office
District Health Office, Lukulu District		
Chikasa, Gift, M	Record Clerk	DHO, Lukulu District
Chiyesu, Christopher	Human Resource Management Officer	DHO, Lukulu District
Mubanga, David	Accounts Assistant	DHO, Lukulu District
Musonda, Raymond	Planner	DHO, Lukulu District
Mutozi, Mark	District Health Information Officer	DHO, Lukulu District
Mvula, Chisomo	Acting MCHC	DHO, Lukulu District
Mwala, Monde	Environmental Health Officer	DHO, Lukulu District
Mwepu, Armstrong, Dr.	District Medical Officer	DHO, Lukulu District
Simataa Sikwa, Martha	Assistant Accountant	DHO, Lukulu District
Lukulu District Communities		
Chibinda, Alexina	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Chinyenmba, Innoncent	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Chiwaya, Dominic	Health Advisory Committee Vice Secretary	Health Advisory Committee, Lukulu
Ibika, Frank	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Kabanda, Alice	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Kalunde, Flavia	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Kandinda, Harrisson	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Kandombwe, Nguvu	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Lilenge, Albert	Health Advisory Committee Vice Chairman	Health Advisory Committee, Lukulu
Lipoba, Fred	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Litia, Margaret	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Lutangu, Frank	Health Advisory Committee-member	Health Advisory Committee, Lukulu
Mahengu, David	Health Advisory Committee-member	Health Advisory Committee, Lukulu

Mankuya, Shadrick	Safer Motherhood Action Group Coordinator	Safe Motherhood Action Group
Mbunji, Rodrick	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Mulangi, Mirriam	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Musenge, Denny	Health Advisory Committee Chairman	Health Advisory Committee, Lukulu
Mwitila, Emeldah	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Sibeso, Sharon	Safer Motherhood Action Group Member	SMAG Member, Lukulu
Sikoshi, Mukolima	Health Advisory Committee-member	Health Advisory Committee, Lukulu
District Hospital, Chadiza District CHADIZA		
Lungu Daka, Matilda	Registered Midwife	Chadiza District Hospital
Mataa Nsala, Michelo	Acting Nursing Officer	Chadiza District Hospital
Mumbi, Mulenga	EHT	Chadiza District Hospital
Simatanga, Humphrey	Hospital Administrator	Chadiza District Hospital
Wilson, Bwalya	Information Officer	Chadiza District Hospital
Zimba, John	Medical Licentiate	Chadiza District Hospital
Western Province, Provincial Health Office, Chipata		
Mseteka, Joseph	Principle nursing officer MCH	Provincial Health Office, Chipata
Mulambya, Jairos Dr.	Communicable Diseases	Provincial Health Office, Chipata
Nkhoma, Kennedy	Planner	Provincial Health Office, Chipata
Ovost, Chooye	Senior health officer	Provincial Health Office, Chipata
District Commissioner's Office, Chadiza		
Phiri, George	District Commissioner	Chadiza District Administration Office
District Health Office, Chadiza		
Banda, Goodward	Procurement and Supplies Officer	DHO, Chadiza District
Chinyama, Chirstine	Ag, DNOS	DHO, Chadiza District
Harra, Jonathan	District Medical Officer	DHO, Chadiza District
Mate, Nasilele	Nutrition Technologist	DHO, Chadiza District
Milupi, Samwalu	Pharmacist	District Hospital
Mwafurirwa, Ruth	DNO – MNCH	DHO, Chadiza District
Mwape, Bright	Pharmacy Technologist	DHO, Chadiza District
Nundwe, Lackwell	Senior Environmental Health Technologist	DHO, Chadiza District
Phiri, Gabriel	Accountant	DHO, Chadiza District
Phiri, Gabriel	Assistant Accountant	DHO, Chadiza District
Sakala, Christopher	TB/HIV/STI Officer	DHO, Chadiza District
Samboko, Julius	Public Health Officer	DHO, Chadiza District
Sejani, Maambo	DNT	DHO, Chadiza District
Siwale Roderick	MFP	DHO, Chadiza District
Tembo, William	EHO Surveillance	DHO, Chadiza District

Chadiza District Communities		
Banda, Anna	Safer Motherhood Action Group Member	SMAG, Chadiza
Banda, Josphine	Safer Motherhood Action Group Member	SMAG, Chadiza
Daniel	Community Based Distributor	DHO/Community, Chadiza
Dickson	Community Based Distributor	DHO/community, Chadiza
Justina Phiri	Safer Motherhood Action Group Member	SMAG, Chadiza
Kabuyana, Catherine	NHC Member	NHC, Chadiza
Kapukuli, Paul	NHC Member	NHC, Chadiza
Kashimanu Shadrick	NHC Member	NHC, Chadiza
Kazevu, Kamana	NHC Member	NHC, Chadiza
Kazevu, Progress	NHC Member	NHC, Chadiza
Loveness	Safer Motherhood Action Group Member	SMAG, Chadiza
Makondo, Oscar	Chairperson/NHC	NHC, Chadiza
Maliti, Bruno	Vice Chairperson/NHC	NHC, Chadiza
Mathew	Safer Motherhood Action Group Member	SMAG, Chadiza
Mulunga, Mwila	Safer Motherhood Action Group Member	SMAG, Chadiza
Phiri, Aaron	Community Based Distributor	DHO/Community, Chadiza
Phiri, Theresa	Safer Motherhood Action Group Member	SMAG, Chadiza
Sitenge, Litia	Area Chief Mushabu Village	NHC, Chadiza
Tembo, Frank	Safer Motherhood Action Group /CBD	SMAG, Chadiza
Tafelansoni Community		
Banda, Christopher	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Daniel	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Falesi	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Floriam	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Genalozi	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Rodwel	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Wardson	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Banda, Whyson	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Alinesi	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Esterror	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Gabriel	Safer Motherhood Action Group Member	SMAG, Tafelansoni

Phiri, Ganizani	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Grandwel	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Jackson	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, John	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Justina	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Kambani	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Kasonya	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Loveness	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Mwatitha	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Mzamose	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Noah	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Richard	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Phiri, Thomas	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Sakala, Agness	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Shonga, Grace	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Tembo, Getrude	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Zulu, Doreen	Safer Motherhood Action Group Member	SMAG, Tafelansoni
Zulu, Ireen	Safer Motherhood Action Group Member	SMAG, Tafelansoni

ZIMBABWE		
Name	**Position**	**Institution**
HARARE		
Bartos, Michael, Dr	Country Director	UNAIDS
Chidawanyika, Henry, Mr	Director RTI	RTI
Chigumira, Ancikaria Mrs	Deputy Director- Nutrition Services	MoHCC
Chinhengo, Tamisayi	Programme Specialist - ASRH	UNFPA
Cisse, Cheikh Tidiane, Mr	Country Representative	UNFPA
Damiso, Choice	Gender Programme Specialist	UNFPA
Darikwa, Patricia	HDF Coordinator	UNICEF
Eaglesmann, Barbara	Director	OPHID
Gerede, Regina, Ms	Deputy Director- Community Nursing	MoHCC
Gwashure, Susan	HIV Testing Services Coordinator	MoHCC
Gwinji, G Dr	Permanent Secretary, MoHCC	MoHCC

Harnish, Dagmar	Technical Specialist SRH and HIV	UNFPA
Hore, Diana	Programme Analyst - RHCS	UNFPA
Jembere Margaret	Programme Coordinator	Kapnek Trust
Jumo, Talent	Director	KATSWE
Kanyowa, Trevor, Dr	FRH Programme Officer	WHO
Karonga, Wisdom, Mr	Deputy Director- Women Affairs	MWAGCD
Katiyo, Joshua, Mr	Health Information & Disease Surveillance	MoHCC
Madzima, Bernard, Dr	Driector - Family Health	MoHCC
Makoni, Agness	Programme Analyst - Maternal Health	UNFPA
Manyenya, Sunday	M&E Analyst	UNFPA
Marangwanda Caroline	Deputy Director	Kapnek Trust
Marume, Moline, Ms	Programme Specialist Gender & HIV	UN Women
Masanga, Margret	Communications Officer	UNFPA
Masiyiwa, Edna, Mrs	Director	WAG
Maudzeke Martha	Programmes Manager	AFRICAID
Mbinda, Absolom, Mr	M&E Officer	MoHCC
Mhlanga, G Dr	Principal Director - Preventive Services	MoHCC
Mhonde, Rudo	M & E Analyst	UNFPA
Mpaya, Joyce, Ms	Chief HIV and AIDS	UNICEF
Mpeta, Edwin	Programme Specialist - RH	UNFPA
Msemburi, Abbigail, Mrs	Assistant Country Representative	UNFPA
Muita, Jane Dr	Country Representative	UNICEF
Murungu Dr.	Deputy National ART Coordinator	MoHCC
Mushavi Dr.	PMTCT & Peadiatric Care and Treatment Coordinator	MoHCC
Mushavi, Angela, Dr	PMTCT & Peadiatric Care and Treatment Coordinator	MoHCC
Nyamukapa, Daisy	Programme Analyst - SRH & HIV	UNFPA
Okello, David Dr	WHO Resident Representative	WHO
Patel, Diana	Deputy Director	OPHID
Raghuvanshi, Vibhavendra, Dr	Technical Specialist MH& FP	UNFPA
Senzanje, Beaula, Mrs	HIV/AIDS Specialist	UNICEF
Shoko, Bertha	Communications Analyst	UNFPA
Sisimayi, Chenjerai, Mr	Health Specialist	WorldBank
Tavadze, Lia	Advisor Gender, HIV Integration	UNAIDS
Yu-Yu, Mr	Assistant Country Representative	UNFPA
PROVINCIAL HEALTH EXECUTIVE - MATABELELAND NORTH		
Goverwa Sibanda, Dr	MCH/TB/HIV Officer	MoHCC
Maphosa Seretse	HIV/STI Focal Person	MoHCC
Masuka Nyasha, Dr	Provincial Medical Director	MoHCC
Sibanda Freeman	Reproductive Health Officer	MoHCC
PROVINCIAL HEALTH EXECUTIVE - MASHONALAND CENTRAL		
Andifasi Precious	HIV/STI Focal Person	MoHCC
Gabaza Malvern	Provincial Pharmacist	MoHCC
Manjonjori Elizabeth, Mrs	Provincial Nursing Officer	MoHCC
Moyo Grace	Accountant	MoHCC
Muchembere Marvelous	Administrator	MoHCC
Mzezewa Nyaradzo	Accountant	MoHCC
Ngandu Lillian, Ms	Reproductive Health Officer	MoHCC

Ngandu Renwick, Mr	Provincial Environmental Health Officer	MoHCC
PROVINCIAL HEALTH EXECUTIVE - MUTARE		
Kanyunyunda, Clifford	Provincial Accountant	MoHCC
Mahati, Venus	Provincial Nursing Officer	MoHCC
Mandimutsira, Jane	RH Focal Person	MoHCC
Mufambanhondo, Emmanuel	Provincial Environmental Health Officer	MoHCC
Tsangamidzi, Charles	Acting Prov. Health Services Administrator	MoHCC
DISTRICT MEDICAL DIRECTORATE - MBIRE		
Chidzwa Edwicks, Dr	District Medical Officer	MoHCC
Dandajena Godfrey,Mr	Destrict Environmental Health Officer	MoHCC
Katikiti Edmore, Mr	Acting District Nursing Officer	MoHCC
Matape Walter, Mr	Pharmacy Technician	MoHCC
Mubambo Joel, Mr	Accountant	MoHCC
Mukokokveka Spencer, Mr	Acting Matron	MoHCC
DISTRICT MEDICAL DIRECTORATE - BINGA		
Majaya	Community Nurse	MoHCC
Mlilo, Dr	District Medical Officer	MoHCC
Mudimba S	Matron	MoHCC
Munsanka V, Mrs	Sister in Charge	MoHCC
Mushangwe E	Assistant Sister in Charge	MoHCC
Muzopa S, Mrs	Sister in Charge	MoHCC
Ncube B, Mrs	Administrator	MoHCC
DISTRICT HEALTH EXECUTIVE		
Dube, Frank	CHW	MoHCC
Gurai, Godhelp	Senior Nursing Officer	MoHCC
Guveya, Kudzanai	Acting District Medical Officer - Chipinge	MoHCC
Mahlathini, Honest	Nutritionist	MoHCC
Makundanyika	DEHO	MoHCC
Mandevhana, Plaxedes	Acting District Nursing Officer	MoHCC
Mukandi, Bright	ADHSA	MoHCC
Mutimurefu, Elijah	DPM	MoHCC
Nyamaende, Lyoyd	A/ACC Chipinge	MoHCC
MUSHUMBI CLINIC		
Chibira Victoria	Registered General Nurse	MoHCC
Mazikana Mirriam	Primary Counsellor	MoHCC
Mutenderedzi Taona	Environmental Health Technician	MoHCC
Nyakazieni Aaron	Registered General Nurse	MoHCC
Takawira Zorodzai	Primary Care Nurse	MoHCC
SIYABUWA RURAL HEALTH CENTRE		
Chitungwa T,	Primary Care Nurse	MoHCC
Dube N, Mr	Primary Care Nurse	MoHCC
Nyaguse Shephered	Youth Facilitator	MoHCC
KARIANGWE MISSION HOSPITAL		
Mbwinde, Mr	Registered General Nurse	MoHCC
St PETERS MISION HOSPITAL		
Chapoterera Rosemary	Sister in Charge	MoHCC
Davison, Taremba Dr	Government Medical Officer	MoHCC
Mbiri, Stephen Dr	Government Medical Officer	MoHCC

Mugarisi, Sibongile	Registered General Nurse	MoHCC

ANNEX 9 BIBLIOGRAPHY

References cited in the text

Almeras, Silene Martino (2015). *Les Kits Familiaux, un pas important vers la couverture universelle en soins de santé. 12 mai 2015. Internal document*.

Canada/H4+ Collaboration (2015). *Accelerating Progress in Maternal & Child Health. Presentation given at inter-country meeting in Douala. Internal document*.

CCORE (2013). *CIDA H4+ Zimbabwe Baseline Assessment Country Report. Community Perceptions on Problems and Barriers in Accessing Maternal Newborn and Child Health Care Services. Unpublished*, Collaborating Centre for Operational Research and Evaluation.

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. Internal document*. Kinshasa.

Chadiza District Health Office (2016). *Progress report to the evaluation team, Power Point Presentation, Eastern Province. Internal document*.

Costa, João (2014). *Estudo de viabilidade da gratuidade para a prestação de cuidados de saúde materno-infantis na Guiné-Bissau no contexto do Projeto H4+, Relatório Final, Abril 2014. Internal document*.

Countdown (2015a). Countdown 2015 data: Coverage and Demographic Indicators, Geneva, World Health Organization. Last updated: 22 September 2015. Available from http://www.countdown2015mnch.org/about-countdown/countdown-data

Countdown (2015b). *Maternal, Newborn & Child Survival: Zimbabwe*. Geneva, World Health Organization. Available from http://www.countdown2015mnch.org/documents/2015Report/Zimbabwe_2015.pdf

DHIS2 (2015). *District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Chipinge District. Internal document*.

GIBS (2014). *Recommandations de la Mission H4+ & RMNCH en RDC, 3-7 Février, 2014. Internal document*. Kinshasa, Groupe Inter-Bailleur pour la Santé (GIBS), République Démocratique du Congo.

H4+ (2012a). *H4+ Annual Workplan Guinea Bissau 2013-2015. Internal document*.

H4+ (2012b). *Interim Progress Report on H4+/CIDA Collaboration. August, 2012. Unpublished*.

H4+ (2012c). *Minutes de la TC du 29/02/2012*.

H4+ (2013a). *Accelerating Progress in MDG 4 and 5: A proposal for Sida/ H4+ collaboration. Situational Analysis Liberia. Approved by Heads of Agencies in February 2013. Unpublished*.

H4+ (2013b). *Annual Narrative Progress Report, Burkina Faso, Jan-Dec 2013. Unpublished*.

H4+ (2013c). *Annual Progress Report, Burkina Faso. Unpublished*.

H4+ (2013d). *Guidance for Documenting Innovative Approaches, November 2013. Unpublished*.

H4+ (2013e). *Initial program proposal. Internal document*.

H4+ (2013f). *Rapport d'étape de la mise en oeuvre des activités de l'initiative H4+ Sida en Côte d'Ivoire (Aout 2013-Avril 2014). Internal document*.

H4+ (2013g). *Report for the 2013 CIDA H4+ Annual Review and Planning Meeting, held at Gonde Lodge, Kabwe, 4-8 November 2013. Internal document*.

H4+ (2014a). *Global 2013-2014 intermediary report to SIDA, Guinea Bissau. Internal document*.

H4+ (2014b). *Guinea Bissau 2013-2014 intermediary report to SIDA, 2014. Internal document*.

H4+ (2014c). *H4+ Mid-term Country Report, Zimbabwe July 2014. Unpublished*.

H4+ (2014d). *H4+ Quarterly Report, 1st Quarter, 2014. Unpublished*.

H4+ (2014e). *H4+ Representatives Meeting: Note de la Réunion de Chefs d'agences H4+ du 07 juillet 2014. Internal document*.

H4+ (2014f). *H4+ viability study for free of charge services. Internal document*.

H4+ (2014g). *H4+JPCS Annual Report 2014. Internal document*.

H4+ (2014h). *Human Interest Stories, UNFPA, Zambia, 2014. Internal document*.

H4+ (2014i). *Mid Term Review in Zambia, Country Report, 2012-2013. Internal document*.

H4+ (2014j). *Rapport de l'atelier de réflexion sur le rapport de la revue à mi-parcours H4+ Canada: Burkina Faso. Internal document*.

H4+ (2014k). *Rapport de la mise en oeuvre des activités de l'initiative H4+ Sida en Cote d'Ivoire (August 2013-April 2014). Internal document*.

H4+ (2014l). *Rapport de la rencontre bilan de mise en œuvre du programme H4/CIDA au Burkina Faso, Ouagadougou le 23 Octobre 2014. Unpublished*.

H4+ (2014m). *Review of 2013 Mid-Term Review & Joint Monitoring visit Findings, 18-22 August 2014, Chaminuka Lodge, Chongwe. Internal document*.

H4+ (2014n). *Revue à mi-parcours des activités H4+ supportés par le Canada au Burkina Faso. Rapport pays. Période couverte: 2012-2013. Avril 2014. Unpublished*.

H4+ (2014o). *Stories from Democratic Republic of Congo and Sierra Leone. May 2014. Internal document*.

H4+ (2015a). *Annual Narrative Progress Report, Lusaka, January 1 – 31st December 2014. Internal document*.

H4+ (2015b). *Annual Report 2014 of the H4+ Canada and Sweden Collaborations. Strengthening and Consolidating Gains for Reaching Every Woman and Every Child*. Available from https://h6partners.files.wordpress.com/2016/02/h4-report-10_16_2015.pdf

H4+ (2015c). *Annual Workplan, 2015-2016, 4 February 2015, Ethiopia. Internal document*.

H4+ (2015d). *Draft Annual Report, H4+. Internal document*.

H4+ (2015e). *Global 2014 Annual Report. Internal document*.

H4+ (2015f). *H4+ Draft Annual Report for the three counties: Grand Kru, Maryland and River Gee, H4+ 2015. Unpublished*.

H4+ (2015g). *H4+ Heads of Agencies Meeting, Minutes of meeting, April 16 2015. Internal document*.

H4+ (2015h). *H4+ Joint Programme Mid- year progress report - January to September 2015 - Cameroon. Internal document*.

H4+ (2015i). *H4+ Presentation to the Global Mission in Guinea-Bissau, 20-24 July 2015, Implementation Review & Way Forward, Powerpoint presentation, Bissau, 2015. Internal document*.

H4+ (2015j). *H4+ SIDA Workplan 2015-2016 Ethiopia, January 2015. Internal document*.

H4+ (2015k). *H4+JPCS Annual Report 2015. Internal document*.

H4+ (2015l). *Heads of agencies meeting minutes, April 16 2015. Unpublished*.

H4+ (2015m). *Mid-Term Review of the H4+/SIDA Collaboration on Reproductive, Maternal, Newborn and Child Health. Final Report. RFP-ETH-2014-MCH/MSP/004. Internal document*.

H4+ (2015n). *Minutes of H4+ Heads of Agency Quarterly Meeting, Lusaka, 6th May 2015. Internal document*.

H4+ (2015o). *Substantiating the Gains in Maternal and Newborn Health in Liberia H4+ Annual Report 2015. Unpublished*.

H4+ (2015p). *Trip report "Mission to Bijagos" 21-22 October 2015. Internal document*.

H4+ (2015q). *Trip report "Mission to Quinara and Tombali" 29 September to 1 October 2015, Guinea Bissau. Internal document*.

H4+ (2016a). *Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations. Format 10 Feb 2016, Burkina Faso. Internal document*.

H4+ (2016b). *H4+ Evaluation reference Group presentation to the evaluation team, 31 May 2016. Unpublished*.

H4+ (2016c). *H4+ Evaluation reference Group presentation, 30 May 2016. Internal document*.

H4+ (2016d). *H4+ Facility River Gee Essential Maternal Drugs Tracer study. Unpublished*.

H4+ (2016e). *H4+ Results Framework 2015-2016. Internal document*.

H4+ (2016f). *Sierra Leone Submission (Feb 2016) for the 2015 H4+ Annual Report. Internal document*.

H4+ (nd-a). *H4+ Sida Collaboration on Accelerating progress in MNH: Liberia Proposals and Monitoring and Evaluation Plan 2013. Internal document*.

H4+ (nd-b). *Minutes, Debrief of the CIDA UN H4+ MNCH initiative 2013 to MCDMCH. Internal document*.

H4+ (nd-c). *Saving Mothers' and Babies' Lives. Internal document (video film)*.

H4+ and Ministry of Health (2012). *H4+ Progress Report for April 2011 to June 2012. Internal document*. Lusaka, Ministry of Health, Republic of Zambia.

H4+ Agencies (2011). *Compte rendu réunion H4 avec Dr Luc de Bernis, le 12/05/2011. Internal document*.

H4+ Agencies (2014). *H4+ meeting minutes: Compte rendu de la réunion H4+ 10/12/2014. Internal document*.

H4+ Agencies (2015a). *Minutes of the UN H4+ Heads of Agencies RMNCAH Meeting 21 October, 2015. Internal document*.

H4+ Agencies (2015b). *Minutes of UN Heads of Agencies H4+ Meeting September 2015. Internal document*.

H4+ Canada (2010a). *DRC H4+ Annual Work Plan 2011-2012. Internal document*.

H4+ Canada (2010b). *DRC H4+ JPCS: Proposal. Internal document*.

H4+ Canada (2011). *Joint Programme Proposal. Internal document*.

H4+ Canada (2012a). *Annual Report 2012. Internal document*.

H4+ Canada (2012b). *Annual Report, Sierra Leone, 2012. Internal document*.

H4+ Canada (2012c). *DRC H4+ Annual Work Plan 2013-2014. Internal document*.

H4+ Canada (2013a). *Annual Report 2013. Internal document*.

H4+ Canada (2013b). *Annual Report, Sierra Leone, 2013. Internal document*.

H4+ Canada (2013c). *DRC H4+ Annual Work Plan 2014-2015. Internal document*.

H4+ Canada (2014a). *DRC H4+ Annual Report 2013. Internal document*.

H4+ Canada (2014b). *DRC H4+ Annual Work Plan 2015-2016. Internal document*.

H4+ Canada (2014c). *H4+ Canada Supported Activities: Mid Term Review in Zambia, Country Report, Period: 2012-2013, 24 April 2014. Internal document*.

H4+ Canada (2015a). *Compte rendu de réunion OMS-UNICEF et l'équipe de mise en œuvre du programme H4+ Canada dans la Région du Nord. Internal document*.

H4+ Canada (2015b). *Compte rendu réunion de coordination H4+ Canada, 25 June 2015. Internal document*.

H4+ Canada (2015c). *DRC H4+ Annual Report 2014. Internal document*.

H4+ Canada (2016). *DRC H4+ Annual Report 2015. Internal document*.

H4+ Country Team (2012a). *Annual Progress Report 2012 (Rapport narrative annuel 2012, République Democratique du Congo. Collaboration H4+/ACDI. Initiative « Accelerating Progress in Maternal and Newborn Health. Mars 2013. Période couvert par le raport: Octobre 2011-Décembre 2012). Internal document*. Kinshasa, H4+ Country Team.

H4+ Country Team (2012b). *H4+ JPCS Annual Progress Report 2012. Internal document*. Kinshasa, H4+ Country Team.

H4+ Country Team (2014a). *2014 H4+ Country Communications Results. Internal document*. Kinshasa, H4+ Country Team.

H4+ Country Team (2014b). *Cameroon: Workshop Report, Biannual Review of H4+ JPCS Programme, July 2014*.

H4+ Country Team (2015a). *Draft TDR Retraite H4+ 2016. Internal document*.

H4+ Country Team (2015b). *Rapport de la retraite sur l'initiative H4+ du 28 au 30 Janvier 2015. Internal document*.

H4+ Country Team (2016). *Rapport de la Retraite H6+ République Démocratique du Congo 2016. Du 06 au 08 Avril 2016. Internal document*.

H4+ DRC (2016). *H4+ Annual Report 2015. Internal document*.

H4+ Global Technical Team (2014a). *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. Internal document*.

H4+ Global Technical Team (2014b). *Canada Annual Narrative Progress Report 2014. Internal document*.

H4+ Global Technical Team (2014c). *Proposed TOR for the Joint RMNCH mission to the DRC 03 to 07 February 2014. Internal document*.

H4+ Global Technical Team (2015). *H4+ Joint International Mission report (Annex 1), July 2015. Internal document*.

H4+ Global Technical Team (2016a). *Documentation: l'institutionnalisation de la surveillance des décès maternels et Réponse (SDMR) du H6 Programme conjoint. Internal document*.

H4+ Global Technical Team (2016b). *DRC 2011-2015 Key Achievements. Internal document*.

H4+ Global Technical Team (2016c). *DRC 2011-2015 Key Achievements. Internal document (Excel sheet)*.

H4+ Global Technical Team (2016d). *The H4+ partnership: Joint support to improve women's and children's health. Annual report 2015 of the H4+ joint programme with Canada and Sweden collaborations, Guinea Bissau 10 Feb 2016. Internal document*.

H4+ Global Technical Team (2016e). *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). Internal document*.

H4+ Global Technical Team (2016f). *Opérationnalisation des services de SONU-B dans les dix pays du H6 Programme Conjoint. Internal document*.

H4+ JPCS (2013). *Canada Annual Report submitted to Canada, 2013. Internal document*.

H4+ JPCS (2014). *UNFPA progress report, Côte d'Ivoire, 2014. Internal document*.

H4+ SIDA (2012). *Annual Narrative Progress Report. Internal document*.

H4+ SIDA (2013). *Rapport de mise en œuvre des activités des initiatives H4+ SIDA, August-December 2013. Internal document*.

H4+ SIDA (2014). *Rapport d'Etape, H4+ Sida, Cote D'Ivoire, Aout 2013-Avril 2014. Internal document*.

H4+ SIDA (2015a). *Mother-Baby Cohort PMTCT Register – An H4+ Innovation to Achieve the 90-90-90 Targets, October 29, 2015*. Available from https://h6partners.wordpress.com/2016/01/13/h4-ethiopia-mother-baby-cohort-pmtct-register-h4plus/

H4+ SIDA (2015b). *Polio Campaign as an opportunity to Identify Fistula Cases, October 29, 2015*. Available from https://h6partners.wordpress.com/2015/12/28/h4-ethiopia-polio-campaign-as-an-opportunity-to-identify-obstetric-fistula-cases/

H4+ SIDA (2015c). *Progress report No 6. Sida/H4+ collaboration on Accelerating Progress in Maternal, Newborn and Child Health. Cameroon: Reporting period: August 2013–June 2015. Internal document*.

H4+ SIDA (2015d). *Rapport standard de progrès annuel de la mise en œuvre de la 6e programme 2009-2015 prolongé à 2015, Côte d'Ivoire. Internal document*.

H4+ SIDA (2015e). *SIDA H4+ Donor Report Cameroon 2015. Internal document*.

H4+ SIDA (2015f). *Task-shifting Procedures to Non-Physician Clinicians to Save Women's Lives, October 29, 2015*. Available from https://h6partners.wordpress.com/2015/12/21/h4-ethiopia-task-shifting-procedures-to-non-physician-clinicians-to-save-womens-lives/

H4+ Stakeholders (nd). *H4+ Stakeholders in Guinea-Bissau (One-page submission on stakeholders). Internal document*.

H4+ Zimbabwe (2012). *Revised Canada Proposal, November 2012. Unpublished*. Harare, H4+ Country Team.

H4+ Zimbabwe (2013). *Report on the H4+ Provincial and District Planning and Review Meeting, 11-12 September, 2013. Unpublished*. Harare, H4+ Zimbabwe.

H4+ Zimbabwe (2014a). *Minutes of the National H4+ Steering Committee 18 June 2014. Unpublished*. Harare, H4+ Zimbabwe.

H4+ Zimbabwe (2014b). *Report on the H4+ Provincial and District Planning and Review Meeting, 23-24 September 2014. Unpublished*. Harare, H4+ Zimbabwe.

H4+ Zimbabwe (2014c). *The use of Point of Care PIMA CD4 Cell Count Machines for HIV Positive Women and their Families in Maternal Newborn and Child Health Settings in Seven Districts in Zimbabwe. Unpublished*. Harare, H4+ Zimbabwe.

INESOR (2012). *Progress Report for April 2011 – June 2012, Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia. Internal document*. Lusaka, Institute for Economic and Social Research, University of Zambia.

INESOR (2013). *Preliminary results for Quarter One and Quarter Two 2013, H4+ JPCS, Lusaka, 2013. Internal document*. Lusaka, Institute for Economic and Social Research, University of Zambia.

INESOR (2014). *Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia, Highlights of Achievements on Selected Core Indicators, March 2014. Internal document*. Lusaka, Institute for Economic and Social Research, University of Zambia.

IRSS (nd). *Les activités menées par l'IRSS en 2013. Internal document*.

John Hopkins University (2015). *Adolescent Sexual and Reproductive Health Strategic Plan Review. 3 November 2015*. Baltimore, John Hopkins University,.

Manicaland Provincial Health Executive (2014). *Provincial BeMONC Post-Training Follow-up for Mbire District. November 2014*.

Ministry of Health (2011a). *National Health Strategic Plan 2011-2015: "Towards attainment of health related, Millennium Development Goals and Other National Health Priorities in a Clean, Caring and Competent Environment"*. Lusaka, Ministry of Health, Republic of Zambia. Available from http://www.moh.gov.zm/docs/nhsp.pdf

Ministry of Health (2011b). *Requête du Burkina Faso aux Fonds H4+ CIDA, juillet 2011, [Proposal to H4+ CIDA]. Internal document*. Ouagadougou, Ministère de la Santé.

Ministry of Health (2014). *Revue à mi-parcours des activités H4+ supportés par le Canada au Burikina Faso. Rapport pays. Période couverte: 2012-2013, Avril 2014* Ouagadougou, Ministère de la Santé, Burkina Faso.

Ministry of Health (nd). *Rapport de la rencontre de planification des activites du programme H4+CIDA. Unpublished*. Ouagadougou, Ministère de la Santé, Burkina Faso.

Ministry of Health and H4+ Canada (2011). *Accelerating Progress for Maternal and Newborn Health in all 13 Districts of Sierra Leone in Collaboration with Canada H4+ Global Initiative. Joint Programme Document. Internal document*.

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. Rapport d'analyse. Cartographie réalisée avec l'appui technique et financier de l'OMS. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2013a). *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. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2013b). *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. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2015a). *Évaluation des indicateurs pour le Suivi du Programme de Sécurisation des Produits de Santé de la Reproduction en République Démocratique du Congo. Rapport 2015. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2015b). *l'Enquête sur la Disponibilité et la capacité opérationnelle des services de santé en République Démocratique du Congo, DSSP/DSNIS, 2014*. Kinshasa, Ministère de la Santé Publique

MoH (2015c). *Rapport d'activité, 4 ème Programme D'Assistance UNFPA, juillet-septembre 2015, Division Provinciale du Kwango. Internal document (Excel sheet)*. Province de Bandundu, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2015d). *Rapport d'activité, 4 ème Programme D'Assistance UNFPA, juillet-septembre 2015, Division Provinciale du Kwilu. Internal document (Excel sheet)*. Province de Bandundu, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2015e). *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. Internal document*. Province de Bandundu, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2015f). *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. Internal document*. Province de Bandundu, Programme National de Santé de la Reproduction, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2016a). *La stratégie de développement de la participation communautaire en RDC. DRAFT. Kinshasa, June 2016. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoH (2016b). *Plan National de Développement Sanitaire 2016-2020: Vers la Couverture Sanitaire Universelle. Mars 2016. Internal document*. Kinshasa, Ministère de la Santé Publique, République Démocratique du Congo.

MoHCC (2013a). *Report on Quarterly Provinces and Districts Review and Planning Meeting, 11-12 September 2013. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2013b). *Summary Report for the Clinical Mentorship Meeting held at Holiday Inn Harare. 24-25 September 2013. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2013c). *Summary Report of the H4+ Review and Planning Meeting, 11-12 September 2013. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2014a). *H4+ Sida Inter-Country Mission Report. 26-30 May 2014. The Kingdom Hotel, Victoria Falls, Zimbabwe. Theme: Accelerating Progress in Maternal and New-born Health. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2014b). *Minutes of H4+ Planning and Review Meeting, 23-25 September 2014. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2015a). *H4+ Basic Emergency Obstetric and Neonatal Care (BEmONC) training assessment: Binga, Cihpinge, Chiredzi, Gokwe North, Hurungwe, and Mbire. September, 2015. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2015b). *Post Training Support for Binga District: Report of a Four Person Team. July, 2015. Unpublished*. Harare, Ministry of Health and Child Care, PMTCT Programme, Government of Zimbabwe.

MoHCC (2015c). *Report on H4+ Planning and Review Meeting, 01-03 June, 2015. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHCC (2015d). *Summary Report of the H4+ Provincial and District Planning and Review Meeting. June, 2015. Unpublished*. Harare, Ministry of Health and Child Care, Government of Zimbabwe.

MoHSW (2015). *Ministry of Health and Social Welfare Activity Report, UNFPA, July-September 2015. Unpublished*. Monrovia, Ministry of Health and Social Welfare, Republic of Liberia.

MoHSW (2016). *Reproductive, Maternal and Newborn Child and Adolescent Health Investment Case, 2016-2020, Republic of Liberia, 2016*. Monrovia, Ministry of Health and Social Welfare, Republic of Liberia.

Mosango Health Zone Team (2016). *Power Point presentation to H4+ JPCS evaluation team on 15 August 2016. Internal document*.

Mtapuri-Zinyowera, S. and Edward T. Chiyaka (2012). *An Evaluation of the Use of Point of Care PIMA CD4 Cell Count Machines for HIV Positive Women and their Families in Maternal Newborn And Child*

Health (MNCH) Settings in Seven Districts in Zimbabwe, 2012. Harare, Ministry of Health and Child Care, Government of Zimbabwe and UNICEF. Available from http://www.unicef.org/evaldatabase/files/POC_final_report_19_December_2012_FINAL_version_zinyowera.pdf

na (2010). *Zimbabwe PEPFAR Operational Plan Report, 2010. Internal document*.

na (2015). *Minutes, UN Agencies meeting, 20th August 2015. Internal document*.

PEPFAR (2010). *Zimbabwe Operational Plan Report FY 2010*. Washington DC, United States President's Emergency Plan for AIDS Relief. Available from http://www.pepfar.gov/documents/organization/145742.pdf

River Gee County Health Team (2016). *Presentation of H6 Programme River Gee County, April 26 2016. Unpublished*.

RMNCH Trust Fund (2016). *La revue du rapport annuel 2015. Internal document*. Kinshasa, République Démocratique du Congo.

Save the Children (2014a). *Annual Workplan 2015, Save the Children, December 31, 2014*.

Save the Children (2014b). *Save the Children 2014 Annual Work plan Output 2.1 Liberia 1 Jan to 31 Dec 2014. Unpublished*.

Save the Children (2014c). *Standard Progress Report, September 2014. Unpublished*.

Search for Common Ground (2015). *Behavioural Change Baseline Study in Cape Mount, Gbarpalu and River Cess. Unpublished*. Monrovia, Search for Common Ground.

Sibanda, T P Goverwa (2014). *Preliminary Report for the Provincial Maternal and Neonatal Health Clinical Mentorship Program for Matebeleland North Province. Unpublished*. Harare, Provincial Maternal and Child Health Officer.

Takesue, Rie (2014). *Des kits familiaux pour l'amélioration de la santé des mères et des enfants*.

TWG (2013). *Minutes of H4+ MoH Technical Working Group (TWG) planning meeting, August 20, 2013. Internal document*.

TWG (2016). *Minutes H4+ Technical Working Group (TWG) 17 March 2016. Internal document*.

UN (2015a). *Minutes of UN Heads of Agencies H4+ Meeting October 2015. Internal document*.

UN (2015b). *Minutes of UN Heads of Agencies H4+ Meeting September 2015. Internal document*.

UN and SIDA (2012). *United Nations and SIDA Collaboration in Reproductive Maternal, Newborn and Child Health in Ethiopia, Work Plan 2013-2015. Internal document*.

UN Women (2014). *Report of a Joint Supervision Mission to Mutare and Masvingo for H4+. Unpublished*. Harare, UN Women.

UNFPA (2010). *Niger – Husbands' schools seek to get men actively involved in reproductive health*. New York, United Nations Population Fund. Available from http://niger.unfpa.org/docs/SiteRep/Ecole des maris.pdf

UNFPA (2014). *Ministry of Health & Social Welfare Project activities April 1-June 30 2014. Internal document*. New York, United Nations Population Fund.

UNFPA (2015a). *Activity Report, December 31, Liberia 2015. Internal document*. New York, United Nations Population Fund.

UNFPA (2015b). *Rapid assessment of Ebola impact on reproductive health services and service seeking behaviour in Sierra Leone. March 2015. Internal document*. Freetown, United Nations Population Fund. Available from http://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA study _synthesis_March 25_final.pdf

UNFPA (2016a). *Bonne pratique de l'UNAAC Bandundu. Internal document*.

UNFPA (2016b). *Final Master H4+ Canada and Sida: Final Financial Expenditures – 2011-2015. Unpublished. Internal document*. New York, United Nations Population Fund, Administrative Agent to H4+.

UNFPA (2016c). *UNFPA Good Practices – EmONC Training Revised. Internal document*.

UNFPA Ethiopia (2014). *Progress Report on the M&E Framework (Jan-Sept 2014). Internal Document*.

UNFPA Ethiopia (2015). *Progress Report 2015. Internal Document*.

UNICEF (2015a). *Contribution Summary to the H4+ Annual Report for 2014, March 2015. Internal document*.

UNICEF (2015b). *A nurse and a family kit help save children's lives. By Yves Willemot*. Available from http://www.unicef.org/infobycountry/drcongo_82141.html?p=printme

UNICEF (2016). *Des kits familiaux pour la santé des enfants? Une innovation réussie! Internal document (video film)*. Available from https://www.youtube.com/watch?v=Kh4fJNef820

UNICEF Zambia (2015). *Annual Narrative Progress Report: H4+ Canada Initiative "Accelerating Progress in Maternal and Newborn Health". April 2014 to March 2015. Internal document*. Lusaka, UNICEF Zambia.

WHO (2012). *WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage*. Available from http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf

WHO (2013a). *Agenda for Clinical Mentorship, September 2013. Internal document*. Geneva, World Health Organization.

WHO (2013b). *Annual Narrative Progress Report – Burkina Faso. Unpublished*.

WHO (2013c). *Report on H4+. Internal document*.

WHO (2014). *H4+ partnership: joint support to improve women's and children's health*. Geneva, World Health Organization, UNICEF, UNFPA, UNAIDS, World Bank. Available from http://www.who.int/reproductivehealth/publications/reports/h4report2013/en/

WHO, and others (2014). *Réunion de coordination inter agence du 29 septembre 2014, 10h à l'OMS. Internal document*.

World Bank (2015a). Health expenditure, private (% of GDP), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS

World Bank (2015b). Health expenditure, public (% of GDP), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

World Bank (2015c). Out-of-pocket health expenditure (% of private expenditure on health), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS

World Bank (2015d). Out-of-pocket health expenditure (% of total expenditure on health), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS

World Bank (2016a). Adult literacy rate, population 15+ years, both sexes (%), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SE.ADT.LITR.ZS

World Bank (2016b). Community health workers (per 1,000 people), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.MED.CMHW.P3

World Bank (2016c). Contraceptive prevalence (% of women ages 15-49), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.DYN.CONU.ZS

World Bank (2016d). Health expenditure, private (% of GDP), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS

World Bank (2016e). Health expenditure, public (% of GDP), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

World Bank (2016f). Nurses and midwives (per 1,000 people), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.MED.NUMW.P3

World Bank (2016g). Out-of-pocket health expenditure (% of private expenditure on health), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS

World Bank (2016h). Out-of-pocket health expenditure (% of total expenditure on health), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS

World Bank (2016i). Population, total, Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.POP.TOTL

World Bank (2016j). Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.MTR.1519.ZS

World Bank (2016k). Unmet need for contraception (% of married women ages 15-49), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.UWT.TFRT

References not cited in the text

Accelerating Progress in Millennium Development Goals 4 and 5: A proposal for SIDA/ H4+ collaboration. Situational Analysis Liberia. Undated. (Approved by Heads of Agencies in February 2013)

Adolescents and Youth, River Gee, Note from Group Discussions, River Gee (June 11, 2016), Liberia

Annex to the Final Report 'Using Behaviour Change Communication through Radio to Minimise Maternal Mortality and Gender Based Violence in Liberia (November, 2015)

Approach to plan the Elimination of Mother to Child Transmission of HIV in the Maternal Newborn and Child Health platform in Liberia, (2014)

ASRAMRES (2015). Problématique de la disponibilité des médicaments dans les CDR présentation à la réunion du GIBS Kinshasa, 15 janvier 2015 (power point présentation), DRC

Banda P, (2015) Maternal Mortality in Zambia: Use of Routine Data Journal of African Population Studies, Vol.29, No.2, 2015

Cape Mount County Health Team, Sinje Palaver Hut, Meeting Note (June 2, 2016), Liberia

Cape Mount Trained Traditional Midwives, Meeting Note (June 2, 2016), Liberia

Chadiza District (2014) Maternal death surveillance and response meeting – Chipata, Quarter 1 2014, Chadiza

Chadiza District (2016) List of Maternal Death Sensitization meetings held in Quarter One 2016.

Chadiza District Commissioner's Office (2016) Minutes of the District Development Coordinating Committee Meeting, Sankhan Lodge, Chadiza, 15 June 2016

Chadiza District Community Hospital (2015) Minutes of a Maternal Death Review held in Chadiza District Community Hospital in the Boardroom, 28 August 2015

Chadiza District Hospital (2013) Presentation by Mrs MN Michelo, Chadiza District, 14 February 2013.

Chadiza District Medical Office (2015) Minutes of the Maternal Death Surveillance and Response Meeting, Farmers Training Centre, Chadiza, 12 October 2015

Chadiza District Medical Office (2016) Report on the traditional leaders' sensitization meeting on maternal death surveillance and response, Chadiza, 9-10 2016.

Chadiza District Medical Office (2016) Stakeholders and health workers during the district MDSR meeting in Katete, Chadiza District, 3 March 2016

Community Health Volunteers (Trained Traditional Midwives (TTMS) and General Community Health Volunteers (gCHVs), Note from Group Discussions, River Gee (7-9 June 2016)

Community Leaders, Focus Group Discussion, Sinje, Cape Mount (2 June 2016)

Community Leaders, River Gee, Meeting Notes (June 7-8, 2016)

County Health Team, River Gee, Meeting Note (June 6, 2016)

County Planning and Baseline Assessment Mission to Three New H4+ Sida supported Counties, (July 5 – 15, 2015).

County Presentation of H6 Programme in River Gee County, April 26, 2016, (Slides 14, 15)

Demand Driven Evaluations for Decisions (3DE) team (2014) "Measuring the impact of mama kits on facility delivery rates in Chadiza and Serenje Districts in Zambia", End of Project Technical Report, Zambia Ministry of Health, Zambia Ministry of Community Development, IDinsight, Clinton Health Access Initiative Lusaka, 28 April 2014

DRC H4+ Country Team (2014). *La logique d'intervention pour H4+ en République Démocratique du Congo, 05/03/2014. Unpublished.*

Early Warning Surveillance and Disease Bulletin, Ministry of Health and WHO, September 28, pg 5. (2015)

Early Warning Surveillance and Disease Bulletin, Ministry of Health and WHO (October 19, 2015)

EN RDC. Programme National Multisectoriel de Lutte contre le Sida (PNMLS), Présidence de la République, République Démocratique du Congo

Evaluation Reference Group Power Point Presentation, H4+, Monrovia, May 30, 2016

Exit Survey, Health Facility Exit Interview, River Gee, June 2016

Family Kits: 9 October 2014. Retrieved on 1 October 2016, DRC, from: http://ponabana.com/des-kits-familiaux-pour-lamelioration-de-la-sante-des-meres-et-des-enfants/

Field Trip Report, Gbarpolu County, Selection Additional Health Centres, July 2015

Final Programmatic Report (for UN Women), Population Services Liberia, April, 2015

GIBS: GIPS dataset 5.11.2015 (Mapping of RMNCH interventions), unpublished.

Global Affairs Canada, UNFPA, UNICEF (2016). End Line Evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011-2016: Final Inception Report

Government of Zambia (2013) Roadmap for Acceleration of Reduction of Maternal, Newborn, and Children's Mortality 2013-2016, Lusaka

Government of Zambia (2014) The First National Maternal Death Surveillance and Response (MDSR) Report, Ministry of Health, Lusaka, 2014.

Government of Zambia (2014) Zambia National Emergency Obstetric and Newborn Care (EmONC) Need Assessment 2014-15, Preliminary Report, 22 October 2015.

H4+ (2012) Monitoring and Evaluation Indicator Reference Guide, United Nations Zambia, CIDA and the Ministry of Community Development, Mother and Child Health, September 2012

H4+ (2013) Minutes of the Debrief Meeting of the CIDA UN H4+ MNCH initiative to MCDMCH, Zambia

H4+ (2014) H4+ Canada Initiative Accelerating Progress in Maternal and Newborn Health, 1 January – 31 December 2014, H4+, Zambia

H4+ (2014) Minutes of the H4+ Technical Working Group Monthly Meeting, 4th March 2014, Zambia

H4+ (2015) Mid-Term Review of the Implementation and Performance of the Revised National Health Strategic Plan 2011 – 2016, Republic of Zambia, Ministry of Community and Development, Mother and Child Health (Final Report), Submitted by Independent Review Team, June 2015

H4+ (2015) Monitoring Mission Report, Zambia, May 2015

H4+ (2016) Joint Programme Implementation Update to the Heads of UN Agencies, UN House, Lusaka, Zambia

H4+ (Undated) H4+ Plan and Budget, Zambia

H4+ Country Support Visit, Monrovia, Liberia 22-26 July 2013.

H4+ Country Team (2015). *RAPPORT NARRATIF ANNUEL 2014. Collaboration H4+/Canada. Initiative "Accélération de la réduction de la mortalité maternelle et néonatale". Période couverte par le rapport: Janvier – Décembre 2014, DRC.*

H4+ Evaluation Reference Group Meeting (led by the Ministry of Health), (May 31, 2016), Liberia

H4+ Global Technical Team (2015). *Overview of 2014 progress - Coordination Mechanisms (Jul 2013-Dec. 2014 – 18 months),* internal Power Point presentation, DRC.

H4+ Heads of Agencies (HoAs), Meeting Minutes, Monrovia, April 16th, 2015

H4+ Heads of Agencies Meeting Minutes, Monrovia, 2 April 2014.

H4+ Heads of Agency Minutes, Monrovia, September, 16, 2015

H4+ JCPS Global Technical Team (2015). H4+ Joint Mission Report: DRC – October 2015

H4+ JCPS 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+ Mid-Term Review, Vol. 1, Global Report, Period: 2012-2013, 30th April 2014, Zambia

H4+ Sida Collaboration, Liberia, Draft Minutes, 26th January, 2015

H4+ Support to Improving Sexual, Reproductive, Maternal, Newborn, Child Health Services, Meeting on Maternal Waiting Home, River Gee, 20th October, 2015

H4+ Technical Working Group Meeting, Minutes, 19 February, 2014, Liberia

H4+ Technical Working Group Review Meeting, Planning Session, March 17th 2016, Liberia

H4+ Technical Working Group, Meeting Notes, April 16, 2014, Liberia

H4+ Zimbabwe (2014). PIMA CD4 Cell Count Machines for HIV Positive Women

H4+ Zimbabwe (2015). Clinical Mentorship Guidelines

H4+ Zimbabwe (2015). Mapping of Maternal Health Work of H4+ and UN Agencies in Zimbabwe.

H4+ Zimbabwe (2016). Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction: H4+ Work Plan.

H4+ Zimbabwe (2016). Catalytic Support to RMNCAH: A Programme of the Government of Zimbabwe, March 2016.

IDInsight, Clinton Health Access Initiative, (2014) Measuring the Impact of Mama Kits on Facility Delivery Rates in Rural Chadiza and Serenje Districts in Zambia. End of project technological report, 28th April, 2014, Prepared by Demand Driven Evaluations for Decisions (3DE) team for Ministry of Community Development and Health, Zambia, April 2014

Implementing Partners, Meeting Notes, Monrovia (June 1, 2016)

Incident Management Systems Meeting (IMS), Minutes, County Health Team, River Gee, Ministry of Health and WHO, (April 29, 2016)

Infection and Control Coordination Meeting, Monrovia, September 10, 2014.Infection Prevention and Control Coordination Meeting.

Institute for National Economic and Social Research (INESOR) (2012) Maternal, Neonatal and Child Health Baseline Survey in Selected Districts in Zambia, Final Report, Lusaka, July 2012.

Institute for National Economic and Social Research (INESOR) (2013) Maternal, Neonatal and Child Health Baseline Survey in Selected Districts in Zambia, Preliminary Results for Quarter One and Quarter Two, Lusaka

Institute for National Economic and Social Research (INESOR) Joint Field Monitoring Checklist One, Accelerating Progress towards Maternal and Neonatal Morbidity and Mortality Reduction in Chadiza, Chama, Kalabo, Lukulu & Serenje, Government of the Republic of Zambia in collaboration with the Government of Canada through Department of Foreign Affairs, Trade and Development and the United Nations H4+ Partners (undated)

Institute for National Economic and Social Research (INESOR) Joint Field Monitoring Checklist Two (What Was Done?), Accelerating Progress towards Maternal and Neonatal Morbidity and Mortality Reduction in Chadiza, Chama, Kalabo, Lukulu; Serenje, Government of the Republic of Zambia in collaboration with the Government of Canada through Department of Foreign Affairs, Trade and Development and the United Nations H4+ Partners (undated)

Institute for National Economic and Social Research (INESOR) Joint Field Monitoring Tool Three, Income and Expenditure, Accelerating Progress towards Maternal and Neonatal Morbidity and Mortality Reduction in Chadiza, Chama, Kalabo, Lukulu & Serenje, Government of the Republic of Zambia in collaboration with the Government of Canada through Department of Foreign Affairs, Trade and Development and the United Nations H4+ Partners (undated)

Institute of Economic and Social Research (INESOR) (2013) H4+ Field Mission to Build Capacity for Monitoring and Evaluation of Maternal and Child Health Activities in H4+ Districts and Indicator Harmonization, University of Zambia, October 2013

Institute of Economic and Social Research (INESOR) (2014) Joint monitoring report Q1 & Q2 2014, Accelerating Progress towards Maternal and Neonatal Morbidity and Mortality Reduction in Chadiza, Chama, Kalabo, Lukulu & Serenje, Lusaka, 2014

Integrated Disease Surveillance and Response Bulletin, Ministry of Health and WHO (May 9-15, 2016), Liberia

Jhpiego Workplan (15 August 2015 to 30 June, 2016), Liberia

Letter of invitation to County Superintendents from WR 30 July 2013, Liberia

Letter of invitation, WHO, August 5, 2013, Liberia

Liberia Annual Narrative Progress Report 2014, H4+ Sida Initiative Accelerating Progress in Maternal and Newborn Health Reporting Period: Mid 2013 to 31 Dec 2014 (DRAFT document)

Liberia Demographic and Health Survey 2013, Liberia Institute of Statistics and Geo Information Services, Ministry of Health and Social Welfare, National AIDS Control Programme and ICF International Inc.Monrovia, 2013.

Maternal and Neonatal Death Surveillance and Response (MNDSR), Assessment Draft Report, Cape Mount, Loaf, Maryland, Montserrado and Sinoe, Ministry of Health, Liberia (March, 2016)

Maternal Death Review, St Timothy's Hospital, Observation Note (31st May 2016), Liberia

Meeting with H4+ Coordinator 3rd June, WHO Office, Monrovia, Meeting Note (2016)

Memorandum of Understanding among International Bank for Reconstruction and Development (International Development Association), The Global Fund, Gavi Alliance, and UNICEF, February 2015.

Ministry of Community and Development, Mother and Child Health and Ministry of Health (2015) Mid-Term Review of the Implementation and Performance of the Revised National Health Strategic Plan 2011 – 2016, Republic of Zambia, Final Report, Lusaka

Ministry of Community Development, Mother and Child Health and Ministry of Health (2013) Adolescent Health Communication Strategy in Zambia, 2013-2015, Republic of Zambia

Ministry of Community Development, Mother and Child Health and Ministry of Health (2015) Zambia National Emergency Obstetric and Newborn (EmONC) Needs Assessment 2014-15, Preliminary report, October 22 2015, Lusaka, Zambia

Ministry of Health & Social Welfare Project Activities, (April 1- June 30, 2014), Liberia

Ministry of Health (2011) National Human Resources for Health Strategic Plan 2011-2015, Republic of Zambia, Lusaka, December 2011

Ministry of Health (2015) National Human Resources for Health Strategic Plan, 2011-2015, Lusaka, Republic of Zambia

Ministry of Health Activity Report, UNFPA, (July-September 2015), Liberia

Ministry of Health and Child Care, Government of Zimbabwe (2014). Minutes of the First National H4+ Steering Committee.

Ministry of Health and Child Care, Government of Zimbabwe (2014/2015). Report on H4+ Planning and Review Meetings

Ministry of Health and Child Care, Government of Zimbabwe (2015). Health Development Fund: Programme Document for A Multi-donor Pooled Fund for Health in Zimbabwe (2016-2020).

Ministry of Health and Child Welfare, Government of Zimbabwe (2007). The Zimbabwe National Maternal and Neonatal Health Roadmap 2007-2015.

Ministry of Health and Child Welfare, Government of Zimbabwe (2009). The National Health Strategy for Zimbabwe (2009-2013): Equity and Quality in Health: a People's Right.

Ministry of Health and Child Welfare, Government of Zimbabwe (2011). Health Transition Fund: A Multi-donor Pooled Transition Fund for Health in Zimbabwe: Supporting the National Health Strategy to Improve Access to Quality Health Care.

Ministry of Health and Social Welfare, 2014 Annual Work Plan Output 2.1 and UNDAF outcome 3.1, Liberia

Ministry of Health and Social Welfare, Project Activities Planning/Monitoring/Reporting, 1st July – 30th September, 2014, Liberia

Ministry of Health and Social Welfare, Project Activities, Report April 1 to June 30 2014, Liberia.

Ministry of Health and Social Welfare, Project Activity Report, 1st October to 30th December (2014), Liberia.

Ministry of Health, Meeting Note, Monrovia (June 1,2016)

Ministry of Higher Education (2013). *REFERENCIELS SAGE-FEMME EN RDC.* Ministère de l'Enseignement Supérieur, Universitaire et Recherche Scientifique, République Démocratique du Congo

Ministry of Higher Education (year unknown). *PLAN DE FORMATION PRATIQUE DE LA SAGE-FEMME.* Ministère de l'Enseignement Supérieur, Universitaire et Recherche Scientifique, République Démocratique du Congo

Ministry of Higher Education (year unknown). *PROGRAMME DE RECONVERSION DES INFIRMIERS EN INFIRMIERS-SAGE-FEMME.* Ministère de l'Enseignement Supérieur, Universitaire et Recherche Scientifique, République Démocratique du Congo

Ministry of Higher Education (year unknown). *PROGRAMME DETAILLE DE COURS FORMATION SAGE-FEMME RDC.* Ministère de l'Enseignement Supérieur, Universitaire et Recherche Scientifique, République Démocratique du Congo

Ministry of Higher Education (year unknown). *PROGRAMME SIMPLE DE COURS FORMATION SAGE-FEMME RDC.* Ministère de l'Enseignement Supérieur, Universitaire et Recherche Scientifique, République Démocratique du Congo

Minutes of H4+ Heads of Agencies Meeting, Who Conference Room, Monrovia, 12 March 2013

Minutes of the meeting held with the H6 Technical Working Group and Heads of Agencies, May 2, 2016-06-24, Liberia

Mission Brief and Trip Report Nairobi March 2016 (UN WOMEN)

Mission Brief and Trip Report to Nairobi, UNWOMEN, March 2016, Quarter 1, 2016

Mission Report, UN Women, (Attendance at H4+ Regional Meeting, Cameroon), November, 26, 2015

MoH (2011). *Enquête par grappes à indicateurs multiples MICS-2010. Rapport Final. République Démocratique du Congo,* République Démocratique du Congo*,* Mai 2011.

MoH (2011). PROTOCOLE NATIONAL DE PRISE EN CHARGE INTEGREE DE LA MALNUTRITION AIGUË «PCIMA » KISANTU, Mars 2011, DRC.

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. Rapport d'analyse. Cartographie réalisée avec l'appui technique et financier de l'OMS.* Ministère de la santé publique, République Démocratique du Congo.

MoH (2013). Cadre d'accélération de la réduction de la mortalité de la mère et de l'enfant en République Démocratique du Congo. Appel à l'action pour tenir nos promesses, Mai 2013, République Démocratique du Congo (hereafter : CAO 4&5)

MoH (2013). *Cadre d'accélération de la réduction de la mortalité de la mère et de l'enfant en République Démocratique du Congo. Appel à l'action pour tenir nos promesses. Kinshasa, 21 Mai 2013.* Ministére de la Santé Publique. République Démocratique du Congo.

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, 2013.* Programme national de santé de l'adolescent, Ministère de la santé publique, Republique Democratique du Congo.

MoH (2013). Politique national de nutrition. Version 2013, DRC.

MoH (2014) Rapport de l'atelier de formation des formateurs provinciaux de la Province du Bandundu en soins obstretricaux et neonatals d'urgences (SONU) pour les zones de sante de Bandundu, Kenge et Mosango du 20 au 27 octobre 2014. Ministère de la santé publique, République Démocratique du Congo.

MoH (2014). *Deuxième Enquête Démographique et de Santé (EDS-RDC II 2013-2014)*, Ministère de la

Moh (2014). *Rapport de l'atelier de consensus sur le suivi de la mission conjointe H4+ RMNCH pour l'appui a la mise en œuvre du cadre d'accélération des OMD 4&5. Mai 2014.* Secrétariat Général, Ministère de la santé publique, République Démocratique du Congo.

MoH (2015). NORMES DE LA ZONE DE SANTE RELATIVES AUX INTERVENTIONS INTEGREES DE SANTE DE LA MERE, DU NOUVEAU-NE ET DE L'ENFANT EN REPUBLIQUE DEMOCRATIQUE DU CONGO. Volume 1-8. Ministère de la Santé Publique.

MoH (2015). Plan de la croisade de vulgarisation des documents normatifs SMNE. Interventions intégrées de santé de la mère, du nouveau-né et de l'enfant en République Démocratique du Congo, Secretariat General, Ministère de la Santé Publique.

MoH (2015). Rapport de l'atelier de formation des prestataires de la Zone de Sante de Bandundu en soins obstretricaux et neonatals d'urgence(SONU), Août 2015. Province de Bandundu, Ministère de la santé publique, République Démocratique du Congo.

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, Ministère de la santé publique, République Démocratique du Congo.

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 (2016). Manuel des procédures d'organisation et fonctionnement des structures et approches communautaires. DRAFT. Kinshasa, June 2016. Avec appui UNICEF.

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, République Démocratique du Congo, Février 2016, p. 3

MoHE (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

Monthly Report for General Community Health Volunteers (gCHVs) Activities, Gbarpolu, January – Planned Parenthood Association of Liberia and H4+, March, 2016

Mosango Health Zone Team (2016). *Accélération de la réduction de la mortalité maternelle et néonatale dans la zone de sante de Mosango. Apport de h4+ et des autres partenaires.* Power Point Presentation given by the Health Zone Team (ECZS) to the Evaluation Team on 14-16 August 2016 in Mosango Health Zone, DRC.

Mubiana Macwan'gi, H4+ PowerPoint Presentation, Institute of Economic and Social Research (INESOR), University of Zambia (undated)

Narrative Project Report for UN Women for the project: Engaging Men as Partners in Sexual Reproductive Health and Rights at the Community Level, UN Women, November, 2015, Liberia.

National Strategic Plan for Adolescent and Young Peoples Sexual and Reproductive Health in Liberia, Ministry of Health and Social Welfare, Liberia, (May, 2014). Pg. 5

Nurses Sinje Clinic, Cape Mount, Meeting Notes, Sinje, Cape Mount, (June 2, 2016), Liberia

Office of the World Health Organisation Representative, Letter to Ministry of Health, December 4, 2015, Liberia

Overview of H6 Programme, Power Point Presentation (up to 2016), May 30, 2016, Liberia

PNLMS (2014). CADRE D'INVESTISSEMENT POUR UNE GENERATION SANS SIDA, DRC.

PNLMS (2014). Plan Stratégique National 2010-2014 de lute contre le VIH et le Sida 2014-2017. Programme National Multisectoriel de Lutte contre le Sida (PNMLS), Présidence de la République, République Démocratique du Congo

Prevention of Mother to Child Transmission (PMTCT) Data, HIV Care, Treatment and Support, 2015 Q4, 2016 Q1, Power Point Presentation (2016), Pg. 2, Liberia

Progress reports using UNICEF template: CODES PCA Title: Child Survival and Development dated Feb-May 2014; Jun-Aug 2014; Oct-Dec 2014, Liberia .

PROJ029 Infection Prevention and Control, Liberia

Rapid Assessment Tool – Ministry of Health, H4+ Liberia

Report of Application of the Bottleneck Analysis, Liberia

Report of Maternal and Neonatal Death Surveillance and Response (MNDSR), Ministry of Health, Power Point Presentation (May 9, 2016), Liberia.

Rie Takesue (2014). Des kits familiaux pour l'amélioration de la santé des mères et des enfants, DRC

River Gee Facility Findings, Observation note (June 6-8, 2016), Liberia

Santé Publique et Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, République Démocratique du Congo, Septembre 2014

Standard Memorandum of Understanding (MOU) for multi-donor Trust Funds and Joint Programmes using Pass-Through Fund Management, ("Final Standard MOU for MDTFs and JPs 10:30:2008"), Liberia. Otherwise Undated

Standard Progress Report, January – March, Save the Children (Implementing Partner) for UNFPA, Programme Period: Jan- March 2014,(June, 2012), Liberia

Standard Progress Report, July – September 2014, Save the Children (2014), Liberia

Summary of Training and Activities supported by H4+ January to December, 2015, Liberia .

Swedish Embassy Monrovia, Meeting Notes, Monrovia (May 31, 2016)

Tafelansoni Rural Health Centre (2014) Minutes of a maternal death review, Tafelansoni, 2014

Tafelansoni Rural Health Centre (2016) H4+ Canada Progress Report, Eastern Province 12 July 2016.

Technical Working Group H4+ Meeting, Meeting Note Record, 21 February, 2013, Liberia

Thibaut Mukaba et al. (2015). *Family Planning Policy Environment in the Democratic Republic of the Congo: Levers of Positive Change and Prospects for Sustainability.* In: *Global Health: Science and Practice*, June 1, 2015 vol. 3 no. 2 p. 163-173
http://www.ghspjournal.org/content/3/2/163.full.pdf+html

TOR for H4+ Programme Coordinator, Liberia

Trip report to Sasstown by UNFPA for supervision and monitoring of SCI, UNFPA, 2014,UN House, Lusaka

UN Maternal Mortality Estimation Inter-agency Group (**MMEIG**) (2015). *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* Downloaded 20 Sep 2016 from:
http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1

UN Women (2014). A Gender Assessment of the Community Structures that Influence Women's and Girls' maternal, Sexual and Reproductive Health Seeking Behaviour in Six Districts in Zimbabwe.

UN Women Mission Report, H4+ Meeting in Cameroon, November, 26, 2015

UN Women, Interview Meeting Notes, Monrovia (June 1, 2016)

UNAIDS, Meeting Note, Monrovia (30 May 2016)

UNFPA (2012). Rapport de mission sur l'inauguration de maternité d'attente de Mosango du 05 Octobre 2012 au 07 Octobre 2012, DRC.

UNFPA (2013) Mission Report to Chipata, Chadiza, Chama, and Serenje to participate in the Mid-Term Review for H4+ Districts, 7-17th October 2013, Zambia

UNFPA (2013). Rapport de mission de restitution de l'enquête SONU et d'élaboration du A`PAO SONU dans la ville de Matadi du 12 au 17 novembre 2013, p. 4, DRC.

UNFPA (2015). Terms of Reference: End Line Evaluation of the H4+ Joint Programme Canada and Sweden (Sida).

UNFPA (2016) Report of the Comprehensive Sexuality Education (CSE) Workshop for Teachers and Health Workers in Chadiza District, Chadiza, 4-6 March 2016.

UNFPA (year unkown) Bonne pratique de l'UNAAC Bandundu (unpublished), DRC

UNFPA Activity Report, December, 31, 2015, Liberia

UNFPA Meeting Note, Monrovia (May 30, 2016),

UNFPA Standard Progress Report, Implementing Partner: Save the Children (1 April to 30 June 2015), Liberia

UNFPA, Travel Report Summary, (April 19-May15, 2014) 4th May, 2014, Liberia.

UNFPA: Investir dans les sages-femmes et autres professionnels compétents dans la pratique de sage-femme pour sauver la vie des mères et des nouveau-nés et améliorer leur santé, DRC.

UNICEF Meeting Note, Monrovia (May 31, 2016)

Weekly Summary Report, United Nationals Population Fund, Reproductive Health Field Assistant, August 24-28, 2015, Liberia

WHO (2007). *Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framwork for Action.* Retrived from: http://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1 on September 11, 2016

WHO (2012) Terms of Reference, National Institute Contract for Monitoring H4+ JPCS delivery 2012-2015, Lusaka, 2012

WHO Country Office, Liberia Newsletter, 12th June, 2014

WHO H4+ Meeting Minutes, WHO Conference Room, May 3, 2016, Liberia

WHO Newsletter August 2015 (with: AAMIN Focus Uniting Against AIDS – Anti-AIDS Media Network Newsletter June 22nd 2015, Liberia

WHO, Meeting Note, Monrovia (May 30, 2016)

Workplan between Save the Children International and UNFPA 01/01/2015 to 31/12/2015. Liberia.

Workplan for the Implementation of the UN Women Component of the H4+ SIDA Collaboration on Accelerating Progress in Maternal and Newborn Health in Liberia. UN WOMEN, (for the period: July 2013 to December 2015)

Workplan Monitoring Report, UN Women, October 21, 2015

Workplan monitoring Tool (Annual), Reproductive Health (Reporting Period: January- December, 2015), Liberia

World Bank (2014) Health Services Improvement Project, Project Appraisal Document, World Bank, Washington DC, February 28th 2014.

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 Group, (2016). Exploring Fiscal Space in Health Budgeting: Update and Overview of Emerging Issues, June, 2016.

World Bank, Meeting Note, Monrovia (June 3, 2016)

World Health Organization (2014). Bulletin of the World Health Association: September 2014. Accessible at: http://www.who.int/bulletin/volumes/93/6/14-146571/en/.

Zimbabwe National Statistics Agency (2016). Zimbabwe Demographic and Health Survey 2015: Key Findings.

ANNEX 10 GLOBAL KNOWLEDGE PRODUCTS SUPPORTED BY H4+ PARTNERS

Global Knowledge Products Supported by H4+ Partners 2011-2015				
Number	**Year**	**Agency**	**Product Title**	**Type**
1	2014	UNAIDS and UNICEF	Mapping of tools to assess and address HIV Related Stigma and Discrimination in Health Care	Tools Mapping
2	2015	WHO	GFF multi-stakeholders meeting, “From 'shopping lists' to investment plans: Supporting countries to develop and finance effective plans in RMNCAH	Article
3	2014	WHO	Meta review on QoC assessments in MNCH published.	Meta-Review-Article
4	2015	WHO	MMR Estimates published Nov 2015 following consultations and follow up with H4+ countries, implementation of methodology for better use of country-level data.	MMR Estimates - article
5	2015	WHO	Global MDSR implementation status monitored and first global report on MDSR implementation published	Monitoring Report (MDSR)
6	2014	WHO	MDSR implementation monitoring tool drafted	Monitoring Tool
7	2015	UNICEF	ENAP Progress Tracking Tool revised, used and data collated from 16 of the 28 ENAP high burden countries.	Monitoring Tool
8	2014	WHO	mHealth ASsessment and Planning for Scale tool developed and launched, to provide mHealth implementers to scale innovations.	Planning Tool
9	2015	UNAIDS	CHW training packages to integrate actions for HIV and TB	Training Material
10	2014	UN Women	Briefing Kit for SRHR in South Asia	Briefing Kit
11	2014	UN Women	Briefing Kit for SRHR in Sub-Saharan Africa	Briefing Kit
12	2014	UN Women	Policy Brief Sexual and Reproductive Health and Rights: the case for engaging citizens in policy making	Policy Brief
13	2013	WHO	RMNCH Policy Compendium developed.	Policy Compendium/Guidance
14	2015	UN Women	Draft Gender Equality Conceptual Framework for RMNCAH developed - global / Regional consultation held in preparation for Women Deliver Conference	Policy Framework - Gender Equality
15	2015	WHO	draft Gender Equality Framework for RMNCAH developed and under review through key stakeholders.	Policy Framework: Gender Equality

16	2013	UNICEF	DIVA Procurement and Supply tool (final version) available.(UNICEF)	Procurement and Supply Tool
17	2013	WHO	WHO recommendations on maternal, newborn, child and adolescent health compiled.	Recommendations Compilation
18	2014	UNFPA	Development and release of the State of the World's Midwives Yearly report in June 2014 (disseminated to 26 countries)	Report SoMY
19	2014	WHO	RMNCH quality of care scorecards using DHS and MICS data for 74 priority countries.	Scorecard - Q0C (tool)
20	2013	WHO	Strategic planning with specific focus on RMNCH continued through the One Health tool for planning and costing.	Software Tool for HSS Analysis
21	2014	WHO	Strategic goals, targets and objectives for ending preventable maternal, newborn and child deaths defined up to 2030. Every Newborn Action Plan	Strategy - ENAP
22	2012	WHO	Mapping of progress and needs in implementation of country commitments: Survey of 53 countries committed to the Global Strategy.	Survey (Mapping)
23	2015	WHO	A tool kit for adolescent health in the context of the Global Strategy and development of RMNCAH investment cases developed .	ToolKit - Planning Adolescent Health
24	2012	WHO	Toolkit for RMNCH strategic planning, implementation, monitoring and reviews.	Toolkit - Strategic Planning
25	2015	WHO	ENAP Progress Tracking Tool revised, used and data collated from 16 of the 28 ENAP high burden countries	Tracking Tool for ENAP (Report)
26	2014	UNICEF	Every Newborn Action Plan developed and disseminated including development of draft C4D strategy;	Action Plan (ENAP)
27	2015	UNAIDS	Literacy and advocacy Kit to support pregnant and breastfeeding women groups/networks of WLHIV, developed and field testing in Zimbabwe in 2015	Advocacy Kit
28	2014	UNAIDS	Advocacy Packs for Age of Consent/Legal Barriers to Access Health Services/Age of Consent Reform	Advocacy Kits
29	2015	UNAIDS	E-analysis tool for the stigma index methodology developed to empower networks of PLHIV to generate analysis through RMNCAH lenses	Analysis Tool
30	2011	UNICEF	A tool for rapid assessment of national (and district) RMNCH plans.	Assessment Tool
31	2015	UNAIDS	Annotated bibliography of community based delivery service costing methodologies compiled and to be published in 2016	Bibliography (in draft)
32	2013	UNICEF	Every Newborn bottleneck analysis (BNA) tool used during country consultations on newborn care.	Bottleneck Analysis Tool

33	2015	WHO	Case studies documenting successes and challenges in MDSR implementation published	Case Studies - Bangladesh
34	2015	UNFPA	ENAP country case studies developed for four countries. (Myanmar, Ghana, Philippines, Pakistan)	Case Studies
35	2015	UNICEF	Country case study fact sheets published and disseminated for Burkina Faso, Cameroon, Serra Leone, Zambia and Zimbabwe.	Training Material
36	2012	UNICEF	Checklist for the rapid review of RMNCH plans.	Checklist
37	2015	WHO	Final draft of all 7 modules of the Essential Childbirth Care (ECBC) course completed	Training Material
38	2015	UNICEF	m-health interventions and Rapid-Pro for community reporting documented pregnancy and newborn care and Ebola at different for a	Dissemination Tool
39	2013	UNICEF	Factsheets with MNH coverage indicators developed for all H4+ Canada countries and over 20 high-burden countries	Fact Sheets (link not found)
40	2014	UNFPA	Midwifery Service framework developed , printed and dissaminated.	Framework: Midwifery
41	2015	WHO	Guidance note on strategic planning for ending preventable maternal, newborn and child, mortality	Guidance Note
42	2015	WHO	Core competencies in adolescent health and the adolescent health and development component in pre-service education	Guidelines
43	2015	WHO	A standards-driven approach to improve the quality of health-care services for adolescents	Guidelines (Policy Brief)
44	2015	WHO	Building an adolescent competent workforce	Guidelines (Policy Brief)
45	2015	WHO	Newborn resuscitation (funded by USAID, UNFPA participated in review)	Guidelines
46	2015	WHO	Feeding low birth weight babies (WHO only; acknowledgements do not mention any other H4+ agencies or JPCS funding)	Guidelines
47	2015	WHO	Guidance note on improving quality of paediatric care;	Guidelines
48	2015	WHO	Use of amoxicillin for treatment of pneumonia .	Guidelines (Evidence Summaries)
49	2013	WHO	Technical guidelines for Maternal Death Surveillance and Response produced	Guidelines
50	2013	UNICEF	MNH communication for development (C4D) guide drafted and in use for disseminating ENAP material.	Policy Brief
51	2014	WHO	QoC panel published in Countdown 2014 Report	Report
52	2015	WHO	IMPAC guidelines updated with latest WHO recommendations.	Guidelines

53	2015	UNFPA	Core competencies for adolescent health and development for health-care providers in primary care settings published	Guidelines
54	2013	UNFPA	RMNH training guidelines for CHWs developed. A mapping of existing training tools for CHWs in SRH/MNH will be available on the WHO website.	Guidelines
55	2015	UNICEF	An integrated C4D guide on MNCH prepared and rolled out in muliple countries.	Guidelines
56	2015	UNFPA	Quality of care during childbirth: evidenced based inputs, outputs and outcomes developed on experience of care to ensure updated tools align to QoC midwifery countries	Guidelines - QoC During Delivery
57	2014	WHO and UNAIDS	Global Standards for Quality Health Care Services for Adolescents published	Guidelines for adolescent QOC
58	2014	UNFPA	Development of the CHW's RMNH training guidance.	Guidelines: RMNH Training
59	2015	WHO	Developed and finalised of the 'Planning handbook for caring for NB and children in the community.	Training Material
60	2014	WHO	BJOG supplement on QoC in MNH to be published in August (WHO staff co-editor and WHO staff contributors)	Journal Article
61	2015	UNICEF	BMJ Supplement published highlighting the bottlenecks and recommendations for overcoming for nine high impact maternal-newborn interventions	Journal Article
62	2013	UNICEF	Final list of essential medical devices for Maternal and Newborn Health compiled.	List of key commodities and devices
63	2015	WHO	List of essential MNCH medicines printed and disseminated	List of key commodities and devices
64	2015	WHO	3 modules developed to help teams support community groups to improve MNH: existing WHO/UNICEF manual ‘Caring for Newborns and Children in the Community	Training Material
65	2015	WHO	Modules developed in partnership with Women and Children First and UNICEF for Improving quality of maternal and newborn health to women's groups in rural settings	Training Material

ANNEX 11 THEORIES OF CHANGE

Figure 1: Overall Theory of Change for H4+ JPCS – Global Level

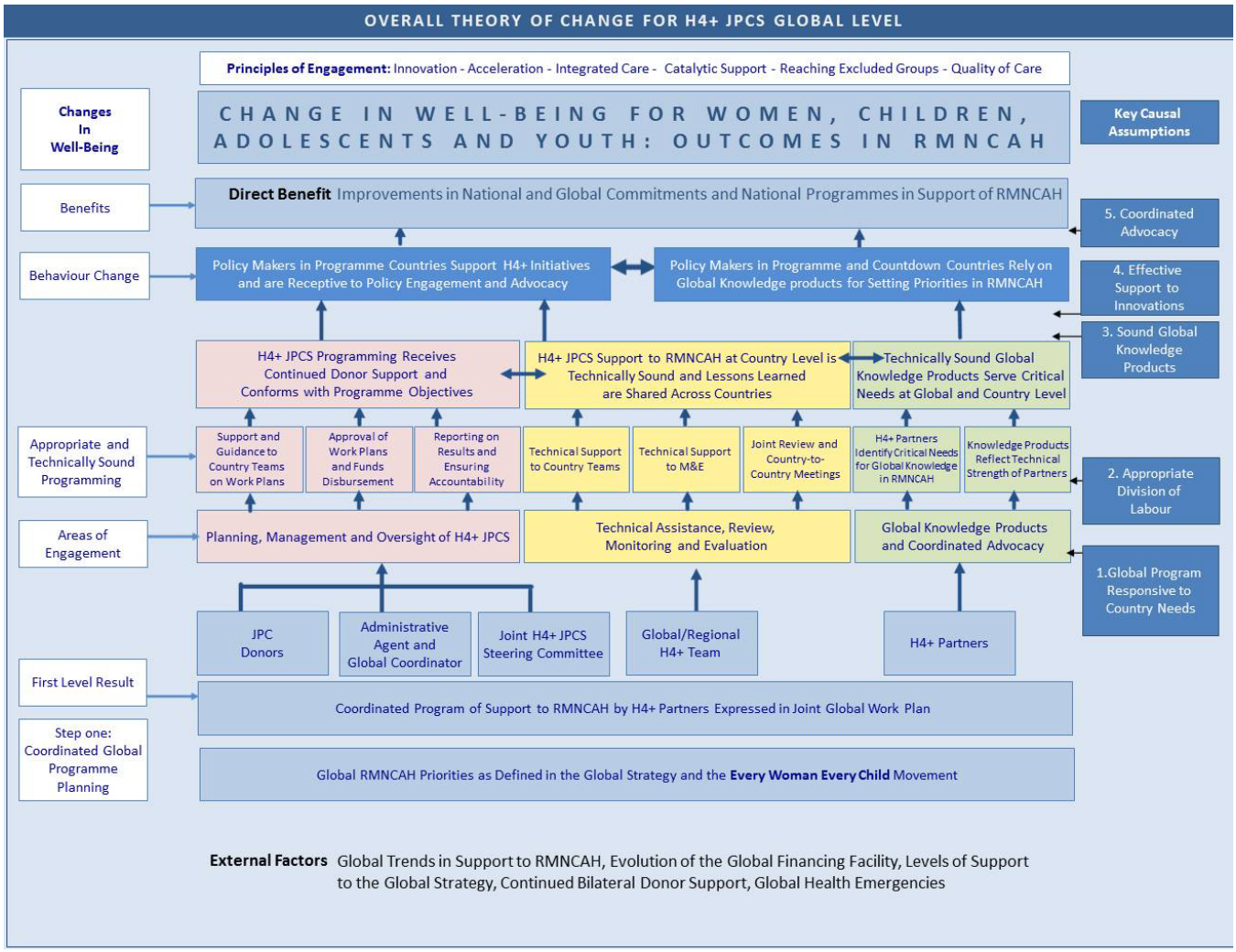
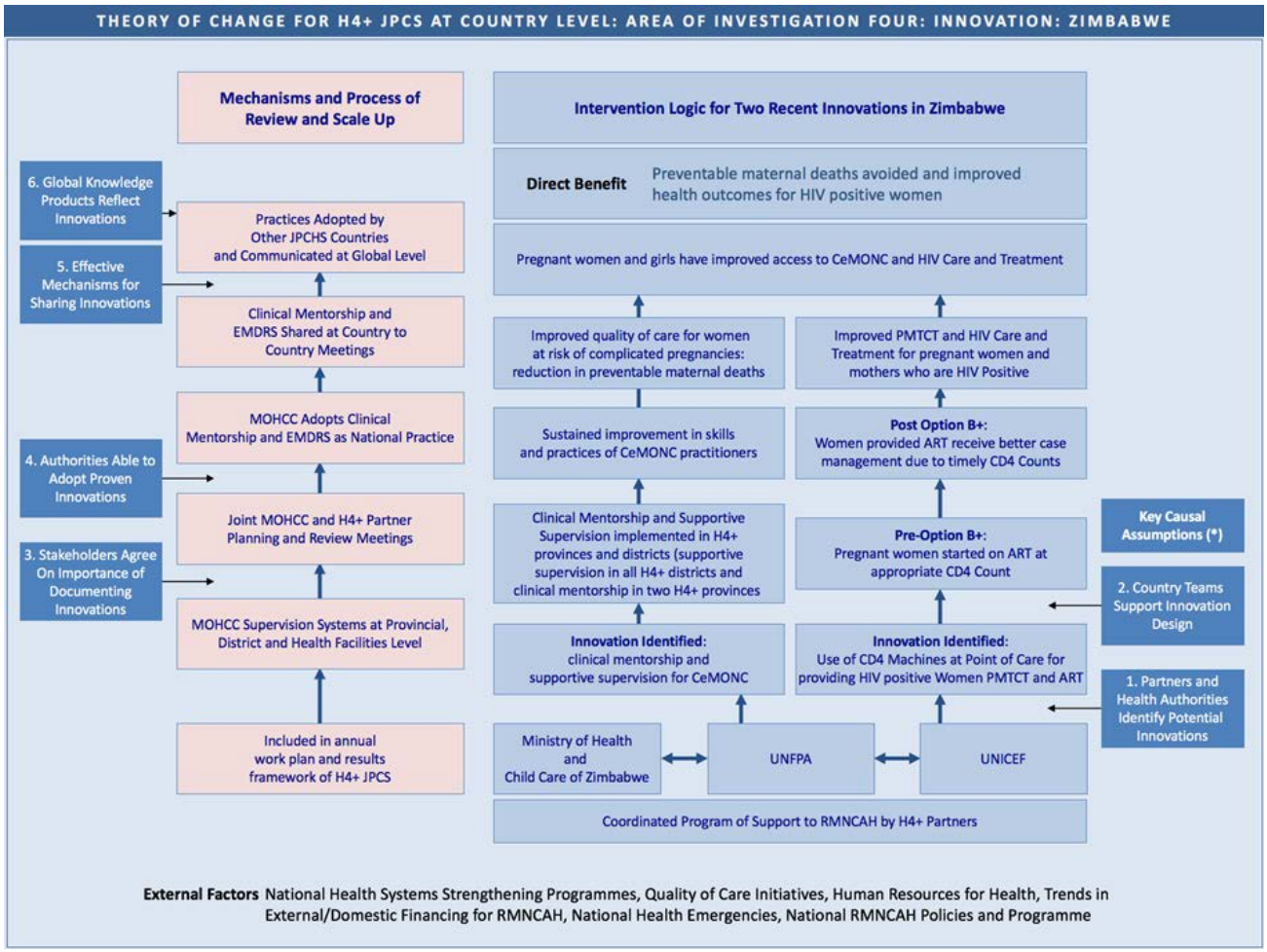


Figure 2: Theory of Change for H4+ for innovation – Zimbabwe example



ANNEX 12 TERMS OF REFERENCE

H4+ TOR.docx