

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



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

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## FOREWORD

The health of women, children and adolescents is essential to human development and progress. In 2000, reducing child mortality and improving maternal health became central components of the Millennium Development Goals (MDGs). By 2010, UNAIDS, UNFPA, UNICEF, UNWomen, WHO and the World Bank forged the H4+ partnership to leverage their respective strengths and provide well-coordinated assistance in the development and implementation of MDG action plans. To accelerate the progress of the health-related MDGs, the H4+ partnership aligned with the Global Strategy for Women's and Children's Health (2010-2015) and the Every Woman Every Child movement. H4+ prioritizes low-income countries with high maternal and child mortality burdens and specific targets for improving, integrating and expanding access to reproductive, maternal, neonatal, child and adolescent health (RMNCAH).

From 2011 to 2016, Canada and Sweden provided significant funding to the H4+ partners to better collaborate and capitalize on each agency's distinct capacities in ten high burden African countries: Burkina Faso, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Guinea Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe. In 2013, the H4+ partners developed a joint results framework under one unified programme: the H4+ Joint Programme Canada and Sweden (H4+JPCS).

This evaluation concludes that H4+JPCS has contributed to strengthening health systems along the continuum of care in RMNCAH at both national and sub-national levels. It has also helped expand access to quality services in underserved and hard to reach areas by consistently targeting the populations most in need - youth, the poorest women and individuals living with HIV/AIDS. The H4+ partners consistently demonstrated their capacity to adjust to new priorities and challenges (such as the Ebola outbreak). The division of labour among partners drew on their comparative strengths and has helped them establish the groundwork for a deeper level of coordination and collaboration.

The H4+ partners could have had an even greater impact. They could have engaged systematically with national governments, to address broader impediments (financial and human resources, infrastructure) to health sector effectiveness, as well as with communities to overcome socio-cultural barriers. While H4+JPCS encouraged innovations, limited information management systems hampered the testing and promotion of comprehensive approaches for youth and the programme's general ability to serve as an effective knowledge broker. As the Joint Programme concludes, the evaluation reveals the need for specific actions as well as new funding sources, especially in underserved areas, to ensure the sustainability of achieved results.

Just as H6 depends on collaboration, this evaluation relied on many exceptional partners. I am deeply appreciative of the considerable time and contributions of colleagues across United Nations agencies, their counterparts at national and sub-national levels, as well as implementing partners. Notably, this evaluation was jointly managed by the evaluation offices of UNFPA, UNICEF and Global Affairs Canada. It also benefitted from the invaluable insights of senior H6 representatives in the Evaluation Reference Group, who co-authored a set of recommendations based on the independent conclusions of the report. I am also extremely grateful to the ten H4+JPCS country teams who generously shared their knowledge. They played a key role in facilitating the extensive evaluation data collection which involved interviews, site visits and focus group discussions to obtain the perspectives of all stakeholders, including programme beneficiaries.

The findings from the evaluation of the H4+ Joint Programme Canada and Sweden are especially relevant in the transition from the MDGs to the Sustainable Development Goals. The post-2015 global development agenda recognizes the health of women, children and adolescents as the cornerstone of public health and depends on unified efforts. I hope that this evaluation proves useful to the H6 partners as they continue their collaboration to support the renewed Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

Louis Charpentier  
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## ABBREVIATIONS AND ACRONYMS

ART	Anti-Retroviral Therapy
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHT	County Health Team (Liberia)
CHW	Community Health Worker
DHE	District Health Executive
DHIS	District Health Information System
DHS	Demographic and Health Survey
DRC	Democratic Republic of the Congo
EMG	Evaluation Management Group
EmONC	Emergency Obstetric and Newborn Care
ENAP	Every Newborn Action Plan
EpMM	Ending Preventable Maternal Mortality
ERG	Evaluation Reference Group
EVD	Ebola Virus Disease
EWEC	Every Women, Every Child
GBV	Gender Based Violence
GKP	Global Knowledge Product
H4+ JPCS	H4+ Joint Programme, Canada and Sweden (Sida)
HBB	Helping Babies Breathe
HDF	Health Development Fund
HMIS	Health Management Information System
HQ	Headquarters
HRH	Human Resources for Health
HTF	Health Transition Fund (Zimbabwe)
HZ	Health Zone
IFYC	Integrated Feeding of the Young Child
IMNCI	Integrated Management of Newborn and Child Illnesses
JANS	Joint Assessment of Annual Health Strategy
KMC	Kangaroo Mother Care
KOIC	Korean International Cooperation Agency
MDG	Millennium Development Goal
MINSAP	Ministry of Health (French) Guinea Bissau
MNDSR	Maternal and Newborn Death Surveillance and Response
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care (Zimbabwe)
NASG	Non-Pneumatic Anti-Shock Garment
NGO	Non-Governmental Organisation

NHA	National Health Accounts
PBF	Performance Based Financing
PLWHA	People Living with HIV and AIDS
PMD	Provincial Medical Directorate
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PoC	Point of Care
PPH	Post-Partum Haemorrhage
PSM	Procurement and Supply Chain Management
RBF	Results Based Financing
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
RO	Regional Office
SDGs	Sustainable Development Goals
Sida	Swedish international development cooperation agency
SMAG	Safe Motherhood Action Group (Zambia)
SRH	Sexual Reproductive Health
ToC	Theory of Change
TTM	Traditional Trained Midwife (Liberia)
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
YFS	Youth Friendly Services

## GLOSSARY OF TERMS USED

**H4+ partnership:** the broad designation/ term used to describe the joined-up efforts of the six member agencies working together (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank).

**H4+ partners:** the six United Nations agencies that are part of the H4+ partnership.

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

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

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

## EXECUTIVE SUMMARY

### **Purpose and scope of the evaluation**

The purpose of the evaluation is to support learning among key stakeholders from the experience of implementing the H4+ Joint Programme Canada Sweden (Sida), 2011-2016 (henceforth “H4+JPCS”). The lessons learned are intended to inform initiatives for delivery of comprehensive packages of services and support in the field of reproductive, maternal, newborn, child and adolescent health (RMNCAH). The evaluation also aims to support the H6 partners in the further development of their collaboration in support of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

The evaluation includes all ten countries participating in H4+ JPCS: Burkina Faso, Cameroon, Côte d’Ivoire, the Democratic Republic of the Congo, Ethiopia, Guinea Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe. It covers the period from March 2011 to August 2016.

### **Background of the evaluation**

In 2008, the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO) and the World Bank launched the H4 partnership as a joint initiative. Its aim was to capitalise on the core competencies of each partner to ensure the continuum of care for maternal, newborn and child health. In 2010, United Nations Secretary General, Ban Ki-moon, launched the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) to accelerate progress to meet Millennium Development Goals 4 (a two thirds reduction in under-five mortality rate) and 5 (a three-quarters reduction in maternal mortality ratio and universal access to reproductive health). Also in 2010, H4+ became the technical arm of the Global Strategy and assumed the role of supporting the 75 high burden countries, where more than 85 per cent of all maternal and child deaths occur. The partnership was expanded to include UNAIDS (in 2010) and UN Women (in 2012) and was renamed the H6 partnership in 2016.

In an effort to accelerate progress toward meeting Millennium Development Goals 4 and 5, Canada (in 2011) and Sweden (in 2012) provided grant funding to the H4+ partners. In 2013, the H4+ partners developed a joint results framework, as a basis for jointly coordinated implementation of H4+JPCS as one programme.

### **Methodology**

The overall approach to the evaluation is focused on identifying the contribution of H4+JPCS to accelerating and improving results in RMNCAH in the ten programme countries and to supporting the implementation of the Global Strategy. In doing so, the evaluation aims to assess the effectiveness and efficiency of the programme in strengthening national and sub-national health systems and improving access to integrated RMNCAH services across the continuum of care. It also identifies the programme’s promotion of innovative methods and assesses the sustainability of the results achieved. By identifying ways H4+JPCS contributed to results, the evaluation also assesses the programme’s added value at global and country levels. Contribution analysis serves as the central analytical framework for the evaluation.

Based on a review of programme documents, interviews with key stakeholders, and an exploratory evaluation mission to Zimbabwe, the evaluation team reconstructed the programme theory of change. This, in turn, guided the identification of key causal assumptions and evaluation questions. This information was captured in an evaluation matrix, which also identifies the indicators, data sources and analytical methods to be used to address the evaluation questions.

Methods of data collection used include country cases studies covering all ten programme countries. Field country case studies were conducted in four countries (the Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe) and desk case studies in six countries (Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau and Sierra Leone). Other sources of evidence include a comprehensive review of programme documents and interviews with key stakeholders at the headquarters of the H4+ partners and among regional and country H4+ teams. In the field case study countries, data collection encompassed a more in-depth review of country-specific documents, key informant interviews, focus group discussions and site visits. Interviews and focus group discussions included H4+ partners, national and sub-national health authorities, health services staff, implementing non-governmental organizations and individual women, girls, men and boys from communities receiving services, or participating in community engagement activities. Finally, the evaluation conducted an on-line survey of key stakeholders in countries with and without active H4+ country team (including countries outside H4+JPCS).

The analysis presented in this report is guided by the evaluation matrix (Annex 1 in Volume 2), where qualitative and quantitative data and information drawn from diverse sources is presented. The matrix structured the work of the evaluation team to test assumptions (from the reconstructed theory of change) and to systematically review the information collected (triangulation) with a view to confirming evaluation findings. Hence the evaluators could provide credible answers to the evaluation questions and identify the programme's contribution to results.

## **Main findings**

**H4+JPCS contributed to strengthening health systems in the ten programme countries by supporting initiatives aimed at addressing eight building blocks of health systems** (health leadership and governance; health financing; health technology and commodities; human resources for health; information systems, monitoring and evaluation; service delivery; demand, including community ownership and participation; and communications and advocacy). At the country level, the programme applied a consistent approach to supporting health systems for RMNCAH which featured: positive alignment with national plans and priorities; the use of consultative planning and needs-identification processes; and engagement at both national and sub-national levels with a strong geographic focus on under-served districts. Interventions were planned and implemented to be complementary with existing support to the health sector and were sometimes catalytic in improving the effectiveness of related programmes (or mobilising resources for RMNCAH). In particular, the programme was effective in supporting efforts to strengthen national and local capacity for emergency obstetric and newborn care (EmONC) and maternal death surveillance and response (MDSR).

**Taken together, programme efforts had the effect of contributing (along with other externally funded programmes and national efforts) to improvements in the availability of quality services in RMNCAH.** These improvements came about despite some shortcomings in the delivery of planned support, including weaknesses in the flexibility and timeliness of programme systems and processes for procuring equipment, supplies and services. The fact that H4+JPCS supports national systems, such as maternal death surveillance and response (MDSR), as well as local capacities and capabilities, has helped to make national health systems function more effectively in delivering RMNCAH services. However, the gains in competencies and in quality of care supported by H4+JPCS are at risk. This is due to largely inadequate (or missing) effective exit strategies that would ensure continuing access to technical, financial and material support to RMNCAH, especially at the local level.

**H4+JPCS made a significant contribution to expanding access to quality integrated care by those most in need in all ten programme countries.** The joint programme was able to achieve this by building on the support it (as well as other programmes) provided to strengthen health systems and improve service quality. As a result, H4+JPCS contributed to improved outcomes, such as a reduction

in home deliveries, improved attendance at antenatal care visits, and access to improved emergency obstetric and newborn care. Regarding the continuum of care, the programme was most effective in supporting the integration of HIV and AIDS programming into health services. However, it was not as effective in supporting the integration of family planning into RMNCAH services because family planning was not always adequately linked to H4+JPCS support.

The programme demonstrated that it is feasible to make progress in strengthening community demand for RMNCAH services within a restricted time frame. The role of UNAIDS and UN Women in supporting community engagements that challenge harmful sociocultural norms, including gender norms, was particularly notable. However, as its efforts to increase the quality and availability of service supply materialized, H4+JPCS faced the important challenge of finding a balance and raising the level of community engagement and demand for these services.

**The ability of H4+JPCS to identify and systematically test and implement coherent, comprehensive policy and programming approaches to meeting the needs of adolescents and youth was uneven.** While some country programmes were more successful than others, H4+JPCS, as a whole, did not effectively contribute to knowledge on how to design and implement measures to meet the sexual and reproductive health needs and rights of adolescents, in particular the needs and rights of girls and women.

**The effectiveness of the programme's response to national and local needs was dependent on effective coordination all along the "coordination chain", from national to district and community level.** For its own planning, coordination and review processes, H4+JPCS relied on a combination of existing country-led mechanisms for coordinating actions in RMNCAH and separate, programme-specific steering committees or technical working groups. The factor that most influenced the effectiveness of programme coordination (and responsiveness) was whether or not planning, coordinating and review mechanisms extended from national to local levels and whether they included effective participation by all implementing partners, including NGOs. Nonetheless, **the programme demonstrated a capacity to adjust and respond to changing needs and priorities at the country level**, including, for example, re-profiling support to countries affected by the Ebola virus disease crisis.

**H4+ encouraged and supported innovation as part of its overall mandate to accelerate and catalyse action in support of improved RMNCAH outcomes**, although adequate systems for supporting innovation as a learning process were not built into the programme from its beginning. As a result, this support was not fully developed until mid-way through the programme's implementation. Nonetheless, in each of the programme countries, there were attempts to implement innovative practices with the potential to improve outcomes in RMNCAH. The practical definition of "innovation" employed by H4+JPCS gave wide latitude to country programmes to identify interventions that made sense within their respective context and, in some countries, national authorities are in the process of adopting the supported innovations as national policy. Overall, however, the programme paid little attention to documenting the innovation design, its rationale or the baseline context for its implementation in order to garner buy-in. This lack of evidence-based documentation has hampered the ability of H4+JPCS to adequately serve as a knowledge broker, both within and outside its sphere of influence.

**The H4+JPCS partners were able to achieve an efficient division of labour at country and global levels, drawing on each partner's mandate and comparative programming strengths.** The partners were also largely able to avoid overlap and duplication in the investments and activities they supported. Over its five-year time frame, the operation of the programme helped the H4+ partners working at the country level to develop a level of collaboration and joint programming that was new to them and would not likely have been achieved otherwise. However, partly because of its different

role in supporting national investments in health (and other sectors), the World Bank was not fully engaged in the H4+JPCS at the country level.

A similar improvement in the level of collaboration among H4+ partners can be seen at the global level. For UN Women and UNAIDS, one effect of the programme has been to provide them with the opportunity to demonstrate the value of community engagement as a means to improving results and outcomes in RMNCAH. For UN Women, it has been an opportunity to highlight the importance of women's empowerment in order to secure their right to RMNCAH services.

**The H4+JPCS programme has contributed to the development of a significant body of global knowledge products that has been noted as useful and technically sound at both the global and country levels.** However, there are indications that the generation of global knowledge products was not well linked to the needs of H4+JPCS country programmes. Experience gained by H4+JPCS at the country level does not appear to have informed the development of global knowledge products. By the same token, guidance developed at the global level has not been systematically communicated to the country level.

**H4+JPCS has demonstrated an ability to provide added value at the global and country levels.** At the country level, the programme enabled the partners to increase the volume and coherence of their policy engagement and advocacy activities. This more coherent and consistent approach to translating global guidance into national policy support has been recognised by health authorities in all programme countries. The programme has also directly supported improvements in the accessibility and quality of services in RMNCAH at national and sub-national levels. These improvements, in turn, have contributed to increased use and, to some degree, improved outcomes in RMNCAH. At the global level, H4+JPCS has contributed to widening participation in the development and advancement of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It has also contributed to deepening the level of collaboration among H4+ partners and to encouraging the development of unified messages on key issues.

## Conclusions

**Conclusion 1. H4+JPCS has contributed to strengthening health systems for RMNCAH at both national and sub-national level, by improving pre-service and in-service training and supervision, especially for emergency obstetric and newborn care and for maternal death surveillance and response systems. This resulted in a positive contribution to service quality and access in RMNCAH. However, the contribution to strengthening health systems could have been more significant. In particular, effort could have been directed at a better balance between supporting the supply of services and strengthening demand by engaging with communities to address socio-cultural barriers to access.**

H4+JPCS support to health systems strengthening was focused on critical needs at both national and sub-national level as agreed between national and sub-national health authorities and H4+ partners. As a result, the funded initiatives were consistent with national plans and priorities in RMNCAH. Interventions also complemented existing and planned programmes of support to the health sector. However, demand generation and community participation activities were often too narrow in geographic reach and in duration, and suffered from a relatively low level of investment. Consequently, they did not achieve the same level of effectiveness as those supporting the supply of services. For investments in demand-generation activities to produce the same level of results, a broader engagement over a longer period of time is required.

**Conclusion 2. At both national and sub-national level, the sustainability of improvements in service quality and availability in RMNCAH is at risk, due to weak or undeveloped exit plans and strategies for the H4+JPCS programme.**

At national level, certain aspects of the programme's positive results are likely to be sustained after programme completion (e.g. improved and updated national policies, guidelines, or curriculum; system-wide improvements such as those in maternal death surveillance and response). However, in targeted, under-served and isolated districts or health zones, gains in the availability and quality of services are more at risk. This risk arises partly because new and pre-existing programmes of support to the health sector in H4+JPCS countries are largely not as flexible or as agile in identifying and responding to specific local needs. Local results are also more at risk because implementing partners often made significant gains in achieving results during the later years of the programme, yet were unable to find sources of support to maintain their presence and consolidate results achieved in the targeted districts after the programme ended.

**Conclusion 3. In implementing the programme at the country level, the H4+JPCS partners missed an important opportunity to systematically engage collectively with national governments to address broader impediments to health sector effectiveness.**

In all programme countries, efforts to strengthen health systems for RMNCAH were constrained by weaknesses in the overall enabling environment. In particular, constraints arose from problems in the policy and resource environment, in particular, in human resources for health, health financing, transport infrastructure, 24-hour electricity and lighting and a reliable supply of clean water in health facilities. H4+ partners engaged effectively in focused advocacy regarding effective policies and programming for RMNCAH. However, they were not as effective in attaining more unified interventions aimed at working with governments to address these wider, cross-sectoral constraints in order to achieve a strengthened health system for delivering results in RMNCAH. H4+JPCS did not take advantage of the World Bank's role in supporting national governments in health sector programming and in other sectors critical to the enabling environment for RMNCAH.

**Conclusion 4. H4+JPCS has contributed to expanding access to services in RMNCAH. It has done so, in part, by consistently targeting the provision of services to underserved and hard to reach geographic areas, and within those areas, populations most in need of services (including adolescents and youth, the poorest women, and people living with HIV and AIDS). H4+JPCS investments and activities have addressed the capability, opportunity and motivation of health service staff to provide quality services in RMNCAH while engaging in focused efforts at demand generation.**

The programme's support to community engagement (combined with improvements in service availability and quality) has contributed to increased levels of trust between community members and health care providers, which has, further, contributed to increased demand for and use of services. In some countries, however, the programme did not adequately support the integration of family planning services in situations where it would have been appropriate. Further, gains in improving access and engaging with communities are at risk, due to inadequate or missing exit strategies.

**Conclusion 5. H4+JPCS missed an important opportunity to develop, test, and promote new, comprehensive approaches to address the needs of youth and adolescents in most programme countries.**

H4+JPCS supported a range of specific interventions aimed at meeting the needs of youth and adolescents, including young girls and women in and out of school, married and unmarried (as well as those of boys and young men). However, these interventions were often fragmented and of

limited effectiveness in reaching the targeted groups. In addition, while H4+JPCS supported efforts to directly address gender inequalities, these interventions, instead of being mainstreamed, were mainly limited to programme output area seven: demand creation. As a result, gender equality initiatives had limited geographic reach, were under-resourced (as with all demand creation and community engagement activities), and were often implemented late in the programme.

**Conclusion 6. H4+JPCS demonstrated a capacity to adjust and respond to changing needs and priorities at the country level, and to respond to specific national challenges, partly through participatory systems of planning and review, which sometimes extended from national to district and facility level.**

Mechanisms for ensuring an adequate response to needs and priorities at the country level were most effective when they included H4+ partners, national and local health authorities and all implementing partners. When mechanisms for coordination did not extend down to the local level, and were not inclusive of all implementing partners, they led to operational problems in delivering H4+JPCS-funded inputs for RMNCAH. As the H4+ partners and national authorities gained experience with the programme, especially with joint planning and review processes, they strengthened and deepened their level of coordination and collaboration. This resulted in more coherent policy engagement and a programmatic response that better suited national and local needs and priorities and was highly appreciated by government partners.

**Conclusion 7. H4+JPCS encouraged and supported innovation as an element in the programme mandate to catalyse and accelerate action in support of improved RMNCAH outcomes. However, H4+JPCS support to innovations seldom adhered to a systematic approach. It did not always support the shift from successfully testing an innovation to documenting the results necessary to develop national policy and scale up innovative practises across the health system.**

In particular, there was a lack of evidence-based documentation that could adequately support policy makers. This weakness in documentation hampered the programme's ability to serve as a knowledge broker, both nationally and across the participating countries. It is also reflective of a general problem of underdeveloped systems and approaches to knowledge management in H4+JPCS.

**Conclusion 8. H4+JPCS partners were able to arrive at an effective division of labour in programme countries. This division of labour drew on the mandate and comparative programming strengths of each partner. It also allowed the H4+ partners to largely avoid overlap and duplication in the investments and activities they supported. The experience of implementing the programme also helped the H4+ partners to develop a deeper level of coordination and collaboration at the global level. However, at the global level this collaboration has been more notable in relation to technical and administrative matters than for strategic issues.**

At the country level, the division of labour for H4+JPCS was based on the use of joint programme planning, implementation, supervision and review processes and effective mechanisms for programme coordination. The availability of dedicated funding for joint programming in RMNCAH, combined with the requirement for a single, unified work programme and results framework, was an important factor contributing to effective collaboration among H4+ partners at the country level.

**Conclusion 9. The primary added value of H4+JPCS in accelerating the implementation of the global strategy has been its positive contribution to improving the availability and quality of essential RMNCAH services in the ten programme countries. This contribution arises mainly from flexibility in jointly programming technical and financial support to RMNCAH in a manner which is also complementary to support provided by other programmes. Additional value can be found in the broader participation of the H4+ partners in the development of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).**

The experience of implementing H4+JPCS helped the partners to develop a deeper level of coordination and collaboration at global as well as at the country level. In addition to strengthening participation by, for example, UNAIDS and UN Women in the development of the Global Strategy (2016 - 2030), the programme contributed to the development of a significant body of useful and technically sound global knowledge products. However, the experience gained by H4+JPCS at the country level was not systematically integrated into global knowledge products and, by the same token, the content of global knowledge products was not systematically communicated to H4+ country teams for use in programme planning.

## **Recommendations**

**Recommendation 1. H6 country teams in the ten H4+JPCS countries (in collaboration with global and regional teams and national health authorities) should undertake actions to make results sustainable by building options for a transition to new funding sources and to retrofit exit strategies to the extent possible.**

While the H4+JPCS programme is reaching its end, there are still opportunities for the H6 teams in each programme country to work with national authorities to ensure that a combination of national and external resources is used to provide flexible, geographically-focused support to those provinces, districts and health facilities that have been critically reliant on the programme. This will require accessing new sources of funding for RMNCAH, as well as earmarking support to coordination mechanisms for RMNCAH programming at a both national and sub-national levels.

**Recommendation 2. H6 partners' efforts to strengthen health systems for RMNCAH at the country level should be designed to achieve a balance between improving the supply of services and strengthening demand by engaging with individuals and communities to address barriers to access, including sociocultural barriers. This should, in particular, strengthen the H6 contribution to the individual potential and community engagement action areas of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It should also incorporate well sequenced and coordinated support.**

The H4+JPCS programme has allowed the H6 partners, their counterparts in national governments, and implementing agencies, to demonstrate the effectiveness of efforts to engage with communities to increase demand for quality services in RMNCAH. There is an opportunity to build on these lessons by increasing the level of investment in community engagement, with a focus on specific barriers for girls' and women's access to (and use of) services and to knowledge for securing their rights. Action in this area would require strengthened technical support for country teams in the field of demand generation and community engagement.

**Recommendation 3. At the country level, the H6 partners should build on the experience of H4+JPCS in order to engage with national governments with "one voice" and ensure that they can collectively influence broader impediments to the health sector (and beyond) including: weaknesses in human resources for health, health financing, and the general enabling environment.**

This would allow H6 partners to address broader constraints to achievements in RMNCAH, which originate outside the mandates of their traditional counterparts. To be effective, action would require joint policy engagement outside the health sector with, for example, authorities for water and sanitation. It would also entail engaging collectively with country-led, multi-stakeholder national coordination platforms.

**Recommendation 4. H6 partners supporting RMNCAH at the country level should ensure that programmes of support address key aspects of sexual and reproductive health and rights (including family planning) for those most left behind, especially for young women and girls. To this effect, H6 partners should invest (globally, regionally and at the country level) in the promotion and dissemination of evidence-based and comprehensive approaches to meeting the needs of adolescents, including young women and girls.**

Thus, the H6 partners will be able to strengthen global, regional and national approaches, by promoting evidence-based, comprehensive solutions that have proven their effectiveness in reaching youth and adolescents. This will require support to the full spectrum of sexual and reproductive health and rights for adolescents and youth, including family planning services. It will also require ensuring that H6 regional and country teams have the required technical expertise and that they engage with actors outside ministries of health (for example ministries of youth and sport, education, employment, gender and social development) and those outside the public sector.

**Recommendation 5. H6 partners should support efforts to strengthen the capacity of national authorities to lead programme coordination mechanisms. These mechanisms should extend to the sub-national level and include all implementing partners and local health service facilities. This will strengthen the contribution made by H6 to the country leadership action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).**

Effective action on this recommendation will require H6 partners to participate in, and support, harmonised and aligned platforms for coordinating support for RMNCAH. It will also require, at least in some countries, support to strengthening national authority capacities in the development and leadership of coordinating mechanisms in RMNCH.

**Recommendation 6. H6 partners should strengthen the learning and knowledge management strategy of the partnership, including the generation and dissemination of evidence-based documentation. Further, in supporting the innovation action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), H6 partners should support systematic approaches to linking evidence to policy and practice.**

The evaluation found that the H4+ partners missed opportunities for learning and knowledge management, in particular for the purpose of generating evidence-based documentation on the results of innovative practices. Effective implementation calls on the development of new learning networks, or strengthened support to existing learning networks, as well as better linking the development and dissemination of global knowledge products to the experience and needs of H6 country teams. It also calls on strengthened technical support and guidance for country teams on evidenced-based approaches to documenting the results of H6 support.

**Recommendation 7. H6 partners should ensure that the division of labour at both country and global level allows for full engagement by all partners to support the community engagement action area of Every Women Every Child and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030); and to strengthen the contribution made by H6 to each of the three pillars of the Global Strategy: (a) country planning and implementation efforts, (b) financing for country plans and implementation including the Global Financing Facility, (c) engagement and alignment of global stakeholders, including the Partnership for Maternal Newborn and Child Health.**

H4+JPCS has been most effective in engaging with national authorities and supporting health systems for RMNCAH when it actively encouraged full participation by all H6 partners. Efforts at supporting increased community engagement and participation were more effective when the programme was able to address socio-cultural barriers to participation, especially for women and girls. H6 partners

need to ensure that programme designs recognise each partner's different ways of working and incorporate those into work plans and funding allocations. It requires H6 country teams to seek funding opportunities and mobilise resources for collective action in support of RMNCAH. H6 partners should also secure funding for the operational components of joint planning, advocacy, review and supervision of their support to RMNCAH.

**Recommendation 8. Within the framework of their collaboration in support of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), H6 partners should develop a clear definition of the work to be done at the regional level, including the corresponding role and responsibilities of regional offices in support of H6 country teams.**

There are opportunities for regional H6 teams to play a stronger role in providing technical and operational support to country teams. This requires H6 global and regional teams, in consultation with country teams, to enhance the roles and responsibilities of regional teams to allow them to take advantage of opportunities for synergies and provide needed support to country teams. To this end, H6 global partners and regional teams will also need to identify and secure the resources necessary to fund regional teams' intervention.

# 1 INTRODUCTION

In 2008, United Nations Population Fund, the United Nations Children’s Fund, the World Health Organization and the World Bank launched the H4 partnership as a joint initiative. Its aim was to capitalise on the core competencies of each partner to ensure the continuum of care for maternal, newborn and child health. In 2010, United Nations Secretary General, Ban Ki-moon, launched the Global Strategy for Women’s Children’s and Adolescents’ Health (2016-2030) to accelerate progress to meet Millennium Development Goals (MDGs) 4 (a two thirds reduction in under-five mortality) and 5 (a three-quarters reduction in maternal mortality and universal access to reproductive health). This initiated the “Every Woman Every Child” movement (EWEC) to put the Global Strategy into action.<sup>1</sup>

Also in 2010, the focus of H4 embraced a broader spectrum of health (including reproductive and child health) in order to help countries put into action their commitments under the global strategy for implementing the integrated package of reproductive, maternal, newborn and child health (RMNCH) services. H4+ became the technical arm of the EWEC strategy and assumed the role of supporting the 75 high-burden countries where more than 85 per cent of all maternal and child deaths occur, including the 49 lowest income countries. The partnership was expanded to include UNAIDS (in 2010) and UN Women (in 2012).

In an effort to accelerate progress toward meeting Millennium Development Goals 4 and 5, Canada (in 2011) and Sweden (in 2012) provided significant grant funding to the H4+ partners. In 2013, at the request of both donors, the H4+ partners developed a joint results framework, as a basis for jointly coordinated implementation as one H4+ Joint Programme Canada and Sweden (hereafter H4+ JPCS).<sup>2</sup>

The H4+JPCS grant funding was designated for expenditures in ten high burden countries in Africa.

**Table 1: Canada and Sweden grant funding for H4+JPCS programme countries**

Supporting Grant Funding	Eligible Countries
Canada	Burkina Faso, the Democratic Republic of the Congo (DRC), Sierra Leone, Zambia, Zimbabwe
Sweden (Sida)	Cameroon, Côte d’Ivoire, Ethiopia, Guinea Bissau, Liberia, Zimbabwe

## 1.1 Objectives of the evaluation

The purpose of the evaluation is to support learning among key stakeholders by drawing on the experience of implementing the H4+ JPCS at global, regional, national and sub-national levels. It has been carried out with a view to: (i) informing similar initiatives for the delivery of the comprehensive package of services and support in the field of RMNCH, (ii) supporting the H4+ partners’ review of the partnership mandate in the post-2015 context, and (iii) supporting accountability of the H4+ partners for the achieved results under the programme.<sup>3</sup>

<sup>1</sup> *H4+: Joint Partnership of United Nations Agencies Working Together to Improve Women’s and Children’s Health. Washington. United Nations Foundation, Every Woman Every Child: <http://www.everywomaneverychild.org/resources/archives/h4-plus>*

<sup>2</sup> *Terms of Reference, End Line Evaluation of the H4+ Joint Programme, Canada and Sweden (Sida) 2011-2016. New York, UNFPA, p 5. See Volume II, Annex 12*

<sup>3</sup> UNFPA, terms of reference, p 6.

The objectives of the evaluation are to:

- Assess the relevance of the objectives and the approach of the H4+ JPCS at global, regional, national and subnational levels, in the context of other partnerships and platforms
- Assess the effectiveness and efficiency of the implementation of the H4+ JPCS at global, regional, national and sub-national levels, specifically: (i) achievements of the programme regarding the strengthening of national health systems at policy and programme level in the ten H4+ JPCS countries and (ii) improvements in the delivery of a comprehensive package of RMNCH services to the population in intervention areas in H4+ JPCS countries
- Assess the sustainability of the results achieved by the programme at global, regional, national and sub-national levels
- Assess the added value of the H4+ JPCS approach and actions for the development of tools and guidelines for RMNCH programming, awareness raising and technical guidance
- Assess to what extent issues of gender equality, social inclusion and equity have been taken into consideration in the implementation of H4+ JPCS
- Identify lessons learned and good practices from the implementation of the H4+ JPCS, and opportunities to improve the cooperation between the six agencies in their support to integrated RMNCAH services in strengthened health systems, through a set of concrete and actionable recommendations.

## 1.2 Scope of the evaluation

The evaluation covers the period from March 2011 to August 2016, when data collection was completed. It covers all ten countries participating in the H4+ JPCS with the *Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe* as field-based country case studies, and *Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau and Sierra Leone* as desk-based case studies. The field country case studies provide the evaluation with tangible, triangulated data and information on the results of the programme at national and sub-national levels. The desk country studies provide insights into the operations and results of the programme in very different contexts such as the Ebola virus disease (EVD) response in *Sierra Leone* (compared with the *Liberia* field case study) and the operation of the programme in small countries with very little support from development partners as in *Guinea Bissau*. In addition, the evaluation covered the contribution made by the H4+ JPCS at global and regional level, including the contribution made by global knowledge products to advancing the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

## 1.3 Evaluation questions

The evaluation addresses six main questions:

1. To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for reproductive maternal neonatal child and adolescent health (RMNCAH),<sup>4</sup> especially by supporting the eight building blocks of health systems?<sup>5</sup>
2. To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality?
3. To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level?

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<sup>4</sup> At the time of the evaluation in 2016, common usage was the term reproductive, maternal, newborn, child and adolescent health (RMNCAH). This phrasing is used throughout the report, except when referring to a document or quoting an interview where other variations such as RMNCH or MNCH were used; (for use of RMNCAH see: <http://www.afro.who.int/en/ghana/country-programmes/3214-reproductive-maternal-newborn-child-and-adolescent-health-rmncah-program.html>).

<sup>5</sup> The WHO health system building blocks and H4+ JPCS programme output areas are described in Table 3

4. To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?
5. To what extent has the H4+ JPCS enabled partners to arrive at a division of labour that optimises their individual advantages and collective strengths in support of country needs and global priorities?
6. To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) (the “Global Strategy”) and the “Every Woman Every Child” movement?

The report addresses these questions by drawing together the evaluation evidence, analysis and findings produced by all data collection and analysis methods: field country case studies, desk country case studies, online surveys, global level key informant interviews, and documentary and data reviews. The present report shows the findings, conclusions and recommendations of the evaluation.

## 2 THE H4+ JOINT PROGRAMME CANADA AND SWEDEN

### 2.1 Programme goal and objectives

The goal and objectives of the programme are shared across both the Canada and Sweden/Sida grant components. They can be summarised as follows:<sup>6</sup>

#### **Programme goal:**

Accelerate progress towards the achievement of Millennium Development Goals 4 and 5, and contribute to the implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) at national level.

#### **Programme objectives**

1. Provide support to national efforts to implement and scale up integrated, equity based reproductive maternal, newborn, child and adolescent health (RMNCAH) efforts in programme countries through coordination and synergies among the H4+ partners.
2. Support national health systems strengthening from strategy development to implementation and monitoring of RMNCAH interventions in partnership with other stakeholders and guided by national health plans.
3. Identify, support and document innovative approaches for roll out in other high-burden countries.
4. Support the strengthening of health information systems and national capacity to analyse and apply data to planning and monitoring with an emphasis on equity and human rights.

### 2.2 Operational levels and expenditures

The H4+ JPCS was designed to operate at three levels:

- The **global and regional** level, where members of the global technical team worked to produce global knowledge products for advancing women’s and children’s health for use in the ten programme countries, and in other high burden countries

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<sup>6</sup> UNFPA, terms of reference, p.59.

- The **national level**, where programme resources were used to finance the H4+ country teams and their activities to strengthen national health systems
- The **local level**, where the H4+ JPCS financed projects and interventions in support of integrated delivery of health services along the continuum of RMNCAH as well as engagement at community level for generating demand for improved services.

**Table 2: H4+ JPCS expenditures 2011 to 2015 by partner and programme level**

Partner	Country level	Global level	Total	Percent of total
UNFPA	25,604,050	4,857,036	30,461,087	41.55%
UNICEF	17,187,043	2,125,490	19,312,533	26.34%
WHO	16,183,619	3,445,420	19,629,039	26.77%
UN Women	2,273,440	200,995	2,474,435	3.37%
UNAIDS	1,128,434	315,118	1,443,552	1.97%
<b>Totals</b>	<b>62,376,587</b>	<b>10,944,060</b>	<b>73,320,647</b>	<b>100%</b>
Percent of total	<b>85.07%</b>	<b>14.93%</b>	<b>100%</b>	

Source: H4+ Canada and Sida: Final Expenditures, 2011 to 2015.

Just over 85 per cent of all expenditures at the end of 2015 were incurred at country level compared to 15 per cent at global level. UNFPA, UNICEF and WHO accounted for 95 per cent of expenditures.

### 2.3 H4+ JPCS and the building blocks of health systems strengthening

The design of the H4+ JPCS follows an expansion of the WHO-developed framework for health systems strengthening.<sup>7</sup> The framework was first articulated in 2010, with the identification of six key building blocks for the development of an effective health system.<sup>8, 9</sup> However, the H4+ partners recognised that the WHO framework specifically “does not take into account actions that influence peoples’ behaviours, both in promoting and protecting health and the use of health care services”.<sup>10</sup> In response, the programme supported initiatives in two areas not covered by the WHO building blocks: demand creation (including community ownership and participation) and communications and advocacy. The resulting focus on eight elements of health systems strengthening is illustrated in the programme theory of change (Figure 2) and below in Table 3.

<sup>7</sup> The H4+ Partnership (2014). *Annual Report 2014 of the H4+ Canada and Sweden Collaborations*, p.13-14.

<sup>8</sup> World Health Organization (2010). *Everybody’s Business, Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework for Action*, p.3.

<sup>9</sup> World Health Organization (2014). *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*, p. vii.

<sup>10</sup> WHO (2014), p. vii.

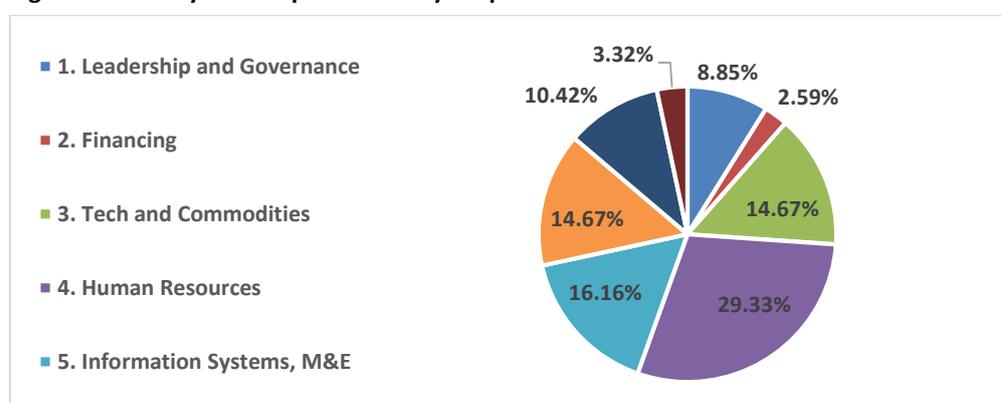
**Table 3: WHO building blocks for health system strengthening and corresponding H4+JPCS output areas with expenditures**

WHO health system building blocks	Corresponding H4+ JPCS output areas	Expenditures	Share
Leadership and governance	1. Leadership and governance	\$5,516,889	8.85%
Health financing	2. Health financing	\$1,613,846	2.59%
Medical products, vaccines and technologies	3. Health technology and commodities	\$9,147,578	14.67%
Health Workforce	4. Human resources for health	\$18,293,163	29.33%
Health Information Systems	5. Information systems, monitoring and evaluation	\$10,077,340	16.16%
Service delivery	6. Service delivery	\$9,145,734	14.67%
	7. Demand, community ownership and participation	\$6,500,878	10.42%
	8. Communications and advocacy	\$2,067,386	3.32%
Total		\$62,362,814	100%

From 2011 to the end of 2015, the H4+ JPCS expended USD 62.4 million at country level on initiatives aimed at these eight output areas of health systems strengthening.

The majority of H4+ JPCS country level investments have been directed at improving the supply of health services and the performance of the formal health sector. The six output areas corresponding to the WHO health sector building blocks accounted for 86.2 per cent of all programme expenditures at country level. Just over 10 per cent of expenditures were dedicated to demand creation.

**Figure 1: Country level expenditures by output area - 2011 to 2015**



Four output areas (technology and commodities, human resources for health, information systems and support to service delivery) account for 75 per cent of expenditures at country level.

The health financing building block accounted for only 2.6 per cent of all expenditures. Five countries reported no programme expenditures in the area, and only three countries (*Burkina Faso, the Democratic Republic of the Congo, and Guinea Bissau*) saw health financing account for more than one per cent of total programme expenditures at country level.

The H4+JPCS provided support to a wide range of interventions aimed at strengthening health systems for RMNCAH. Support ranged from policy support, needs analysis studies, and technical advice for RMNCAH, to efforts to strengthen training and supervision of staff. Programme support also included provision of commodities and equipment (ambulances, motorbikes, operating theatre

equipment) as well as improvements to physical infrastructure.<sup>11</sup> In all ten programme countries, H4+ JPCS has supported investments and activities at the national, regional/provincial and local levels.<sup>12</sup>

## 3 METHODOLOGY

### 3.1 Evaluation approach

The evaluation was designed using **contribution analysis** as its central, **theory based, analytical approach**. It is based on a credible theory of change (ToC) illustrating the causal links and causal assumptions that inform the programme chain of effects. The evaluation developed programme theories of change for the country level, which absorbs 85 per cent of programme expenditures (see figure 2), the global level as well as for the promotion of innovations in RMNCAH (see Annex 11).<sup>13</sup>

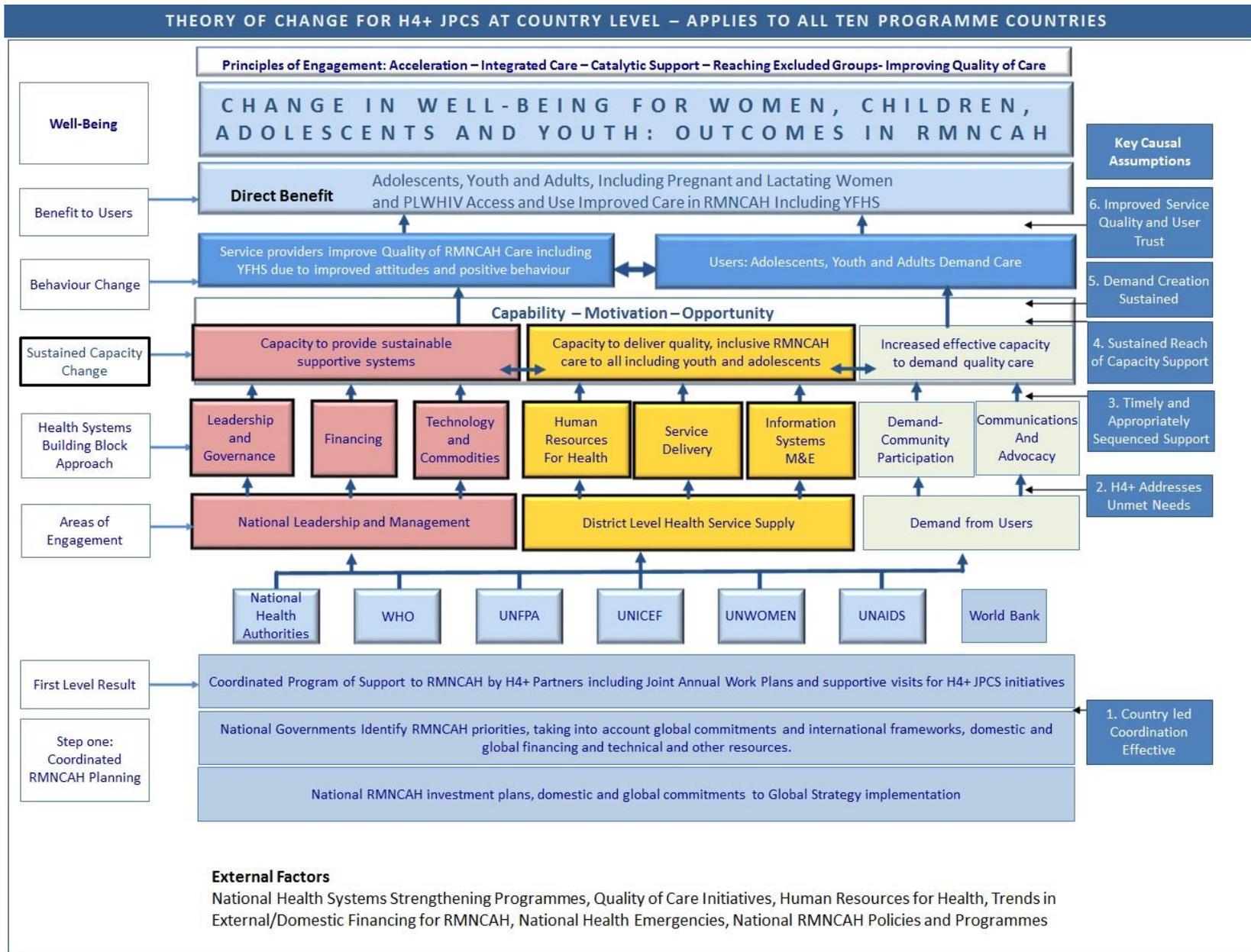
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<sup>11</sup> Volume II, Annex 4 presents a detailed overview by country of the activities to strengthen the capacity of the health system to provide accessible, quality services for RMNCAH.

<sup>12</sup> Terminology varies across countries as to how sub-national levels of the health system are labelled. For ease of use, this report makes use of provincial to designate the first level of decentralisation and the district to represent the second (as opposed to regions, counties or health zones).

<sup>13</sup> Global Affairs Canada, UNICEF and UNFPA, End Line Evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011-2016): Final Inception Report. May, 2016.

Figure 2: Theory of change at country level



The evaluation developed an evaluation matrix including, for each of the six evaluation questions: the assumptions to be verified, the indicators to be gathered and data collection sources and methods to be used. The matrix presents the data and information in support of the evaluation findings and can be found in Volume II, Annex 1 of this report.

## 3.2 Data collection

The evaluation used a combination of qualitative and quantitative methods for data collection and analysis, and triangulated the information drawn from each method. Quantitative methods (closed elements of the online survey, profiles of financial data, trend analysis of RMNCAH outcomes data) helped to relate the programme operations to trends in both inputs and outcomes. Qualitative methods (document reviews, interviews, focus group discussions, open elements of the on-line surveys) provided the evaluation with a deeper insight into the operations of the H4+ JPCS, and its contribution to outcomes.

Data collection methods used include:

1. A comprehensive review of global, regional and country level documents
2. A review and profiling of internationally available data on outcomes in RMNCAH for the ten programme countries
3. Key informant interviews and focus group discussions with key stakeholders at global, regional, national and sub-national levels
4. Four field country case studies (*the Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe*)<sup>14</sup>
5. Six desk country case studies (*Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau and Sierra Leone*)
6. An on-line survey of H4+ JPCS supported agencies, partners and key stakeholders.

Methodologies used are described in more detail in Annex 2.

### 3.2.1 Limitations

The most important limitation is the challenge of ensuring that results attributed to H4+ JPCS are not, in fact, due to the operations of other programmes of external support to the health sector. For the most part, this has been avoided by carefully examining the role of other programmes, questioning whether or not the interventions supported by H4+ JPCS are complementing and augmenting those results. The problem of attribution was less acute because, in eight of the ten programme countries (excepting Ethiopia and the DRC), H4+ JPCS support was purposely targeted to under-served, difficult-to-reach locations, where support from other programmes was limited and could be verified

Given the limited scale of funding provided by H4+JPCS in each programme country (when compared to larger programmes of support provided by multilateral and bilateral development partners), the evaluation did not attempt to provide a quantitative estimate of the contribution to changes in outcomes made by H4+JPCS. Rather, the evaluation drew on a mixture of qualitative and quantitative evidence to test the causal assumptions underlying the programme theory of change.

A final limitation worth noting is the response to the online surveys. For both the survey of H4+ country teams and key stakeholders (conducted in the 38 countries with a functioning H4+ country

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<sup>14</sup> The published reports can be found at <http://www.unfpa.org/admin-resource/evaluation-h4-joint-programme-canada-and-sweden-2011-2016>

team) and the awareness survey (conducted in the remaining countdown countries) response rates were 33 per cent. As a result, the evaluation has made careful use of the results of these surveys.

## 4 ANALYSIS AND EVALUATION FINDINGS

This section presents the findings of the evaluation as they relate to its six evaluation questions. The findings are organised by evaluation questions and their underlying themes. The detailed evidence base for the evaluation findings is provided in the matrix (Annex 1).

### 4.1 Strengthening health systems

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

#### Summary

- H4+ JPCS programme designs at country level have been **consistently aligned with national plans and priorities** and **aimed at addressing** important **needs and opportunities** for health systems strengthening at national, provincial and district levels.
- Programme initiatives have been designed to **complement the support provided by other**, often larger, **programmes**. They have **sometimes been catalytic** in improving the effectiveness of other interventions.
- The programme has supported initiatives that contributed to **improving the capacity of national and local health systems** for service delivery in RMNCAH.
- H4+ JPCS made a **significant contribution to improving the accountability** of health services, especially through its support to **maternal death surveillance and response** systems.
- Especially at sub-national level, the **gains in improving RMNCAH services** achieved with the support of H4+ JPCS **are at risk**, due to **weak and sometimes missing exit strategies**.
- The H4+ JPCS **did not fully realise opportunities to address broader dimensions of the enabling environment** for health systems strengthening in RMNCAH.

#### 4.1.1 The H4+ JPCS and critical health systems strengthening needs

For supporting evidence see Volume II, Annex 1, Assumption 1.1.

A pre-condition for effective support to health systems strengthening by H4+ JPCS was the identification of critical needs and an appropriate match between national needs and H4+ JPCS investments. This required country programmes to be: (i) aligned with national plans and priorities, (ii) developed through a consultative planning process, (iii) focused on critical, evidence-based needs for support to the health system and (iv) targeted at specific, under-served geographic areas.

#### Alignment with national plans and priorities

H4+ JPCS support was well aligned with national plans and priorities in the health sector generally, and in RMNCAH in particular. From the *National Health Development Plan* (PNDS) in the Democratic Republic of the Congo (DRC) through the *Liberia National Health Strategy*, the *National Health Strategic Plan* in Zambia and the *National Health Strategy* in Zimbabwe, higher level national health strategies identified objectives in RMNCAH that could be supported by the programme. These included goals in maternal mortality reduction, improvements in newborn and child survival, strengthened prevention of mother to child transmission (PMTCT) of HIV and improvements in reproductive health and family planning in order to promote safe motherhood.

In most countries, H4+ JPCS was also able to draw on sub-sectoral roadmaps with a specific focus on RMNCAH. Examples include the *National Reproductive Health Policy* in Zambia, the *Maternal, Newborn and Child Health Roadmap* in Zimbabwe, the *Ethiopian Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality* and the *Reproductive and Child Health Strategic Plan 2011-2015* in Sierra Leone. The alignment of the programme with national plans and priorities was also highlighted by respondents to the on-line survey of H4+ partners and stakeholders. Eighty-nine per cent of respondents indicated that the programme seeks to support the national health plan in their country, and 84 per cent confirmed that it supports the national RMNCAH road map.

### Country-led, consultative planning

While H4+ JPCS programming aligns with national priorities in health and in RMNCAH, there remains the question of whether or not the processes for identifying areas requiring support were nationally led. While national health authorities often played a leadership role in identifying which aspects of health systems strengthening should be addressed by the programme, the extent and the evolution of this leadership role varied across countries and, in some countries, changed over time.

In most cases, the relevant division or directorate of the Ministry of Health took a leadership role in the development of the original programme proposal for support under H4+ JPCS. Yet the level of engagement and leadership provided by national health authorities varied over time. In *Zimbabwe*, national leadership was limited in the first two years of the programme and was only fully realised in 2014, when the Ministry of Health and Child Care (MoHCC) established a National H4+ Steering Committee. In the *Democratic Republic of the Congo*, in contrast, the Division for Family Health and Special Groups and the Department for Planning and Research of the Ministry of Health (MoH) took on a leadership role during the development and early years of the programme. However, this leadership role diminished in 2015 and 2016, with the declining effectiveness of the national MNCH task force.

Generally, national health authorities led the process of identifying areas for H4+ JPCS support to health systems strengthening at national level. In Cameroon, for example, the Ministry of Health took a leadership role in coordinating H4+ JPCS activities and took an active role in the workshop to develop the first programme workplan.

### Critical needs identified

The process of identifying needs was often accompanied and informed by H4+JPCS supported baseline studies aimed at delineating gaps in services and barriers to participation.

**Table 4: Examples of country level diagnostic studies and needs identified**

Country	Baseline study	Needs identified
DRC	EmONC needs assessment	<ul style="list-style-type: none"> <li>- Health zones with no EmONC services</li> <li>- Deficiencies in equipment for EmONC</li> <li>- Human resource weaknesses</li> </ul>
Ethiopia	National EmONC review	<ul style="list-style-type: none"> <li>- Bottlenecks in access to EmONC</li> <li>- Training needs for midwives</li> </ul>
Liberia	Situation analysis for RMNCAH	<ul style="list-style-type: none"> <li>- Poor utilisation of facilities</li> <li>- Under-served geographic areas</li> <li>- Lack of female empowerment</li> <li>- Harmful cultural traditions and practices</li> </ul>
Zambia	Review of achievements in reducing maternal, neonatal and child morbidity and mortality	<ul style="list-style-type: none"> <li>- Shortage of skilled health personnel</li> <li>- Low rate of skilled birth attendance</li> <li>- Poor family planning services</li> <li>- Weak EmONC services</li> <li>- Limited use of referrals</li> <li>- Lack of maternity waiting shelters</li> </ul>

Zimbabwe	National integrated health facility assessment and H4+ quarterly planning meetings	<ul style="list-style-type: none"> <li>- Poor availability of EmONC supplies and equipment</li> <li>- Weaknesses in commodity availability</li> <li>- Underutilised youth friendly corners</li> </ul>
Burkina Faso	EmONC and reproductive health (RH) needs assessments	<ul style="list-style-type: none"> <li>- Poor geographic and facility coverage of EmONC</li> </ul>
Cameroon	National study of distribution of health workers in remote areas	<ul style="list-style-type: none"> <li>- Identified need to increases in staffing and redeployments to remote/inaccessible areas.</li> </ul>
Guinea Bissau	Gap analysis of MCH services	<ul style="list-style-type: none"> <li>- Gaps in family planning (FP), gender-based violence (GBV), adolescent health and EmONC</li> </ul>
Sierra Leone	Mapping needs of RMNCAH services during Ebola virus disease (EVD) recovery	<ul style="list-style-type: none"> <li>- Infrastructure improvement needs</li> <li>- Essential medicines and supplies</li> <li>- Training and supportive supervision</li> </ul>

### Geographic focus

With the exception of *Ethiopia*, all the H4+ JPCS programme countries followed a strategy of targeting a sub-set of health districts with poor outcomes in RMNCAH, usually under-served and hard-to-reach districts.

**Table 5: Geographic targeting of H4+ JPCS support**

Country	Geographic target	Key criteria used for selection
DRC	Nine health zones in three provinces	<ul style="list-style-type: none"> <li>- At least two H4+ agencies already present</li> <li>- Able to complement existing programmes</li> <li>- Accessible from the capital</li> </ul>
Liberia	Originally three counties with three added later	<ul style="list-style-type: none"> <li>- Under-served counties</li> <li>- Poor geographic access (hard-to-reach)</li> <li>- Remote rural populations</li> </ul>
Zambia	Five of eleven worst performing districts	<ul style="list-style-type: none"> <li>- Poor maternal health indicators</li> <li>- Poor geographic access (hard-to-reach)</li> <li>- High levels of poverty</li> <li>- Lowest levels of donor support</li> </ul>
Zimbabwe	Six districts	<ul style="list-style-type: none"> <li>- High burden of maternal mortality</li> <li>- Poor geographic access (hard-to-reach)</li> <li>- High levels of poverty and illiteracy</li> </ul>
Burkina Faso	Nine health districts	<ul style="list-style-type: none"> <li>- High maternal, newborn and infant mortality</li> </ul>
Cameroon	Five districts in one region (of ten in the country)	<ul style="list-style-type: none"> <li>- Low levels of RMNCAH services</li> <li>- High maternal and neo-natal death ratios</li> <li>- High prevalence of poverty</li> </ul>
Côte d'Ivoire	Eight health districts in three regions	<ul style="list-style-type: none"> <li>- Poor indicators in maternal and child health</li> <li>- Most urgent unmet needs in MNCH</li> </ul>
Ethiopia	No discernible geographic targeting but activities are supported at district level.	
Guinea Bissau	All regions but with special emphasis on seven	<ul style="list-style-type: none"> <li>- Highest child and under-12 months mortality ratios</li> </ul>
Sierra Leone	Two districts of 13 after (originally all 13 districts)	<ul style="list-style-type: none"> <li>- Under-served and vulnerable pregnant women and adolescents to be targeted.</li> </ul>

#### 4.1.2 Complementary/catalytic interventions

For supporting evidence see Volume II, Annex 1, Assumption 1.2.

H4+ JPCS-supported investments and initiatives were expected to complement those of other programmes. They were also to support catalytic interventions that contributed to increasing the effectiveness of other programmes or attracting more resources in support of RMNCAH.

### **Avoiding duplication and overlap and ensuring complementarity**

H4+JPS interventions were planned in a conscious effort to avoid overlap and duplication with other programmes, and to provide complementary support. In the *Democratic Republic of the Congo*, this mainly meant that the programme needed to ensure complementarity with the national government's health facility equipment project when providing support to training and commodities. In *Sierra Leone* complementarity involved ensuring that H4+ JPCS support to health financing did not conflict with World Bank support to results-based financing (RBF) in peripheral health units. In *Liberia*, it meant concentrating support in counties receiving no sustained support from any other external support.

In *Zimbabwe*, efforts to avoid duplication and overlap extended as far as the district level. District hospital staff took part in joint planning sessions involving the District Health Executive, the Ministry of Education, MoHCC headquarters staff, and the H4+ partners. These consultations identified potential investments complementing large programmes of support to the district, most notably the multi-donor health transition fund (HTF) and the World Bank-supported results-based financing programme.

In *Burkina Faso*, the health districts developed and presented consolidated annual work plans to the Ministry of Health and to all partners at national levels for funding during a "session to finance work plans". The H4+ country team provided guidelines to the districts and regions on what activities could be funded under H4+ JPCS, in order to avoid duplication and overlap.

#### **Box 1: Complementarity and integration with World Bank-supported health programmes**

While the World Bank (WB) was a member of H4+ throughout the programme period, it did not receive funding under either the Canada or Sida grants and did not engage in H4+JPCS-funded activities, either directly or through support of a local implementing partner. The World Bank is also not an RMNCAH technical agency in the same way as some members of the partnership. However, the World Bank did provide significant funding for national investments in health systems strengthening in the H4+JPCS countries, including the four field case study countries. These included, but were not limited to, large scale investments in performance-based financing of health facilities. The World Bank also does not normally have a large complement of health sector-focused staff in its country offices and the staff is responsible for a large portfolio of investments.

For these reasons, World Bank staff often did not take part in processes for planning, operational coordination and review and assessment of H4+JPCS country programmes. This does not mean, however, that there was no effort on the World Bank's part to coordinate support with the H4+ JPCS initiatives of the other five H4+ members. In *Zimbabwe*, for example, the World Bank advised the Ministry of Health and Child Care to ensure that quality of care indicators used for allocating financial rewards to health facilities include indicators for care in RMNCAH. This helped to align incentives under the bank-financed results-based financing programme, with H4+ JPCS support aimed at strengthening the quality of care.

### **Contributing to the effectiveness of other programmes**

Examples of H4+ JPCS contributing to improving the effectiveness of other programmes are less plentiful than those where it complements or adds to their results. Sometimes this effect comes about through the ongoing application of a policy or guideline supported by H4+ JPCS at national level. In the *Democratic Republic of the Congo*, H4+ JPCS supported the development of a national emergency obstetric and newborn care (EmONC) training manual. This manual is being used by other development partners supporting the health sector, including USAID, the Korean International Cooperation Agency (KOICA), and Pathfinder International.

Sometimes, as in *Zambia*, newer programmes drew on elements of the H4+ JPCS experience in their design. A newly introduced three-year (2016-2019) programme of support to health facilities in the Eastern Province (including in H4+ JPCS districts) will build on the work of H4+ JPCS, especially in providing commodity support and support to training of safe motherhood action groups (SMAGs).

In *Zimbabwe*, there is a mutually reinforcing link between H4+ JPCS and the health transition fund, which supplied retention bonuses to ensure that skilled staff benefiting from H4+ JPCS-supported training and supervision are retained. In turn, H4+ JPCS-supported training and supervision helps to ensure that the staff receiving retention bonuses are more effective in providing services. This catalytic effect was limited to the six districts (and associated provinces) receiving H4+JPS support.

### **Mobilising resources for RMNCAH**

In some countries, the H4+ partners were able to build on their experience with the programme to jointly secure more programme funding for RMNCAH. In the *Democratic Republic of the Congo*, this included funding from the Muskoka initiative<sup>15</sup> and the RMNCH Trust Fund,<sup>16</sup> as well as internal funding from the H4+ partners and an increase in resources from the national government. In 2014, it also included supporting the government in creation of a national budget line for family planning. The same year, in *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.

In *Liberia*, UNFPA submitted an application for additional maternal health funding jointly with UNICEF and WHO. More importantly perhaps, in *Sierra Leone*, H4+ JPCS-supported advocacy contributed to efforts by civil society to lobby for increased government financial support to RMNCH. In 2014, in *Zambia*, the programme provided technical support to sensitise 38 parliamentarians so that they could advocate for funding for RMNCAH during budget debates. In the *Democratic Republic of the Congo* and *Côte D'Ivoire*, the H4+JPCS annual report for 2015 notes that the programme also helped secure a national commitment to the Global Strategy for Women's, Children's and Adolescents' Health (2016 to 2030).

### **4.1.3 Contributing to improved capacity for service delivery in RMNCAH**

For supporting evidence see Volume II, Annex 1, Assumption 1.3.

As noted in Annex 4, in every programme country, the H4+ JPCS made investments across a wide spectrum of activities aimed at strengthening the supply and quality of services in RMNCAH. These interventions covered (on the supply side) all six WHO building blocks of health systems strengthening. The evaluation assessed the results of these efforts at building capacity by examining:

- How H4+ JPCS support at national level contributed to health systems capacity
- How support to pre- and in-service training contributed to gains in competencies and skills
- Whether gains in skills were verified and supported by supervision and follow up
- Whether gains were supported by appropriate equipment and essential commodities
- Whether basic infrastructure was adequate and how it was supported
- Whether the programme provided appropriate support to incentives.

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<sup>15</sup> Under the umbrella of the Canada-led Muskoka initiative, in 2012, the Government of France launched a 95 million Euro programme to support RMNCAH strategies and programmes in Benin, Burkina Faso, Guinea, Madagascar, Mali, Niger, CAR, DRC, Senegal, Chad, Togo.  
([http://www.who.int/workforcealliance/media/news/2012/cop\\_mnch\\_cameroon.pdf?ua=1](http://www.who.int/workforcealliance/media/news/2012/cop_mnch_cameroon.pdf?ua=1))

<sup>16</sup> The RMNCH Trust Fund, established in 2013 by UNICEF, the UN Population Fund (UNFPA) and the World Health Organization (WHO) is designed to finance high impact, priority interventions that countries have already included in their reproductive, maternal, neonatal and child health plans. The RMNCH Trust Fund comprises funding from the Government of Norway and DfID.

### National level capacity building initiatives

The H4+ JPCS supported the development of national policies, guidelines, and curricula in specific areas of RMNCAH in all ten programme countries. It also provided direct support to national pre-service training institutions delivering training in RMNCAH.

**Table 6: Examples of H4+ JPCS support to capacity development in national systems**

Country	Interventions
Democratic Republic of the Congo	<ul style="list-style-type: none"><li>- Support to development of national health accounts</li><li>- Training equipment for national/provincial midwifery training institutes</li><li>- Revision of midwives training curriculum to allow three year, direct-entry programmes (instead of after nursing training)</li><li>- Training of national pool of EmONC trainers</li></ul>
Ethiopia	<ul style="list-style-type: none"><li>- Support to the national accelerated midwifery training programme</li><li>- Support to five universities as centres for fistula prevention and repair</li></ul>
Liberia	<ul style="list-style-type: none"><li>- Support to an EmONC needs-assessment and EmONC training strategy</li><li>- National adolescent and youth reproductive health strategy and training materials developed</li></ul>
Zambia	<ul style="list-style-type: none"><li>- Support to revised staffing policies allowing retired midwives to replace nurses sent for midwifery training</li></ul>
Zimbabwe	<ul style="list-style-type: none"><li>- Support to development of national EmONC training manuals</li><li>- Support to development of the national EmONC plan</li></ul>
Burking Faso	<ul style="list-style-type: none"><li>- Development of national PMTCT training manuals for service providers</li></ul>
Cameroon	<ul style="list-style-type: none"><li>- Development of the first national midwives training curriculum</li><li>- Development of on-line training courses for student midwives</li></ul>
Guinea Bissau	<ul style="list-style-type: none"><li>- Contracting external experts to provide EmONC training to trainers</li></ul>
Sierra Leone	<ul style="list-style-type: none"><li>- Support to national roll out of basic EmONC training</li><li>- Emphasis of need for MNCAH during Ebola virus disease (EVD) recovery</li></ul>

### Gains in skills and competencies at national and sub-national level

In all ten programme countries, the evaluation found evidence of H4+ JPCS support to training often with a particular emphasis on in-service, competency-based training and use of training aides such as mannequins. Key informants placed particular emphasis on the effectiveness of H4+ JPCS support to in-service, competency-based training in RMNCAH.

**Table 7: Training for improved skills and competencies in RMNCAH supported by H4+ JPCS**

Training interventions	DRC	Liberia	Zambia	Zimbabwe	Burkina	Cameroon	Côte	Ethiopia	Guinea-	Sierra
National/provincial <b>EmONC</b> instructors trained or recruited	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Provincial/district/facility health staff trained in comprehensive and basic <b>EmONC</b>	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
<b>Competency-based training</b> of midwives	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Health service staff trained in <b>helping babies breathe</b>	♦	♦								
Health service staff trained in use of the <b>partograph and when/how to initiate referral</b>	♦	♦	♦	♦						♦
Health service staff trained in <b>kangaroo mother care</b>	♦	♦								
Service providers, including community-based distributors trained in <b>family planning</b>	♦	♦	♦		♦	♦			♦	
<b>Community health workers (CHWs) and health volunteers</b> trained in antenatal care, family planning and nutrition		♦			♦	♦		♦	♦	
Health service staff trained in <b>integration of HIV in RMNCH, in PMTCT and in paediatric anti-retroviral therapy</b>	♦		♦	♦	♦	♦		♦	♦	
Health service staff trained in <b>integrated management of newborn and child illnesses (IMNCI) and infant and young child feeding (IYCF)</b>			♦	♦	♦	♦	♦	♦	♦	
Health staff trained in <b>prevention of obstetric fistula</b>					♦			♦		
Health staff trained in infection prevention and control for pregnant women in the context of the <b>Ebola virus disease</b>		♦								♦
Health service staff trained in identification, referral and treatment of <b>obstetric fistula</b>					♦			♦		
Provincial/district/facility health service staff trained in <b>youth-friendly services</b>		♦		♦	♦					

During the field country case studies in the *Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe*, the evaluation sought to verify the gains in skills and competencies expected to result from H4+JPCS support.

In the *Democratic Republic of the Congo*, for example, gains in skills and competencies noted in the supervision reports and confirmed by health providers included: use of the partograph; new caesarean techniques; active management of labour (including management of post-partum haemorrhage); management of eclampsia, shock and neonatal infections; patient-centred antenatal consultations; and improved attitudes towards women in labour. Staff members at the visited health facilities and training centres reported examples of how they had been able to save the lives of women after having been trained in EmONC. Further, focus group discussions with a variety of community groups pointed to higher degrees of satisfaction with the quality of services and outcomes for women and children.

**Box 2: A significant H4+ JPCS contribution: basic and comprehensive emergency obstetric and newborn care and effective referral systems and processes**

H4+ JPCS support to EmONC services in all ten countries represents one of its most significant contributions. At national level, support was provided for the development of national EmONC needs-assessments, plans and guidelines, as well as revising pre-service training curricula and supporting national and provincial level

pre-service training institutions for doctors, nurses and midwives.<sup>17</sup> In all ten countries, H4+ JPCS invested in support for the training of health facility staff in basic and comprehensive EmONC. Support to in-service, competency-based EmONC training was often accompanied by investments in supportive supervision of front-line staff and by provision of training equipment (mannequins) and decision aides, such as the partograph. The combination of training and the availability of tools allowed service providers to make better decisions on referrals and to avoid the second of the “three delays” contributing to avoidable maternal deaths.<sup>18</sup>

In addition, all ten countries received support from the programme, in procuring and distributing essential medicines for EmONC, including oxytocin and misoprostol. In some countries, as in *Zimbabwe* and *Zambia*, essential operating theatre equipment was provided so that at least one hospital in a target district could provide caesarean sections. In many programme countries, H4+ JPCS provided support to transport and communications services (ambulances, training for drivers, motorbikes, fuel, radios and mobile phones) to allow the referral system to function.

In *Guinea Bissau*, to overcome the lack of national expertise in EmONC training, H4+JPCS supported the contracting of eight international experts to train health professionals in EmONC. In *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 provided because midwives were more confident. In particular, 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. They were also able to identify the key steps to managing emergencies, 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),<sup>19</sup> chlorhexidine gel<sup>20</sup> and, to a lesser extent, kangaroo mother care (KMC).<sup>21</sup>

In *Zambia*, trained staff were able to identify the key steps to managing different obstetric emergencies when asked by evaluators. They also knew how to use the equipment, drugs and procedures they had been taught, including the use of the infant aspirator, the correct use of kangaroo mother care and the use of misoprostol. They were confident in the use of the partograph and about referring complex cases for higher level care in a timely manner.<sup>22</sup> One midwife in Lukulu district hospital explained how she had resuscitated a newborn baby using skills she had only just learned in the preceding months. She said it made her “feel strong to be able to save the life of this baby” and prior to the training, she would not have known what to do.

In *Zimbabwe*, staff of the MoHCC, H4+ JPCS partners and NGO implementing partners pointed to gains in specific skills and competencies, including: basic and comprehensive EmONC; prevention of mother to child transmission of HIV (PMTCT) and paediatric anti-retroviral therapy (ART); option B+ management;<sup>23</sup> integrated management of neonatal and child illnesses (IMNCI); and youth friendly services (YFS).

<sup>17</sup> Unfortunately, (as in *Zambia*) nurses trained to be midwives often return to lower paid nursing posts, as no new positions for midwives have been created or funded.

<sup>18</sup> The three-delay model of factors contributing to maternal mortality identifies critical delays as: 1, deciding to seek care; 2, identifying and reaching a health facility; and 3, receiving adequate and appropriate care. *WHO Bulletin: Applying the Lessons of Preventing Maternal Mortality to Global Emergency Health*. Accessible at: <http://www.who.int/bulletin/volumes/93/6/14-146571/en/>

<sup>19</sup> The non-pneumatic anti shock garment is used to manage post-partum haemorrhage and was introduced to the southeast counties by the H4+. It is discussed in section 4.4. (See Volume II, Annex 3 for vocabulary of medical terms used throughout the report).

<sup>20</sup> Chlorhexidine Gel is 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. See for example: [http://www.usp.org/sites/default/files/usp\\_pdf/EN/PQM/chlorhexidine\\_technical\\_brief\\_jul\\_1\\_2014.pdf](http://www.usp.org/sites/default/files/usp_pdf/EN/PQM/chlorhexidine_technical_brief_jul_1_2014.pdf)

<sup>21</sup> Kangaroo Mother Care (KMC) is an approach to nurturing small and sick babies using skin-to-skin contact.

<sup>22</sup> During the facility visits at five health facilities in Lukulu and Chadiza districts, staff were asked open questions about the use of the partograph, criteria for referral, conditions for using particular drugs or equipment and their experience since returning from training, July 2016. Altogether, in 2015, 39 midwives were trained in EmONC.

<sup>23</sup> Option B+ refers to revised WHO guidelines for treatment of HIV positive pregnant and breastfeeding women (WHO 2016).

### **Testing, follow up and supervision to verify and reinforce skills and competencies**

If the intended gains in skills and competencies in RMNCAH experienced by health services staff as a result of H4+ JPCS-supported training are to result in improved care, it is important that these gains are monitored. It is notable that the health authorities in the H4+ JPCS countries have often invested in pre-and post-testing (and in follow-up) of training. Effective follow up and testing of the impact of training took place in the *Democratic Republic of the Congo, Zambia, Zimbabwe, Burkina Faso and Ethiopia*. Post-tests and follow up missions to assess competencies and skills often reported positive gains as a result of training.

However, there were sometimes negative results. For example, in the *Democratic Republic of the Congo*, post-training reviews and supervision reports noted deficiencies in the use of the partograph, and use of older, less effective practices in newborn care. In Zimbabwe, training and review reports also made negative observations on the use of the partograph. The same reports noted deficiencies such as the non-availability of standard delivery kits, the general condition of labour and delivery wards, and the lack of post-partum haemorrhage packs. In Sierra Leone in 2015, the H4+ heads of agencies noted that most of the in-service training programmes in the districts were not supported by supervision and mentoring.

In both the *Democratic Republic of the Congo* and *Zimbabwe*, training supervision reports included recommendations for refresher training and increased supervision and mentoring. In *Zimbabwe*, senior MoHCC staff noted that H4+ JPCS had “led the shift to more follow-up and ongoing assessment of training initiatives”.

H4+ JPCS has made a significant contribution to improving the capability of health services staff to provide essential services in RMNCAH, especially at sub-national level. The renewed confidence and professional pride, which comes alongside the gains in skills and competencies, was observed during interviews, observations and focus group discussions with health services staff in all four field country studies. By strengthening confidence and professional pride, capacity development investments also addressed the motivation of health services staff.

#### **4.1.4 Supporting necessary equipment, infrastructure and incentives**

For supporting evidence see Volume II, Annex 1, Assumption 1.4.

Improved quality of care, resulting from improved skills, requires that staff have access to the relevant essential equipment, medicines and supplies for RMNCAH. Staff also require adequate infrastructure, including health facilities that meet required standards, reliable electrical supply for 24-hour lighting, and adequate water and sanitation services. All this support needs to be appropriately sequenced so that it is available when needed: the absence of one element can undermine the utility of another.

#### **Equipment, essential medicines and supplies**

The H4+ JPCS programme was able to support the procurement and distribution of essential equipment, medicines, and supplies for RMNCAH services to health facilities in all ten programme countries. However, the effectiveness of this support varied from country to country, with some experiencing relatively few issues and others facing significant challenges.

In the *Democratic Republic of the Congo* important EmONC equipment, materials and drugs supported by H4+JPCS were either missing, inadequate or delayed at the health zone level. Seventy per cent of the facilities visited by the evaluation team had experienced frequent stock-outs of essential drugs, including magnesium sulphate, antibiotics, calcium gluconate, contraceptives (implants), and HIV test kits. Site visits also revealed that syringes for manual vacuum aspiration,

protective clothing, suction cups and aspirators were missing in nearly all facilities. Training reports and interviews also indicate that equipment and materials necessary for training were not delivered on time or in sufficient quantity.

In *Liberia*, H4+ investments in ambulances, VHF radios and support to training helped to strengthen the referral network in a way that made a substantial and visible difference to maternal health. Despite problems with faulty radios (partially overcome by staff using their personal mobile phones) the referral system was visibly operational and actively being used. However, tracer studies conducted by the evaluation team indicated that health facilities in the counties supported by H4+ JPCS continued to experience stock-outs of essential medicines (oxytocin, gentamycin, ampicillin and chlorhexidine).

In *Zambia*, the evaluation noted some problems in the availability of contraceptives and a mismatch between the provision of training for midwives and delivery of appropriate supplies. *Zimbabwe* also reported some persistent issues in supply, including slow transfer of funds to the district level and, in the earlier years of the programme, problems in the supply of oxytocin and magnesium sulphate. However, health facilities located in districts supported by the World Bank-funded results-based funding programme were able to procure missing supplies using these funds.

### **Infrastructure**

In all four field case study countries, the programme was attempting to support services and health facilities facing difficult challenges with infrastructure and access to essential services. The most notable challenges were the intermittent supply of electricity (for lighting the 24-hour EmONC services) and intermittent or non-existent supplies of clean water. The H4+ JPCS invested in efforts to provide reliable electricity and clean water for health facilities in Liberia and Zambia.

In *Liberia*, the ability of the H4+ partners to use the JPCS to identify, deliver and sustain critical infrastructure improvements to achieve 24-hour service was mixed. All five health facilities visited in River Gee had – in principle – the means to generate their own power through either a generator or a solar panel. However, none of the facilities had fuel to power a generator, and, for several, the solar panels worked poorly or there were no suitable light bulbs. The end effect was little or no lighting after dark. Another example of ineffective H4+ investments given by the River Gee County Health Team (CHT) concerned wells, which were fitted with submersible pumps operated by generators without consulting the county health team or its water sanitation and hygiene (WASH) team. As many wells run dry in the summer, the pumps had all burned out and were no longer working.

In *Zambia*, in contrast, the programme demonstrated an ability to effectively facilitate access to additional power where it was needed, mainly through the provision of solar panels. However, investments in the installation of water systems (pumps, wells, towers and piping) were less successful, due to problems in procurement.

### **Procurement Issues**

Overall, H4+ JPCS support to the provision of equipment, essential medicines, other commodities and improvements in infrastructure made a positive contribution to strengthening health services. Yet, persistent problems in the availability and sequencing of critical inputs supported by the programme, had the effect, at times, of reducing the significance of that contribution.

Important weaknesses in the flexibility and effectiveness of H4+ JPCS systems and process for procuring equipment, supplies or services were evident in both *the Democratic Republic of the Congo* and *Zambia*. In the *Democratic Republic of the Congo*, the programme had to contend with a weak

procurement and supply-chain management (PSM) system<sup>24</sup> despite significant investments to strengthen its performance. In *Zambia*, H4+ procurement delays affected the flow of H4+ support to both infrastructure installation and the supply of equipment and furniture. Delays in installing water supply systems in two health facilities were a result of the decision to procure equipment and services centrally, rather than through district health offices working with the provincial procurement office. As a result, local suppliers were excluded and central procurement resulted in higher costs and significant delays.

### Incentives

Where the H4+ JPCS was involved in directly supporting financial incentives for health service staff engaged in RMNCAH (the *Democratic Republic of the Congo*, *Côte d'Ivoire* and *Guinea Bissau*) it was most often through support to results-based funding programmes in districts not directly served by World Bank-supported programmes.

In the *Democratic Republic of the Congo*, H4+ JPCS supported the introduction of results-based funding in four health zones to provide financial incentives to the health zone teams, health facility staff and community health workers (CHWs) to improve RMNCAH service delivery. In *Guinea Bissau*, H4+ JPCS provided support to an incentive bonus scheme providing an addition to the salaries of health professionals. The programme is credited with demonstrating the viability of incentives to address compensation issues for health professionals. As originally planned, following completion of H4+JPCS support, the programme was funded by the European Union.

In some countries, the problem of how to provide adequate incentives for health service workers was addressed by other programmes using national or external funds. In *Zimbabwe*, doctors, nurses and midwives all received retention bonuses, financed out of a multi-donor pooled fund administered by UNICEF – the health transition fund. In addition, both the health transition fund and a separate World Bank-funded results-based funding programme provided performance financing at the facility level that could also be used to augment salaries.

In *Liberia*, however, when H4+ JPCS supported the re-purposing of traditional birth attendants as trained traditional midwives (TTM) the local practice of compensating them in kind for their original role did not continue, with a resulting loss of livelihoods.

#### Box 3: Negative impacts on the livelihoods of traditional birth attendants in Liberia

Re-purposing the work of trained traditional midwives represented an important strategy for encouraging women to deliver in a health facility rather than at home. Based on interviews with health staff and focus group discussions, volunteer community-based health workers like trained traditional midwives were highly motivated to do their jobs. However, there were problems in maintaining the motivation and status of the trained traditional midwives and their ability to realise a benefit from their new role. In every community visited, the trained traditional midwives noted that, by abandoning their role as traditional birth attendants, they effectively lost their livelihood. The community used to support them by providing them with eggs, carrying water, assisting them with farming, etc. as “payment” for their services during labour and delivery. However, in their new role to accompany mothers to the health facility, they were less valued in a material way, and their livelihoods had effectively disappeared. This meant they had to choose between tending their farms and accompanying women to the clinic, as the community no longer helped.

### 4.1.5 Strengthening accountability through maternal death surveillance and response

For supporting evidence see Volume II, Annex 1, Assumption 1.4.

H4+ JPCS investments in support of maternal death surveillance and response (MDSR) systems in the ten programme countries represent an important contribution to improved accountability by

<sup>24</sup> The national PSM system: *Système National d'Approvisionnement en Médicaments Essentiel*

governments, health service managers and health service providers. MDSR also represents a critical tool for health systems to effectively engage in efforts to reduce avoidable maternal and newborn deaths.

It is significant that H4+ JPCS in support to MDSR systems at country level was able to draw on guidelines also developed with programme support at the global level (Table 14). H4+ country teams in the ten countries also developed and implemented workplans that included technical support to strengthening the MDSR system at national level as well as ongoing support to MDSR reviews and (as in *Zimbabwe*) electronic data reporting systems.

Highlights of support to MDSR from the four field case study countries include:

- In the *Democratic Republic of the Congo*, H4+JPCS supported the establishment of the national maternal death surveillance and response system, including MDSR committees at health zone, provincial and central level, and the training of health zone teams in 39 zones. Maternal deaths are now included in the list of notifiable diseases in the national disease surveillance system
- In *Liberia*, H4+JPCS invested in establishing and technically supporting the MDSR process at national level, while also supporting the application of MDSR reviews in the H4+ focus counties to ensure the process was maintained. It also helped to revitalise national commitment to MDSR, following the end of the Ebola virus disease (EVD) outbreak
- In *Zambia*, the H4+ JPCS invested in technically supporting the development and implementation of the MDSR system while supporting the application of MDSR reviews in the H4+ focus districts and provinces
- In *Zimbabwe*, H4+ JPCS provided a full spectrum of support to maternal and newborn death surveillance and response systems.

#### Box 4: Support to maternal and newborn death surveillance and response systems in Zimbabwe<sup>25</sup>

In *Zimbabwe*, the H4+ JPCS programme engaged in a comprehensive programme of support to MNDSR. At the **national level**, the programme provided ongoing policy support to strengthening the MDSR through:

- Supporting the development and finalisation of national MNDSR guidelines
- Supporting the development of a national MNDSR data base
- Supporting the role out of an electronic system for gathering and centrally analysing MDSR data
- Supporting the establishment of a national MNDSR committee.

The national level work was then followed up at **provincial and district level** by:

- Providing support to training, mentoring and supportive supervision in MNDSR
- Supporting regular provincial and district level MNDSR meetings (including providing support to provincial health teams for supervision activities)
- Supporting the role-out of the electronic MNDSR system to the district hospital level
- Ongoing support to training in MNDSR.

The H4+ JPCS-sponsored work in MNDSR in *Zimbabwe* was supported through the UNFPA as an H4+ country team member, based on global technical guidelines issued in 2013.<sup>26</sup> These were followed by a sub-regional workshop on MDSR held in Libreville in 2014, an MDSR monitoring tool published in 2014 and the first global report on MDSR implementation in 2015.<sup>27</sup>

<sup>25</sup> The WHO guidance document uses term MDSR but the system being supported by H4+ JPCS in Zimbabwe is best termed Maternal and Newborn (or peri-natal) Death Surveillance and Response.

<sup>26</sup> WHO, *Maternal Death Surveillance and Response: Technical Guidance – Information for Action to Prevent Maternal Death*. World Health Organization, 2013.

<sup>27</sup> H4+ Global Coordinator, 2015 annual report of the H6 Joint Programme with the collaboration of Canada and Sweden. Appendix 6. RMNCH Knowledge Products and Public Goods: 2011-2016. August, 2016

#### 4.1.6 Improvements in quality of care

For supporting evidence see Volume II, Annex 1, Assumption 1.5.

The H4+ JPCS has contributed to improved skills and competencies for doctors, midwives, nurses and other skilled health service providers across the spectrum of services in RMNCAH, but especially in all aspects of EmONC. It has also helped (with deficiencies in some countries) to provide health professionals with the necessary equipment, medicines and supplies to put these skills into practice.

Nearly all interviewed stakeholders pointed to improvements in the quality of care in RMNCAH being provided by health service providers at district and facility level (with the important exception of services for youth and adolescents, especially young women and girls). Some highlights regarding improvements in quality of care include:

- In the *Democratic Republic of the Congo* health facilities supported by H4+ JPCS were more likely to offer a range of RMNCH services and less likely to suffer stock-outs of essential medicines and contraceptives
- In *Liberia*, a functioning referral system relying on radios, mobile phones, ambulances, and the knowledge of facilities staff to make appropriate referrals
- In *Zambia*, health services staff able to identify key steps in responding to maternal emergencies and demonstrate effective use of equipment, medicines and procedures
- In *Zimbabwe*, enhanced capacity for caesarean sections and more rapid improvements in outcome indicators in maternal, newborn and child health in supported districts than reported nationally.

#### 4.1.7 Sustainability of health systems strengthening efforts

For supporting evidence see Volume II, Annex 1, Assumption 1.5.

The gains in the quality of care in RMNCAH supported by H4+ JPCS are at risk as the programme comes to an end. These risks arise on the supply side in relation to the capacity of health services to provide quality care. On the demand side, the risks arise from the potential rapid decline in community engagement activities and the breakdown of levels of trust attained.

In the programmes supported H4+ JPCS, the risk of a decline in the levels of skills, competencies and improved service quality is linked to the absence of effective exit strategies in most programme countries. To be effective, these strategies would need to ensure that adequate training, supervision, equipment, essential medicines and commodities (as well as funds for maintenance of equipment and facilities) would continue to be provided in a flexible and integrated way to the provinces, districts, counties and zones supported by the programme. In some countries, health facilities staff referred to this problem as “the cliff” which they saw looming at the end of the funded H4+ JPCS support. Aspects of this situation in different programme countries include:

- In the *Democratic Republic of the Congo*, despite an effort to identify alternative sources of funding for activities in the health zones supported by H4+ JPCS, some elements of the programme will likely not be sustained (including support delivered by UN Women)
- In *Liberia*, little thought has been given to an exit strategy or sustainability plan. The enabling environment is a major constraint to the development of better services. Efforts to address – or circumvent – these constraints have been partially successful, but these efforts are at risk if the programme ends without sufficient consideration given for sustaining gains. At the time of the evaluation, H4+ partners were supporting the government of Liberia in the development of an investment case for funding under the Global Financing Facility (GFF)
- In *Zambia* post-programme arrangements were discussed with district health teams and facility staff. Both districts visited have carved out allocated budgets to continue sending one

nurse per year to be trained in midwifery. However, arrangements to sustain all the main elements of the H4+ programme were not well advanced and few concrete commitments to sustaining achievements were in place

- In *Zimbabwe*, there are concerns over the continued availability of retention bonuses for staff as the health transition fund is merged into the new health development fund (HDF). Key informants also fear disruptions in support for supportive supervision as the health development fund may not have a flexible approach to meeting the needs of under-served districts.

#### 4.1.8 A significant contribution to health systems strengthening with sustainability at risk

The programme was aimed at contributing to strengthening health systems in the ten H4+JPCS countries by supporting initiatives to strengthen all the WHO building blocks of health systems, as well as demand creation and advocacy. Within each of these building blocks, support has been directed to activities and investments specific to RMNCAH policies, programmes and services. At country level, the programme has applied a consistent approach to supporting health systems with minor differences among programme countries. The features of this approach include:

- Positive alignment with national plans and priorities for the health sector, especially as they relate to RMNCAH strategies and programmes
- Use of consultative planning and needs-identification processes, with varying degrees of country leadership and sub-national participation
- Policy engagement and capacity development at national and sub-national level, but with a strong geographic focus on a sub-set of under-served districts or health zones (with the intent of informing national practice with positive lessons learned at local level)
- Efforts to plan and implement initiatives which are complementary, and sometimes catalytic, to existing and planned programmes. Complementarity of programming has been achieved in more instances than genuinely catalytic support. Nonetheless, the examples of catalytic support, which improved at least the local effectiveness of other programmes, are significant
- Investments aimed at building skills and capacities at national and local level, especially in EmONC and MDSR
- Investments in support of service delivery (through provision of essential supplies for RMNCAH), in necessary equipment and in some improvements to infrastructure.

Taken together, these efforts have had the effect (especially in the targeted districts and health zones) of contributing to evident improvements in the availability of quality services in RMNCAH. This contribution came about despite some shortcomings in the delivery of planned support, including weaknesses in the flexibility and effectiveness of programme systems and processes for procuring equipment, supplies or services. Overall, these weaknesses did not seriously undermine the positive contribution made to improving services in RMNCAH.

The combination of H4+JPCS support to national systems such as MDSR and sub-national capacities in RMNCAH has contributed to making the system function better (at least in some dimensions), especially when H4+JPCS is viewed as one element in a wider set of programmatic interventions. Opportunities for H4+ partners to jointly influence national policies and programmes aimed at addressing system-wide deficits in resources, infrastructure and health financing, varied from country to country. Yet the potential to address broader dimensions of the enabling environment for strengthening the health system (including RMNCAH) through the H4+ JPCS was not fully realised.

Unfortunately, the gains in staff skills and competencies in the quality of care in RMNCAH are at risk, as the programme comes to an end. This threat is directly linked to the apparent weakness of exit strategies aimed at ensuring continuing access to technical, financial and material support to

RMNCAH at national, but especially, at local level. The weakness of exit strategies and subsequent efforts to ensure sustainability may be a result of the relatively compressed time frame of the programme, especially for investments in community engagement. As a result, the sustainability (permanence) of the gains supported by the programme can be seriously questioned.

Some researchers have argued that health systems strengthening requires “*permanently* making the system function better, not just filling gaps or supporting the system to produce better short term outcomes”.<sup>28</sup> This implies that sustainability is a key determining factor in distinguishing between health systems support and health systems strengthening. It is notable that sustainability has been an important challenge for the programme, especially at local level.

## 4.2 Expanded access to integrated care

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

### Summary

- The H4+ JPCS consistently **targeted underserved districts and, within these, the populations most in need of RMNCAH services**, including **adolescents and youth, the poorest women, and people living with HIV/AIDS**, improving trust between health centres and communities and strengthening quality of care.
- Some H4+ JPCS countries have invested more in **community engagement and mobilisation and this has had visible impact**. The **role of UN Women and UNAIDS, in supporting community engagement and challenging harmful cultural behaviours, including gender norms, is notable**.
- H4+ JPCS has, over time, **increased support to engagement with youth and adolescents and addressed their needs in RMNCAH**. However, **interventions in some countries have not been effective**. In particular, **efforts to reach young girls at risk of early pregnancy and/or early marriage have been insufficient in scope**, with limited duration and reach.
- H4+ JPCS **gains are at risk due to missing, under-developed, foreshortened or unrealistic exit plans for the programme**.

### 4.2.1 Targeting the disadvantaged and marginalised

For supporting evidence see Volume II, Annex 1, Assumption 2.1.

#### The geographically isolated and chronically under-served

With the exception of *Ethiopia*, the H4+ JPCS consistently targeted underserved and marginalised districts and zones in each programme country. Within these, H4+ explicitly aimed to target the most disadvantaged – or the neediest – groups. These included the geographically isolated, youth and adolescents, people living with HIV and AIDS (PLWHA), the disabled, and the poorest.

In most of the H4+ JPCS countries, communities that lived far away from fixed health services were identified as a particular target group. For example, in *Zimbabwe*, some communities were concerned about wild animals and in *Zambia*, the hardest places to reach were those that were also sparsely populated, making economies of scale difficult to achieve. In *Liberia*, as in *Ethiopia*, *the Democratic Republic of the Congo*, and *Guinea Bissau*, isolation was exacerbated by a poor road network, limited transport options and long periods when access was impossible (during the rainy season).

<sup>28</sup> Chee, Connor, Lion and Pielemeier. *Why differentiating between health system support and health system strengthening is needed*. The International Journal of Health Planning and Management (2012). Published online in Wiley Online Library (wileyonlinelibrary.com), p.3.

H4+ JPCS programmes aimed to overcome access barriers, using a range of interventions that targeted distance and isolation. Examples include: more and better trained community health workers who live closer to the community; the construction of maternity waiting shelters to enable women (and often their families) to travel to health facilities in advance of their delivery; and support to strengthening outreach services through the provision of transport options.

In *Zambia*, some communities (for example in Tafelansoni, Eastern Province) constructed small structures so that antenatal visits and other services could be done in privacy and out of the sun or rain. Also, health workers were able to reach communities regularly because they had functioning motorbikes (procured by the H4+ JPCS) and a monthly fuel allowance.

### **Adolescents and youth, especially girls**

Reaching adolescents and youth, especially but not exclusively girls, was a defined objective of the H4+ JPCS. Adolescents and youth were identified as a primary target group in the country programme proposals. However, in most countries (*Burkina Faso, Cameroon, Côte d'Ivoire*, and the *Democratic Republic of the Congo* in particular), the majority of activities targeting adolescents were only implemented mid-term, or towards the end of the programme, rather than integrated from the start. In *Zambia, Zimbabwe* and *Liberia*, H4+ JPCS addressed youth earlier in the programme lifecycle and multi-faceted approaches were used to find, engage and meet the needs of young people (see Box 5). The main youth-oriented interventions supported by H4+ JPCS programmes were:

- Youth centres to deliver youth-friendly sexual and reproductive health services in the community (*the Democratic Republic of the Congo, Zimbabwe*)
- Youth corners, for example, in market places and in fixed clinics (*Zambia, Zimbabwe*)
- Health clubs at school, supported by a local midwife or a teacher (*Liberia*)
- The integration of youth-friendly sexual reproductive health (SRH) services in health facilities (*Liberia*) and in health clinics in secondary schools and universities (*Côte d'Ivoire*)
- Advocacy for including sexuality education in the curriculum (*Liberia, Zambia*)
- Training teachers and nurses from the same community together, to enable them to work together to talk to young people about sexuality and reproductive health and to support their needs better (*Zambia, Côte d'Ivoire*)
- HIV and AIDS and family planning media campaigns (*the Democratic Republic of the Congo*)
- Training and supporting a cadre of peer educators (*the Democratic Republic of the Congo, Guinea Bissau, Liberia, Zambia*).

Activities focused on expanding access to comprehensive sexuality education, voluntary HIV counselling and testing, and contraception. Where young people gathered regularly (for example in the health clubs), they discussed issues including gender based violence (GBV), gender norms and the role of men and boys, contraception and the benefits of delaying first births, staying in school and avoiding HIV and other sexually transmitted infections.

#### **Box 5: Strengthening the H4+ JPCS approach to youth and adolescents in Zambia**

The 2013 H4+ JPCS mid-term review found that there were few specific objectives focusing on adolescents and youth in the H4+ programme in Zambia. The UNFPA country representative responded by noting that family planning, adolescent health and early marriage were not yet adequately addressed by the H4+ JPCS. Partly in response, the Western Province health authorities developed a youth-friendly approach to service delivery, whereby youth could attend clinics at unscheduled times, and consult whichever staff member they preferred. The H4+ JPCS also began funding teacher training in youth comprehensive sexuality

education and experimented with joint teacher-nurse training.<sup>29</sup> The ideal outcome of these innovations would be fewer youth dropouts, fewer pregnancies, and more knowledgeable young people. Reaching young people with comprehensive services was also identified more concretely as a programme objective after the mid-term review. H4+JPCS then moved to support comprehensive sexuality education delivered through schools, after-school clubs, and youth-friendly health corners. These investments were considered “**a good innovation brought by the project capable of being replicated in other locations**”.<sup>30</sup>

Some countries appear to have achieved positive results in reaching adolescents and youth. For example, in target communities in River Gee County (*Liberia*), adolescent attendance for reproductive health at one clinic increased from 11 per cent of all visits to 26 per cent by 2015. Significantly, in these communities, the village chiefs, religious and other community leaders are supportive of students embracing contraception and see it as a means to ensure that girls stay in school. Thus, despite their general lack of approval, they recognised that the distribution of contraception was a critical step to addressing the problem of teenage pregnancies. In *Côte d’Ivoire*, efforts were made to integrate RMNCAH services into school health clinics, with a strong focus on family planning and the distribution of free contraceptives to youth. These efforts provided a rare, positive approach to youth-friendly services through collaboration between the Ministries of Health and Education.

However, despite some success, meeting the needs of adolescents and youth was a weak performance area for the H4+ JPCS, especially around actions to reach young girls in and out of school before their first pregnancy. In *Zimbabwe*, making contraception available to adolescent boys and to young girls at risk of early pregnancy and early marriage was not an explicit part of the programme. Girls were reluctant to use youth-friendly service sites that were co-located with health facilities, since this would publicly indicate they were seeking contraceptives. In *the Democratic Republic of the Congo*, the H4+ JPCS missed an important opportunity to reach adolescents and youth, as activities were limited in both reach and duration, particularly with regard to family planning, comprehensive sexuality education and condom distribution, especially for young girls.

H4+ partners supported different approaches to targeting adolescents and youth according to their respective mandate and technical expertise, but there were no joint efforts to coordinate the implementation of these activities. The H4+ JPCS clearly lacked a strong, unified vision and a technically sound approach to addressing, in a coherent and comprehensive way, the needs and multifaceted barriers to a better adolescent sexual and reproductive health.

The programme division of labour (Section 4.5, table 13) sees UNFPA, UNAIDS and UNICEF most active in support to improving reproductive and maternal health services for adolescents and youth while UNAIDS most often provides support to organizations working with people (including adolescents) living with HIV and AIDS. UN Women has clearly taken the lead role in supporting interventions directly addressing gender equality. In the field case study countries, this included UN Women’s support to implementing agencies engaged in:

- Supporting income generating activities (*Liberia*)
- Sensitising men and boys to support women and girls’ equality, access to RMNCAH activities and in prevention of gender based violence (GBV) (*the Democratic Republic of the Congo, Liberia, Zimbabwe*)
- Empowering young women and girls
- Researching community structures that influence the reproductive and maternal health of women and girls.

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<sup>29</sup> This strategy was tested by UNFPA in North West Province in Zambia before being rolled out across the H4+ programme.

<sup>30</sup> Peer educators, Lukulu District, Western Province, Zambia

Given the combined expertise of the H4+ partners at country level, H4+JPCS missed a real opportunity to develop a cohesive and comprehensive strategy for addressing the needs of youth and adolescents.

### People affected by HIV and AIDS

An important sub-group targeted by the H4+ JPCS, were people living with HIV and AIDS or people at risk of becoming infected with HIV, including newborns. Every country included activities targeting populations most at risk from HIV and AIDS, including:

- The prevention of mother to child transmission (PMTCT) (or elimination of mother to child transmission - eMTCT)
- Early infant diagnosis
- Paediatric anti-retroviral therapy (ART)
- Prevention, including through male circumcision, education, and condom distribution
- Addressing associated cultural and behavioural barriers to HIV prevention, including gender based violence, gender roles in society, early marriage, patriarchal social arrangements and others.

In *Zimbabwe*, for example, the H4+ JPCS programme aimed to improve access to PMTCT and paediatric anti-retroviral therapy programmes, by bringing services closer to communities and increasing trust that quality services would be available and effective. The H4+ JPCS acted to extend the reach of established national programmes and bring target districts up to the same level of access as other better-performing districts. The provision of point of care CD4 machines, training, supportive supervision and community mobilisation to build demand for services, were some of the programme components that helped to overcome barriers to people living with HIV and AIDS.

### The disabled

Few H4+ JPCS countries specifically targeted the disabled. For example, in *Liberia*, *Zambia* and *Zimbabwe*, no specific aspect of the programme aimed to identify and meet the sexual and reproductive health needs of disabled people. Senior officials at the Ministry of Health in *Zambia* recognised that the H4+JPCS had not comprehensively identified and supported minority groups including the disabled. There were a few exceptions to this common trend. In *Burkina Faso*, the H4+ JPCS supported the implementation of the national strategy targeting young handicapped persons, in part, through sensitising health workers and community-based health volunteers. Some were taught sign language as well. The 2015 annual report reveals 1,127 disabled clients were referred to health facilities: 369 for family planning services, 403 for sexually transmitted infection screening and treatment, and 355 for HIV testing and counselling.

### The poorest

In several countries, the H4+ JPCS invested in policies and programmes aimed at helping users overcome financial barriers to accessing essential RMNCAH services.

#### Box 6: H4+ JPCS interventions aimed at reducing financial barriers for target populations

**The Democratic Republic of the Congo's voucher scheme to reduce delivery costs:** Vouchers distributed through the family kit enabled women to access basic RMNCAH services at subsidised cost.

**Côte d'Ivoire social franchise schemes:** These were schemes to support NGOs and women's groups to use a range of mechanisms to support each other to pay the costs of essential health care.

**Sierra Leone in-kind health support:** A voucher scheme provided in-kind services to teenage girls, pregnant women, mothers and newborns. It was tested in only two districts.

**Burkina Faso and the Democratic Republic of the Congo's community financing schemes:** In the *Democratic Republic of the Congo*, H4+ JPCS activities focused on supporting voluntary community health insurance

schemes (*mutuelles de santé*) in some of the H4+ JPCS districts. Given the well-known methodological, technical and administrative challenges with community insurance schemes (which limit their efficacy), the evidence for supporting such schemes through the H4+ JPCS over other interventions to strengthen demand was weak.

**Guinea Bissau and Burkina Faso National “free of charge” policy and implementation:** The aim of the “free of charge” policy was to eliminate user fees for pregnant women, children under five and adults over 60 (*Guinea Bissau*). H4+ JPCS also supported the development of the national “free of charge” policy in *Burkina Faso*.

Where the H4+ JPCS worked to remove financing barriers for target populations, efforts were aimed primarily at reducing the direct costs of RMNCAH services for users. In some countries, efforts focused on supporting the implementation of a broader sub-national or national strategy in the target districts. However, the H4+ JPCS mainly appeared to support individuals to access services within existing systems by working through social franchises, vouchers and other schemes.

*Guinea Bissau* was the only H4+ JPCS country that spearheaded a major national policy shift aimed at introducing a significant transformation to the existing system, in this case, to entirely remove all user fees for all pregnant women, children under five, and adults over 60. This “free of charge” policy process (including research, advocacy, planning and cost modelling) was signed into practice through a Ministry of Health decree. The financing needed to replace user fees (for example, to fund salary incentives and essential drugs) came initially from the H4+ JPCS and an EU-funded RMNCAH programme. However, EU funding soon absorbed all the costs and covered the whole country. The H4+ country team in *Guinea Bissau* used its convening power, technical authority and the resources available through the H4+ JPCS, to support the government to enact this substantial policy shift, which affected everyone in the country rather than limited numbers in a few districts.

#### 4.2.2 Integrated services and the continuum of care

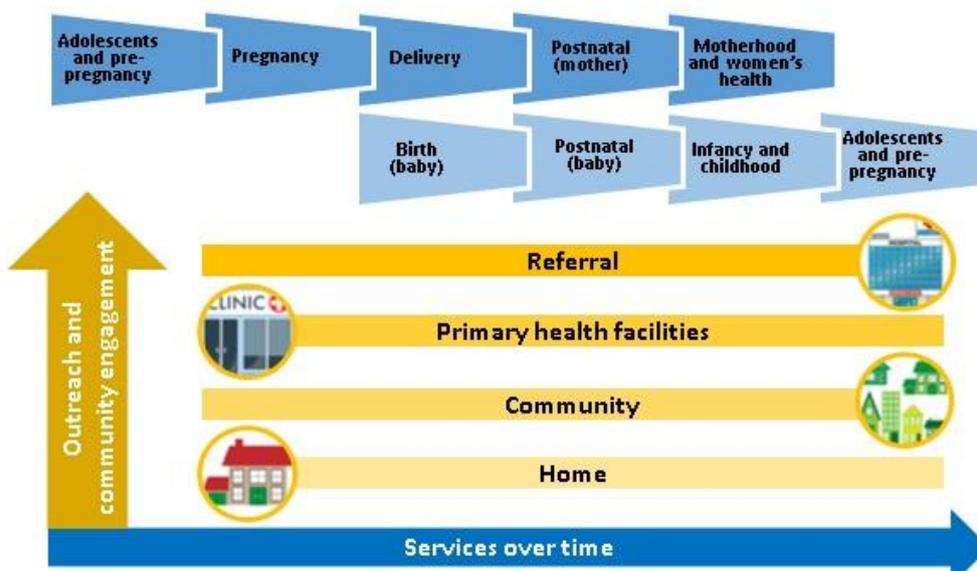
For supporting evidence see Volume II, Annex 1, Assumption 2.2.

Strengthening the continuum of care through integrated service delivery<sup>31</sup> was one of the main objectives of the H4+ JPCS. As Figure 3 shows, the continuum of care requires the integration of services over the full life course (time) but also the interlocking of services across different settings (place).

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<sup>31</sup> WHO defines integrated service delivery as: “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.” For The Partnership for Maternal, Newborn and Child Health, “[the] continuum of care for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. The two dimensions of the continuum of care are time (services delivered over a lifespan) and place (referring to the places where care is delivered starting with the home).

Figure 3: The two dimensions of the continuum of care



Source: A composite based on PMNCH graphics: [http://www.who.int/pmnch/about/continuum\\_of\\_care/en/](http://www.who.int/pmnch/about/continuum_of_care/en/)

The H4+ JPCS addressed the multidimensional challenge of a strengthened integration of RMNCAH services in a number of ways:

#### Between the home and the community

The main thrust of linking households to communities lay in social mobilisation and engaging people in conversations about gender, gender relations, violence, social norms, beliefs about illness and health, and knowledge building. The H4+ JPCS invested resources in all its target countries to support empowerment and mobilisation for health. In *Liberia and the Democratic Republic of the Congo*, the programme invested a significant proportion of its funds in first understanding, and then addressing, harmful social beliefs and practices. In H4+ JPCS focus districts, for example, it was commonly believed that a woman experiencing a difficult labour or even dying, was being punished for some “past transgression”.

The comprehensive approach to tackling these beliefs, together with strengthened referral and (largely) well-planned and delivered improvements to the quality of services, led to documented changes in the expression of community views and a steady decline in home births. Much of the success in *Liberia* appears to be due to the integration of carefully thought-out programmes conceived by UN Women and UNAIDS and delivered through local NGOs.

#### Box 7: Understanding barriers and developing interventions in Liberia

In *Liberia*, H4+ JPCS commissioned various situation analyses to help identify what social and behavioural attitudes, knowledge and practices were creating barriers to better RMNCAH results generally, and to specific interventions including family planning uptake, early antenatal care visits and skilled birth attendance. These analyses identified concerns by communities about the quality of services they were able to access, including the absence of trained staff, poor equipment and outages of essential drugs. Furthermore, an important finding was the identification of beliefs about why women have difficult pregnancies (e.g. a punishment for transgressions).

In response to these findings, H4+ investments, at the community level, included formal training courses for health volunteers and traditionally trained midwives, and informal discussion groups and clubs for men, youth and students and young mothers. These investments were supported by UN Women and UNAIDS (through their implementing partners) and by UNICEF, UNFPA and WHO, either directly and/or through their implementing partners. Each H4+ partner had a slightly different approach to community engagement and worked in various communities.

In focus group discussions and meetings with community leaders, it was evident that the approach adopted by the H4+ JPCS increased the willingness and openness of the communities to access antenatal care, skilled delivery and uptake of family planning, especially among adolescents.

In *Zambia*, by contrast, one H4+ member observed that although they had undertaken a fair amount of community mobilisation, they had missed out on working at a “*deeper level*” on the persisting core beliefs in the community.

### **Between communities and the primary health facilities**

Integrating service delivery between community and health facility level relies on the relationship between community health workers (CHWs)<sup>32</sup> and formal health workers. Many H4+ JPCS programmes included components aimed at strengthening this bond (*Guinea Bissau, Ethiopia, Liberia, Sierra Leone, Zambia, Zimbabwe*). Training community health workers to refer women to the clinic, rather than try to conduct deliveries themselves, was a common feature of all the country level work of the H4+ JPCS. At the same time, health workers were encouraged to mentor and support community health workers and to see them as an extension of the formal health services.

In several countries, the H4+JPCS used incentives to strengthen the demand for services by the community. The most notable included the mama pack in *Zambia* and *Liberia*, and the family kit in *the Democratic Republic of the Congo* (Box 5). Although these interventions were appreciated and clearly helped to increase attendance, they were difficult to sustain, sometimes created distortions in local referral systems<sup>33</sup> and were not systematically incorporated into national or even sub-national policy. Unlike *Liberia*, in *Zambia*, the mama pack in *Zambia* was subject to rigorous cost-effectiveness analysis to determine its potential impact if taken to scale.<sup>34</sup>

#### **Box 8: Strengthening community demand: mama packs and family kits**

##### **Mama packs (also called mama-baby kits) distributed in *Zambia* and *Liberia***

The “mama pack” is a collection of useful baby items including a hat, diaper, a blanket, Vaseline, plastic bath and other products given to women who had attended antenatal services *and* delivered in the facility in both *Zambia* and *Liberia*. The kits were out of stock in *Zambia* from mid-2015 and in *Liberia* since 2014, despite the intention of the H4+ JPCS partners to procure more. Mama packs were appreciated by the communities and mentioned frequently by midwives, mothers, health volunteers as well as senior ministry of health officials, or other cooperating partners and H4+ partners themselves. National health authorities in both countries indicated that they planned to scale up use of the mama pack.

##### **Family kits distributed in the *Democratic Republic of the Congo***

The “family kit” consisted of products and vouchers to encourage access to essential maternal and newborn services. Products were basic commodities to support health, while vouchers provide access to services at a

<sup>32</sup> The term “community health worker” is used to refer to all health workers based in the community and trained to provide services to community members. Thus, community health volunteers, traditional trained midwives, village health workers are all captured under this label.

<sup>33</sup> For example, the maternity ward La Cité de la Maternité in Mbanza-Ngungu Health Zone of the DRC was trained and equipped to be an EmONC site and, prior to the kit distribution, was heavily used by surrounding communities for deliveries. However, the vouchers in the family kit were for services at a different referral hospital which then became overcrowded while the maternity ward at *La Cité* emptied out.

<sup>34</sup> For example, in *Zambia*, a cost benefit analysis found that for a USD 4 input, the mama pack increased attendance for pregnancy and delivery care by 44 per cent and, if rolled out nationally, would avert 457 deaths for a total cost of USD 3490 per death averted. This is comparable to the costs per death averted of long acting insecticide treated bed nets (LLIN) for malaria at USD 3400. See: *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.

subsidised flat-rate cost (*tarif forfaitaire*). The voucher for antenatal care reduced the cost by half to USD 1.5 and, for an assisted delivery, to USD 7.5. If referred by a primary health centre, there was also a voucher for a caesarean section reducing the cost from USD 150 to USD 50. The kits targeted three levels of distribution. Firstly, to the household, the kit included oral rehydration solution with zinc, paracetamol, and micronutrients to enable families to treat diarrhoea, fever, and some forms of malnutrition; secondly, to pregnant women, a delivery kit to support access to ante and post-natal services and an assisted delivery; and thirdly, to the health facility, amoxicillin to support the prompt treatment of pneumonia in children.

### **Within primary health facilities**

In most countries, integration was effected in a number of ways, including through policy, programming, and training. In some settings, efforts were made to integrate critical, related services within health facilities in order to increase access for users. A good example of this is the significant effort made by the H4+JPCS to integrate PMTCT and paediatric anti-retroviral therapies into maternal and newborn services in facilities in target districts in *Zimbabwe*.

However, integration did not encompass all services, and the *Zimbabwe* field study shows that family planning was not well integrated into MNCH services in target districts. This may have been because there was a national family planning programme and the H4+ JPCS elected to focus its efforts and resources elsewhere. Some countries did pay more attention to the integration of family planning, but most H4+ JPCS countries were weak in addressing the family planning needs of adolescents.

### **4.2.3 Building demand for quality, integrated services**

For supporting evidence see Volume II, Annex 1, Assumption 2.3.

Building demand for quality (integrated) services among communities that were selected because they were marginalised, underserved, or neglected, was a challenging process requiring multiple levels of engagement. Community engagement was given varying degrees of support in H4+ JPCS countries. The H4+JPCS combined investment in building community demand across the ten countries averaged 10.42 per cent of all expenditure. However, this masks a significant variation across the ten H4+ JPCS countries. As little as 2.1 per cent of all H4+ JPCS expenditures in *Ethiopia* were targeted toward community demand while in *Liberia* it was 27 per cent (almost three times the average of the ten H4+ JPCS countries). *Guinea Bissau*, *Sierra Leone* and *Zambia* all spent under ten per cent while *Burkina Faso*, *Cameroon*, *Côte d'Ivoire*, *the Democratic Republic of the Congo*, and *Zimbabwe* spent between 10 and 13 per cent.

Along with an articulated sense of purpose to strengthen integration and the continuum of care, H4+ country teams invested in community engagement and mobilisation using a wide range of strategies and approaches. Generally speaking, these were adopted by H4+ partners in accordance with their specific roles, expertise or mandates.

UNAIDS focused strongly on the use of mass communications (mass media, print material, radio programming) while UNFPA worked more directly through support to community groups (peer educators, traditional and religious leaders, police). UNICEF also provided direct support to community organisations (to combat gender based violence) alongside material support to, for example, maternity waiting shelters. UN Women was the most active of all H4+ agencies in supporting the development and operation of community-based organizations engaged in addressing issues of girls' and women's empowerment and adolescent sexuality. WHO in contrast, provided most of its support to supply-side efforts such as the mama kits, but also engaged with communities on MNDSR. For a more detailed listing of community engagement efforts, see Annex 4.

### **Dimensions of community engagement**

Investment in community engagement was found in every H4+ JPCS country. In most settings, community engagement efforts went well beyond targeting mothers and their children and were

broadly based, including the active engagement of traditional leaders, religious leaders, older community members, teachers, police, health service staff more broadly and others following acknowledged best practice.<sup>35</sup> In several countries (*Cameroon, Côte D'Ivoire, the Democratic Republic of the Congo, Liberia and Zimbabwe*), mass media programmes including radio talk shows, were supported alongside activities that focused on specific communities.

### **Supporting interventions aimed at promoting gender equality**

Most countries also made efforts to address gender constraints, gender based violence, patriarchal views, early marriage, the role of men in supporting a healthy pregnancy and delivery and other social and cultural norms that limit the ability of girls and women to secure their sexual and reproductive rights.

#### **Box 9: Highlights of H4+JPCS supported interventions to promote gender equality**

In the **Democratic Republic of the Congo**, H4+JPCS supported a client satisfaction survey, assessing the level of satisfaction with RMNCAH services among women (2013). In 2015, UNFPA provided funding (USD 150,000) from its Canada grant allocation so that UN Women could support community outreach in Mosango and Kenge Provinces. The activities included training and involvement of religious leaders to support the promotion of women's rights and the fight against gender-based sexual violence as well as support to boys' and men's clubs to counter gender based violence.

In **Liberia** UNAIDS supported radio discussion programmes aimed at engaging men on gender equality issues including women's right to safe delivery, access to HIV and AIDS prevention and treatment and freedom from gender based violence. UN Women **supported community organizations discussing gender issues including violence. It also built peer educators' capacity for addressing gender equality, including separate groups for men, young mothers and adolescent girls and boys.**

In **Zambia**, H4+ JPCS provided support to youth centres, providing information and services on comprehensive sexuality education, gender based violence counselling, girls' empowerment and safe abortion services.

In **Zimbabwe**, UN Women supported a local women's rights organization to develop safe spaces as entry points for young people to discuss their sexual experiences and work on health and rights while identifying factors that limit them. They work directly with young women and girls (and boys) but also with parents, teachers, health-care providers and police. Issues of gender equality are also aired in meetings of women's and men's forums, supported by H4+JPCS. At district-level "be heard" festivals, adolescent girls share their experience with matrons, police, counsellors and educators. Community members report a more open discussion on preventing early pregnancy, early marriage and gender based violence (including among men) as well as the sexual rights of women.

Direct H4+JPCS support to efforts addressing gender inequality were mainly evident under programme output 7: demand creation, community ownership and participation. As a result, these were subject to the same constraints as other demand-side interventions: a small share of overall programme expenditures (10.42 per cent), a limited geographic reach, and funding that only became operational after the Sida grant was initiated.

There were, however, efforts to engage with service providers to improve their understanding of gender equality issues. For example, in *Ethiopia*, 114 government representatives and 228 health workers underwent training in gender mainstreaming in the health sector, clinical responses to gender based violence, and respectful service delivery sensitive to the particular needs of women. In

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<sup>35</sup> For example, see the UNICEF approach to social mobilisation and community engagement: [https://www.unicef.org/cbsc/index\\_65175.html](https://www.unicef.org/cbsc/index_65175.html) or from UNFPA: <http://esaro.unfpa.org/en/news/new-tool-men-and-boys-engagement> and UNAIDS: [http://www.unaids.org/sites/default/files/media\\_asset/20120628\\_JC2281\\_PromisingPracticesCommunityEngagements\\_en\\_0.pdf](http://www.unaids.org/sites/default/files/media_asset/20120628_JC2281_PromisingPracticesCommunityEngagements_en_0.pdf)

*Guinea Bissau*, support to the national health information system was directly focused on promoting gender equality. The H4+ partnership helped the Ministry of Health launch a full revision of the national health information indicators (SNIS). Attention was paid to the integration of gender equality and equity in data collection and analysis approaches.

### **The added value of UN Women and UNAIDS**

It is worth noting that in the six Sida grant-funded countries where UN Women was also engaged as an H4+ partner, the quality of community engagement was improved. The work undertaken by UN Women added significantly to the knowledge base of the H4+ JPCS and enabled the programme to target its activities better. An example can be found in *Zimbabwe*, where significant investment in community demand had been delayed from the onset of the programme. Once UN Women joined the programme (late 2012 and early 2013), demand-side activities were more diverse, including setting up peer support groups and safe spaces for youth, groups aimed at adults (men's groups, engaging parents etc.), addressing stigma around HIV and fistula, and establishing community-focused activities to encourage the use of health services. The advent of the Sida grant also saw increased efforts in community engagement and participation supported by UNAIDS. These efforts included support of mass-media campaigns on PMTCT and the rights of PLWHIV, as well as engaging with traditional leaders to address gender inequality.

### **Community focused accountability**

The establishment or revitalisation of community health governance structures was a feature of several H4+ JPCS programmes. In *Liberia*, the neighbourhood health committees helped ensure the safety and maintenance of the health facility. These committees also discussed community health problems and helped to design and implement solutions. Committees, in several of the H4+ JPCS focus districts, were willing and active in helping to build maternity waiting shelters.

There are different examples of community engagement geared towards revitalising community health structures and governance. In *Zambia*, the Community Health Advisory Committee in Lishuwa was "trained to maintain the facility and the health posts" but also to "recognise danger signs and to refer any form of bleeding".<sup>36</sup> In Binga, *Zimbabwe*, the Health Centre Committee meets quarterly to discuss matters of greatest concern to the community and the health centre. Their role includes helping disseminate information and education to the community. The Health Centre Committee in Mbire, *Zimbabwe* also helped to make bricks for the maternity waiting shelter.

## **4.2.4 The capacity triangle**

For supporting evidence see Volume II, Annex 1, Assumption 2.4.

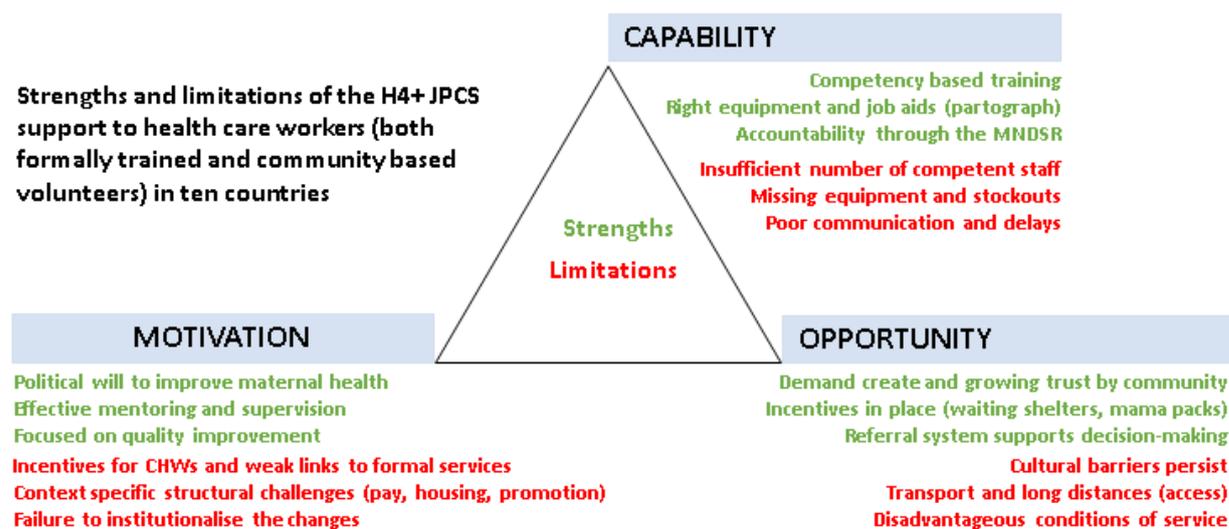
Every H4+ JPCS country invested in capacity strengthening aimed at improving the quality of RMNCAH care. While their shape and size varied, all programmes contained components of training (section 4.1.3), equipment and supplies (section 4.1.4) and efforts to strengthen access to improved services by underserved groups (section 4.2.3). In and of itself, training is usually not sufficient to effect significant quality gains, and the theory of change for the H4+ JPCS anticipated simultaneous investments to stimulate motivation and opportunity in addition to capability, all intending to change service provider behaviour. The relationship between capability, opportunity, motivation and behaviour change is often referred to as the COM-B model.<sup>37</sup>

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<sup>36</sup> Reference Volume II, Annex 1, Assumption 2.3

<sup>37</sup> For a full discussion of the COM-B model of behaviour change see: Michie et al., *The behaviour change wheel: A new method for characterising and designing behaviour change interventions* in *Implementation Science* 2011, 6:42 <http://www.implementationscience.com/content/6/1/42>

Figure 4: The capacity triangle<sup>38</sup>



### Capability

Investment in the capability of health facility staff is indicative of the consistency of H4+ JPCS across countries. Investments in capacity development as a means of strengthening quality of care took the form of: competency-based training, improved supervision, and expanded mentoring. Training and support to community health workers was also integrated into the programme in most H4+ JPCS countries. In the *Democratic Republic of the Congo*, 1,830 health extension workers were trained in 2014, while 120 community health workers were trained to distribute contraceptives in 2012, and 410 in 2013. Training included a range of key skills and behaviours encapsulated in community oriented EmONC, reproductive health, newborn health and HIV prevention courses and covered:

- Referring women to the clinic for antenatal care, delivery and postnatal care
- The warning signs in pregnancy (and the need for prompt referral)
- Helping babies breathe in their first days of life
- Advocating for family planning, delayed first births, and birth spacing
- Referral to the clinic for HIV testing and treatment
- In some countries (e.g. *Zambia* and *the Democratic Republic of the Congo*), infant nutrition and feeding.

Across the H4+ JPCS countries, community health workers expressed commitment to their work and pride in their roles supporting their communities. Yet, they also expressed their desire for more training, more integration into the health system and more consistent replenishment of their equipment (bicycles, raincoats, torch batteries to walk with women in labour more safely at night).

### Motivation

Motivation among formal and informal health workers improved as a result of the different programme investments, including investments in competency-based EmONC training. In *Zambia*, a midwife, recently returned from the H4+ JPCS EmONC course, explained how she had resuscitated a newborn at birth for the first time in her career. She said it made her feel “proud and strong”. In *Zimbabwe*, *Burkina Faso* and *the Democratic Republic of the Congo*, staff mentoring by older and more experienced health workers was seen to have a positive impact on skills and adherence to training. Improved skills and knowledge, combined with greater scope to use them, have contributed to increased motivation.

<sup>38</sup> Unless otherwise suggested, this section on the capability triangle refers primarily to evidence captured in the Evaluation Matrix under Assumption 2.2, lines 37-70.

The terms and conditions of employment were a common challenge and main demotivating factor for health workers. The main demotivating factors for staff related overwhelmingly to terms and conditions of service. Starting with low salaries, these encompassed opaque promotion policies, unpredictable and onerous re-posting arrangements (often taking health workers away from their families for months at a time), poor staff accommodation, and little or no supervision at times. Other than in *Guinea Bissau*,<sup>39</sup> there is no evidence the H4+ JPCS used its platform to try to engage with human resources policies at national or sub-national level. Most programmes operated within the confines of the existing context.

### Opportunity

The opportunity for health workers to deliver quality services increases when the right equipment and supplies are available and when more users attend services. In many of the H4+ JPCS districts stock-outs of essential supplies, staff shortages and challenges linked to the enabling environment (poor communications, long distances), limited the full potential of the staff to deliver quality services (see section 4.1.4). In terms of user demand, there was a visible increase in demand especially for institutional births and contraception services with some district health information system (DHIS) data suggesting a decline in maternal deaths.<sup>40</sup> In Lukulu, *Zambia*, attended births increased from 48 per cent in 2012 to 64 per cent in 2015. In Binga district, *Zimbabwe*, attendance by men accompanying their partners to antenatal care services reached 60 per cent in comparison to 11 per cent in other, non-H4+ JPCS districts, according to provincial health authorities.

In almost all H4+ JPCS programmes, service usage was significantly enhanced by the refurbishment or construction of maternity waiting shelters, an intervention that enabled women in remote areas to take up residence near the health facility, improving access to skilled attendance at delivery.

#### Box 10: Maternity waiting shelters

The maternity waiting shelters emerge as one of the main achievements of the H4+ JPCS programme, and a significant aid to increasing opportunity to reach quality services for the underserved. Maternity waiting shelters are not a new concept, but where they already existed in target communities they were dilapidated, poorly equipped and unsafe structures.

The H4+ JPCS supported building or refurbishing maternity waiting shelters in most countries and they consistently attracted a positive response from communities. For example, in *Zimbabwe* and in the *Democratic Republic of the Congo*, the development of maternity waiting homes attached to district hospitals and primary health facilities was credited with increasing access to facilities. This contributed to reducing time lost in reaching an appropriate health facility, one of the delays causing maternal deaths.

The process of building the maternity shelters often contributed to strengthening community engagement. They allowed women to respond positively to advice to deliver at a health facility, despite the challenges of poor roads and long distances.

<sup>39</sup> In Guinea Bissau, the H4+ JPCS used its role and resources to motivate for a nation-wide reform of user fees including the elimination of all fees for pregnant women and children, coupled with a salary incentive for all health workers. This is the only example of national scale policy action on human resources for health identified in the JPCS.

<sup>40</sup> While H4+JPCS has invested in supporting the reliability of DHIS systems in programme countries they often still under-report maternal deaths in the community. For that and other data quality reasons the evaluation has used this information to indicate trends over time rather than for absolute values.

#### 4.2.5 Balance, reach and sustainability

For supporting evidence see Volume II, Annex 1, Assumption 2.5.

##### **Developing trust between RMNCAH service providers and users**

As noted in section 4.1, H4+ JPCS support has contributed to visible improvements in the quality of RMNCAH services in target districts. These improvements have been enhanced by increased engagement with communities that have helped to challenge and shift harmful social practices and have brought about changes to community attitudes. For example, in *Liberia*, communities were quick to note that with the H4+ programme, it was “not necessary for women to die in pregnancy” if they went to the health facility. Indeed, one H4+ JPCS achievement may have been to foster this very idea: that women do not “have to die” during pregnancy and delivery when they have access to facilities like maternal waiting shelters and a reinforced referral network. This belief, coupled with improved quality care, helped combat the lack of trust between the community and the health services.

##### **Getting the balance right between supply- and demand-side investments**

The amount invested in community engagement and demand creation varied significantly across the H4+ JPCS countries. In general, country level programmes focus on strengthening supply-side quality more than demand creation. *Liberia*, for example, had the most developed community engagement and demand-creation approach. Yet, after the comprehensive engagement strategy was developed and funded, it became evident that each health facility had up to six catchment areas geographically. To reach all areas required up to three or four hours walking, while the funding for community engagement anticipated covering just one catchment area. As a result, much of the small budget to deliver a specific part of the programme (aimed at supporting men’s clubs) was spent funding individuals to travel significant distances to participate in one club rather than in six different communities. In *Zimbabwe*, community engagement activities often covered only one or two wards (out of as many as 30) in any given district.

##### **Lack of sustainability**

When asked, respondents in different countries were able to give some examples of which H4+ JPCS contributions would, or at least could, be sustained into the future:

- *The Democratic Republic of the Congo*: EMONC and HIV training modules; RMNCAH policy guidelines; the midwifery training curriculum; the family kit approach, integrated into national policy; the maternity waiting facility in Mosango; some aspects of national capacity strengthening (e.g. for MNDSR)
- *Liberia*: The MDSR process (as long as the national political commitment continues); capacitated community health workers who accompany women to the health facilities for safe delivery (especially if the planned new community health worker strategy is implemented); maternity waiting facilities; solar lighting to enable 24-hour deliveries and other clinic improvements; improved pre-service training for midwives and nurses
- *Zambia*: Specific commitments from the ministry to roll out strengthened RMNCAH services, including, for example, hiring retired midwives, enabling enrolled nurses to qualify as midwives, institutionalising the mama-packs; expanding MDSR processes across all districts; improved RMNCAH related infrastructure; expanding key policies, like the 48-hour postnatal check for mother and baby
- *Zimbabwe*: Upgrades in provider skills and infrastructure (provided a continued supply of life-saving RMNCH commodities); OR Upgrades in provider skills and infrastructure (provided the supply of life-saving RMNCH commodities continues); strengthened MNDSR systems at national, provincial and district level; the national policy of supportive supervision.

However, despite the potential for continuity, no country appeared to have invested in ensuring a managed, coordinated and coherent transition to a post-H4+ JPCS environment.

Across all H4+ JPCS countries, the sustainability of project investments remains unsecured. On both supply and demand sides, exit plans for H4+ JPCS were often underdeveloped. In most countries, little thought had been given to the termination of the programme and what would happen next. Transition arrangements were raised in some countries (for example, in *Zambia*) in 2013, although not followed through in a coherent way. Indeed, in several countries, end-of-programme arrangements were not communicated coherently to either the central or sub-national governments. There was weak planning at district level and insufficient links to follow-on programmes even where these did exist. In *the Democratic Republic of the Congo*, the H4+ JPCS community activities (particularly those targeting youth and rural women) came to an abrupt end without a clear plan to sustain them. There is, thus, significant potential to lose the gains achieved and to break trust with the community.

In addition, in the course of delivering results, the H4+ JPCS led to unintended consequences and sometimes, having addressed one layer of problems, exposed new ones, which remain outstanding as the H4+JPCS comes to an end. For example, in some cases, where traditional midwives were re-trained as community health workers, they effectively lost their livelihoods, since the payment structure associated with traditional birth attendants was not replaced in the new system. Another example of secondary consequences concerns the availability of food in maternity waiting shelters. While some country programmes tried to address food constraints (*Guinea Bissau*), others were unable to fully engage with the problem, or integrate a solution into the programme (*Zambia*).

The net result of this is the risk of a rapid erosion of the considerable gains made by the H4+ JPCS in the underserved areas where it has focused. This erosion entails not just backsliding on health gains but actually damaging trust with communities and eroding the confidence of host countries in the capacity of the H6 to support health systems strengthening. The loss of incentives to health staff was consistently raised across countries as an immediate and high impact effect of the imminent end of the programme, along with arrangements for the supply of basic RMNCAH commodities where the H4+ JPCS had been instrumental in supporting those.

#### **4.2.6 Expanding access: the need for greater emphasis on community engagement**

Ultimately, across the ten countries, the H4+JPCS made a significant contribution to achieving one of its main objectives: expanding access to quality, integrated care for those most in need. By investing in strengthening community demand for services in these areas, the programme contributed to improved outcomes such as reduced home deliveries, better attendance for four or more antenatal care visits, and increased uptake of family planning.

The importance of investing in demand-side strengthening became clear during programme delivery across all the H4+ JPCS countries. Where most successful, this engagement was targeted at different population groups and difficult geographic locations, and advocacy was used to increase demand for specific services. By focusing on marginalised populations and underserved geographical areas, the H4+ JPCS helped national authorities to expand services to previously excluded populations. The H4+JPCS was, largely, tasked with expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women.

The H4+JPCS demonstrated that it is feasible to make considerable progress around strengthening community demand within a restricted time frame (five years or less). However, getting the balance right between supply-side and demand-side efforts is challenging and, in most H4+JPCS countries, efforts were focused more on supply than demand. It is evident that the nature of demand-creation work is quite different from supply-side investment and requires extensive engagement within communities. These efforts were not costly (at just 10.42 per cent of total programme expenditures)

and could have benefited from a greater share of programme resources. The H4+ JPCS country (*Liberia*) that most convincingly engaged with demand-side strengthening spent a quarter of its budget on demand creation, including community ownership and participation. In addition, terminating the programme without sufficient handover or continuity arrangements in place could be harmful to community trust there and elsewhere.

On the whole, programmes that invested early on in building community demand were more successful at reaching targeted populations and in demonstrating a growth in demand. While not exclusively so, much of the demand-generation investment focused on community mobilisation, challenging norms and behaviours, building community skills and leadership, and strengthening communication, advocacy and educational processes. These interventions tend to be time intensive and slow to develop or take hold, but through establishing or revitalising community health worker programmes, the H4+ JPCS was able to strengthen integration of services, especially at the primary care level.

The ability of the H4+ JPCS to identify and systematically test coherent, comprehensive policy and programming approaches to meeting the needs of adolescents and youth was uneven, however. While some country programmes (*Liberia*) were more successful than others (*Zimbabwe*), the H4+ JPCS, as a whole, was not an effective instrument for making a substantial contribution to knowledge about how to design and meet the sexual and reproductive health needs of young people.

There were other missed opportunities to integrate a full range of services across the continuum of care, including family planning (*Zimbabwe*) and few of the H4+ JPCS countries addressed the specific needs of disabled communities. On the other hand, the H4+ JPCS was effective at supporting the integration of national and sub-national HIV and AIDS policy and programming into health services, including the early detection of HIV in new-borns, the integration of Option B+ policy, and the expansion of paediatric anti-retroviral therapy services.

The H4+ JPCS has also been able to implement some important demand-side innovations, which have been effective and practical (retraining community health workers to accompany pregnant women to the health facility, distributing mama packs, building maternity waiting shelters) approaches to reaching marginalised communities and increasing access to vital RMNCAH services. However, with a few exceptions, these demand-side activities were not well documented, formally assessed or measured and few were integrated systematically into national policy or on track to be scaled up methodically. As a result, other development partners were not always aware of H4+JPCS-funded improvements. The opportunity to demonstrate to other partners or other countries how to make progress around building demand for integrated services was thus not fully optimised.

### 4.3 Responding to national and local needs

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

#### Summary

- The H4+ JPCS programme **responded to national needs and priorities** and was aligned to national RMNCAH policies and programmes. **Ministries of health actively participated in original programme designs**, ensuring that the **interventions were well embedded in the national policy framework** for RMNCAH.
- The **effectiveness of the H4+ JPCS coordination mechanisms** and their responsiveness **varies significantly among countries**. Some have established an effective “coordination chain” all the way from national to district levels, which **enabled the H4+ country teams to effectively track and respond to needs**. In others, this chain was less inclusive of all stakeholders (especially NGO implementing partners), and never extended to the district level.

- The **effectiveness** of H4+ JPCS coordination is **dependent on the level of government leadership**.
- **H4+ partners speak with one voice and are more effective in providing coherent policy advice to governments**. Collaborating on the planning and implementation of a **jointly-funded programme improved coordination** among the H4+ partners.
- H4+ JPCS has been **responsive to changing conditions and emerging needs**, notably through the reprogramming of activities to better respond to the Ebola recovery period, and an increased focus on youth in many countries.

### 4.3.1 Effective country-led coordination and planning

For supporting evidence see Volume II, Annex 1, Assumption 3.1. and Assumption 3.2.

#### Establishment of effective H4+ JPCS coordination mechanisms at national level

After an initial period of adjustment, the H4+ JPCS was well coordinated at the national level in most countries, usually through an interlocking set of coordinating mechanisms, including:

- Monthly inter-agency technical meetings
- Joint coordinating meetings with the participation of ministries of health and H4+ partners
- Quarterly or biannual heads of agencies meetings
- Joint field supervision visits (ministries of health and H4+ partners)
- Inter-country meetings, (which provided an opportunity for ministries of health and H4+ partners to jointly present and discuss programme achievements and challenges)
- Integration of H4+ JPCS coordination into existing planning and review mechanisms.

Mechanisms for jointly planning, coordinating and implementing the programme were not uniform in all programme countries and were not static over time. Table 8 presents the most important features of H4+JPCS coordination mechanisms in each country. They illustrate the adaptive and evolving nature of the coordination arrangements used by the programme in the changing national contexts it encountered.

**Table 8: Features of programme coordination mechanisms by country**

Features of Programme coordination and review mechanisms	Countries where features are evident
Ministry of health and H4+ partners jointly develop annual workplans and frameworks	All ten countries
NGO implementing partners participate in developing annual workplans and budgets	Cameroon, Zambia, Zimbabwe
National ministry of health technical working groups and H4+ partners coordinate implementation and review progress	Ethiopia, Liberia, Zambia,
A formal national steering committee for the H4+ JPCS	Burkina Faso, Zimbabwe
Joint planning and supervision undertaken by ministries of health, H4+ partners and implementing NGOs at both national and sub-national levels	Cameroon, Zambia, Zimbabwe
Coordination of H4+JPCS implementation through a broader RMNCAH Task Force, committee or technical working group.	Sierra Leone, DRC (at times)

In all ten countries, ministries of health and H4+ members jointly developed annual workplans and monitoring and evaluation frameworks through a consultative process. Regular H4+ planning and coordination meetings were most often attended by ministry of health representatives and H4+ members. In a few countries (*Cameroon, Zambia, Zimbabwe*), non-governmental implementing

partners also joined in planning meetings. In those countries, joint field supervision visits helped ministry of health and H4+ partners to gain a shared understanding of gaps and progress at the operational level.

In *Burkina Faso* and *Zimbabwe*, there was no formal national H4+ coordination mechanism until mid-2014, after which both countries established a national H4+ JPCS steering committee in response to an urgent need to improve programme coordination and collaboration among key stakeholders at all levels. In *Zimbabwe*, coordination became very effective under government leadership after this point, while H4+ partners in *Burkina Faso* continued to face challenges in establishing joint coordination with the ministry of health. This was partly due to the high turn-over of ministry of health staff caused by ongoing political instability and a lack of visibility of the H4+ JPCS at sub-national level.

In *Sierra Leone*, the programme relied on existing mechanisms for coordinating RMNCAH activities, including the national technical working groups on reproductive and child health and the national health sector coordinating committee. This worked reasonably well during the first two years of the programme. However, in 2014, with the advent of the Ebola virus disease crisis and an internal crisis in the Reproductive and Child Health Directorate of the Ministry of Health, these mechanisms were suspended or did not function well. In 2016, heads of agencies in Sierra Leone recommended re-establishing effective H6 coordination.

In the *Democratic Republic of the Congo*, coordination of the H4+ JPCS has shifted from use of a pre-existing sub-committee of the national health sector coordinating committee, to a separate joint national H4+ JPCS coordination committee established in 2012. It was then reintegrated into the national RMNCAH Task Force in 2015. Unfortunately, this reintegration has coincided with a decrease in the effectiveness of programme coordination in the *Democratic Republic of the Congo*.

The effectiveness of programme coordination mechanisms varies considerably across the ten H4+JPCS countries. While there is no one combination of the features, outlined in Table 9, that proved especially effective, appropriate combinations of these features and other, contextual factors did have a demonstrable impact on the effectiveness of H4+JPCS.

### **Coordination mechanisms are inclusive and reach to sub-national levels**

H4+ partners recognised that using existing structures for coordination would require operational coordinating platforms from central to sub-national levels, yet not all countries had such platforms.

In recognition of this weakness, many H4+ JPCS programmes supported activities to strengthen existing RMNCAH or health sector coordinating committees. In the *Democratic Republic of the Congo*, the H4+ JPCS provided financial and technical support to district review and planning meetings as well as to national and regional RMNCAH Task Force meetings, although this support seemed to diminish significantly in 2015 and 2016. In *Cameroon*, the H4+ coordinator (UNICEF) was based in the Extreme North region, which facilitated frequent participation in planning and review meetings and contributed to capacity development of regional and district health teams. The H4+ JPCS in *Ethiopia* provided support to the 2013-14 annual health sector review meeting at both national and regional levels.

Despite these efforts, there were variations among countries with regard to responsiveness to local needs and to the effectiveness of sub-national coordination with key stakeholders. In *Cameroon*, *Zambia* and *Zimbabwe*, this process worked well because H4+ JPCS established coordination mechanisms that extended all the way to district level. In *Zambia*, the efforts made by the H4+ JPCS to deliver the programme largely through district health authorities (as implementing partners) helped to build local capacity and enabled coordination at sub-national levels.

### Box 11: Responding to the needs of local health authorities in Cameroon

In *Cameroon*, the H4+ coordinator (UNICEF) is based in the UNICEF regional office in the Extreme North Region. This facilitates capacity development of regional and district health authorities and enables closer monitoring and supervision of H4+ JPCS activities. Key features of this coordinating mechanism include:

- Weekly H4+ JPCS coordinating meetings convened by the Regional Health Department with the participation of the H4+ coordinator, H4+ focal points (United Nations agencies) based in regional offices and staff of the Regional Health Department
- Ad hoc and quarterly review and planning meetings of district health teams and regional health departments, improving communication and responsiveness to local needs
- A better understanding by the H4+ coordinator of challenges/needs at district levels, leading to more integrated support of RMNCAH.

The programme took effective steps to link the national and sub-national levels by:

- Establishing a “core team” comprised of ministry of health representatives and H4+ members from both the central and regional levels
- Identifying a direct national counterpart to the H4+ coordinator at the ministry of health in Yaoundé, with meetings on a monthly basis.

The coordination process encourages attendance by a wide range of key stakeholders, from local community and health facility to central level, for coordination, planning and review meetings.

#### Missed opportunities to effectively respond to subnational needs

H4+JPCS did miss some opportunities to effectively respond to local needs and strengthen programme coordination. This is particularly evident in the planning and timely sequencing of inputs among H4+ members themselves and with other RMNCAH partners.

In the *Democratic Republic of the Congo* and *Liberia*, NGO implementing partners were not invited to participate in the H4+ JPCS coordinating mechanisms, which adversely affected the complementarity of their activities at health facility and community levels. In both countries, implementing partners had not met as a group during implementation of the programme. They had no opportunity to coordinate their efforts to minimise duplication, or to develop a coherent policy approach.

In *Zambia*, while H4+ JPCS was generally responsive to health authorities at national and subnational levels, it also had some unresponsive features. For example, H4+ JPCS created a separate monitoring process running in parallel to the national health management information system, to track the H4+ JPCS indicators. This added little value to Zambian information systems. Similarly, the shift from district-centred procurement to use of the UNICEF central procurement system sometimes led to procurement of equipment and materials that did not correspond to local needs or systems.

In *Burkina Faso* and the *Democratic Republic of the Congo*, coordination was not effectively extended to sub-national levels. In both countries, local health authorities did not have a clear understanding of H4+ JPCS and felt that the planning approach was more top-down than bottom-up.

Factors sometimes limiting the responsiveness of H4+JPCS to local needs include:

- Poor communications between different levels of the ministry of health structures (district health teams, provincial health departments and ministry of health at central level)
- Insufficient national capacity (and limited support from partners) to organise provincial or regional planning and review meetings
- Irregular participation of H4+ members in planning meetings and lack of timely feedback on the workplans from headquarters to district and facility levels.

## The role of national authorities in H4+ JPCS coordination

H4+ JPCS strived to place national health authorities at the centre of the programme by supporting country leadership and ownership. However, the extent and nature of the leadership role taken by national health authorities varied among the programme countries.

**Table 9: Aspects of national engagement in coordination**

Features of national leadership and coordination	Countries where features are evident.
Ministry of health engaged in programme planning	All ten countries
Ministry of health demonstrated leadership by linking programme to national RMNCAH coordinating mechanisms and established programmes	Cameroon, Ethiopia, Guinea Bissau, Zambia and Zimbabwe
Health authorities' leadership role in coordination extends to sub-national levels	Cameroon, Zambia, Zimbabwe
H4+JPCS national planning, coordination and review meetings chaired by senior ministry of health staff	Cameroon, Côte d'Ivoire, Zimbabwe
Lack of national coordinating capacity limits health authority leadership	Burkina Faso, the DRC, Liberia

In countries where the technical working groups or national steering committee was chaired or co-chaired by senior ministry of health officials and attended by a range of ministry officials as well as H4+ focal points, H4+ JPCS interventions were aligned and largely consistent with national policy for RMNCAH.

Selecting the districts as primary implementing partner in *Zambia* placed the national health authorities in a leading role. In *Ethiopia*, the H4+ JPCS clearly contributed to an already on-going national strategy and RMNCAH plan led by the ministry of health. H4+ partners reacted positively by supporting the leadership role of the ministry of health and by engaging in coordination and planning mechanisms at all levels.

### Box 12: Country leadership and ownership of H4+ JPCS in *Guinea Bissau*

In *Guinea Bissau*, from its beginnings, the H4+ JPCS programme proved responsive to national needs and priorities by involving the ministry of health (MINSAP) in initial planning and by conducting detailed gap analysis studies in RMNCAH. Features of national leadership in *Guinea Bissau* include:

- H4+ JPCS coordination led by the MINSAP, which was also the principal implementing partner
- Biannual meetings convened by MINSAP to coordinate the H4+ JPCS grant and the European Union funded programme (PIMI) to implement high impact MNCH interventions
- A close technical and working relationship between the PIMI team and H4+ partners with regular meetings to “coordinate approaches during implementation”
- Coordination mechanisms and processes designed to continue operating (to coordinate other programmes) after the completion of the H4+JPCS
- Active engagement by MINSAP, the H4+ partners and the European Union in efforts to build continuity in funding support going forward.

In some countries (*Burkina Faso, the Democratic Republic of the Congo, Liberia*), government engagement and leadership of H4+ JPCS programme coordination was less effective. In *Liberia*, the structure of H4+ JPCS, including its coordination mechanisms and implementation modalities, did not place the country fully at its centre. A large share of the H4+ JPCS programme was delivered through NGO implementing partners rather than through national and sub-national county health authorities, which limited their involvement in coordination.

In the *Democratic Republic of the Congo*, the ministry of health leadership and involvement in joint coordination was reportedly effective until the end of 2014, but diminished from 2015 onward. As the task of H4+JPCS coordination was integrated into the national RMNCAH task force in 2015 (and the

Division for Family Health was unable to convene any of the four planned task force meetings) the net effect was to suspend joint coordination of the programme for at least that year. In the same year, the decision of the H4+ coordinator (UNFPA) to drop provincial health departments and NGOs from the list of implementing partners and replace them with only one partner (the ministry of health at central level) caused disruptions in working relationships and weakened the sub-national component of programme ownership.

### 4.3.2 Flexible responses to changing conditions

For supporting evidence see Volume II, Annex 1, Assumption 3.3. and Assumption 3.4.

#### Responsiveness of H4+ JPCS coordination to changing needs

H4+ JPCS used existing health sector coordinating platforms as well as quarterly and annual review and planning meetings to identify and respond to changing conditions and emerging needs at national and subnational levels. In some places, disruptive changes were limited to the introduction of new approaches or reprogramming of activities. In *Liberia* and *Sierra Leone*, H4+ JPCS was confronted by the Ebola virus disease epidemic and a nearly total suspension of H4+ JPCS coordination in 2014.

**Table 10: Examples of flexible responses and reprogramming by H4+JPCS**

Examples of flexible responses and reprogramming
<b>Burkina Faso:</b> Parent-child-dialogue introduced at the request of the Division for Family Health to strengthen youth and adolescent interventions; health financing support to free services policy.
<b>Cameroon:</b> Bottleneck analysis (2013) identified: emergencies in the Far North region, insecurity and insufficiency of human resources as key impediments. 2015-16 Action Plan adjusted to directly address identified challenges.
<b>Côte d'Ivoire:</b> Family planning and other RMNCAH services integrated into practices in health clinics of secondary school and universities.
<b>The Democratic Republic of the Congo:</b> H4+ JPCS interventions re-aligned to: a) fit the 2013 RMNCAH road map (e.g. the family kits approach), b) increase the focus on youth over the lifetime of the programme and, c) support the national health sector coordinating committee (introduced in the 2015-2016 workplan).
<b>Ethiopia:</b> A mentorship programme for midwives introduced in response to identified gaps in performance.
<b>Guinea Bissau:</b> Five planned activities were re-programmed in 2015-16 as no longer needed.
<b>Zambia:</b> Increased focus on adolescent, male involvement in RMNCAH, and preventing early pregnancies over time.
<b>Zimbabwe:</b> Operational need for increased investment in training and supportive supervision for EmONC raised by districts in 2013 were addressed in programming for 2014 and 2015.

#### H4+ JPCS responsiveness to the Ebola epidemic

The outbreak of Ebola virus disease in 2014 severely affected the H4+ JPCS programme in *Liberia* and *Sierra Leone*. In both countries, programme implementation slowed down, expenditure rates almost stopped and coordination mechanisms broke down during the outbreak. Most staff in United Nations agencies, including H4+JPCS focal points, were deployed in direct support of the overall Ebola virus disease response. The crisis disrupted programme coordination structures and brought innovative experiments to a halt. The H4+ partners demonstrated their ability to contribute to the response and, after the most acute phase of the crisis had passed, acted quickly to re-vitalise the programme in both *Liberia* and *Sierra Leone*.

#### Box 13: H4+ JPCS responsiveness to the Ebola epidemic

In *Liberia*, the outbreak of Ebola virus disease had a major impact on the H4+JPCS. Most programmes across the country were suspended as a matter of course (on the instruction of the President). H4+ JPCS was *de facto* interrupted for a considerable period. A large proportion of maternal health facilities were closed across *Liberia*, especially through the middle and end of 2014. Training was abandoned and routine activities were

delayed. All health facilities in River Gee county were completely closed (during October 2014), due to a lack of infection-prevention control materials.

Despite a nearly total collapse of the programme during the Ebola virus disease, there are positive examples of effective adjustments and reprogramming. As the outbreak ended, three new counties were added to the H4+ JPCS programme in Liberia as a direct response to the disease. Additional funds were allocated to help the worst affected counties respond to health systems strengthening challenges.

In *Sierra Leone*, the H4+ JPCS programme shifted strongly to commodity support in response to the Ebola virus disease crisis while advocating for a quick return to prioritising MNCH during the post-crisis recovery programme to make up for lost momentum. As early as March 2014, H4+ agencies began to advocate for the need to ensure safe delivery during the Ebola crisis. As a result, they reprogrammed 2014 funding to provide medicines, equipment and supplies for infection prevention and control and safe delivery services.

#### **H4+ JPCS and other coordination mechanisms for RMNCAH**

H4+ JPCS coordinating committees did not generally overlap or duplicate the work of other RMNCAH and health sector coordinating mechanisms. In many countries, the H4+ JPCS programme provided financial or technical support to diverse coordinating committees responsible for: the annual health sector review meetings at national and provincial levels (*Ethiopia*); Joint Assessment of National Health Strategies (JANS) (*Guinea Bissau*); the national and provincial RMNCH Task Force meetings (*the Democratic Republic of the Congo*); or the coordination of revision and consolidation of the national HMIS indicators (*Guinea Bissau*).

The programme also helped to strengthen the RMNCAH focus of other national committees. H4+ JPCS often played a leading role in supporting the government to establish national MDSR committees and other high-level multi-sectoral platforms for coordinated action in RMNCAH. In *Liberia*, H4+ JPCS supported the revitalisation of the national MDSR committee through a national and county level process. In *Cameroon*, joint advocacy efforts by the H4+ members reportedly led to the establishment of a multi-sectoral National Committee to Fight Maternal Neonatal and Infant Mortality by the President's Office with strong operational linkages to H4+ JPCS coordination. In *Guinea Bissau*, the H4+ JPCS was effective in advocating for a more coherent and unified approach to RMNCAH, shaping a new national platform for coordination, and aligning the few other donors present in the country to national RMNCAH priorities.

On the other hand, the programme missed some opportunities to strengthen the RMNCAH focus of national health sector coordination. In *Burkina Faso*, *Liberia* and *Zambia*, the H4+ JPCS programme had little discernible influence on shaping or establishing new national coordination platforms for RMNCAH. In some countries (*the Democratic Republic of the Congo*, *Liberia*, *Zambia*), bilateral donors (Global Affairs Canada, DFID and USAID) expressed a concern that H4+ members have not 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.

#### **4.3.3 H4+ JPCS and the changing nature of the partnership**

For supporting evidence see Volume II, Annex 1, Assumption 3.1.

##### **H4+ JPCS effects on partnerships among H4+ members**

The experience of designing and implementing the H4+ JPCS programme has had a positive influence on the level and substantive nature of partnership among the H4+ members. It has enabled them to speak in a more unified, coherent way on maternal and neonatal health policy and to build a more team-based approach to programme implementation. This positive change was raised as one of the most significant achievements of the H4+ JPCS by health authorities (national and sub-national), H4+ country team members as well as bilateral and NGO development partners active in RMNCAH.

Senior ministry of health officials reported a significant change in the willingness of the H4+ partners to work together and recognised the improved coordination among United Nations agencies brought about by the H4+ JPCS. In *Liberia, Zimbabwe* and *Zambia*, senior ministry of health staff commented that H4+ members speak more consistently in support of policies and priorities. “Before the advent of the steering committee, one H4+ partner would come to us and say, let’s do X, then another would come and say let’s do Y. Even among the H4+ partners themselves, the visibility of H4+ was very low” (*Zimbabwe*).

Others noted that H4+ members used to work in silos, but speaking with the same voice has had a positive effect on joint H4+/ministry of health collaboration: “We have learned to work together. 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 (...). Now, activities are better coordinated [among H4+ agencies]. That is the most important change” (*the Democratic Republic of the Congo*).

In some countries, encouraged by the positive results of improved coordination at both institutional and operational levels, WHO, UNICEF and UNFPA have submitted additional joint programme funding applications as a group, building on their experience of delivering together. In *Burkina Faso, the Democratic Republic of the Congo* and *Zambia*, the H4+ members were awarded grants by the RMNCH Trust Fund to roll out a similar or complementary package to the H4+ JPCS in the same or additional districts.

#### **Role of joint programming of H4+ JPCS funds**

The experience of jointly programming H4+ JPCS funds was a critical factor bringing the H4+ members closer together and reaching new levels of coordination and partnerships in RMNCAH.

As noted by one H4+ partner representative, what made the H4+ JPCS work was the availability of even a small amount of flexible, catalytic funding: “We need the funds ‘to gel’. The funding helps us mobilise to do the work – to come together as a movement.” Another said, “We are making sure that the funding is going to the right places and at the same time, coming together in terms of our thinking.” In the *Democratic Republic of the Congo*, designing and implementing a joint programme at district level allowed H4+ partners achieve the necessary results at operational level, to show government and other partners in RMCNAH what can be achieved through more efficient coordination and collaboration.

#### **Sustainability of new levels of coordination**

Ministry of health representatives and H4+ members consistently noted that the new levels of coordination that H4+ JPCS brought about in many countries will continue after the end of the programme. In the *Democratic Republic of the Congo*, H4+ members stated that 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”. This view is shared by key stakeholders in *Burkina Faso, Cameroon, Côte d’Ivoire* and *Zimbabwe*.

However, H4+ members and ministry of health officials also stressed that a minimum level of financial resources will be necessary to sustain the collaboration, including joint field visits and planning and review workshops. In *Zimbabwe*, senior managers at the MoHCC indicated that the main features of H4+, including its coordinating mechanisms, will be incorporated in the new “Health Development Fund” programme: “What H4+ has brought to the situation that is new is a new era of coordination. The government has recognised how effective the H4+ coordination has been and wants to use the model in the coordination of the new Health Development Fund” (H4+ country team member). However, they also fear that the focus on MNCAH and on innovation that came with the national H4+ JPCS steering committee (and the funded initiatives it coordinated) may be lost.

### 4.3.4 Responding to national needs and strengthening H4+ collaboration

The effectiveness of H4+ JPCS response to national and local needs was dependent on effective coordination, all along the “coordination chain”, from national to district and community level. This effectiveness, in turn, was often conditioned by the political environment, national commitment and leadership. Although these conditions have shaped and influenced the ability of H4+ JPCS to be responsive to national and local needs, H4+ members also had an important responsibility and role to play in actively supporting and strengthening national coordination.

At national level, in most countries, H4+JPCS opted to create a separate technical working group or national steering committee to coordinate joint planning and implementation. In some countries, the joint coordination platforms either had a very slow start or were only established towards the mid-term (such as in *Zimbabwe* or *Burkina Faso*). The programme could have benefitted from a much faster set-up of these coordinating mechanisms and a more effective linking of the “coordination chain” from national to sub-national levels, as it would have improved alignment and responsiveness to local needs. Once in operation, however, these dedicated, H4+-focused coordination mechanisms were effective in matching programming to needs and priorities at a national level.

Those countries that relied on existing national coordinating mechanisms in RMNCAH to coordinate the work of H4+JPCS often experienced difficulties. In the *Democratic Republic of the Congo*, *Burkina Faso* and *Sierra Leone*, existing health sector coordination platforms functioned sub-optimally in the absence of strong national leadership. In fact, broader coordinating mechanisms were unlikely to direct effective attention to programmatic issues relevant to H4+JPCS. Resorting to broader national coordinating mechanism also runs the potential risk of diluting a strong programme focus on RMNCAH and innovation, as in *Zimbabwe*, where the H4+ JPCS coordination mechanisms will be rolled into the larger Health Development Fund coordinating platform. However, the sustainability of coordination efforts is more likely if coordination of RMNCAH interventions is consolidated under existing health sector structures.

Over time, the H4+ partners strengthened and deepened the level of coordination and collaboration characterising their level of partnership. This was based on the experience of jointly programming H4+JPCS funding, dedicated specifically to action in support of RMNCAH. The result was a more coherent policy engagement with national and local health authorities and a programmatic response which better suited national and local needs and priorities. It also helped to reduce barriers to effective collaboration among other stakeholders, including health authorities and bilateral partners.

## 4.4 Supporting innovation

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

### Summary

- In all ten H4+ JPCS countries, one or more **innovations were identified and implemented**; several were **potentially of high impact**.
- There were clear examples of **linkages to global best practices and guidance**, although this was not well described or documented.
- There was **no consistent pattern of support from either the global or the regional level to foster innovation** across the countries reviewed.

- H4+ country programmes documented innovations and good practices; however, there was an emphasis on the generation of narratives and human interest stories. **Overall, there was a lack of systematic evidence-based documentation that quantifies investments and costs.**
- **There was no process for the systematic sharing of knowledge with decision makers; this** led to missed opportunities for influencing stakeholders beyond the H4+ partnership.
- There has been **success in generating interest from national authorities in some H4+ JPCS-supported innovations**, with some emerging plans for inclusion in national policies and programmes, although the future for implementation is unclear, given the end of funding.

#### 4.4.1 Defining innovation and identifying potential, high impact innovations

For supporting evidence see Volume II, Annex 1, Assumption 4.1.

A major objective of the H4+ JPCS is to identify, document and support innovative approaches to deliver effective interventions and to provide evidence of what works for adaptation and rollout in other high-burden countries. Midway through the implementation of H4+ JPCS, the secretariat issued a guidance note for documenting innovations, which included a definition of an innovation in the context of H4+: “Novel or newly packaged, scalable approaches aimed at improving outcomes relevant to the continuum of maternal and newborn care.”<sup>41</sup> The guidance further stipulated that the approaches identified as innovative were not required to be new to the global public health domain, but could be new to a specific country programme context.

##### Identification of potential, high impact innovations

This practical definition allowed countries to identify practices that made sense in their own specific context. It also resulted in a diverse range of innovations identified or supported by H4+ JPCS. In all ten countries, innovations were identified and implemented. However, it was not always clear how a particular innovation was identified, on what evidence it was based, and what design process led to its selection. Nevertheless, several potentially high impact innovations were identified and implemented contributing to improved RMNCAH services (Table 11).

##### Link to global best practices

Most of the H4+ supported innovations responded to health system challenges and, as such, were well aligned with the goal of supporting improved RMNCAH services. There were also some clear examples of linkages to global policies and practices (Table 11). However, innovations were most often seen to originate in a “common sense” approach to adopting good practices or revitalising practices that had worked before but required regeneration.

**Table 11: H4+ innovations related to capacity, supply and demand considerations<sup>42</sup>**

Country	Innovative intervention	Genesis of innovation
<b>Capacity-related innovations</b>		
<b>DRC</b>	Competency-based EmONC training	Global best practice
<b>Liberia</b>	Trained traditional midwives	Country-based innovation
<b>Zambia</b>	Contracting retired midwives approach	Country-based innovation
<b>Zimbabwe</b>	Clinical mentorship	Country-based innovation, based on WHO guidelines

<sup>41</sup> H4+ Agencies 2013. *Guidance for Documenting Innovative Approaches*, November 2013, p. 3.

<sup>42</sup> For an in-depth description of each innovation see Volume II, Annex 4: Interventions and Innovations by Programme Country.

Supply-related innovations		
<b>DRC and Guinea Bissau</b>	Maternity waiting homes <sup>43</sup>	Global best practice
<b>Liberia</b>	Non-pneumatic anti-shock garment (NASG)	Emerging global best practice, under study and WHO guidance
<b>Liberia</b>	Solar suitcase portable power system	Global innovation
<b>Zambia</b>	Postnatal checks at 48 hours after delivery	Country-based innovation
<b>Zimbabwe</b>	Point of care (PoC) CD4 machines	Global innovation
Demand-related innovations		
<b>DRC</b>	Family kit approach with vouchers	Country-based innovation
<b>DRC</b>	Flat rate pricing of EmONC services	Country-based innovation
<b>Zambia and Liberia</b>	Mama packs	Global practice

#### 4.4.2 Supporting design, implementation and monitoring of innovations

For supporting evidence, see Volume II, Annex 1, Assumption 4.2.

##### Global and/or regional technical assistance in support of innovation

There was no consistent pattern, from either the global or the regional level, to providing technical support innovation across the countries reviewed. H4+ JPCS was late in engaging with regional offices and did not develop terms of reference specifying their role in providing technical support to country teams.

Some countries, however, counted on, and had access to, regional and international experts who provided technical assistance to implement innovative approaches under H4+ JPCS. In the *Democratic Republic of the Congo*, UNICEF received support to develop the family kit approach from technical teams based in headquarters and the regional office (RO) in Dakar. In *Liberia*, an H4+ implementing partner, Save the Children, conducted training courses on EmONC, the non-pneumatic anti shock garment (NASG) and kangaroo mother care (KMC). In *Zambia* and *Zimbabwe*, on the other hand, technical support generally came from within the country. For example, in *Zambia*, the support for the retired midwives approach came from within H4+ partners for the design and development of contracts and supervision. In *Zimbabwe*, each H4+ agency relies on internal expertise and on MoHCC and had access to, and used, country-based institutions and consultants.

##### Application of practical tools to support innovation programming

Country managers implementing H4+ innovations utilised guidelines and documents in a variety of ways. *Burkina Faso* consulted documentation produced by UNFPA for implementing the husbands' school approach in *Niger* to guide replication of this approach and to garner constructive men's engagement in supporting wives to access RMNCH services. In the *Democratic Republic of the Congo*, staff drew on documents provided at H4+ JPCS inter-country meetings and regional workshops, in particular standards and guidelines related to EmONC for competency-based, in-service capacity development, and data collection and reporting tools. In *Liberia*, the introduction of non-pneumatic anti-shock garments was based on WHO guidance on the prevention and treatment of post-partum haemorrhages (PPH) and the interagency-produced compendium of essential equipment for managing maternal and newborn emergencies (WHO, UNFPA, UNICEF).

<sup>43</sup> 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](http://apps.who.int/iris/bitstream/10665/63432/1/WHO_RHT_MSM_96.21.pdf)

Similarly, WHO-produced guidance was the basis for the development of national level guidelines for clinical mentoring produced in *Zimbabwe* in 2015. However, more generally, the H4+ team in *Zimbabwe* was unaware of many of the global products disseminated by headquarters for use in programming. Many of these products were quite relevant to the initiatives being undertaken in-country and (despite the production by H4+ of a compendium of case studies to inform countries about innovative approaches in MNCH) were not well communicated to country teams.<sup>44</sup>

#### 4.4.3 Documentation and gaps in the innovation cycle

For supporting evidence see Volume II, Annex 1, Assumption 4.3.

Although H4+ promoted a practical definition for innovation (see 4.4.1), it did not have a systematic process or model in place to support the innovation process. Ideally, this process would include the full cycle of innovation, with all the stages shown in Figure 5 below. It is unrealistic to expect H4+ to document every programme innovation according to this cycle, especially given the relatively short time frame for programme implementation. However, the cycle provides a roadmap to indicate where documentation exists and where there may be gaps to support an understanding of the programme implications for future replication and scale up of a specific innovation.

**Figure 5: The innovation to policy and scale-up process**



#### Information on the success or failure of innovation

The H4+ global team offered the country teams guidance for documenting innovations (Box 13), a process somewhat more simplified than the cycle described in Figure 5. Country programmes were urged to provide descriptive summaries, using a case study format, or as an academic/peer review journal article. This did not translate into systematic, evidence-based documentation that quantifies costs and results. Instead, it resulted in the generation of narratives that offer stories of “what works.” As a result, the programme lacked a proactive learning agenda that prioritised key, strategic innovations that were being tested in more than one country.

<sup>44</sup> Volume II, Annex 1, Assumption 4.3

#### Box 14: H4+JPCS guidance for documenting innovative approaches, November 2013

##### Proposed sections:

- 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
- Results: these should include progress, coverage and verified results and whether it is being replicated elsewhere
- Lessons learned: these should include enabling and constraining factors, and how these were respectively leveraged or overcome.

Country offices responded to requests from headquarters to document good practices that could be used for promotional purposes. In general, these stories are helpful for communicating the work of the project, but do little to assess success or failure of an innovation or contribute to an understanding of the innovation process. In *Guinea Bissau*, case studies on the experience of maternity waiting homes, midwifery training, and gender quality tracking are in development. In *Cameroon*, efforts to document activities continue, including the H4+ experience with MNDSR.

In *Liberia*, H4+ country partners indicated their interest in documenting innovations, but found it difficult to dedicate time to this task. Likewise, in *Burkina Faso* there are indications (in reports and minutes from coordination meetings) that documenting innovation is a priority, however, there are no specific recommendations on how to carry this forward. While innovation was highlighted as a priority of the programme in *Zimbabwe*, the routine and intensive acts of programme coordination take precedence over investing in documenting the process and results for future use.

However, H4+ has occasionally supported more systematic documentation of innovation. In *Côte d'Ivoire*, a study was conducted to assess the "husbands' school" initiative and explore men's knowledge, attitudes and practice related to post-natal care, family planning, STI/HIV, and gender based violence. In addition, four surveillance missions were conducted in three regions with the results used to inform guidance on the husbands' school approach.

##### Knowledge sharing of innovations for decision makers

H4+JPCS has not incorporated a programme-wide process for systematically generating and compiling information that would help others to take advantage of lessons learned. Country teams managed this process in different ways with varying results in the extent documentation on innovations was shared. In the *Democratic Republic of the Congo*, H4+ JPCS provided support for sharing good practices across health zones. In the two health zones where H4+ JPCS was active (Mosango and Mbanza-Ngungu) officials from other zones visited to observe and learn from the experience, of providing lower, fixed-rate pricing for EmONC services. In *Ethiopia*, H4+ JPCS contributed to the development of new PMTCT monitoring and evaluation tools and helped to disseminate them through a training of trainers for MNCH providers and programme managers. Eventually, this resulted in an electronic training package distributed to 1,000 PMTCT sites across the country.

Officials in *Zimbabwe* indicated that H4+ JPCS-supported consultations with sub-national stakeholders have been effective mechanisms for disseminating information about promising practices. They noted that this was important for engendering buy-in from health personnel within participating districts. In other countries, there were limited efforts to share knowledge on innovations with policy makers and other influential partners. For example, in *Liberia*, despite the promise of scaling up the use of non-pneumatic anti-shock garments, there has been no assessment of the costs, logistics and training needed to support policy maker decision-making. This resulted in a

missed opportunity to make an important contribution to current efforts to study this technology globally.

#### 4.4.4 Replication and scaling of innovations within countries

For supporting evidence see Volume II, Annex 1, Assumption 4.4.

Replication and scale-up are more likely to occur when there is a deliberate, stepwise process which includes careful assessment and planning, stakeholder support and buy-in, and the availability and allocation of sufficient resources to ensure quality implementation. There are many gaps in the innovation-to-policy/scale-up process most often used by H4+JPCS, when compared with the model described in Figure 5. However, there are several examples that illustrate the interest of national authorities in H4+ JPCS-supported innovations, and some emerging plans for inclusion in national policies and programme plans (Table 12). Examples from the *Democratic Republic of the Congo* and *Liberia* are moderately encouraging, while those from *Zambia* and *Zimbabwe* illustrate the problem of limited or inadequate longer-term funding which can undermine the sustainability of supported innovations. Also, as the H4+ JPCS initiative is ending, it is unclear whether there is adequate momentum and commitment for scaling up innovations, especially in those countries which targeted the programme in specific geographic areas.

**Table 12: Status of selected H4+ JPCS innovations**

Country/Innovation	Status of replication and/or scale-up
<i>DRC</i> <b>Family health kit approach</b>	The family health kit approach was first piloted and implemented in Mbanza-Ngungu and then extended to four other health zones (HZ) in other provinces. The government (supported by UNICEF) has decided to implement it in other health centres in partnership with World Bank, the Global Fund, the European Union, and GAVI, the Vaccine Alliance.
<i>DRC</i> <b>Competency-based EmONC training</b>	H4+ JPCS supported the development of training materials which laid the foundation for expanding quality MNCH care beyond the targeted regions. The competency-based manual is now used by all development partners. H4+ JPCS funding also helped create a national three-year midwife education curriculum.
<i>Liberia</i> <b>Non-pneumatic anti-shock garment</b>	The use of the anti-shock garment has become widespread in the H4+ health facilities in the three focus counties in <i>Liberia</i> (Maryland, Grand Cru and River Gee). H4+ partners indicated they plan to roll the use of NASG out in three additional counties with the eventual aim to integrate it into national policy.
<i>Liberia</i> <b>Solar suitcase</b>	There is a plan to monitor how the installation of solar units affects attendance at facilities, and to use this information to prepare support to install solar suitcases in a more facilities.
<i>Zambia</i> <b>Retired midwives</b>	Although this innovation was widely appreciated by stakeholders, there is no funding allocated in the public budget as it is not permissible by regulation. However, the government has changed the policy and extended retirement age to from 55 to 62 years to keep skilled midwives in the workforce. In the Eastern Province, Sida is funding contracts for retired midwives.
<i>Zimbabwe</i> <b>Clinical mentorship</b>	The new Health Development Fund (HDF) programme is anticipated to carry forward H4+ JPCS investments, including the clinical mentorship and supportive supervision. Funds pledged for this programme are below the needs identified and the resources of the Government of Zimbabwe are inadequate for supporting non-personnel related expenses (transport and lodging) for mentorship

#### 4.4.5 Replication of innovation and learning across country programmes

For supporting evidence see Volume II, Annex 1, Assumption 4.5 and Assumption 4.6.

There were several modes used to exchange information about promising innovations among programme countries. For example, H4+ JPCS annual reports and other materials (brochures) highlight information for use by non-programme countries. However, as noted in previous sections, there is no evidence regarding actual dissemination and no information as whether these materials have generated interest by health authorities for potential inclusion in planned programmes.

Inter-country H4+ planning meetings and international conferences were opportunities to exchange information and present results from innovations being tested. For example, UNICEF (Office of Innovation) has supported the UNICEF country team from the *Democratic Republic of the Congo* to document and present innovations. The family health kit approach has been shared within UNICEF as well as with other stakeholders at global level through presentations in London, Mexico and Tunisia. Regional study tours were also arranged to promote exchanges among countries, for example, to promote the husbands' school approach in *Niger* for participants from *Burkina Faso*.

Regional offices also shared and distributed global knowledge products to country offices. However, this was done as a matter of offices' routine, without any specific strategic promotion aligned with the H4+ RMNCH agenda. In interviews, regional and global informants had difficulty recalling or identifying critical innovations supported by H4+ JPCS.

#### 4.4.6 Supporting innovation with limited use of opportunities for learning

H4+ JPCS encouraged and supported innovation as part of the project mandate to accelerate and catalyse action in support of improved RMNCAH outcomes. However, this support came midway in the programme and therefore, the focus on innovation was not 'baked into' programme expectations. More importantly, adequate systems for supporting innovation as a learning process were not established. Given the relatively short time frame of the programme, it is not surprising that it did not develop a systematic process incorporating full innovation and learning cycle (figure 5).

Nevertheless, in each of the countries reviewed, there were attempts to implement innovation interventions with the potential to improve RMNCAH outcomes. The practical definition employed by H4+ JPCS gave wide latitude to country programmes to identify interventions that made sense in their context. The examples of revitalising old practices (clinical mentorship) and adopting a tested global best practice (competency-based EmONC training) and labelling them "new" or "innovative" was a refreshing departure from the common pitfall of privileging "innovation for innovation sake." However, steps 1-3 of the innovation cycle were loosely adhered to in practice, with little attention paid to documenting the innovation design, its rationale or the baseline context for its implementation.

The lack of evidence-based documentation has hampered the programme's ability to adequately serve as a knowledge broker, both within and outside its sphere of influence (steps 4-7 of the innovation cycle). Information contained in brochures and human interest stories is not sufficient to influence decision makers to consider new ways of doing things. It is also not enough to produce the evidence. More systematic attention is required to undertake multiple modes of dissemination in order to garner buy-in and engage others to adopt or adapt new approaches (steps 8-10). Very little was done to address the needs of decision makers to support adoption of innovations. Overall, H4+ JPCS did some good work, but missed the opportunity for carrying innovative thinking forward.

## 4.5 Division of labour

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

### Summary

- At national level, H4+ JPCS country teams have attained a **division of labour consistent with the mandates and comparative strengths of the partners**. In some countries, this has extended to district levels. However, in others, a clear division of labour **has not been achieved at local levels** – especially regarding the work of implementing partners.
- H4+ partners have developed a **higher level of collaboration and joint programming** at country level through the operation of the programme.
- A similar, yet not as complete, **improvement in the level of collaboration among the programme partners can be seen at global level**, including more effective **advocacy** and collaboration on global knowledge products.
- **Global knowledge products have not been well linked to country programmes**. These products do not systematically draw on the experience gained at country level. Guidance on global knowledge products was not systematically provided to country teams.

### 4.5.1 Coordination and division of labour: country level

For supporting evidence see Volume II, Annex 1, Assumption 5.1 and 5.2.

#### Coordinating and planning mechanisms and the division of labour

During the programme design phase and in subsequent coordination and review meetings, H4+ JPCS country teams (and their partner national authorities) worked to harmonise approaches to support RMNCAH and to identify those areas of programming that each would support.

In *Zimbabwe* and *Zambia*, coordination of engagement by the H4+ JPCS partners worked through country-led mechanisms developed specifically for H4+ JPCS (a national steering committee in *Zimbabwe* and a H4+ JPCS technical working group in *Zambia*). In both countries, they also coordinated their roles through pre-existing national coordination forums on RMNCAH. In *Zambia*, however, there was no evidence that the members of the technical working group were coordinating with other major stakeholders in RMNCAH. In the *Democratic Republic of the Congo*, coordination mechanisms established early in the programme cycle worked well, until the end of 2014. While the participation of the ministry of health became less robust in 2015, the H4+ partners continued to organise inter-agency meetings.

In the remaining H4+ programme countries, a variety of mechanisms were used to assign roles and coordinate partner engagement, ranging from a joint planning mission at regional level (*Côte d'Ivoire*) to monthly technical working group meetings with the Ministry of Health and Family in *Ethiopia*. In *Sierra Leone*, the decision was to rely on existing government-led coordinating bodies, rather than develop a new mechanism for H4+ JPCS. In *Liberia*, H4+ country team members reported that they had experienced areas of overlap at the beginning of the programme, and noted that it took “some hours of discussion” to agree on how to allocate roles in a coherent way, especially where more than one partner had the competence to undertake a task.

Most importantly, across all ten countries there was an effort to use the national planning and coordinating mechanisms to rationalise the roles played by each H4+ partner.

### Appropriate division of labour among H4+ JPCS partners

Table 13 illustrates the division of labour regarding the roles and functions of the H4+ JPCS partners at country level in the *Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe*. Clearly, a given partner may take on a different role and function in one country than another. For example, UNICEF took the lead in support to IMNCI in *Liberia*, while WHO took on that role in *Zimbabwe*. For some tasks, more than one partner may provide support. In both the *Democratic Republic of the Congo* and *Zimbabwe*, UNFPA and WHO combined forces to provide support to the national structures and processes for coordinating policies and practices in RMNCAH. Also in *Zimbabwe*, UNICEF and UNAIDS collaborated in providing support to PMTCT and paediatric anti-retroviral technology, because of the long history of support by UNICEF, including the introduction of use of portable CD4 machines at the point of care.

Interviews with H4+ country teams, national health authorities, staff of health services and community members indicated that most actors understood and agreed with the logic of the roles played by H4+ JPCS partners at country level.

**Table 13: Task-based roles of H4+ JPCS partners**

Assigned roles of H4+ JPCS partners in the four field case study countries <sup>45</sup>				
Role and Function	DRC	Liberia	Zambia	Zimbabwe
• H4+ coordinator	UNFPA	WHO	UNICEF	UNFPA
• Support to national task force and policy environment for RMNCAH	UNFPA WHO	WHO		UNFPA WHO
• Supporting adaptation of international guidelines on quality of care in RMNCAH				WHO
• Midwifery policy and advocacy, support to midwife training and to quality assurance	UNFPA	UNFPA WHO	UNFPA	UNFPA
• Construction and support of maternity waiting shelters and annexes			UNFPA UNICEF	UNFPA
• Strengthening EmONC training and post-training supervision	UNFPA WHO	UNFPA	WHO	UNFPA/ UNICEF
• Support to national, provincial, and district MDSR systems	WHO	UNFPA WHO	UNFPA	UNFPA
• Technical advice and support to information management and DHIS2			UNAIDS	UNFPA
• Support to mobile health and electronic MDSR			UNICEF	UNFPA
• Support to national obstetric fistula programme		UNFPA		UNFPA
• Procurement of training aides for midwives and for EmONC capacity building	UNFPA WHO	WHO		UNFPA
• Support training of community based health workers and volunteers		UNFPA	UNICEF	UNFPA UNICEF
• Support to transportation (motorbikes, bicycles) for community level			UNICEF	UNICEF
• Supporting youth-friendly services adolescent health and sexuality education	UNFPA UNICEF		UNFPA	UN AIDS UN Women

<sup>45</sup> For evidence on entries in Table 14, see Volume II, Annex 1, Areas of Investigation 1 and 2.

Assigned roles of H4+ JPCS partners in the four field case study countries<sup>45</sup>

• Educational materials for community involvement	UNFPA			
• Partnerships with religious Leaders	UNFPA			
• Provision of equipment, medicines, commodities	UNICEF	UNFPA WHO	UNICEF	UNFPA UNICEF
• Support to IMNCI (including family kits)	UNICEF			WHO
• Support to PMTCT and paediatric HIV treatment	UNICEF WHO	UNICEF	UNICEF	UNICEF
• Strengthening monitoring and evaluation	UNICEF	WHO	UNICEF	UNFPA
• Supporting pricing incentives and subsidies for RMNCAH services	UNICEF WHO			
• Introduction/support to results based financing	WHO			
• Support to national health accounts	WHO			
• Support to running water and/or solar power for facilities		UN Women	UNFPA UNICEF	
• Support to income-generating activities	UN Women			
• Engaging men and boys around RMNCAH activities, gender based violence, gender equality	UN Women	UN Women		UN Women
• Support to organizations empowering young women and girls	UN Women	UN Women		UN Women
• Researching community structures that influence reproductive and maternal health of girls and women		UN Women		UN Women
• Engage traditional leaders in RMNCAH	UN Women			UNAIDS
• Supporting training of community group leaders and community-based advocates			UNFPA	UN Women
• Support to national PMTCT and HIV and AIDS plans and programmes	UNAIDS	UNAIDS	UNAIDS	UNICEF UNAIDS
• Mass media campaigns on PMTCT		UNAIDS	UNAIDS	
• Water, sanitation and hygiene		UNICEF		
• Reducing violence against girls and women programme		UNICEF		

As already noted, the World Bank was never intended to act as a direct participant in delivery of H4+JPCS funded support at country level and is, as a result, not included in table 13. However, in the *Democratic Republic of the Congo*, there was operational coordination between the World Bank and the WHO, which was involved in administering the results-based financing (RBF) programme in two health zones. In *Zimbabwe* the evaluation noted good operational cooperation between H4+ JPCS and the World Bank regarding the use of RMNCAH related quality of care indicators in determining the performance payments to health facilities. These were integrated into H4+ JPCS supported check lists for supportive supervision.

In all four field case study countries, the evaluation found evidence that the H4+ JPCS made best use of the individual strengths of the H4+ partners. In the *Democratic Republic of the Congo*, this use of partner core strengths was apparent in the support by UNFPA to midwifery and EmONC training. In

*Liberia*, it was particularly noticeable in the support provided by UN Women and UNAIDS both of which, despite having smaller grants, pursued their area of expertise through well-chosen partnerships with implementing partners working on community engagement, behavioural change, raising awareness and building demand.

Missing in the division of labour at country level was a clear and articulated joint role for all H4+ JPCS partners in advocacy and policy engagement in wider issues of the enabling environment for RMNCAH. The World Bank country offices could have played a major part in such a union for the H4+ partners. With its broader mandate and involvement in providing support across many sectors, the Bank is well positioned at country level to strengthen H4+ partner efforts to engage in cross-sectoral advocacy with key national authorities (including those outside health ministries).

#### **Avoiding duplication and overlap**

The evaluation found few significant examples of duplication and overlap in H4+ JPCS programming at country level. Initially in *Liberia*, according to country team members, there had been duplication in the community engagement approaches used by some implementing partners, particularly around HIV and AIDS prevention and sensitisation. However, once this was identified, adjustments were made and the duplication was eliminated. In *Zambia* and *Zimbabwe*, the practice of planning interventions and assigning roles to H4+ partners, based on participatory processes for planning and reviewing programming down to the facilities level, was effective in avoiding duplication and overlap.

There were potential (and sometimes realised) risks of duplication in the operation of the H4+ JPCS in the *Democratic Republic of the Congo*. Perhaps the clearest example was the provision of equipment and materials for EmONC training by both WHO and UNICEF. WHO provided materials for in-service training while UNFPA delivered those for pre-service midwifery training with little or no evidence found of coordination of these two tasks by the H4+ partners. This lack of coordination was the source of gaps in procuring the appropriate material for EmONC training.

#### **4.5.2 Achieving a greater level of collaboration (country and global level)**

For supporting evidence see Volume II, Annex 1, Assumptions 5.2 and 5.4

##### **Collaboration at country level**

H4+ partners were able to engage in a more fully collaborative form of programmatic support to RMNCAH at country level through the operation of the programme.

In the *Democratic Republic of the Congo*, the H4+ JPCS led to more collaborative programming among H4+ partners primarily at national level. The inter-agency annual retreats and monthly technical meetings served as an important forum to discuss and agree on a division of labour between the agencies and to plan and review activities collectively. However, the improved collaboration and coordination at national level does not appear to have led to more effective and comprehensive programme delivery at the health zone and health facility level. Rather, there were problems in coordinating the timely delivery of key inputs, such as training aides and essential commodities, particularly with regard to necessary equipment and material for quality EmONC services.

In *Liberia*, based on the respective strengths of its individual members, the H4+ JPCS programme helped the partners identify priorities, articulate an overall approach, speak with one voice to the government and other stakeholders, and combine resources to address the RMNCAH challenges on the ground. Similarly, in *Zambia*, the collaborative efforts by H4+ partners are much more effective than they would be through separate initiatives, mainly because the RMNCAH continuum of care could not be addressed by one United Nations agency operating within the confines of its mandate. An example of effective collaboration can also be found in *Burkina Faso* where the H4+ JPCS

programme enabled the partners to work closer together and share information much more fully. This higher level of coordination has had the added benefit of increasing H4+ partner cooperation and collaboration on other programmes.

In all four of the field case study countries, the programme is perceived at national, provincial and district levels as one single programme, not a series of investments funded by different partners. In *Zimbabwe*, while staff of provincial medical directorates, district health executives, hospitals, health centres and clinics generally knew which H4+ partner provided specific forms of support, they always referred to H4+ JPCS as a single programme.

### **Coordination and collaboration at global level**

While the H4+ JPCS has achieved an effective division of labour and a more fully realised level of collaboration at country level, there is a more mixed picture of the level of collaboration achieved by the partners at global level. Almost all key informants agree that the experience of jointly programming under H4+ JPCS improved the level of coordination among the partners. At the same time, they acknowledged that this improvement took considerable time. As noted by a UNFPA senior staff person, it was not easy for the H6 partners “to move beyond just adding to what they already wanted to do and fund genuinely collaborative activities”.

From the perspective of UN Women, the programme structure and processes at a global level helped to create a space where they could advocate for a strong gender equality perspective in terms of the programmes normative content, operations and coordination. In their view, the programme brought UN Women into the process of global dialogue in support of the Global Strategy. By participating in H4+ JPCS at global level, UN Women was able to leverage its comparative strength in gender equality. UNAIDS senior staff also indicated that coordination and collaboration had improved over the life of the H4+ JPCS programme, although it took time to arrive at the right arrangements to support collaboration, and has remained a challenging task. Interviews with senior staff of both WHO and UNICEF indicated that the H4+ JPCS programme funding allowed them to do more joint programming together than they could have otherwise undertaken, especially concerning the development of global knowledge products (see section 4.5.4).

Yet, those interviewed also pointed to difficulties in the structure and operations of the H4+ JPCS at a global level, which somewhat limited the level of collaboration achieved. Current and former senior staff at WHO and UNFPA noted that it was much easier to achieve coordination and to collaborate around technical and operational matters, than to agree on strategies and directions. They indicated that the H4+ JPCS had helped the partners to achieve the “One UN” aspiration at a technical rather than a strategic level.

The view, that collaboration was mainly technical rather than strategic, was shared by a number of senior H6 partner staff, including several members of the Deputy Executive Committee. They pointed out that this higher-level management committee spent most of its time engaged with technical matters, without seeming to grapple with the overall strategic question of how H4+ JPCS could accelerate progress in RMNCAH. Similarly, more than one member of the Global Steering Committee for H4+JPCS indicated that focusing on the design and execution of the funded H4+ JPCS programme might, in fact, have distracted the partners from adequately considering what their most effective individual and collective roles might be at global level.

On the other hand, the experience of H4+ as a partnership *and* as a joint programme have, together, contributed to an improved level of inter-partner collaboration at global level. In the words of one external stakeholder with a long history of engagement with the H4+/H6 partnership: “There is a much greater expectation that the partners will develop elements in common rather than separately. There is now an assumption of collaboration that did not exist eight years ago.”

### 4.5.3 Increased effectiveness in advocacy

#### **H4+ JPCS and advocacy at country level**

The most evident improvement in the effectiveness of H4+ partner policy engagement and advocacy at country level is directly related to their ability, during and after the experience of implementing the programme, to “speak with one voice”.

In the *Democratic Republic of the Congo* and *Zimbabwe*, national health authorities clearly stated that, prior to the programme, they received disjointed and often uncoordinated policy inputs from the different partners. In both countries, they volunteered a “before and after” comparison that described how the United Nations H4+ partners were now coordinated around a common set of messages. In particular, H4+JPCS partners were effective in advocating for national commitments to the Global Strategy (2016-2030), as noted in section 4.1. In *Zimbabwe*, the Ministry of Health and Child Care senior staff remarked that H4+ partner policy engagement was now more coherent and effective and could be used as a model for arriving at common messages under the multi-donor Health Development Fund.

Evidence of improved effectiveness in advocacy and policy engagement at country level can also be found in collaborative resource mobilisation for RMNCAH programming. In the *Democratic Republic of the Congo*, UNICEF, UNFPA and WHO jointly proposed a programme, which was funded by the RMNCH Trust Fund, for two tranches, totalling USD 26.2 million. Similarly, in *Burkina Faso*, the partners advocated for, and secured, a national budget line for reproductive health products and funded the first phase of the national strategy to provide family planning services free of charge. Finally, in *Sierra Leone*, the H4+ partners, using H4+ JPCS funds, supported civil society organizations in their successful lobbying for an increase in the budget of the Directorate of RMNCH, which almost doubled (from USD 2.689 million to USD 5.757 million) between 2011 and 2014.

However, the programme partners missed an important opportunity to engage, alongside the World Bank, in effective advocacy to address the larger, enabling environment and cross-sectoral issues, which so clearly impact on national ability to provide accessible, high quality services in RMNCAH.

#### **H4+ JPCS and advocacy at global level**

The H4+ JPCS has helped the H6 partners take a much more active leadership role at global level in the development of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016 - 2030) than they did for the first Global Strategy. The improvement in the advocacy efforts of the H6 partners came about because, at least to some degree, the H4+ JPCS funding allowed them to work more collaboratively to develop a common position and voice. Much of this common voice could be seen in the stronger global knowledge products that were produced at global level during the programme period (see section 4.5.4).

Not all global level key informants felt that the programme had contributed to a very significant improvement in the effectiveness of the partners in policy engagement and advocacy at global level. One key stakeholder noted that the H4+/H6 partners continue to take part in global processes for setting the agenda in RMNCAH as individual organisations, rather than a collective recognisable as the H6 partnership. In her view, the H4+/H6 as a body or group was “not particularly present in the global arena for RMNCAH over the past five years”. However, another external stakeholder noted that the H6 partners played a strong role in the development of the new Global Strategy, pointing that, by contrast, the 2010 version was largely produced by a small group of experts at WHO

Most members of the H4+ JPCS global steering group pointed to the development of global knowledge products as perhaps the single most important element in the improved effectiveness of advocacy at global level.

#### 4.5.4 Developing and disseminating useful global knowledge products

For supporting evidence see Volume II, Annex 1, Assumptions 5.6 and 5.7.

##### **Producing high quality, useful global knowledge products with the support of H4+ JPCS**

The 2015 annual report of the H4+ JPCS provides a listing of the global knowledge products and “global public goods” supported by the programme from 2011 to 2015.<sup>46</sup>

Many of the entries in that listing gather together more than one product or activity, and, once disaggregated, a total of 134 different global products or activities can be identified (along with the responsible H6 partner). However, the list includes many products or activities that do not fit the category of “global knowledge products” as per the definition proposed by the present evaluation (in the absence of a definition by the programme):

- A global knowledge product consists of a strategy, conceptual framework, guideline, tool, toolkit, scorecard, manual, policy brief or briefing kit, fact sheet, case study, training materials/course design or approach for improving RMNCAH policy, advocacy and/or programme assessment, design, implementation, monitoring or evaluation. A global knowledge product can also include a peer-reviewed synthesis or journal article that captures programmatic experience or lessons learned
- A global knowledge product is designed to be used globally, i.e., to benefit stakeholders beyond the H4+ partners and to be used across different countries or regions
- The product is created through a collaborative process that includes two or more of the H4+ partner organizations. It may have a single lead partner as the main author, but at least one other H4+ partner has contributed to its development (or to a companion piece with direct links to the product in question).

The evaluation finds that approximately one-half (65) of the listed items fit the above criteria (see Volume II, Annex 10). Listed items that were excluded because they did not fit the definition of global knowledge products include: meeting minutes, trip reports, annual reports, routine progress reports, workplans, H4+ specific planning tools, reports on technical assistance, policy dialogues, advocacy events, project briefs, partnership-building activities and specific country evaluations and reports. In addition, several items were excluded because they were led and funded mainly by partners and donors beyond H4+ JPCS, with involvement of only one United Nations agency.<sup>47</sup>

The 2015 Annual Report did not provide a consistent way to acknowledge H4+ collaboration in the development of a given document, or to identify how it has been supported by H4+ JPCS. Further, the H4+ JPCS global workplans do not include a level of detail that allows for the identification of the specific budget amount or levels of effort associated with the production of global knowledge products. As a result, the list of 65 may either over-, or under-estimate the number of global knowledge products that can be reasonably attributed to H4+ JPCS. Nonetheless, the 65 products presented in Annex 10 represent a considerable body of valuable work, much of which was validated during the field country case studies.

WHO was the lead agency for a majority of the 65 documents (34), followed by UNICEF (13), UNFPA (7), UNAIDS (5) and UN Women (4). The largest number of items produced were guidance documents (17), followed by tools/toolkits (13), policy briefs (7) and training materials (6), articles (5) and programmatic frameworks (3).

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<sup>46</sup> UNFPA, Annex 6 to the *2015 annual report of the H6 Joint Programme, with the collaboration of Canada and Sweden*.

<sup>47</sup> For example, the H4+ staff included the following reference in the global knowledge products listing, “*Revision of Lives Saved Tool for updating the One Health and LiST instruments*”. UNICEF was the only United Nations agency participating in this effort which is led by Johns Hopkins, funded by the Gates Foundation and includes many other non H4+ partners.

In interviews, global and country team members pointed to products that they felt were most technically sound and operationally useful and which most clearly demonstrated the collaborative nature of H4+ JPCS-supported work at global level. Table 14 provides an overview of some products mentioned most often during interviews.

**Table 14: Technically sound and useful global knowledge products**

Global knowledge products	Lead Agency (ies)	Type of product
Mapping of tools to assess and address HIV-related stigma and discrimination in health care	UNAIDS, UNICEF	Planning tool
<i>Every Newborn Action Plan</i> (ENAP) and related guidelines, tools, reports, case studies	UNICEF, WHO, UNFPA	Action plan
ENAP bottleneck analysis tool	UNICEF	Planning tool
Planning handbook: <i>Caring for Newborns and Children in the Community</i>	WHO/UNICEF, UNFPA	Planning guidance
Meta review on quality of care standards in MNCH	WHO	Standards
<i>The State of the World's Midwives Yearly Report</i>	UNFPA	Advocacy tool
<i>Technical Guidelines for Maternal Death Surveillance and Response</i> (MDSR)	WHO	Guidelines
MDSR implementation monitoring tool	UNFPA	Monitoring tool
<i>Ending Preventable, Maternal Mortality</i> (EpMM)	WHO	Action plan
British Medical Journal supplement on MNCH	UNICEF	Advocacy tool
Maternal, newborn and child health score cards	WHO	Planning tool
RMNH training guidelines for community health workers	UNFPA	Guideline

These, and the remaining 53 global knowledge products, represent useful additions to the ongoing development of good practices in RMNCAH. They also have shown their utility at both the global and country level. However, it is not clear to what extent they can be considered “full products” of the H4+ JPCS programme as they cannot be clearly linked to programme funding or other forms of support.

### Communicating global knowledge products to country level

H4+ country team members pointed to the usefulness of global knowledge products to inform programming at country level. However, they noted weaknesses in the link between these products and the work at country level both in terms of (a) how country level experience informs global knowledge products, and (b) how the programme communicates the results of global work to the country level. As one member of the Global Steering Committee noted: “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 workplans, with very little crossover. The global work plan was done in accordance with the ongoing work of larger coalitions and was not based on what was happening at country level in H4+ JPCS.”

Members of the Global Steering Committee, along with current and former headquarters and regional staff of UNFPA, UN Women and WHO, all questioned how well the programme had communicated the messages developed at global level to the country teams. Key informants at WHO, UN Women and the World Bank suggested that the apparent disconnect between global products supported by H4+ JPCS, and the work at country level was partly due to the existing architecture for global policy setting and research in RMNCAH. They felt that the inter-agency process for identifying priorities for global policy setting and research in RMNCAH (including the work

of multilateral organizations, global foundations, universities and international NGOs) proceeded according to its own schedule, independent of the work of programmes like H4+JPCS.

#### 4.5.5 Effective division of labour

The H4+ JPCS partners were able to establish and use effective mechanisms for coordinating their work at country level and achieved an efficient division of labour, drawing on each partner's mandate and comparative programming strengths. In addition, they were largely able to avoid overlap and duplication in the investments and activities they supported. In some countries, such as the *Democratic Republic of the Congo*, these mechanisms for coordination were not as effective at sub-national level and some problems of duplication (or just as often, gaps) in the support did occur.

Because of its very different role in supporting health systems strengthening, the World Bank, for the most part, did not participate in the coordination and review mechanisms and processes used by the programme at country level. This contributed to the missed opportunity for the partners to address more pressing and broader national issues limiting the effectiveness of the health system in RMNCAH. The World Bank, as a more active member of H4+JPCS at country level, could have used its history of engagement with national authorities outside the ministry of health to strengthen H4+ JPCS advocacy for initiatives to address the issues relating to transport, energy, water and sanitation and human resources that constrain the effectiveness of services in RMNCAH.

Despite these limitations, it is clear that the operation of the programme over its five-year time frame, helped the H4+ partners working at country level to develop a level of collaboration and joint programming that was new to them and would not likely have been achieved without the programme. A similar, albeit not as complete, improvement in the level of collaboration among H4+ partners can be seen at global level. Staff with experience of the programme at global level credit it with supporting a higher level of collaborative and joint effort, especially in the development of global knowledge products. On the other hand, they acknowledge that this level of collaboration has been difficult to achieve and maintain. For UN Women and UNAIDS, a key effect of the programme has been to provide them with space for advocating for investments in promoting demand and engaging with communities. For UN Women, it has also been an opportunity to highlight the issue of women's empowerment and knowledge, in order to secure their right to RMNCAH services.

There is some agreement that, at global level, collaboration was concentrated on technical and administrative matters rather than strategic issues. In fact, members of both the Global Steering Committee and the Deputy Executive Director's Committee noted that discussions seldom dealt with strategic questions regarding the best role for the partnership and the H4+ JPCS as a programme within it.

Finally, the H4+ JPCS programme has contributed to the development of a significant body of global knowledge products, which have been noted as useful and technically sound at both the global and country levels. Difficult to determine, however, is the specific nature and extent of programme support to any given global knowledge product claimed by H4+ JPCS. Furthermore, there are clear indications that the generation of global knowledge products was not well linked to the needs of country programmes. Experience gained at the level of H4+ JPCS programming at country level does not appear to inform decisions on which global knowledge products to pursue. Equally, guidance developed at the global level is not systematically communicated to country level.

## 4.6 The added value of H4+ JPCS

**Question Six:** To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) (the Global Strategy) and the "Every Woman Every Child" movement?

## Summary

- The **primary added value** of the H4+JPCS has been its positive **contribution to improving the availability and quality of essential RMNCAH services at country level**, especially in targeted, under-served provinces, districts and health zones.
- The added value of H4+JPCS at country level is mainly the **result of the flexibility of funded, joint programme support to RMNCAH which complements (and is sometimes catalytic to)** the work of other, often larger programmes and sources of funds.
- The programme has contributed to **more coherent policy engagement and advocacy** for RMNCAH by the H4 partners at both global and country levels.
- The H4+ JPCS has contributed to **the development of a significant body of global knowledge products that have proven useful at country level.**

### 4.6.1 The H4+ JPCS approach and strengthened support at national level

For supporting evidence see Volume II, Annex 1, Assumptions 6.1 and 6.4

#### **Supporting RMNCAH services with flexible, catalytic interventions**

As described in detail in sections 4.1 and 4.2, H4+JPCS was able to support interventions at national and sub-national level that were complementary to other, often larger, programmes of support to RMNCAH. Further, these interventions were sometimes catalytic: they either contributed to improving the effectiveness of the programmes they complemented or helped to mobilise increased resources for RMNCAH. This contribution was strongest in the under-served provinces, health zones and districts targeted by H4+JPCS, and was also felt at national level. Specific contributions by H4+JPCS at country level include:

- Promoting evidence-based protocols and standards for RMNCAH services in national guidelines
- Targeting populations most in need, in under-served districts, including youth and adolescents
- Supporting improvements in EmONC through pre-service and in-service training and supportive supervision
- Strengthening accountability and improving the response to maternal and newborn deaths through support to MNDSR systems and processes at national and sub-national levels
- Strengthening referral systems in an effort to eliminate or mitigate the “three delays” which contribution to maternal mortality
- Supporting community engagement and demand-side activities which helped to build trust between community members and service providers.

As a result of these actions, the H4+ JPCS contributed to improvements in the quality, availability and accessibility of RMNCAH services across the ten programme countries. These improvements have led to increased use of RMNCAH services which may, in turn, contribute to improved outcomes in RMNCAH. However, there is still a major challenge, noted in Section 4.2, to develop a more coherent, comprehensive and effective approach to extending quality services in RMNCAH to youth and adolescents. The preceding sections also point to operational challenges and missed opportunities in the support provided by H4+JPCS, on both the supply and demand side of RMNCAH. These challenges limit the results of, yet do not fundamentally undermine the added value of the programme.

### **Improved consistency and coherence in policy engagement in support of the Global Strategy**

As described in section 4.5.3, the H4+ JPCS helped the country teams to improve the effectiveness of policy engagement and advocacy at country level. In each of the four field case study countries, this most often involved translating global guidance on RMNCAH into national policies. Examples of specific policy interventions at country level consistent with advancing the goals of the Global Strategy include:

- In the *Democratic Republic of the Congo*, support to the development of the national policy and guideline for integrated treatment of acute malnutrition of pregnant women and children
- In *Liberia*, advocating for accelerated and focused action on maternal and newborn mortality reduction by engaging with national health authorities, other health partners, the national parliament and line ministries
- In *Zambia*, working with the Ministry of Health to accelerate development of a policy focus and programme priority on RMNCAH beginning as early as 2011
- In *Zimbabwe*, using the newly available resources of the H4+ JPCS to develop guidelines for clinical mentoring in EmONC and in clinical mentoring for health service staff.

In the *Democratic Republic of the Congo*, *Liberia* and *Sierra Leone*, the H4+ partners were able to build on the experience of the H4+ JPCS to provide strong support to national health authorities in the development of an investment case to apply for resources for RMNCAH activities to the Global Financing Facility. Perhaps more importantly, the H4+ JPCS approach with its flexible application of investments in RMNCAH at national and sub-national levels met with a positive response by national health authorities. They reported that the “H4+ JPCS approach” better suited their needs and provided more coherent and consistent engagement and support at national and sub-national level.

#### **4.6.2 Adding value at global level**

For supporting evidence see Volume II, Annex 1, Assumptions 6.1 and 6.3

#### **Widening and deepening the global policy development and advocacy agenda**

There is a consensus among H4+ partner staff and other stakeholders at global level that the advent of H4+ JPCS did bring new perspectives and a more coherent set of voices to the global agenda-setting process for RMNCAH and support of the Global Strategy. Particularly from the perspective of UNAIDS and UN Women, the dedicated funding provided by the programme (specifically the Sweden/Sida grant) enabled them to add value to global processes by bringing:

- Clear human rights and gender equality perspectives to processes at global level
- Strong focus on community engagement and empowerment to the agenda-setting process
- Closer attention to structural and sociocultural factors within communities that may limit access to quality services in RMNCAH and other health-seeking behaviours
- Explicit emphasis on the needs of youth and adolescents.

For headquarters and regional staff of UNFPA, UNICEF and the WHO, the key added value of H4+ JPCS rests in their enhanced ability to collaborate on joint policy positions and advocate with a common voice for advancing the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030). H4+ JPCS represented a way forward in a context where the restrictive nature of each partner’s mandate and the need to link all sources of funding to explicit results at country level, make funding collaborative policy and advocacy efforts extremely difficult. H4+ JPCS made it possible to fund collaborative global activities which, according to many of those interviewed, could not have been funded from other resources. Thus, the H4+ JPCS widened the global agenda-setting process by funding active participation by UNAIDS and UN Women, while deepening collaboration at a global level.

### 4.6.3 Additionality at global level

For supporting evidence see Volume II, Annex 1, Assumption 6.2.

The evaluation could not determine whether the many initiatives and the global knowledge products produced with the support of H4+ JPCS could not, or would not, have been undertaken without its financial support. At global level, the added value was primarily identified as the system of interactions, meetings and joint collaboration which could not have been developed and operated without the programme. Interviewees highlighted their new-found ability to come together regularly and plan and implement global advocacy and agenda-setting efforts. Some reported that this allowed the partners to be “the driver of the process leading to the development of the Global Strategy (2016-2030)”.

Others, however, questioned the assertion that the H4+ partners would not have taken part in global efforts to advance the RMNCAH agenda in the 2011 to 2016 period without the H4+ JPCS. In fact, they suggested that the partners participated in global agenda-setting efforts in RMNCAH as individual agencies who represented their own interests rather than as a unified group.

On balance, the programme has supported both a broader (with effective participation by UN Women and UNAIDS) and a deeper level of collaboration among the partners at global level and this has helped them to contribute more effectively to advancing the agenda of the Global Strategy. What is less clear, however, is the level of H4+ JPCS support to the generation of global knowledge products and which of those products would not have been developed if it was not for the support of H4+ JPCS.

### 4.6.4 Adding value at country and global level

The H4+ JPCS has enabled the partners to increase the volume and coherence of their policy engagement and advocacy activities at country level. This more coherent and consistent approach to translating global guidance into national policy support has been recognised by health authorities in all programme countries. The programme has directly supported improvements in access and quality of services in RMNCAH at national and local levels which, in turn, have contributed to increased use and, to some degree, improved outcomes in RMNCAH, especially at district and health facility level.

At global level, H4+ JPCS has contributed to widening participation in the development and advancement of the Global Strategy for Children’s, Women’s and Adolescents’ Health (2016-2030). It has also contributed to deepening the level of collaboration among H6 partners at a global level and to encouraging the development of common positions and unified messages on key issues.

The programme has also supported the development of a significant body of global knowledge products which, in turn, have been useful in country programming for RMNCAH. However, the link between global and country level workplans is relatively weak.

## 5 CONCLUSIONS

**Cluster A.** Strengthening health systems for reproductive, maternal, neonatal, child and adolescent health (RMNCAH)

**Conclusion 1: The H4+JPCS has contributed to strengthening health systems for RMNCAH at both national and sub-national level, by improving pre-service and in-service training and supervision, especially for emergency obstetric and newborn care and for maternal death surveillance and response systems. This resulted in a positive contribution to service quality and access in RMNCAH. However, the contribution to strengthening health systems could have been more significant if a**

**better balance had been achieved between supporting the supply of services and strengthening demand by engaging with communities to address socio-cultural barriers to access.**

- ▶ **Based on:** Findings for evaluation question one: Programme contribution to strengthening health systems for RMNCAH.

The H4+JPCS has provided focused support to RMNCAH services in programme countries based on jointly identified critical needs at both national and sub-national level, a support that was well aligned with national priorities and plans in RMNCAH. Programme interventions have also complemented existing and planned programmes of support to the health sector. They have sometimes been catalytic in enhancing the effectiveness of other programmes or contributing to mobilising additional resources. The programme contribution to health systems strengthening for RMNCAH has been most apparent in the provinces, districts and health zones targeted in each country, rather than at national level. However, demand generation and community participation activities were often too narrow in geographic reach and duration to achieve the same level of effectiveness as those supporting the supply of services.

In addition, in some countries, problems arose in the delivery of crucial planned inputs of essential supplies, commodities, equipment and training aids. Problems of timeliness or sequence could most often be traced to slow systems of procurement (including national systems), or to weak mechanisms for coordination among implementing partners, especially at sub-national levels.

**Conclusion 2: At both national and sub-national level, the sustainability of the improvements in both availability and quality of RMNCAH services are at risk due to weak or undeveloped exit plans and strategies for the H4+JPCS programme.**

- ▶ **Based on:** Findings for evaluation question one: Contribution to strengthening health systems for RMNCAH and question two: Contribution to expanding access to quality, integrated care.

H4+JPCS contributed to strengthening health systems for RMNCAH in programme countries at both the national and local levels. At national level, certain aspects of this positive result are likely to be sustained after programme completion (improved and updated national policies, guidelines, curriculum and system-wide improvements, such as those in maternal death surveillance and response). However, at sub-national level, where the programme targeted specific, under-served and isolated districts or health zones, the gains in the availability and quality of services are most at risk.

This risk arises partly because new and pre-existing programmes of support to the health sector in H4+JPCS countries are largely not as flexible or as agile in identifying and responding to specific local needs. Local results are also more at risk because implementing partners often made significant gains in achieving results during the last year of the programme, yet were not able to fund sources of support to maintain their presence (at least at the same level) and consolidate results achieved in the targeted districts after the programme ended. To the extent these risks are realised and improvements are not sustained, it would be more appropriate to refer to the H4+JPCS as a programme providing needed health systems *support* rather than health systems *strengthening*.

**Conclusion 3: In implementing the programme at country level, the H4+ JPCS partners missed an important opportunity to engage collectively with national governments to address broader impediments to health sector effectiveness.**

- ▶ **Based on:** Findings for evaluation question one: Programme contribution to strengthening health systems for RMNCAH.

In all programme countries, the evaluation found that efforts to strengthen health systems for RMNCAH were constrained to a greater or lesser extent by the overall enabling environment. In particular, constraints arose from problems in the overall policy and resource environment for human resources for health, for health financing, for transport infrastructure, for 24-hour electricity and lighting and for a reliable supply of clean water in health facilities. H4+ partners did engage effectively in focused advocacy regarding effective policies and programming for RMNCAH. However, they could have been more effective in working together on more unified, pro-active interventions aimed at working with governments to address these wider, cross-sectoral constraints to a strengthened health system for delivering results in RMNCAH.

**Cluster B.** Contributing to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups

**Conclusion 4: H4+JPCS has contributed to expanding access to services in RMNCAH. It has done so, in part, by consistently targeting the provision of services to under-served and hard to reach geographic areas, and within those areas, populations most in need of RMNCAH services (including adolescents and youth, the poorest women, and people living with HIV and AIDS). H4+ JPCS investments and activities have addressed the capability, opportunity and motivation of health service staff to provide quality services in RMNCAH, while engaging in focused efforts at demand generation.**

- ▶ **Based on:** Evaluation findings for evaluation question two: Programme contribution to expanding access to integrated services.

As a result of support to expanding access to quality services and to community engagement, the programme has contributed to increased levels of trust between community members and health care providers. These efforts have contributed to increased usage of higher quality, more integrated (especially for HIV and AIDS response) services in RMNCAH. As with programme support to health systems strengthening, H4+ JPCS support to increasing access across the continuum of care was sometimes weakened by problems with the timely, well-sequenced delivery of essential inputs. Gains made in improving access to integrated care were also at risk due to inadequate or missing exit strategies.

In contrast to progress made in integrating RMNCAH services and the HIV and AIDS response, the programme sometimes failed to adequately support the integration of family planning services in situations where it would have been appropriate.

**Conclusion 5: The H4+JPCS missed an important opportunity to develop, test, and promote new, comprehensive approaches to addressing the needs of youth and adolescents in most programme countries.**

- ▶ **Based on:** Findings for evaluation question two: Programme contribution to expanding access to integrated services.

The H4+JPCS supported a range of specific interventions aimed at meeting the needs of youth and adolescents, including young girls and women both in and out of school, married and unmarried women (as well as interventions aimed at boys and young men). However, these interventions were often fragmented and of limited effectiveness in reaching the targeted groups. The H4+ partners generally did not collaborate effectively in support of comprehensive approaches to meeting the needs of youth and adolescents.

In addition, while H4+JPCS supported efforts to directly address gender inequalities, these interventions, instead of being mainstreamed, were mainly concentrated under programme output area seven: “demand creation, including community ownership and participation”. As a result,

specific gender equality initiatives had limited geographic reach, were relatively under-resourced and were often implemented later in the programme.

#### **Cluster C.** Responding to emerging and evolving needs of national health authorities and other stakeholders

**Conclusion 6: The H4+JPCS demonstrated a capacity to adjust and respond to changing needs and priorities at country level, and to respond to specific national challenges, partly through participatory systems of planning and review, which sometimes extended from national to district and facility level.**

- ▶ **Based on:** Findings for evaluation question three: Programme response to evolving needs of stakeholders at national and sub-national level.

Reliance on pre-existing, broader national coordination mechanisms for RMNCAH, or on dedicated H4+JPCS working groups or steering committees, was not the determining factor in responding effectively to national and local needs. Rather, responsiveness was dependent on the level of leadership assumed by national health authorities and whether the “chain of coordination” extended from national to district (and even health facility) level. Mechanisms for coordination were most effective when they included H4+ partners, national and local health authorities and all implementing partners. When mechanisms for coordination did not extend down to the local level and were not inclusive of all implementing partners, this led to operational problems in delivering H4+ JPCS-funded inputs for RMNCAH programming.

As the H4+ partners and national authorities gained experience with the programme, especially with joint planning and review processes, the H4+ partners strengthened and deepened their level of coordination and collaboration. This resulted in more coherent policy engagement and a programmatic response that better suited national and local needs and priorities, and was highly appreciated by government partners. The programme demonstrated an ability to respond effectively to changes in the context of RMNCAH by acting effectively to support the response to the Ebola virus disease (EVD) emergency in *Liberia* and *Sierra Leone*.

#### **Cluster D.** Contributing to the identification, testing and scale-up of innovative approaches in RMNCAH

**Conclusion 7: H4+JPCS encouraged and supported innovation as an element in the programme mandate to catalyse and accelerate action in support of improved RMNCAH outcomes. However, H4+JPCS support to innovations seldom adhered to a systematic approach when supporting the shift from successfully testing an innovation to documenting the results necessary to develop national policy and scale up innovative practices across the health system.**

- ▶ **Based on:** Findings for evaluation question four: Programme contribution to identifying, testing and scaling up innovative approaches to RMNCAH.

In each programme country, the programme attempted to implement innovations based on a practical definition of innovation, which encompassed a spectrum of “innovative practices”, from the application of new technologies and programme approaches to revitalising effective practices (which have fallen into disuse), or adopting a tested global practice that is new to a given country. In most programme countries, the evaluation identified examples of useful innovations that had met with positive interest from national health authorities. However, the process of identifying and supporting innovations was not accompanied by evidence-based documentation produced by H4+ country teams that, in turn, could adequately support policy makers. This weakness in documentation

hampered the programme's ability to serve as a knowledge broker both nationally and across the participating countries. It also reflects a general problem of underdeveloped systems and approaches to knowledge management in H4+JPCS.

**Cluster E.** Arriving at a division of labour that optimises their individual advantages and collective strengths in support of country needs and global priorities

**Conclusion 8: The H4+JPCS partners were able to attain an effective division of labour in programme countries. This division of labour drew on their respective mandate and comparative programming strengths. It also allowed the H4+ partners to largely avoid overlap and duplication in the investments and activities they supported. The experience of implementing the programme also helped the H4+ partners to develop a deeper level of coordination and collaboration at global level. However, at global level this collaboration has been more notable in relation to technical and administrative matters than for strategic issues.**

- **Based on:** Findings for evaluation question five: Extent that H4+ JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths.

The allocation of roles and responsibilities among H4+JPCS partners was based on the use of joint programme planning, implementation, supervision and review processes, as well as effective mechanisms for programme coordination. The different role of the World Bank in supporting national health systems, and its attendant relative absence from programme planning and coordination mechanisms at country level, contributed to the missed opportunity for the H4+ partners to collectively address broader issues limiting the effectiveness of the health system in addressing needs in RMNCAH. Similarly, the late, and more limited, involvement of UNAIDS and, especially UN Women, towards the end of the joint programme, limited the effectiveness of H4+JPCS in engaging with communities to address socio-cultural barriers to access to RMNCAH services.

**Cluster F.** Providing added value and contributing to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) and the "Every Woman Every Child" movement

**Conclusion 9: The primary added value of the H4+JPCS in accelerating the implementation of the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) (hereafter the Global Strategy) has been its positive contribution to improving the availability and quality of essential RMNCAH services in the ten programme countries. This contribution arises mainly from the flexibility in jointly programming technical and financial support to RMNCAH in a manner which is also complementary to support provided by other programmes. Additional added value can be found in the broader participation of the H4+ partners in the development of the Global Strategy.**

- **Based on:** Findings for evaluation question six: Extent that H4+JPCS contributed to accelerating implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

The experience of implementing the H4+JPCS helped the partners to develop a deeper level of both coordination and collaboration at global and country level. At country level, the programme enabled the H4+ partners to increase the volume, intensity and coherence of advocacy efforts in support of the Global Strategy. At global level, it contributed to increased participation by UN AIDS and UN Women in the development and advancement of the Global Strategy.

Finally, the H4+JPCS programme has contributed to the development of a significant body of useful and technically sound global knowledge products. However, the programme lacked a systematic approach to identifying, monitoring and reporting on its role in the generation and use of global knowledge products.

## 6 RECOMMENDATIONS

The evaluation recommendations are derived directly from the evaluation conclusions and were developed jointly through an iterative process by the evaluation team and the Evaluation Reference Group.

### Recommendation One: Sustainability

**H6 country teams in the ten H4+ JPCS countries (in collaboration with global and regional teams and national health authorities) should undertake actions to make results sustainable by building options for a transition to new funding sources and to retrofit exit strategies to the extent possible.**

- ▶ **Priority:** Medium
- ▶ **Based on conclusions:** 1, 2 and 4.
- ▶ **Directed to:** H6 country teams with support from regional and global teams

#### Operational actions

- I. Requires H6 country teams to engage in advocacy with national health authorities and other line ministries to ensure flexible, geographically focused elements of H4+ JPCS are reflected in ongoing and new programmes.
- II. Requires exploring other sources of funding, including bilateral RMNCAH donors, non-traditional donors and other health financing mechanisms to sustain programme gains.
- III. Requires earmarked resources to maintain and support coordination platforms at sub-national level (at a minimum for time and travel of staff).

### Recommendation Two: A balance between supply of services and demand creation

**H6 partners' efforts to strengthen health systems for RMNCAH at country level should be designed to achieve a balance between improving the supply of services and strengthening demand by engaging with individuals and communities to address barriers to access, including socio-cultural barriers. This should, in particular, strengthen the H6 contribution to the individual potential and community engagement action areas of the Global Strategy for Women's Children's and Adolescents' Health (2016-2030). It should also incorporate well sequenced and coordinated support.**

- ▶ **Priority:** High
- ▶ **Based on conclusions:** 1, 2, and 4.
- ▶ **Directed to:** H6 country team, in coordination with regional and global teams

#### Operational actions

- I. Requires H6 country teams, when mobilising resources for RMNCAH, to advocate for an adequate focus on demand-side activities that address socio-cultural barriers, over a sufficient time frame for generating observable positive results (normative changes).

- II. Requires specific focus on the barriers to women’s access to services, including but not limited to, discrimination-free services, gender norms that limit women from seeking out services, and awareness of the rights of women, young women, and adolescents to demand services.
- III. Requires H6 global and regional teams to provide technical support (for country teams) in the area of demand generation and community engagement.
- IV. Requires H6 country teams to engage with and support national stakeholders active in community engagement (inside and outside ministries of health), including civil society organizations.
- V. Requires advocacy for engagement with implementing partners (including NGOs and private sector actors) in government-led processes of coordination, especially at sub-national level.

### Recommendation Three: Addressing broader constraints to RMNCAH

**At country level, the H6 partners should build on the experience of H4+ JPCS in order to engage with national governments with “one voice” and ensure that they can collectively influence broader impediments to the health sector (and beyond) including: weaknesses in human resources for health, health financing, and the general enabling environment.**

- ▶ **Priority:** High
- ▶ **Based on conclusions:** 1 and 3.
- ▶ **Directed to:** H6 country, regional and global teams

#### **Operational actions**

- I. Requires engagement of all H6 country team partners in a joint programme of advocacy and policy engagement, extending beyond the health sector (including, for example, authorities for water and sanitation). This should include engaging with country-led multi-stakeholder country coordination platforms for RMNCAH.
- II. Requires collaboration of H6 agencies at strategic and technical level, as well as ad hoc funding to facilitate coordination (meetings, transport, field visits, etc.).

### Recommendation Four: Addressing sexual and reproductive health and rights

**H6 partners supporting RMNCAH at country level should ensure that programmes of support address key aspects of sexual and reproductive health and rights (including family planning) for those most left behind, especially for young women and girls. To this effect, H6 partners should invest (globally and at country level) in the promotion and dissemination of evidence-based and comprehensive approaches to meeting the needs of adolescents, including young women and girls.**

- ▶ **Priority:** High
- ▶ **Based on conclusion:** 5.
- ▶ **Directed to:** H6 country and global teams and H6 partner senior management

#### **Operational actions**

- I. Requires that global, regional and country-specific programmes of support to RMNCAH address the full spectrum of sexual and reproductive health, including family planning initiatives, as an important component of integrated RMNCAH information and services.

- II. Requires H6 partners to ensure that regional and country teams have, collectively, the technical skills and tools to effectively design and implement programmes covering the full spectrum of the RMNCAH agenda.
- III. Requires H6 country teams to engage with: (i) actors outside the ministry of health including, for example, ministries of youth and sports, education, employment, gender and social development, (ii) partners outside the public sector by including country led multi-stakeholder platforms where possible.
- IV. Requires effective joint advocacy and investments in addressing socio-cultural barriers for young people to access sexual and reproductive health and rights, including access to contraceptive information and services for adolescent girls (married and unmarried).

#### Recommendation Five: Strengthening national capacity for programme coordination

**H6 partners should support efforts to strengthen the capacity of national authorities to lead programme coordination mechanisms. These mechanisms should extend to the sub-national level and include all implementing partners and local health service facilities. This will strengthen the contribution made by H6 to the country leadership action area of the Global Strategy for Women’s Children’s and Adolescents’ Health (2016-2030).<sup>48</sup>**

- ▶ **Priority:** Medium
- ▶ **Based on conclusion:** 6.
- ▶ **Directed to:** H6 country teams

#### **Operational actions**

- I. Requires H6 country teams to advocate for, and actively participate in, planning and coordinating mechanisms that extend to local levels and are inclusive of key stakeholders.
- II. Requires H6 partners to participate in, and support, harmonised, coordinated and aligned platforms for coordinating support for RMNCAH, including country-led, multi-stakeholder platforms.
- III. Requires H6 partners to support to efforts to strengthen the capacity of national authorities in the development and leadership of coordinating mechanisms in RMNCAH.

#### Recommendation Six: Strengthening learning and knowledge management

**H6 partners should strengthen the learning and knowledge management strategy of the partnership, including the generation and dissemination of evidence-based documentation. Further, in supporting the innovation action area of the Global Strategy for Women’s Children’s and Adolescents’ Health (2016-2030), H6 partners should support systematic approaches to “linking evidence to policy and practice.”<sup>49</sup>**

- ▶ **Priority:** High
- ▶ **Based on conclusion:** 7
- ▶ **Directed to:** H6 country and global teams

#### **Operational actions**

- I. Requires the joint development of learning networks or support to, and engagement with, already existing thematic learning networks.

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<sup>48</sup> World Health Organization (2015), p.7.

<sup>49</sup> World Health Organization (2015), p.7.

- II. Requires that (i) experiences at country level consistently inform the development of global knowledge and that (ii) global knowledge products are effectively disseminated and used within the framework of south-south collaboration and inter-country exchange.
- III. Requires (i) strengthened technical support and guidance for country teams on evidence-based approach to documentation, and (ii) reinforced role of regional teams in monitoring and supporting innovation efforts.
- IV. Requires H6 global team to prioritise support to global knowledge products based on:
  - (i) Gaps in technical knowledge and guidance in RMNCAH, identified through programming experience of H6 country teams.
  - (ii) Documented, evidence-based lessons on effective programming for RMNCAH, building on practical field experiences by H6 country teams.
  - (iii) The identification of “what works” and “what does not work”, with clear and rigorous parameters to guide the documentation process of promising practices.

#### Recommendation Seven: Effectively engaging all H6 partners

**H6 partners should ensure that the division of labour at both country and global level allows for full engagement by all partners to support the community engagement action area of Every Woman Every Child and the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030) and to strengthen the contribution made by H6 to each of the three pillars of the Global Strategy (2016-2030): (a) Country planning and implementation efforts, (b) Financing for country plans and implementation including the Global Financing Facility, (c) Engagement and alignment of global stakeholders, including the Partnership for Maternal Newborn and Child Health.<sup>50</sup>**

- ▶ **Priority:** Medium
- ▶ **Based on conclusions:** 1, 3 and 9.
- ▶ **Directed to:** H6 country and global teams, bilateral partners

#### Operational actions

- I. Requires the H6 teams (at global and country levels) to undertake collaborated efforts to attract necessary resources for joint programming by all partners.
- II. At country level, requires country teams to (i) seek funding opportunities and mobilise resources for action in support of RMNCAH as a collective group, (ii) secure funds for operational components of joint planning, advocacy and supervision, including staff time and travel at country level.
- III. Requires H6 global team to coordinate activities at global level to ensure alignment with other stakeholders, including PMNCH.
- IV. Requires continuing *joint* H6 support (as the preferred technical arm of the Global Strategy 2016-2030) to countries in their partnership with the Global Financing Facility (GFF).

#### Recommendation Eight: Defining roles and responsibilities of regional teams

**Within the framework of their collaboration in support of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), H6 partners should develop a clear definition of the work to be done at the regional level, including the corresponding role and responsibilities of regional offices in support of H6 country teams.**

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<sup>50</sup> World Health Organization (2015), p. 77.

- ▶ **Priority:** Medium
- ▶ **Based on conclusion:** 6
- ▶ **Directed to:** H6 global team, H6 regional teams, senior management of H6 partners

#### **Operational actions**

- I. Requires global and regional management teams of H6 partners, in consultation with country teams, to jointly agree on detailed roles and responsibilities of global, regional and country H6 teams and communicate these to all partners.
- II. Requires H6 global partners and regional teams to identify and secure resources to fund regional team activities in support of H6 teams at country level.

## LIST OF ANNEXES (VOLUME II)

1. Evaluation matrix
2. Methodology and data limitations
3. Vocabulary of medical terms used in the report
4. H4+ Interventions and innovations by country
5. Financial profile of H4+ JPCS in programme countries
6. Trends in indicators of RMNCAH
7. List of “Countdown Countries” including H4+ JPCS
8. Persons met and interviewed
9. Bibliography
10. Global knowledge products supported by H4+ partners
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