

H6 Annual Report 2015

2015 annual report of the H6 Joint Programme,
with the collaboration of Canada and Sweden

Working together
towards the health
and well-being of all
Women, Children
and Adolescents



How the H6 partnership provides joint support to improve women's and children's health



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Abbreviations

| | | | |
|---------------|--|-------------------|--|
| AIDS | Acquired Immunodeficiency Syndrome | ENAP | Essential Newborn Action Plan |
| ANC | Antenatal Care | EPMM | Ending Preventable Maternal Mortality |
| ARI | Acute Respiratory Infection | EVD | Ebola Virus Disease |
| ASRH | Adolescent Sexual Reproductive Health | EWEC | Every Woman Every Child |
| BEmONC | Basic Emergency Obstetric and Newborn Care | FEBAH | Fédération Burkinabée des Associations pour la Promotion des Personnes Handicappées (Burkina Faso) |
| CAG | Community Advocacy Group | FP | Family Planning |
| CARE | Cooperative for Assistance and Relief Everywhere | GBV | Gender-Based Violence |
| CARMMA | Campaign for the Accelerated Reduction of Maternal Mortality in Africa | GFF | Global Financing Facility |
| CBD | Community-Based Distributors | GMNH | Global, Maternal, Newborn Health |
| C4D | Communication for Development | GS | Global Strategy |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care | HBMNC | Home-based Maternal and Newborn Care |
| CFR | Case Fatality Rate | HEW | Health Extension Workers |
| CHW | Community Health Worker | HIV | Human Immunodeficiency Virus |
| CRS | Catholic Relief Services | HMIS | Health Management Information system |
| DBS | Dried Blood Spot | HR | Human Resources |
| DFID | Department for International Development Assistance (UK) | HRH | Human Resources for Health |
| DI | Development Information | HSTP-V | Health System Transition Plan - Fifth |
| DRC | Democratic Republic of the Congo | HW | Health Worker |
| DFATD | Department of Foreign Affairs, Trade and Development, Canada | ICM | International Confederation of Midwives |
| EID | Early Infant Diagnosis | IMCI/IMNCI | Integrated Management of (Newborn) and Childhood Illnesses |
| EmONC | Emergency Obstetric and Newborn Care | IMPAC | Integrated Management of Pregnancy and Childbirth |
| EMTCT | Elimination of Mother-to-Child Transmission | IPC | Infection Prevention and Control |
| ETAT | Emergency Triage Assessment and Treatment | LiST | Lives Saved Tools |
| EU | European Union | MH | Maternal Health |
| | | M-Health | Mobile Health: the Practice of Medicine and Public Health Supported by Mobile Devices |

and acronyms

| | | | |
|-----------------|--|-----------------|--|
| M&E | Monitoring and Evaluation | RMNCH | Reproductive, Maternal, Newborn and Child Health |
| MCH | Maternal and Child Health | SBA | Skilled Birth Attendant |
| MDG | Millennium Development Goal | Sida | Swedish International Development cooperation Agency |
| MDSR | Maternal Death Surveillance and Response | SMAG | Safe Motherhood Action Group |
| MMR | Maternal Mortality Ratio | SMS | Short Message Service |
| MNCH | Maternal, Neonatal and Child Health | SRMNCAH | Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health |
| MNCAH | Maternal, Newborn, Child and Adolescent Health | SRH | Sexual and Reproductive Health |
| MNDSR | Maternal and Neonatal Death Surveillance and Response | SRHR | Sexual and Reproductive Health Rights |
| MNH | Maternal and Neonatal Health | STI | Sexually Transmitted Infection |
| MoH/FMoH | Ministry of Health | TA | Technical Assistance |
| MoHS | Ministry of Health and Sanitation (Sierra Leone) | TBA | Traditional Birth Attendant |
| MoHS | Ministry of Health and Social Welfare | TF | Trust Fund |
| MWA | Midwifery Workforce Assessment | TOR | Terms of Reference |
| NBC | Newborn Care | TOT | Training of Trainers |
| NGO | Non-Governmental Organization | TWG | Technical Working Group |
| OBGYN | Obstetrics and Gynecology Physician | UN | United Nations |
| OOP | Out Of Pocket expenses | UN Women | United Nations Entity for Gender Equality and the Empowerment of Women |
| PEPFAR | President's Emergency Plan for AIDS Relief | UNAIDS | Joint United Nations Programme on HIV/AIDS |
| PLAN | Plan International | UNFPA | United Nations Population Fund |
| PLHIV | People Living with HIV | UNICEF | United Nations Children's Fund |
| PMNCH | Partnership for Maternal, Newborn & Child Health | USAID | United States Agency for International Development |
| PMTCT | Prevention of Mother-to-child Transmission (of HIV) | WHA | World Health Assembly |
| PoC | Point of Care | WHO | The World Health Organization |
| QoC | Quality of Care | YFS | Youth Friendly Services |
| RHR | Reproductive Health and Rights | | |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health | | |





Introduction: The H6 partnership



Introduction: The H6 partnership

Background

Maternal and child survival has improved markedly during the Millennium Development Goals era, which began in 2000. Both maternal mortality and under-five mortality have been reduced by about half since 1990, and the rate of improvement has accelerated since 2000.¹

Seventy-five countries with high rates of infant, child and maternal mortality received support to build the capacities of their national health systems to achieve the Millennium Development Goals (MDGs) by 2015, especially the four key health-related goals: MDG 4, “to reduce under-five child mortality;” MDG 5, “to improve maternal health;” MDG 3, “to promote gender equality and empower women” and MDG 6, “to combat HIV and AIDS.”

In 2010, the United Nations Secretary-General launched the Global Strategy for Women’s and Children’s Health to mobilize global support for accelerated progress at the country level. The Strategy has helped build momentum through the coordinated efforts of bilateral donors, multilateral agencies, Non-Governmental Organizations (NGOs), professional associations and existing global networks.

The year 2015 was a milestone in global health, as the MDG era came to a close and a new 2030 development agenda was set in motion, focused on Sustainable Development Goals (SDGs). The SDGs approach global challenges in a holistic manner through social development, economic growth and environmental protection. Building upon progress made in the past and lessons learned while achieving MDGs 4 and 5, the world is now embarking on the next set of health commitments under the SDGs, including ending all preventable maternal and child deaths and improving adolescent health by 2030.

In September 2008, UNICEF, UNFPA, WHO and the World Bank created the joint H4 initiative to provide collective and collaborative support for maternal and newborn health in low-income, high-burden countries through harmonized response. Later, UN Women and UNAIDS joined the efforts and the partnership was renamed H4+. H4+ was tasked with supporting the acceleration of progress towards achieving the MDGs, especially reducing child mortality (MDG 4) and improving maternal health (MDG 5). Efforts to combat HIV/AIDS, malaria and other diseases (MDG 6) and the promotion of gender equality and women’s empowerment (MDG 3) were an integral part of momentum-building. At the global and country levels, the H4+ partners formed teams that leveraged the respective strengths of each agency to provide well-coordinated technical assistance in the development and implementation of national plans for Reproductive, Maternal, Newborn, Child and Adolescent Health, or RMNCAH.

In 2010, H4+ aligned its efforts to support the mobilization and implementation of commitments made by 58 of the 75 high-burden countries themselves, as well as by NGOs and the private sector, to the United Nations Secretary-General Ban Ki-moon’s Global Strategy for Women’s and Children’s Health.

In the post-2015 era, being ‘fit for purpose’ entails the UN further implementing its ‘Delivering as One’ approach to common country programming in collaboration with national governments and leading the implementation of aid effectiveness principles for better harmonization and alignment. The centrality of RMNCAH in the 2030 sustainable development agenda, alongside the evolving global health architecture, provides the opportunity to strengthen H4+ in order to reaffirm the UN agencies’ crucial role in supporting

¹ *Countdown to 2015: A Decade of Tracking Progress for Maternal, Newborn and Child Survival.* (2015)



countries in improving the health and well-being of women, children and adolescents, as well as to address universal access to quality RMNCAH services. As the ‘technical arm’ of the Global Strategy since 2010, the H4+ partnership has needed to strengthen its purpose, structure and value proposition to effectively support countries implementing the renewed Global Strategy for reaching the new RMNCAH targets. Moreover, a re-positioning of H4+ was required to maintain relevance and, specifically, in recognition of the need for a truly multi-sectoral approach which places equal importance on the role of each of the six partner agencies.

As a result, the H4+ partnership has been renamed H6 to capitalize on UN structures and longstanding relationships at the global, regional, national and sub-national levels, for both advocacy and technical exchanges around women’s, children’s and adolescents’ health.



The synergy of the H6 agencies: Specialized expertise in working together on the RMNCAH agenda

The purpose of the H6 partnership is

“to leverage the collective strengths and distinct advantages and capacities of each of the six health agencies in the UN system to support countries with high burdens of maternal, child and adolescent mortality and morbidity in their efforts to improve the survival, health and well-being of women, newborns, children and adolescents.”

Member organizations of H6:



UNFPA is the lead UN agency for delivering a world where every pregnancy is wanted, every birth is safe, and every young person’s potential is fulfilled.



UNICEF is the lead UN agency for advocating for the protection of children’s rights to help meet their basic needs and to expand their opportunities to reach their full potential.



UNAIDS, the Joint UN Programme on HIV/AIDS, has a shared vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination. It works closely with global and national partners towards ending the AIDS epidemic by 2030 as part of the Sustainable Development Goals, including by eliminating new HIV infections in children and keeping their mothers alive and healthy.



UN Women, the UN entity for gender equality and women’s empowerment, focuses on tackling the root causes of maternal, newborn and child mortality and morbidity, including gender inequality and social determinants of health. Specific focus is placed on recognizing and addressing harmful gender norms in women’s and children’s health.



WHO, the World Health Organization, supports countries in delivering integrated, evidence-based and cost-effective care for mothers and babies during pregnancy, childbirth and the postpartum period.



The World Bank Group supports a reproductive health action plan that targets interventions in high-burden, low-income countries to help achieve equitable, affordable and quality care for women and children, particularly the most disadvantaged.

The context of the H6 Joint Programme

In 2011 and 2012 respectively, the governments of Canada and Sweden mobilized a combined grant of US\$102 million to strengthen the technical, convening and advocacy roles of the H6 partnership at the global and country levels. The collaboration of Canada and the Swedish International Development Cooperation Agency (Sida) aimed to accelerate progress towards achieving MDGs 4 and 5 in 10 identified countries of sub-Saharan Africa, as well as to collectively enable H6 partners at the country, regional and global levels to facilitate knowledge management and capacity development to attain the MDGs.

Since Canada's collaboration began in 2012, H6 has worked at the global and country levels in five countries—Burkina Faso, the Democratic Republic of the Congo (DRC), Sierra Leone, Zambia and Zimbabwe. Similarly, since the collaboration with Sida began in 2013, H6 has worked at the global and country level in six additional countries—Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe. Zimbabwe is the only recipient of financial support from both collaborations.

These 10 countries were identified and selected based on well-established criteria and the programme was designed to provide catalytic and strategic support to strengthen national health systems in line with national health plans. All 10 identified countries are low- and low-middle income and rank among the lowest in Human Development,² with high maternal, infant and child mortality rates. While all of these countries face some constraints and challenges, each has demonstrated the potential for success in reducing maternal and child deaths.

The interventions were planned at the national level to strengthen policy, strategies and plans to create an enabling environment for achieving RMNCAH goals. While the sub-national geographic

areas identified for the programme in each country were often characterized by remoteness and inaccessibility, they received support through the provision of integrated RMNCAH service packages designed to inform policy as a result of lessons learned in earlier activity implementation. The proposed policy and programme interventions are well known, effective and evidence-based and are routine in other countries. Each country team planned and implemented innovations to address programmatic barriers through local solutions, while also addressing gender inequalities and the root causes of high mortality. Each country prioritized interventions by considering the local context in order to achieve the roll-out of interventions in a holistic manner.

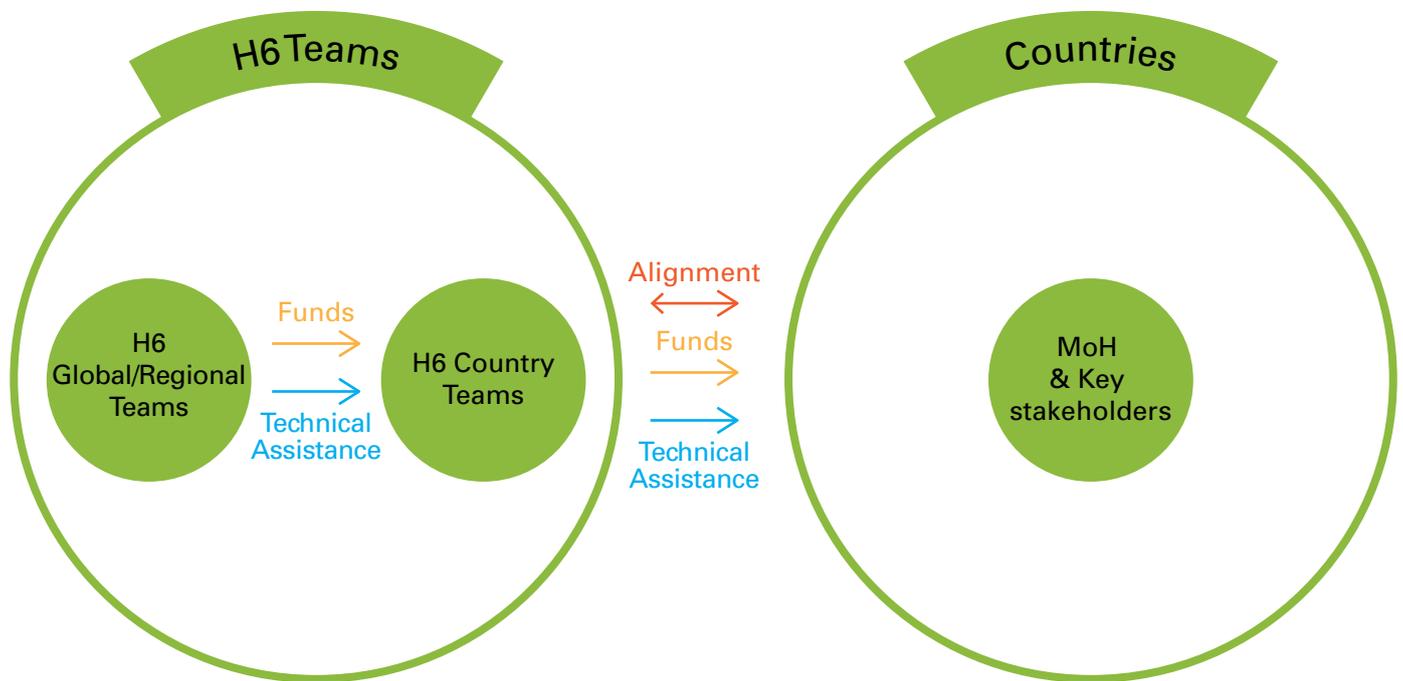
In each of the 10 countries, H6 supports the development and implementation of national Sexual and Reproductive Health (SRH) strategies and action plans in close collaboration with the Ministers of Health (MoH) and key stakeholders (see Figure 1), using a country/sub-national assessment when necessary to analyze the situation and needs.

The programme design at the country level follows an expanded 'health system building-block' approach, which includes leadership and governance, financing, technologies and commodities, human resources, health information and service delivery, along with community ownership and communications for demand-generation and advocacy for mobilizing commitments and resources.

The year 2015 witnessed steady progress. Interventions designed to overcome challenges—both from within the programme and from external factors—matured; national policies, systems and processes were aligned to enhance the effectiveness and efficiency of RMNCAH interventions for the health and wellbeing of mothers and children.

² UNDP, *Human Development Report*, 2013.

Figure 1: Structure and Country Interaction



H6 worked closely with national governments to strengthen their national health systems, expand their skilled human resource base in RMNCAH and build their capacities in management and monitoring. Ultimately, the focus of these interventions is to increase demand for, and access to, quality RMNCAH services and strengthen programme management by introducing accountability mechanisms such as the institutionalization of Maternal Deaths Surveillance and Response (MDSR) systems.

Nevertheless, despite high hopes and high expectations that progress could be accelerated to meet MDGs 4 and 5, country-driven planning was met with challenges.

In two of the programme countries, Liberia and Sierra Leone, the Ebola Virus Disease (EVD) epidemic strained national capacities. The H6 Joint Programme responded swiftly to contribute to key stakeholders' collective efforts under national leadership to revive Maternal and Newborn Health (MNH) care. In other countries, armed conflicts, such as with Boko Haram in Cameroon and political instability in Guinea Bissau, further complicated programme management.

In all programme countries, capacity-building took place for individuals and institutions alike, with pre-service training for midwives and in-service training for health care providers at the community, regional and national levels for a range of skills needed for an integrated package of RMNCAH services. Capacity-building efforts focus on technical skills as well as awareness-raising about gender equality and rights issues among health care providers. Similarly, in each country resources were committed to improve the service environment through needs-based interventions and to improve the provision of life-saving drugs and medicines. Based on need, systemic weaknesses in Health Management Information Systems (HMIS) were addressed, as were concerns about the quality and completeness of the data therein. Interventions will continue in 2016 to build the capacities of key stakeholders and to support improvements in data management.

There were delays in procurement and, at the sub-national level, in receiving funds through different channels from partners' Ministries of Health, which often faced competing priorities. National coordination committees, or mechanisms,



were established under government leadership in all countries to play an oversight and stewardship role to address barriers and facilitate the implementation of planned activities.

In spite of these challenges, catalytic and strategic support of the H6 Canada and Sida collaborations has contributed significantly to the process of building health systems, increasing demand for services, informing policy, expanding the skilled human resource base and linking community structures with service delivery systems in each country.

This report highlights the progress made in each country in carrying out work plans to improve Quality of Care (QoC), promote equitable access to core services and support the establishment of accountability mechanisms for the health of women and children. Case studies from various countries illustrate the importance of protecting the lives of the most vulnerable women and children and helping them sustain their health gains.

Finding new opportunities to reduce maternal and child mortality

Guinea Bissau is among the countries that are worst hit by the brain drain. In order to counter the scarcity of skilled service providers, the H6 Joint Programme mobilized international experts to support the nation in rebuilding a skilled human resource base. Five physicians (two pediatricians, two gynecologists and an anesthesiologist) are providing medical assistance in Bissau, Bafatá and Gabu, improving the functioning of hospitals, reorganizing services, introducing clinical standards and protocols, training national health staff and providing hands-on health care to women and children.

Dr. Rafaela Santos Padilla, a United Nations Volunteer and pediatrician from Cuba, provided services in the Pediatric Department of Simão Mendes Hospital in Bissau between September 2014 and September 2015.

"I had always dreamed of coming to Africa," says Dr. Padilla, who came to Guinea-Bissau under the auspices of the H6 initiative with the goal of reducing maternal and neonatal mortality. She had worked in developing countries before, but arriving in Guinea-Bissau was unique. She quickly realized that *"Africa is different—for historical reasons, because of the conditions of the countries themselves, and because of people's beliefs and ways of thinking about life."*

She suffered from culture shock, and she cried a lot. *"There were patients who arrived at the hospital too late, and I could do nothing,"* Dr. Rafaela recalls. Coming from a country with

a lower child mortality rate, she was not used to seeing children die. *"For the Guinean there is only one path for human beings, life and then death,"* she says. But she refused to accept this. She told her colleagues in the pediatric ward, *"When you see a child, you feel tenderness and affection because there is life, and admiration for what this life can become in the future."* She constantly reminded her colleagues, *"Childhood is the passport to the future of Guinea-Bissau."*

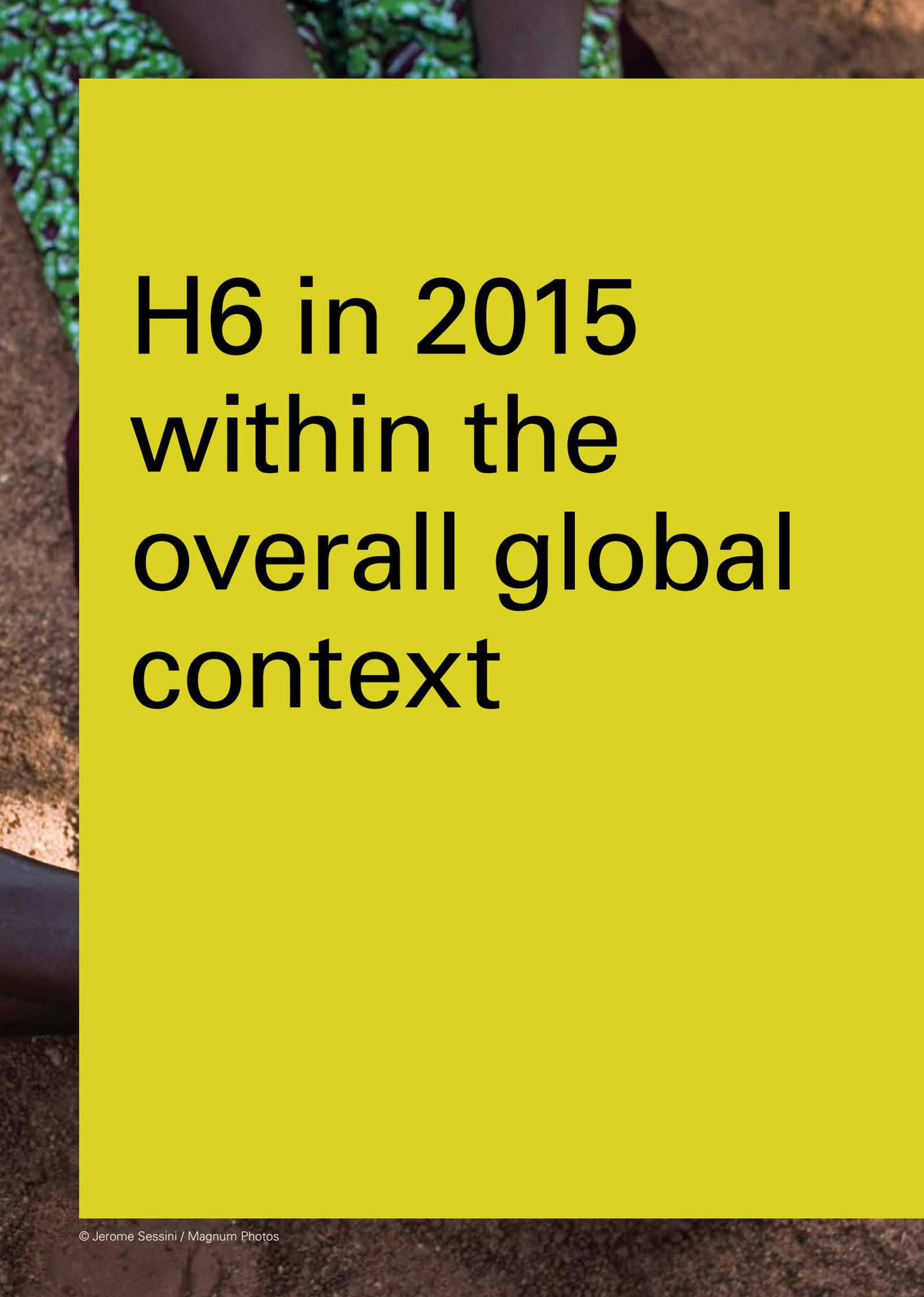
Dr. Rafaela shares the daily victories that underlined her commitment to the cause of *"more and better health for the children of this country."*

Today there is a functioning system, to the point where she believes that *"Pediatrics is now a leading service in the Hospital,"* highlighting the major changes made. Dr. Rafaela took comfort in knowing that the people she had worked with are now not only more qualified, but also more interested and more excited about their work.

With similarly uplifting stories, Dr. Ramon Soto, from Cuba, the only anesthesiologist in the country, offered intensive training to 20 anesthesiology technicians. Dr. Sibide, from Mali, and Dr. Exposito, from Cuba, are pediatricians working in the eastern regions of Bafata and Gabú. Dr. Osoria from Cuba and Dr. N'tcha from Niger are gynecologists helping to reduce maternal mortality.







H6 in 2015 within the overall global context

Before this report describes in detail the H6 Joint Programme supported by Canada and Sweden, it is important to situate the overall work of H6 within the wider developments of 2015. As already mentioned, the year 2015 was a milestone in global health: the era of the MDGs ended; the 17 SDGs were adopted by world leaders; most importantly, the Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy)³ was launched. Moreover, the Addis Ababa Action Agenda of the Third International Conference on Financing for Development and the Global Financing Facility (GFF) in support of Every Woman Every Child (EWEC) were also established. H6 played a crucial role in these global developments while continuing to provide additional support at the country level through the H6 grants from Canada and Sweden, the RMNCH Trust Fund supported by Norway and the UK, and the Muskoka grant from France.

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)

The Global Strategy was developed under the auspices of the United Nations Secretary General. H6 partners at the Deputy Executive Director's level were part of the multi-stakeholder Strategy and Coordination Group and guided the development of the Global Strategy, facilitated by the Executive Office of the United Nations Secretary General and Every Woman Every Child. The World Health Organization, with the other H6 partners, coordinated the content development and writing of the Global Strategy, collaborating with several institutions and individual experts who contributed to the Writing Group and to a series of technical and strategy publications in *The British Medical Journal*.⁴ H6 partners also coordinated and supported the various Global Strategy development work streams, as well as supporting member state consultations on the development of the Global Strategy, including global discussions at the 68th World Health Assembly (WHA), the 41st G7 summit, and the 132nd assembly of the Inter-Parliamentary Union. Every Woman Every Child regional consultations to develop the Global Strategy were hosted by the governments of India, South Africa, and the United Arab Emirates, as well as by the Partners in Population and Development inter-governmental network.

The Operational Framework

The Operational Framework for the Global Strategy is a resource that supports countries in implementing the Global Strategy. It was developed through a broad consultation with a number of partners, building on the inputs of a wide constituency into the Global Strategy itself. On behalf of H6, UNICEF co-chaired the writing group for the Operational Framework with the government of India and partners in population and development. Each of the H6 agencies also contributed members to the writing group, which included representatives from member states, civil society groups, the private sector, bilateral development partners and other donors. A number of consultations were held to inform the Operational Framework, mostly on the sidelines of meetings co-organized by member states and H6 agencies. UNICEF also coordinated an online consultation on the penultimate draft. The final version of the Operational Framework⁵ was released in May 2016 at the WHO World Health Assembly. H6 agencies contributed material and tools to this final version, and will continue to update this 'living' document as part of their joint efforts to support country implementation of the Global Strategy.

Global Strategy indicator and monitoring framework

At the request of the EWEC movement, WHO, with H6 partners, coordinated the technical development and writing of the Global Strategy Indicator and Monitoring Framework⁶ report, in close collaboration with several institutions and individual experts. An extensive technical review and consultative process underpinned the development of this report and included a WHO online survey and post-2015 working group consultations coordinated by the UN Foundation and PMNCH. H6 partners and several other institutions provided technical inputs through the survey and consultations. H6 and other technical experts also reviewed the proposed Global Strategy indicators at a meeting in Montreux, Switzerland, and made recommendations that informed the final framework published in May 2016. H6 partners also participated in a two-day, multi-stakeholder, multi-country accountability workshop in Johannesburg organized by PMNCH.

³ http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

⁴ http://static.www.bmj.com/sites/default/files/attachments/resources/2015/09/who_supplement.pdf

⁵ http://www.everywomaneverychild.org/images/content/files/EWEC_OPERATIONAL_FRAMEWORK_2016.pdf

⁶ <http://www.who.int/life-course/publications/gi-Indicator-and-monitoring-framework.pdf>

The 60 participants developed a road map to implement the Unified Accountability Framework for the Global Strategy and provided further inputs to the development of the indicator and monitoring framework.

Commitment mobilization

In September 2015, more than 100 organizations and 39 countries made commitments in support of the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030).⁷ These commitments already represent over US\$25 billion for improving the health and wellbeing of women, children and adolescents. In addition, six more countries are already planning to set up formal H6 mechanisms in 2016.

UNFPA and WHO, on behalf of H6, have driven the mobilization of political commitments from 31 countries with high burdens of maternal and child mortality and morbidity. These commitments include the development and implementation of policies and strategies to improve access to quality Reproductive, Maternal, Newborn, Child, and Adolescents' Health services, covering improvements in health financing; service delivery; Human Resources for Health (HRH); commodities and supply chain; community mobilization; and monitoring and evaluation. Half of above 31 countries have made specific commitments to:

1. increase the national budget for health with a specific focus on RMNCAH,
2. improve the health and wellbeing of adolescents,
3. address financial barriers to accessing RMNCAH services, mostly by accelerating access to universal health coverage,
4. increase access to Family Planning (FP) services (including strengthening supply chains for reproductive health commodities and essential medicines for maternal, newborn and child health),
5. and improve service delivery, including integration of the provision of RMNCAH services.

In addition to supporting the mobilization of political commitments from additional countries and working with them to define specific targets for these commitments, H6 is supporting countries in the implementation and monitoring of their commitments.

H6 country coordination

Among the 75 countries with high burdens of maternal and child mortality and morbidity, 35 (47%) reported having a functional H6 country coordination mechanism. In each of these countries, one of the six member organizations coordinates the partnership to facilitate the provision of joint technical support and advocacy for RMNCAH at the country level.

H6 aims to support nationally-led efforts to mobilize and coordinate the public, private and civil society sectors around national RMNCAH priorities. By supporting nationally-owned RMNCAH coordination mechanisms, which are functioning in most of the 75 high-burden countries and involve UN agencies and other technical and financial partners, H6 seeks to build linkages and foster coordination and collaboration across the sectors that directly and indirectly influence the health and wellbeing of women, newborns, children and adolescents, including nutrition, human rights, education, gender-equality, water, clean air, sanitation, hygiene and infrastructure.

Moving forward, it is proposed that collaborations among the H6 member organizations be strengthened in the countries with high burdens of maternal, child and adolescent mortality.

The Global Financing Facility⁸

The GFF business plan places great emphasis on the development of country-led, prioritized and costed RMNCAH Investment Cases. The GFF Technical Working Group (GFF TWG), a team led by WHO and composed of technical experts from the H6 and other constituencies represented in the Investors' Group, worked to ensure coordinated follow-up and technical assistance in the development of RMNCAH Investment

⁷ <http://everywomaneverychild.org/news-events/news/1140-commitments-compendium-in-support-of-the-global-strategy>

⁸ <http://globalfinancingfacility.org/>

Cases in the GFF countries. In addition, at the request of the GFF Investors' Group, the GFFTWG informed the development of guidance notes and the operationalization of three papers on quality assurance mechanisms for Investment Cases, modalities for country platforms and approaches to the provision and coordination of technical assistance requested by GFF-supported countries.

In June 2015, the GFFTWG convened a very productive workshop on the theme, "From 'shopping lists' to Investment Plans – Supporting countries in developing and financing sound Investment Plans for Women's, Children's and Adolescents' health." The workshop brought together 46 participants from countries and bilateral and multilateral partner organizations. It focused on three inter-related issues: strengthening country-level investment plans; streamlining planning tools and improving the development impact of technical assistance and addressing the quality of these plans. The results of the workshop included a recognition of the need to support the development of sound investment plans to insure buy-in from all partners; the prioritization of high-impact, cost-effective interventions within the investment plans; predictable financing aligned with multi-year planning cycles from development partners; simplification of technical assistance support with a focus on building longer-term capacity at the country level; the need for multi-sectoral approaches, including gender, and the need for streamlined approaches and tools for RMNCAH. Following the workshop, H6 has responded with a series of concrete actions, including the identification and training of a team of technical consultants and the preparation of an RMNCAH toolkit, among other things. At the second meeting of the GFF Investors' Group in February 2016 in St Albans, the Chair of the Investors' Group thanked the TWG for their contributions and noted that the GFFTWG had completed its mandate.

RMNCH Trust Fund

The RMNCH Strategy and Coordination Team (SCT) was hosted by UNICEF and comprised of three partner agencies – WHO, UNICEF and UNFPA. The RMNCH Trust Fund, funded by the government of Norway and DFID, was managed by the SCT with UNFPA acting as its administrative agent. The SCT, in its mandate to follow up on the

recommendations of the UN Commission on Life-Saving Commodities and to facilitate the country engagement process (which lead to multi-million dollar investments in 19 countries) has consistently worked with a number of partners, including, and perhaps most importantly, UN agency members of H6. US\$200 million were invested in catalytic, gap-filling, high-impact interventions contributing to important increases in access to services and commodities. Building on its experience, the SCT also played an active role in 2015 in developing the GFF business plan and supporting the development of countries' Investment Cases.

French Muskoka Initiative⁹

The French Muskoka initiative involves eight sub-Saharan countries (Benin, Côte d'Ivoire, Guinea, Mali, Niger, Senegal, Chad and Togo) and is implemented by UNFPA, UNICEF, UN Women and WHO. The total investment in this initiative for 2012-2016 is EUR 95 million (EUR 19m per year) from the French ministry of Foreign Affairs, and an additional EUR 1.5m per year from the UNICEF French National Committee to implement essential family practices. The initiative plays a catalytic role at the regional level, as well as addressing the strengthening of health systems in these countries in areas such as planning, coordination and implementation of high-impact interventions for women and children (maternal health, family planning, sexual health and reproduction for youth and teenagers, infant and child health, nutrition, community health). It supports financially and technically the regional mechanism Harmonisation for Health in Africa (HHA) which aims to coordinate technical support to countries for health systems strengthening, as well as Monitoring and Evaluation (M&E). Within this mechanism, it also supports five Communities of Practices (financial access to health, district health services, pharmaceuticals, quality of obstetric care in hospitals and Human Resources for Health). The French Muskoka fund co-funds the TV series "C'est la Vie" which was broadcast in 2015 on international francophone TV networks (Canal Horizon/A+ canal and TV5 Monde) and will be broadcast in 2016 on all Francophone African national TV channels, potentially reaching tens of millions of families. Its aim is to bring information to families on all issues related to Maternal and Newborn Health (MNCH) and violence against women in an entertaining manner.

⁹ <http://ffmuskoka.org/>

Next steps

In 2016, H6 in its new format will continue to perform its diverse roles of providing technical assistance, facilitating and convening and advocacy. It will build on the achievements of 2015 and support countries in integrating the SDGs into their national plans and strategies, as well as implementing steps toward acceleration and innovation.



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The H6 partners supported the government of Uganda to capitalize on the Global Financing Facility (GFF) – a new financing platform in support of the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

The H6 mobilized through technical assistance, targeted financial support and advocacy in the development of Uganda’s Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health – sharpened plan for Uganda; Civil Registration and Vital Statistics and Health Financing Strategy.

The H6 worked collectively throughout in support of Uganda’s Ministry of Health; harnessing each partner’s strengths while coordinating closely with other stakeholders through the existing country platform led by the Ministry. The Uganda RMNCAH Investment Case provides a unique opportunity for all stakeholders to mobilize and align their support and resources behind it. In this respect, a World Bank group IDA project (US\$ 110 million) and a GFF Trust Fund grant (US\$ 30 million) is under preparation. As the Investment Case moves to implementation, the H6 partners will support the government alongside other development partners and stakeholders to effectively implement the plan at all levels of the health system to deliver improved health and well-being for women, children and adolescents.



Progress of the H6 Joint Programme in 2015

The H6 partnership has unique capacities to draw on and roles to play in supporting the Global Strategy for Women’s and Children’s Health, known as the Every Woman Every Child initiative. At the global and country levels, each of the six organizations benefits from longstanding partnerships and trust. They are often called upon as reliable and credible partners who bring technical expertise to address the continuum of RMNCAH challenges.

As detailed in Figure 2, the H6 partnership has three major roles at both the global and country levels:

- 1. a technical role;
 - 2. a convening and coordination role; and
 - 3. an advocacy and communication role.
1. **Technical:** support countries as they develop, implement and monitor RMNCAH policies, national plans, strategies/investments and

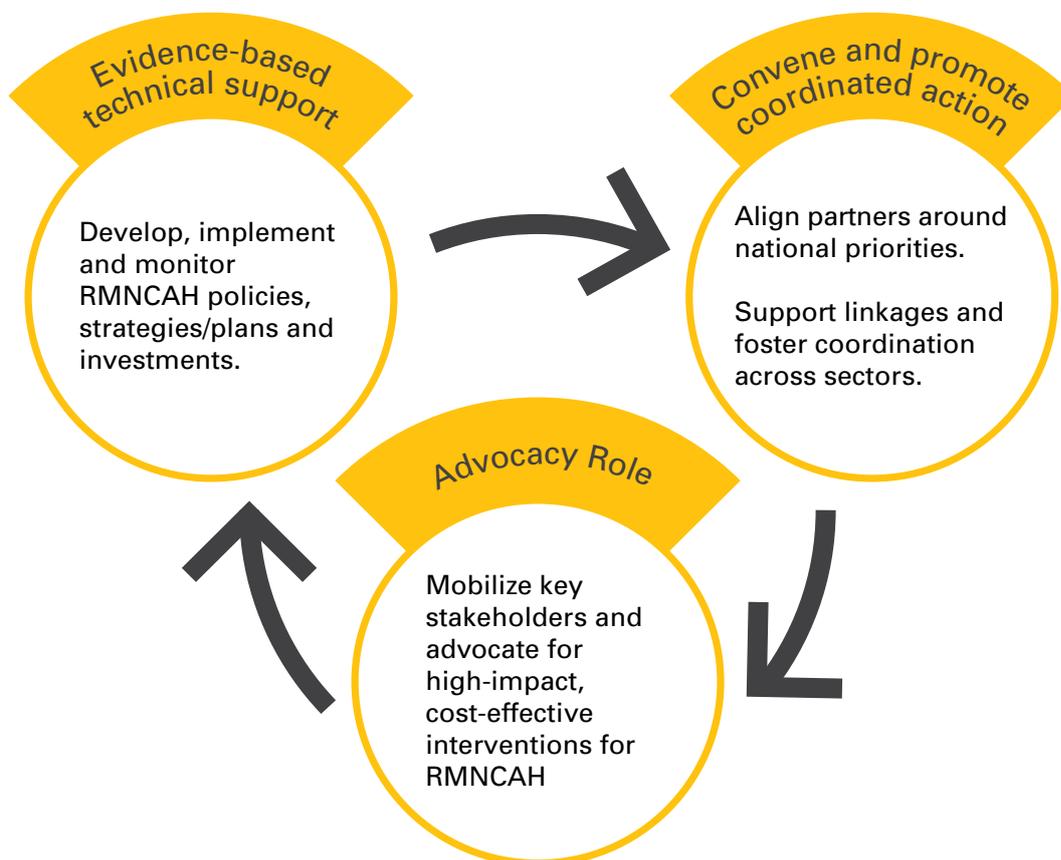
programmes through the provision of Technical Assistance (TA) on RMNCAH interventions, M&E, and health systems strengthening;

2. **Convening** (mostly at country level): support national governments, align partners around national priorities and facilitate linkages between sectors, including sourcing of TA and south-south cooperation. Convergence in this case involves creating harmonized response for technical assistance, including creating synergies for resources complementary to domestic resources, and coordination for rallying support for advocacy.

3. **Advocacy:** mobilize commitment and resources for RMNCAH by involving key stakeholders.

In 2015, by leveraging its technical strength and collective drive, H6 demonstrated encouraging progress against the background of systemic and environmental challenges that each country faced.

Figure 2: H6 roles and responsibilities: three roles, three levels



H6 technical leadership at the global level

H6 developed and disseminated high-quality global public goods and knowledge products (see below) and promoted the use at the country level of evidence-based practices for informing policies and programmes. It supported the development of several distinct knowledge products, including reports, policy briefs, policy compendiums, tools, technical guidelines, recommendations, analyses, action plans and best practices. For each global-level activity, one partner leads and the other H6 partners collaborate.

In addition, the H6 global team, representing technical professionals from each of six H6 partner agencies, provided specific management, coordination, technical assistance and oversight support to the 10 countries in the Canada and Sida collaborations, as well as to other countries with active H6 teams. (See Appendix 5 for a table of countries with active H6 teams.)

Global public goods and knowledge products for RMNCAH

In 2015, H6 generated and disseminated RMNCAH technical and policy briefs, knowledge products, protocols and standards targeted to the 75 high-burden countries. Notable achievements in 2015 at the global level included:

UNAIDS

- Two community engagement indicators, developed under H6, have been embedded in a human rights, gender equality and community engagement tool as part of the WHO global validation process for the Elimination of Mother-To-Child Transmission (EMTCT) of HIV and syphilis;
- Development of a Community Health Worker (CHW) training package to help RMNCH teams implement community groups describing roles and responsibilities of community health worker;
- Development of a Literacy and Advocacy Kit to support pregnant and breastfeeding women living with HIV in communities with limited levels of literacy;
- An annotated bibliography of community-based delivery service costing methodologies;
- A People Living with HIV Stigma Index electronic analysis tool to expand the online database and improve the website interface so that users can more effectively analyze data on relevant HIV and reproductive, maternal and child health issues from Cameroon, Ethiopia, Kenya, Nigeria, Uganda and Zimbabwe;
- A road map to achieve better health for adolescents was developed by adolescents and young people in close collaboration with UNICEF;
- Co-launched the global standards for quality health-care services for adolescents (WHO);
- UNAIDS and WHO launched a multi-stakeholder Agenda for Zero Discrimination in Health Care for 2016-2017;
- UNAIDS supported a mapping that identified over 80 existing tools to assess and address HIV-related stigma and discrimination in health care, to provide evidence for actions.

UNICEF

- Led the development of the Essential Newborn Action Plan (ENAP) country case studies on progress for newborns in four countries;
- Documented innovations for H6 countries;
- Developed an integrated Communication for Development (C4D) guide on MNCH, prepared and rolled out in multiple countries;
- Compiled a bottleneck analysis and situation

assessments for Iraq, Nepal and Malawi, followed by the development of national plans;

- Developed and finalized the *Planning Handbook for Caring for Newborn and Children in the Community*;
- Published the BMJ¹⁰ Supplement highlighting bottlenecks and recommendations to be overcome in nine high-impact maternal-newborn interventions;
- Revised and used ENAP Progress Tracking Tool. Data collated from 16 of the 28 ENAP high-burden countries;
- Documented and disseminated M-Health interventions and Rapid-Pro for community reporting at the Mexico Global Maternal Newborn Health (GMNH) Conference.

WHO

- Developed a policy brief on strategic planning for ending preventable maternal, newborn and child mortality;
- Revised Lives Saved Tool (LiST) for updating the OneHealth and LiST instruments;
- Held a multi-stakeholder consultation for GFF investment;
- Disseminated a tool kit for adolescent health in the context of EWEC GS 2.0 and the development of RMNCAH Investment Cases;¹¹
- Adolescent health, pre-term, maternal and peripartum sepsis and Newborn Care (NBC);
- Created a feasibility test of WHO QoC indicators for MNCH care in facilities;
- Monitored global MDSR implementation status, published first global report on MDSR implementation and convened global workshop;
- Conducted in-depth evaluation of MDSR implementation in Guinea Conakry and Burkina Faso and national capacity-building for quality of care assessment and improvement in Congo, Malawi, Swaziland, Tanzania and DRC;
- Updated Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines with latest WHO recommendations; published Maternal Mortality Ratio (MMR) estimates.

UNFPA

- Introduced H6 News and posted 76 stories, case studies and programme updates generating 1,697 views. Similarly, on Twitter (Sept 2014 - March 2016) 4,790 tweets on H6 generated more than 42,800 impressions with 266 followers.
- Regular interaction is ensured with the advocacy working groups of EWEC, ENAP, EPMM and Johnson & Johnson;
- Conducted the Midwifery Workforce Assessment (MWA) for Tanzania and Mozambique;
- Developed, printed and disseminated the H4+ Handbook *Conducting a Sexual, Reproductive, Maternal, Newborn and Adolescent Health Workforce Assessment*. And organized three regional workshops for dissemination of the MWA tool;
- Organized three regional gap analysis workshops with the International Confederation of Midwifery (ICM);
- Field tested the midwifery service framework in Lesotho and Bangladesh;
- Modified Di-Monitoring tool followed by training of all 10 country teams;
- Oversaw the Sida-Canada budget for coordination purposes, both on global and country levels, and provided regular follow-up with countries for desired guidance;
- Organized H6 joint missions to seven programme countries and coordinated the annual inter-country meeting; and
- Organized planned steering committee meetings.

¹⁰ British Medical Journal.

¹¹ The term "Investment case" has been assigned to the Global Financing Facility by the World Bank for RMNCH investments.

UN Women

- Developed a draft conceptual framework for Gender Equality in RMNCAH. When finalized, the framework will be a tool to help ensure that the needs and priorities of women and girls are fully taken into account when planning and delivering RMNCAH services;
- Held two regional global citizen reporter advocacy trainings in sub-Saharan Africa and South Asia. A total of 60 reporters were trained on sexual rights and reproductive rights in the context of RMNCAH and the SDGs;
- Three policy briefs have been developed; one global brief, one for sub-Saharan Africa and one for South Asia. The briefs address human rights and gender equality for Sexual and Reproductive Health Rights (SRHR) and RMNCAH and focus on what works and what is needed for leaders at all levels to engage and support SRHR.



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Repairing Injustice

“My shame is gone!” said 18-year old Aisha Katawala proudly. She had just been discharged from Chinhoyi Provincial Hospital’s Obstetric Fistula Repair Camp in Zimbabwe’s Mashonaland West Province. The surgery was free, thanks to a partnership between H6, the Ministry of Health and collaborating partners.

Aisha had suffered from fistula for eight years following a sexual assault when she was only 10. *“I was raped by my uncle and no one believed me. Just before my 11th birthday, I suffered a difficult and traumatizing labour at home.”* After three days of agonizing labour, Aisha’s family finally brought her to the hospital, but it was too late. Aisha delivered a stillborn child by caesarean and developed fistula as a result of the prolonged labour.

“I began to leak urine through my vagina. No one wanted to be around me.” On returning to her community, Aisha was ostracized by her family and friends because of her condition. *“My school friends all went on to become wives and mothers; my own life was one of isolation and sorrow.”*

Things began to improve for Aisha when she heard a radio announcement about a free Obstetric Fistula Repair Camp in Chinhoyi. Upon hearing the announcement, Aisha immediately phoned the hotline number. *“I was so excited, I began to pray that I would get a date for the surgery soon.”* Aisha’s prayers were answered when she received a call informing her that she was in line for free surgery at Chinhoyi Provincial Hospital.

Now a new woman, Aisha is filled with self-confidence, exclaiming *“Look at me today! I am a woman, complete and dignified. My shame is gone!”* The campaign initiative has been welcomed by the community as it resolves the matter of social exclusion that comes with fistula, changing the lives of once-hopeless women. *“It has been an eye-opener for us,”* said Dr. Collett John Mawire, Medical Superintendent at Chinhoyi Provincial Hospital.



H6 technical leadership at the country level

(achievements per country are detailed in Appendix 1)

H6 involvement at the country level included work at both policy and programme levels that focused on strengthening health systems.

Support for policies

In all countries, H6 interventions aligned with national health plans and supported the creation of an enabling policy environment to strengthen national health systems, including:

- Advocacy and facilitation to enhance domestic resource allocation for the RMNCAH sector;
- Capacity-building and promoting the use of evidence-based protocols and standards to improve the quality of RMNCAH services;
- Supporting the development of strategy and policy documents and the removal of financial barriers to the implementation of free RMNCAH care services;
- Strengthening monitoring processes to improve effectiveness and accountability, including MDSR;
- Supporting the preparation of national health accounts to strengthen accountability;
- Supporting Ministries of Health, programme managers and health workers to effectively integrate gender-responsive measures in policy, programming and service delivery for RMNCAH.

Specific policy support at the country level included:

- **Burkina Faso** – Review of the Human Resource Development Plan (2016-18) and institutionalization of modular Emergency Obstetric and Newborn Care (EmONC) and Integrated Management of Childhood Illnesses (IMCI) training at the National School of Public Health;

- **DRC** – Review of HRH Strategic Plan 2016-2018 and development of national health accounts for MNCH;
- **Sierra Leone** – Support to the MoHS to develop a process to review the reproductive and child health policy as well as strategy and technical support for the development of post-abortion guidelines followed by training of health functionaries;
- **Zambia** – H6 advocacy resulted in MoH authorizing Community-Based Distributors (CBD) to offer Depo Provera (DMPA) and a scaling up of Mama Kits interventions based on evidence generated by the H6 Joint Programme. *The Management of Pediatric HIV manual* was also updated;
- **Cameroon** – Dissemination of the Strategic National RMNCAH plan (2014-2020) and development of national MDSR guidelines and tools;
- **Côte d'Ivoire** – Support to the dissemination of key strategic documents on FP, HIV, Gender Based Violence (GBV), adolescent/youth health, EmONC and ICM norms and the development of eight district operational plans for Maternal and Child Health (MCH);
- **Ethiopia** – The H6 country team participated in the development of the HSTP-V, elaborated RMNCAH strategies for 2016-2020 and developed a national midwifery road map (2015-2025);
- **Guinea Bissau** – H6 advocacy resulted in the announcement of a legal decree for the compulsory notification of maternal deaths or near-miss cases and the establishment of MDSR committees at the national and regional levels. A national guide and strategic document for integrated clinical care for People Living with HIV was developed;
- **Liberia** – A comprehensive RMNCAH policy was developed and national MNDSR guidelines and protocols were reviewed and revised;



Courtesy of H6 Country Team - Cameroon

- **Zimbabwe** – Development of national nutrition communication strategy and surveillance guidelines, as well as national clinical mentorship guidelines for MNH care.

Support for programmes

In identified geographical areas of each country, the H6 Joint Programme focused on strengthening the quality of RMNCAH services and enhancing community engagement to meet demand and increase the use of these services. The activities at the sub-national level aim to feed into the policy level for up-scaling desired interventions nationally and to strengthen national health systems.

In the 10 countries supported by Canada and Sida grants, innovative solutions are being developed and tested on an on-going basis to address locally specific RMNCAH issues.

During 2015, all H6 Joint Programme countries received support for:

- Supplies of equipment and essential medicines for mothers, newborns and children to improve the quality of care. Ebola-affected programme countries Liberia and Sierra Leone received additional supplies for Infection Prevention and Control (IPC);
- Skills enhancement of human resources for health by strengthening pre-service training (support to midwifery/primary health care

providers' schools) and in-service training on EmONC, IMNCI, NBC, FP and Prevention of Mother-to-child Transmission (of HIV) (PMTCT);

- Training and sensitization of healthcare workers on gender equality, rights and harmful gender norms. This includes the identification and case handling of incidences of Gender Based Violence, including psychosocial support and care;
- Improving access to RMNCAH services through enhanced integration of MNH, FP, IMNCI, PMTCT and HIV services in health facilities, strengthened referrals from communities to facilities and between facilities, and through the establishment of outreach services;
- Strengthening health management information systems at national/sub-national levels and institutionalization of MDSR;
- Generating demand for RMNCAH services at the community level through community mobilization, radio and media campaigns, as well as building the advocacy capacity of community groups and creating community forums for discussion of harmful social norms and barriers to RMNCAH services;
- Working with men and traditional leaders to raise awareness and sensitize them on gender equality and the need and importance of women and adolescent girls accessing RMNCAH services.

How H6 strengthened health systems in Ebola-affected regions of Sierra Leone and Liberia in 2015



Courtesy of H6 country team - Liberia

At present, the H6 Joint Programme is being implemented in two Ebola-affected countries—Sierra Leone and Liberia.

In Sierra Leone, several assessments conducted by the government and/or its partners revealed that the health sector was disproportionately affected by the EVD outbreak, which eroded recent progress towards the Millennium Development Goals. Being first responders, health workers became infected as they provided routine care and support to sick patients. Community confidence in the sector and in the delivery of critical maternal and child health services declined. The EVD outbreak also increased mortality and morbidity from other health conditions as a result of communities' fear of catching Ebola, ultimately leading to the avoidance of functioning facilities.

In 2014, the H6 Joint Programme organised IPC training and provided supplies to health facilities nationwide. In 2015, two of the country's 13 districts received support in training 2,100 CHWs to reach each household to raise awareness and bring individuals, families and communities back to health care facilities to access MNH care.

H6 partners also supported a national review of the 2011-2015 RMNCAH strategy; this will directly lead to the development of a new strategy to respond to the new Global Strategy of EWEC. The H6 agencies are also contributing to the MoHS 24-month initiative for the accelerated reduction of maternal and child mortality.

In Liberia, Ebola survivors, especially females, are stigmatized and face many challenges in the community. The programme supported the training of 25 staff from MoH, the Ministry of Gender, NGOs and INGOs to provide psycho-social support to EVD-affected households, emphasizing issues of GBV in the context of Ebola. A series of 12 radio drama and talk shows was produced and broadcast to address the concerns of survivors about how to deal with stigmatization as a result of Ebola infection. The programme also supported outreach and sensitization activities at the community level, providing opportunities for women, men and youth to openly discuss sexual and reproductive health issues, including Maternal and Newborn Death Surveillance and Response, sexual and Gender-Based Violence and Family Planning. The sessions included a question and answer period in which community members who demonstrated an understanding on some of the issues received a digital radio. A total of 60 digital radios were distributed as audience incentives to participate.

Specific programme support at the country level included:

- **Health financing:** H6 provided technical and financial support for the implementation of national health financing strategies to address financial barriers to deliveries by Skilled Birth Attendant (SBA) and access to EmONC. In Burkina Faso, for example, H6 complemented government funding for Cesarean section operations. H6 also strengthened the management capacities of community-based health insurance (mutuelles) and the design and implementation of performance-based financing in DRC;
- **Health technologies:** H6 supported the provision of essential care for mothers, newborns and children in 639 health facilities across the 10 countries. The drugs, medicine, equipment and supplies were provided for EmONC, NBC, IMNCI, FP, PMTCT and blood products. In Liberia, Sierra Leone, Guinea Bissau and Zambia, ambulances were procured and supplied to enhance the referral process. In Sierra Leone and Liberia, IPC materials and supplies were procured and distributed to revive MNH care in health facilities offering MNH services. In Burkina Faso and Liberia, support was also provided to strengthen managers' capacities at different levels for logistics and supply management systems;
- **Human resources**
 - **Pre-service training:** H6 supported the strengthening of human resource capacities and the availability of equipped labs, including mannequins, in 56 pre-service training institutions in the 10 countries. It supported a national public health school in Burkina Faso, two sub-national midwifery schools and two EmONC training centers in the DRC, and 13 schools for MCH aides in Sierra Leone. In all, H6 has provided financial support to 274 pre-service midwifery students in Sierra Leone since 2012. In Cameroon, 10 midwifery schools and one sub-national midwifery school received support for teaching aids. In Côte d'Ivoire, tutors were trained in EmONC to improve the quality of midwifery internships in health facilities. In Ethiopia, 13 midwifery schools were equipped with needs-based training materials. A national midwifery school in Guinea-Bissau received the support of an internationally trained midwifery tutor hired to facilitate the adoption of the ICM curriculum in two midwifery training schools, where tutors also received training. In Liberia, 12 sub-national midwifery/nursing training institutions were equipped;
 - **In-service training:** H6 supported capacity-building for health care providers in EmONC, IMNCI, NBC, PMTCT, Family Planning and management skills. In 2015, more than 13,500 health care providers were trained: 3,485 in EmONC, 3,302 in newborn and infant care, 1,364 in PMTCT as well as HIV prevention and treatment, 858 in Family Planning, 130 in youth-friendly services and 103 in health care management; 4,334 CHWs also received training. (See Appendix 2 for details);
 - **Health information systems, Monitoring & Evaluation:** The H6 Joint Programme supported the strengthening of MDSR in all programme countries. This included setting up a rapid SMS system for real-time notifications of maternal and newborn deaths in Burkina Faso and the integration of maternal deaths in the mandatory list of diseases and cases to be reported in DRC, Ethiopia and Guinea Bissau. H6 also supported the strengthening of HMIS at national and sub-national levels in most countries by supporting supervision and improving the data collection tools and data collection/analysis/management skills of health managers and providers. In Zambia, 55 provincial and district officials received orientation on the MDSR process. In Zimbabwe, electronic maternal and perinatal death database systems were piloted in two provinces and 152 health workers were trained on the HMIS and electronic database. In Liberia, support was given to revise existing national HMIS tools and programme indicators integrated into national HMIS tools. Burkina Faso supported the development of scorecards for RMNCAH and the training of 14 administrators. In Sierra Leone, 26 M&E and data entrants were trained in data collection and the analysis of key indicators of RMNCAH. In Ethiopia, support was given for self-assessments on quality maternal and newborn health in 30 hospitals and the midterm review of the elimination of mother-to-child HIV transmission (EMTCT) strategy was completed. A monitoring system for PMTCT for mother and baby cohorts was introduced, linking mothers with their babies in a single register and allowing health facilities to track the interventions the mother and child receive. This enables systematic monitoring and follow-up of the mother throughout her pregnancy, and of both mother and child during delivery and post-partum.

- **Health Service Delivery:** H6 supported the provision of skilled human resources, strengthening service environments and referral systems in 639 health facilities in all 10 programme countries.

High-frequency radios enhanced communication among 41 health facilities in Zambia and 18 in Liberia. In DRC, coverage of FP and EmONC services reached nine targeted zones where 18 health facilities were made functional by establishing referral linkages with mission hospitals. In Sierra Leone, 6,000 women benefited from outreach Antenatal Care (ANC) and Post-Natal Care services in hard-to-reach areas and 2,100 CHWs engaged in door-to-door campaigning in two districts to raise awareness of the threat of Ebola for mothers, newborns and children. In addition, 89 service providers offered post-abortion care using new guidelines.

In Burkina Faso, national FP week reached 56,632 new users of family planning services. Obstetric fistula surgeries were performed on 16 women; 28,957 obstetrical complications were managed with a Case Fatality Rate (CFR) of only 1.4 per cent; 984 parents (950 women and 34 men) and 986 adolescents (828 girls and 160 boys) were counseled on SRH rights. Zambia reported the rehabilitation of 14 maternity waiting homes and labour rooms equipped with solar power backup, and the provision of quality MNH care at 30 health facilities.

In the far north of Cameroon, H6 supported 91 facilities in providing MNCH care and 189 CHWs provided services to 15,209 children under five. In addition, 11,026 malaria cases, 1,777 diarrhea cases, 2,406 cases of Acute Respiratory Infection (ARI), 273 cases of malnutrition and 1,402 pregnancies were treated in villages located over 5 km from integrated health centres. Côte d'Ivoire integrated MNH, FP and HIV services in 11 health facilities, provided 25 MNH outreach consultations and community-based distributors (CBDs) of modern contraceptive methods for FP and child health. Performance-based financing was monitored in health centers in eight intervention districts.

Guinea Bissau recruited eight international experts (three OBGYN, four pediatricians, and one anesthetist) for delivery of Comprehensive EmONC (CEmONC). National providers were trained on standards and procedures in Basic EmONC (BEmONC) / CEmONC which incorporate aspects of gender/HIV/GBV at two regional

hospitals. In Ethiopia, midwifery standards were disseminated to 695 midwives to improve the quality of midwifery services; CEmONC training enabled 11 hospitals to become functional; 240 Health Extension Workers (HEW) were trained to identify fistula cases; 65 health workers were trained in the screening of fistula patients. Training for HEWs included gender equality, identification of harmful traditional practices and SRHR, including psychosocial support for GBV survivors.

In Liberia, H6 provided three ambulances for referrals in three southeast counties, 150 CHWs conducted home visits and nine retired midwives were re-engaged to revive BEmONC services in 18 health facilities for post-Ebola recovery. In Zimbabwe, quality MNH care was provided in 37 health facilities. Ten nurses and 10 doctors were trained to repair obstetric fistula. Two camps were held and 78 cases were repaired. Parent-to-child communication interventions begun in the Hurungwe district to address adolescent fertility and five health facilities were renovated to improve the service environment.

- **Demand—including community ownership and participation:** Increasing community ownership and participation focused mostly on the training of community health workers in MNH, and 4,334 CHWs were trained by the H6 Joint Programme in 2015. Support to communities consisted of improving the organizational and managerial capacities of women's and men's groups/associations, such as the 30 Husband Schools in Burkina Faso and the Safe Motherhood Action Groups in Zambia, as well as the mobilization of community and religious leaders to promote RMNCAH and gender equality and prevent GBV. In Zimbabwe, 40 CHWs were trained in awareness-raising on HIV testing, counseling and PMTCT; 33 safe spaces for young women were set up; three district festivals were organized for young women to discuss and learn about RMNCAH issues; 3,295 men and women were reached with information, and traditional and religious leaders were actively engaged.

In Liberia, 26 adolescent peer groups were established and 120 stakeholders were sensitized on programme participation and activity implementation; 211 community cadres and leaders were trained in HBMNC and are now fully involved in programme implementation, including monitoring. Guinea Bissau reported the training of 772 CHWs for awareness generation and community participation on MNH in two regions of the country.

In Ethiopia, eight regional workshops on gender mainstreaming were organized. For health care providers, H6 supported a national safe motherhood advocacy campaign and consultative meetings were held to identify and document best practices for reducing gender discrimination and harmful practices, as well as increasing women's demand for health care. Côte d'Ivoire supported Husband Schools in 20 new locations to address GBV and promote FP, institutional deliveries and PMTCT. Communication for RMNCAH was strengthened by linking community groups with health facilities. To help generate demand, communication materials were disseminated and three youth counseling units for RMNCAH and PMTCT were set up.

Awards for good performance were given out in Cameroon. In DRC, 27 public administration cadres were sensitized on HIV and GBV; 1,420 CHWs supported community FP interventions; 100 community and religious leaders were sensitized on RMNCAH and 2,000 young boys were sensitized on GBV. In Sierra Leone, 10 resource centers were established for information-sharing and over 335 Husband Schools were set up in different communities to promote SRH and awareness of gender issues. An advocacy group of former Traditional Birth Attendants (TBA) promoted the identification of danger signs in pregnancy as well as FP and GBV case referrals in communities.



Addressing gender inequality: tackling the root causes of poor RMNCAH outcomes

Recognizing that poor maternal health outcomes are often a result of gender inequality, the H6 Joint Programme assigns high priority to interventions aimed at addressing the root causes of maternal, newborn and child mortality and morbidity, including gender inequality.

Socio-cultural constructs and practices that discriminate against women, such as unequal power relationships, a failure to prioritize women's health, limited access to financial resources and restricted individual autonomy, can have limiting effects on women's access to health care. Similarly, painful morbidities like obstetric fistula stigmatize and isolate young women suffering from it. Recognizing the implications of gender inequality on RMNCAH outcomes, H6 programming takes an active approach through both the supply side (health systems and inputs) and demand side (community engagement, health-seeking behaviour and women's empowerment) to implement gender-responsive interventions and pursue improved RMNCAH outcomes. Key achievements of 2015 include the following:

- **In Burkina Faso**, thanks to advocacy by a key stakeholder consortium supporting gender issues, a law prohibiting violence against women and girls was passed by the national assembly in 2015;
- **In the Far North region of Cameroon**, the poorest in the country, H6 has supported efforts to address the root causes of low utilization of health facilities and lack of health-seeking behaviour since 2014. In response to this, 73 women's groups received technical and material support estimated at between US\$400 to US\$900 to develop income-generating activities and to promote RMNCAH. The women's groups carried out activities such as awareness-raising on RMNCAH and on the importance of accessing services, and birth preparedness, including plans to overcome financial barriers. This approach catalyzed the women's financial empowerment and also facilitated their access to health services, particularly delivery in health facilities;
- **In Ethiopia**, the Ministry of Health has developed a manual on *Gender Mainstreaming in the Health Sector*. Through a series of workshops to cover all the states of the country, leaders and programme managers in the regional health bureau and within the MoH were introduced to the guide and trained in the gender barriers women face in the health sector. These workshops will prepare them for gender-responsive planning, budgeting and programme implementation;
- **In Côte d'Ivoire**, a social franchise strategy provided 18 women's groups with material resources for economic independence and gainful employment at the local level. This resulted in financial empowerment and greater access to reproductive health services, specifically family planning. In addition to the economic empowerment of women, men's involvement in reproductive health rights and their promotion, has been increased through the establishment of Husband Schools. This has helped to promote greater gender equality, as reproductive rights and services are no longer seen as a "woman's affair."
- **In Guinea-Bissau**, H6 introduced gender markers into data collection tools for maternal and child health. At the community level, 19,200 young people were trained in GBV, HIV and reproductive health to act as peer educators at the local level in all H6 intervention regions;
- **In DRC**, efforts have been made to engage community leaders and groups in a self-help approach based on the active engagement of chiefdoms, to promote both communities' traditional values and gender equality. Equality between men and women, and in particular the prevention of violence against women, is a topic addressed during training for community



Courtesy H6 country team - Zimbabwe

leaders as well as young and adult community health officers. Women's empowerment has been made a priority in various areas of health. In addition to improving their financial access to health care through strengthened financial capabilities, this also promotes women's decision-making power in their communities;

- **In Zimbabwe**, safe spaces (forums) were created in the communities for adolescent and young women for confidence-building activities, engagement and information sharing on adolescent sexual and reproductive health; more than 15,000 women attended 33 forums by the end of 2015. By the end of 2015 an additional 35 male Community Based Advocates were trained (10 each in Chipinge and Mbire and 15 in Chiredzi). This was the result of the increased success of door-to-door visits, the rise in male involvement in family counseling on GBV and the advantages of early bookings at clinics;

- **In Sierra Leone**, with support from the H6 Joint Programme, the Ministry of Social Welfare, Gender and Children initiated a community empowerment project engaging TBAs in community advocacy and outreach programmes on GBV prevention and Reproductive Health and Rights (RHR) issues, including Family Planning. From 2012 - 2013, the Ministry, supported by H6, formed and trained Community Advocacy Groups (CAG) in all 13 districts of the country. CAGs continually engage in community outreach in their respective chiefdoms and districts, promoting referrals and family planning awareness in their communities.

Key results in 2015 in H6 Joint Programme countries

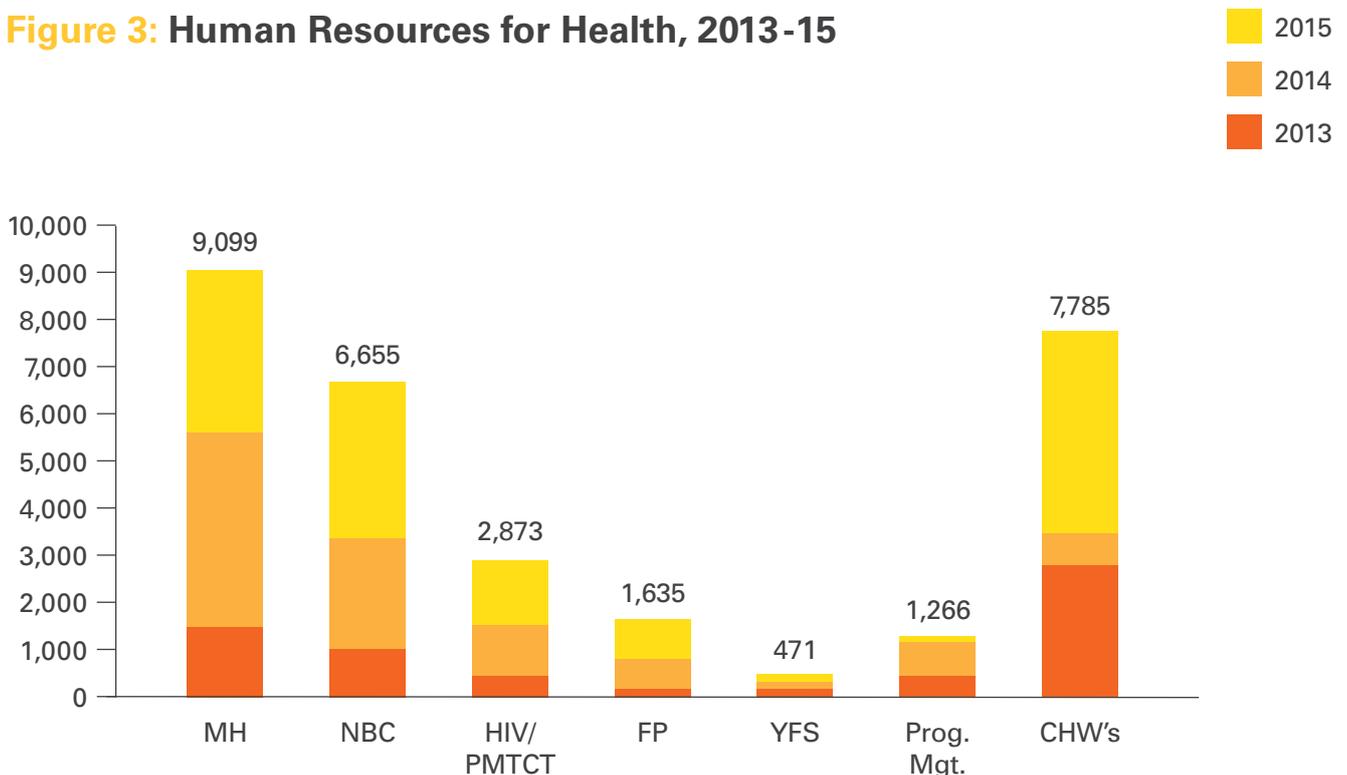
Human resources

Each H6 Joint Programme country was equally challenged by a scarcity of skilled health care workers for the provision of RMNCAH care to enhance maternal and child survival and health. Conscious efforts have been made to improve the quality of pre-service training of midwives by revisiting curricula and building the capacities of tutors and by providing teaching aids for training centres to enable students to practice their skills through modular trainings. Similarly, the capacities of individuals and institutions were built to enable them to initiate needs-based training of in-service health care providers (health workers, doctors and CHWs), to generate awareness and increasingly engage individuals, families and communities. An increase in skilled deliveries was observed in facilities implementing the project due to an increase in trained midwives. Over the past three years, a total of 29,784 individuals received training in a wide range of skills in the realms of EmONC, IMNCI, FP, PMTCT, NBC and community awareness.

In 2013, 6,398 individuals, in 2014, 9,810 individuals and in 2015, 13,576 individuals were trained in RMNCAH knowledge and skills to expand the base of skilled human resources for health for the improved provision of RMNCAH care. These numbers represent 22 per cent, 33 per cent and 46 per cent of the total 29,784 who were trained, respectively, for 2013, 2014 and 2015. At the same time, the protocols and standards for quality of services were reinforced to institutionalize quality of care in the national health system and sustain the gains already achieved.

- **Burkina Faso:** H6 successfully advocated to maintain the national budget line with a commitment of 375 million CFA of domestic resources towards contraceptives and to mobilize donor funding for remaining interventions. This resulted in a 50 per cent reduction in the cost of contraceptives.

Figure 3: Human Resources for Health, 2013-15



- **DRC:** High-level advocacy support resulted in US\$2.5 million being spent by the national government on contraceptives (for the first time in DRC) as well as in the development of the country's FP vision 2030.
- **Sierra Leone:** Since 2013, 274 midwives have completed pre-service training, nearing the target of 300. All 13 MCH aides training centres built their capacities to organize quality training. Three General Practitioners received financial support to undergo post-graduate courses in obstetrics and gynecology in Nigeria; to build in-house capacity for CEmONC services in their home country.
- **Zambia:** The H6 Joint Programme provided innovative Mama Kits in five districts to help motivate mothers to deliver in health facilities with SBA assistance. Based on the evidence generated, RMNCAH partners adopted Mama Kits in an additional 19 districts supported by EU and RMNCAH trust fund, while MoH mobilized other partners to scale up the Mama Kits in other parts of the nation.
- **Cameroon:** As a means to promote accountability in the national health system, national MDSR guidelines and tools were developed by the H6 Joint Programme before being implemented nationwide to institutionalize an MDSR initiative.
- **Côte d'Ivoire:** In order to promote evidence-based strategies, protocols and standards in the entire country, H6 supported the printing and dissemination of key strategic documents on Family Planning, HIV, PMTCT, GBV, adolescent/youth health, the provision of EmONC services and the use of ICM norms for pre-service midwifery education.
- **Ethiopia:** 300 identified health facilities (10 per cent of the total) were provided with SBAs in an effort to task-shift and tackle health worker shortages. In the past three years, 252 Integrated Emergency Surgical Officers were trained, nearing the target of 283, and placed in designated health facilities offering lifesaving maternity care.
- **Guinea Bissau:** In order to strengthen the national health system, H6 recruited eight international experts (three OBGYNs, four pediatricians and one anesthetist) to deliver CEmONC services and train national providers in two regional hospitals. Thus far, 40 health care providers have been trained in the required BEmONC skills. Similarly, one international midwifery expert supported the National Midwifery School in the adoption of the ICM curriculum and training of tutors to impart quality training in pre-service midwifery schools.
- **Liberia:** In three hard-to-reach South East counties with few SBAs, H6 supported 15 BEmONC workers in three referral hospitals to maintain MNH care during and in the recovery phase of the Ebola epidemic. An increase in institutional deliveries from 33 per cent in 2014 to 50 per cent in 2015 was reported in the intervention facilities.
- **Zimbabwe:** Although a large number of health care providers received skills enhancement training, the replication and use of the newly acquired skills was sub-optimal. Realizing this, H6 designed a clinical mentorship programme which proved successful, prompting the development of National Clinical Mentorship guidelines for MNH to sustain the gains of investments in pre-service training for MNH services.

H6 Joint Programme financial management and coordination

At the global level

Programme management

The H6 global technical team provides techno-managerial and oversight support for the H6 partnership. The H6 Joint Programme coordination unit is located at UNFPA and is the administrative agent of the Canada and Sida grants. A team of professionals provides guidance, support and facilitation to H6 country teams to develop needs-based and context-specific work plans, in addition to monitoring programme progress and reporting results.

The H6 coordination unit is responsible for organizing Joint Steering Committee meetings and reporting compliance with decisions made. Two of these meetings were held in 2015. The first took place on 18-19 March to approve 2015 – 2016 work plans and to review progress. A second was held on 16 December to review programme progress and to consider reprogramming, including no-cost extension requests for H6 countries.

The annual inter-country review meeting was held from 2-6 November 2015 in Douala, Cameroon. Some 104 participants from 10 programme countries, representing Ministries of Health, H6 country teams, H6 global and regional technical teams and representatives of Sida and Canada were present. The global technical team updated participants on recent global and regional developments following the transition from MDGs to SDGs before reflecting with countries on their implications for the H6 partnership in the post-2015 era. Progress in implementing the H6 Joint Programme during 2015 was reviewed, reprogramming was approved and corrective actions for optimum use of resources for 2015-16 were identified. In addition, the

End Line Evaluation of the H6 Joint Programme, its objectives, scope, process timeframe, and implications for the H6 countries, were discussed. The meeting also promoted cross-learning among H6 countries and teams.

Financial management

The H6 Joint Programme follows the pass-through modalities of grant management of UN agencies.

- For the Canada collaboration: Of the total 2015-16 budget (US\$13.5 million) about 11 per cent (US\$1.5 million) is dedicated to global-level activities. In the entire programme cycle, only 10 per cent of Canada collaboration funds will be used for global-level activities and the remainder will be for country-level activities. The recipients of funds of the H6 Canada grant of CAD \$50 million for 2011-16 are WHO, UNICEF and UNFPA.
- For the Sida collaboration: Approximately US\$6 million (11 per cent) of the total budget (US\$ 52 million) was dedicated to global-level activities. The overall expenditure rate reported for 2015 is 50 per cent of the approved work plan of US\$ 30.4 million for 2015-16. With the exception of the World Bank Group, all five H6 partners are recipients of funds under the H6 Sida collaboration.

H6 stakeholder coordination and convening role

The convening role of H6 provides an edge to this unique partnership. In 2015, H6 organized meetings, participated in joint events and joint missions and organized specialized coordination meetings with evolving mechanisms such as the Global Financing Facility.

The weekly H6 teleconferences for global technical teams provided regular opportunities to review progress and make suggestions to the H6 Joint Programme countries, as required, and to discuss coordinated efforts and endeavours. During the reporting period, 32 weekly H6 teleconferences were organized for the global technical teams represented by all H6 partners and representatives of EWEC for improved coordination, more efficient exchange of information, and harmonized responses to key issues and opportunities. The decisions made during the weekly calls are well documented for follow-up.

During 2015, H6 actively participated in the development of the United Nations Secretary-General's Every Women and Every Child Global Strategy 2.0. H6 successfully mobilized political commitments for it from 31 high-burden countries from August 2015 onwards. GS 2.0 focuses on life cycle approaches for the health and wellbeing of women, adolescents and children.

At the country level

Programme management

In each of the 10 H6 joint partnership countries, one of the H6 agencies has been appointed to act as the H6 focal point or country coordinator, overseeing and coordinating implementation at the country level. The collective efforts of country teams, in close collaboration with MoH, lead the country-level programme (Table 1).

Table 1: H6 lead agencies in H6 Joint Programme countries

| | |
|--------|--|
| UNFPA | Côte d'Ivoire, DRC, Guinea-Bissau, Sierra Leone and Zimbabwe |
| UNICEF | Cameroon and Zambia |
| WHO | Burkina Faso, Ethiopia and Liberia |

For the countries of the Canada collaboration, in 2015-16, 192 activities were planned. Of those, 109 have been completed, 61 are on-going and only 21 have yet to be started. The activity completion rate of 2015 was 57 per cent with 60 per cent resource utilization, indicating optimum utilization of resources by June 30, 2016. On the other hand, the fact that implementation rates decreased during 2015 for Zambia and Burkina Faso from the last four years' averages, in both absolute and average terms, requires attention.

For the Sida collaboration in 2015-16, 40 per cent (or 129) of the 324 activities that were planned were completed; 146 activities (45 per cent) were started and are ongoing; 49 activities (15 per cent) are yet to begin. Implementation rates for completed and ongoing activities were high in all six countries, averaging 84 per cent. They ranged from 76 per cent in Liberia, 79 per cent in Côte d'Ivoire, 80 per cent in Cameroon, 86 per cent in Ethiopia, 87 per cent in Zimbabwe to 96 per cent in Guinea Bissau.

In November 2015, during the inter-country review meeting of Joint Programme countries, many activities that were found to be of less immediate concern were dropped in the reprogramming process.

Financial management

In 2015-16, 90 per cent of the total budget (US\$13.5 million) for the Canada collaboration was designated for country-level activities. The average fund utilization was 60 per cent for country-level activities.

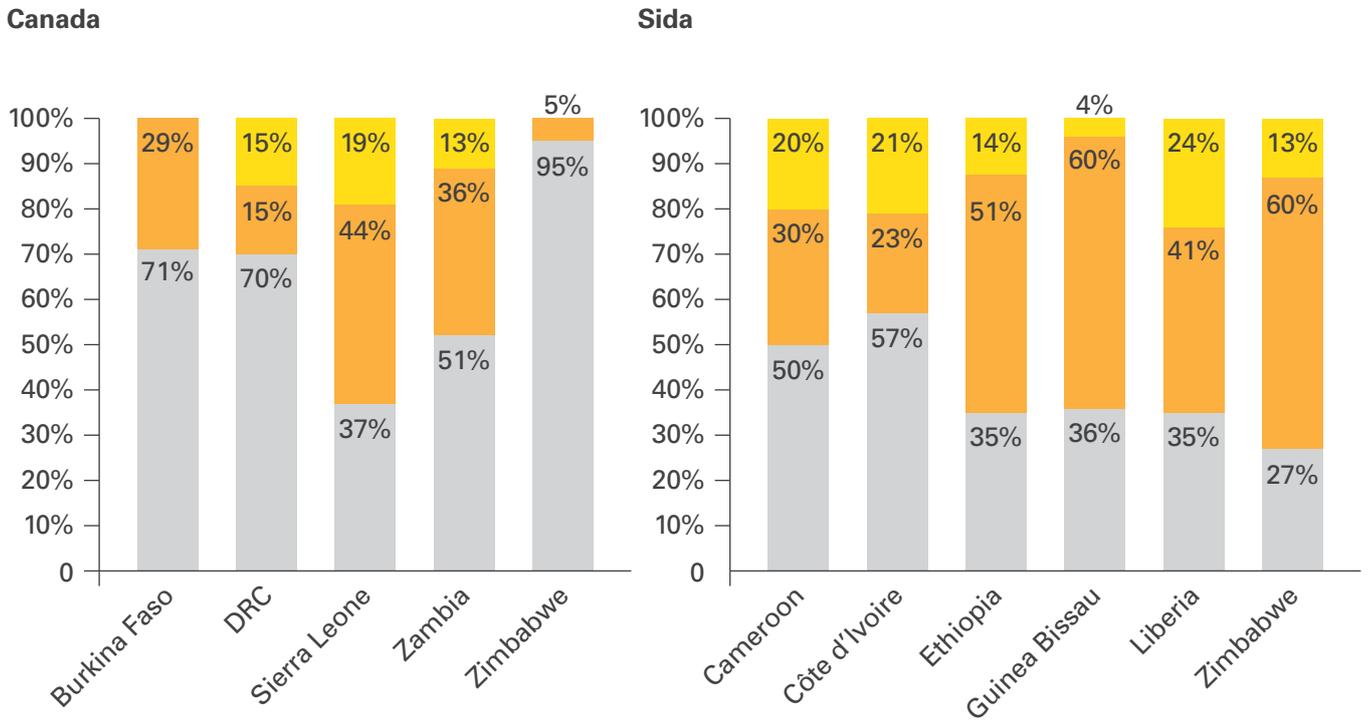
In Zambia, the 2015 provisional expenditure rate was about 47 per cent, in Burkina Faso and Sierra Leone about 51 per cent and in DRC 79 per cent. The rate was higher in Zimbabwe (93 per cent) due to the fact that only US\$0.5 million was provided under the Canada collaboration.

Under the H6 Sida collaboration, 87 per cent (US\$35.9 million) of the 2015-16 budget is dedicated to country-level activities.

The 2015-16 expenditure rates averaged 50 per cent. They were much lower in four countries: Liberia (41 per cent), Côte d'Ivoire (45 per cent), Ethiopia (48 per cent) and Cameroon (50 per cent). In Cameroon, implementation was affected by the Boko Haram conflict, and in Liberia the pace of implementation in three new North West counties was slow in 2015.

**Figure 4: H6 Joint Programme
Activity Implementation Rate 2015**

IR (Not started)
IR (Ongoing)
IR (Completed)



**Figure 5: Joint Programme Canada collaboration countries
Financial progress (provisional expenditures) 2015**

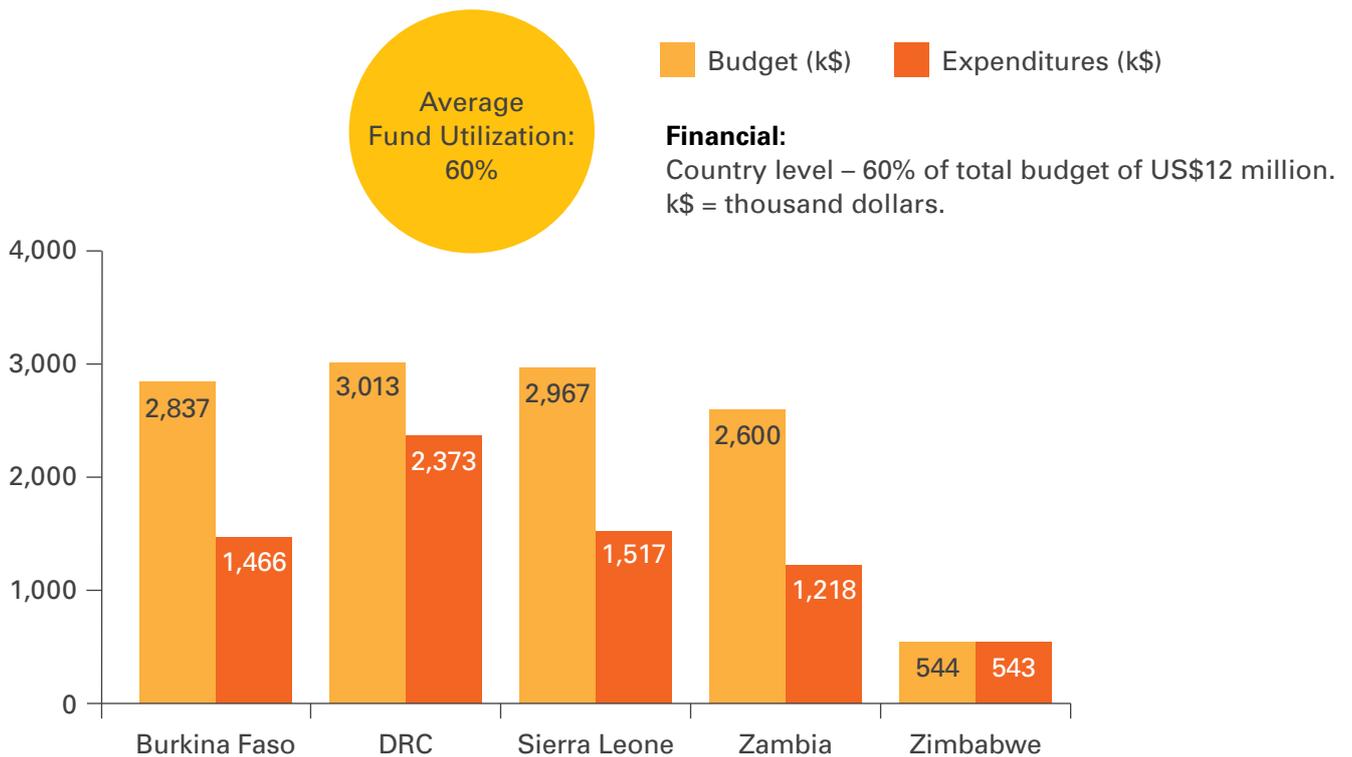
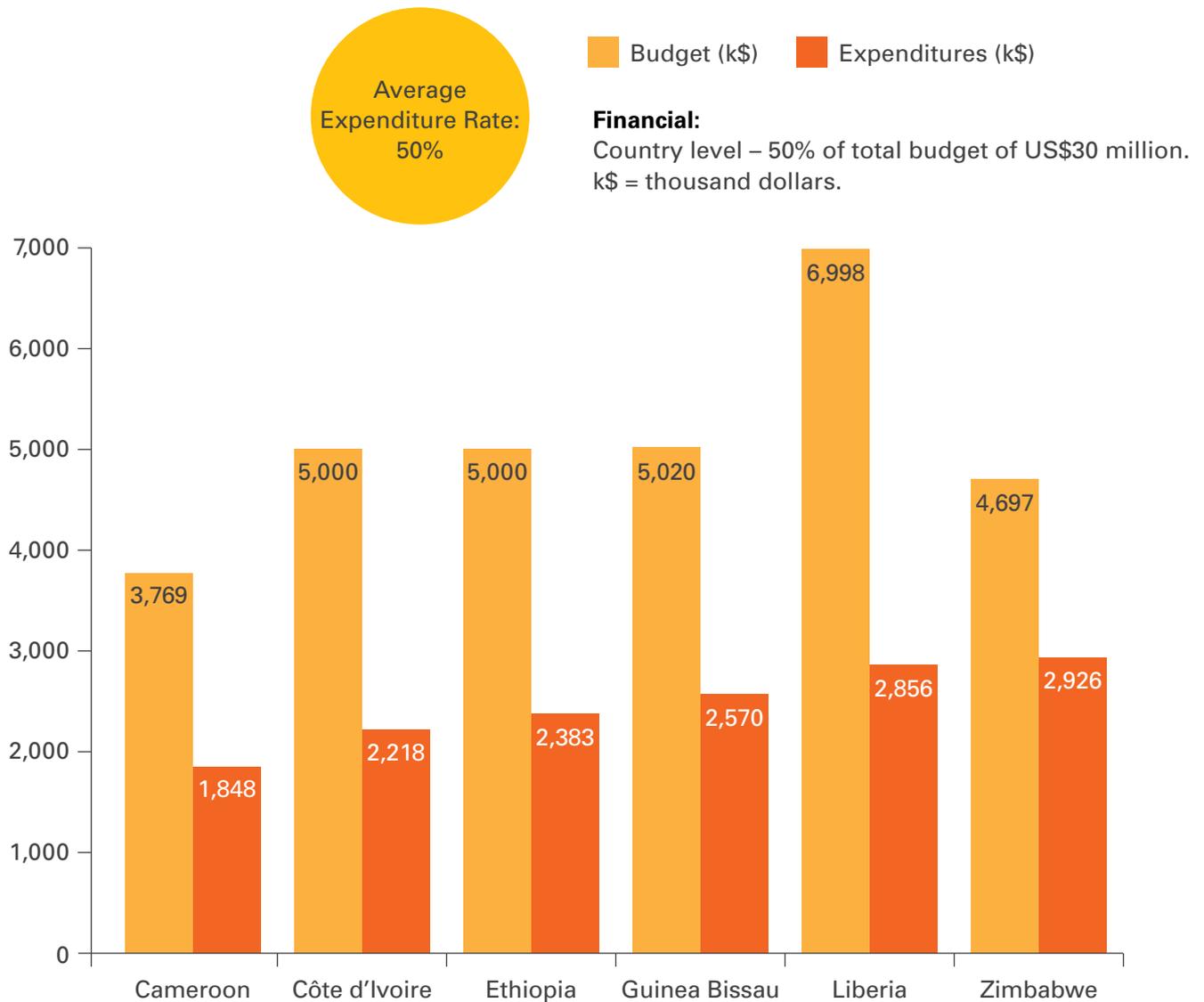


Figure 6: Joint Programme Sida collaboration countries financial progress (provisional expenditures) 2015



H6 stakeholder coordination and convening role

In 2015, the Joint Programme held 99 meetings in the Canada collaboration’s five countries, bringing together representatives from civil society, national and sub-national ministries, NGOs and the private sector. Also during 2015, the numbers of Joint Programme coordination meetings of H6 partners within the countries ranged from three in Burkina Faso and Zambia to 18 in Ethiopia.

In the Sida collaboration countries, H6 played a similar role during 2015, convening 347 meetings with representatives from civil society, national and sub-national ministries, NGOs and the private sector to enhance coordination and harmonized responses in the RMNCAH sector.

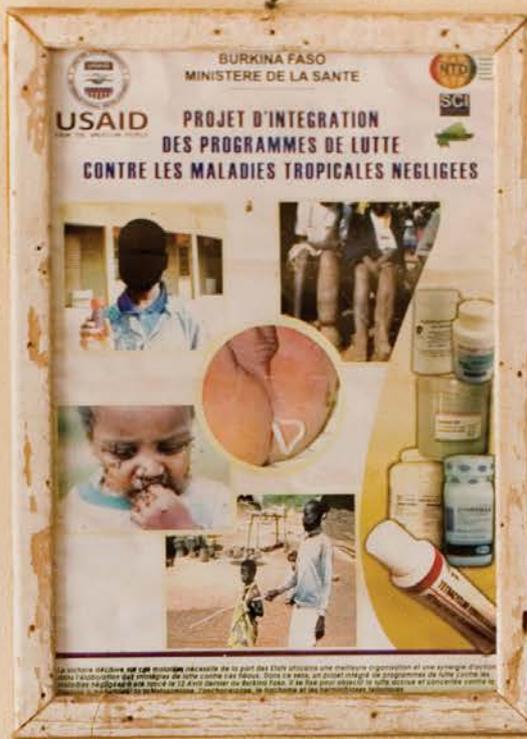
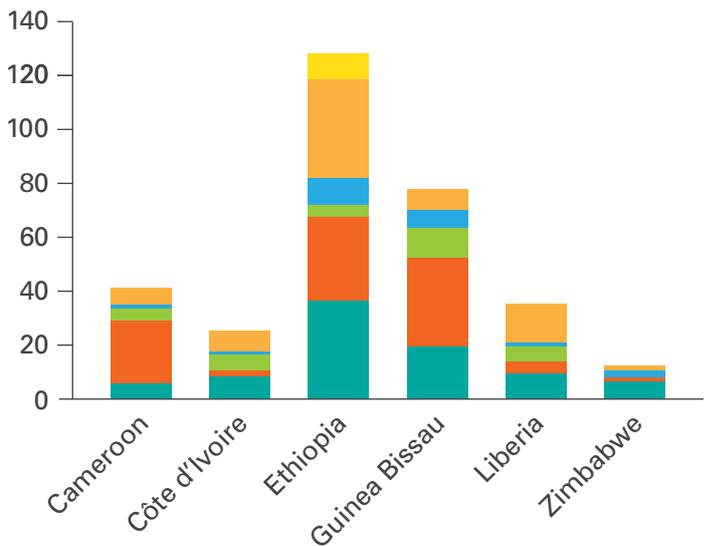
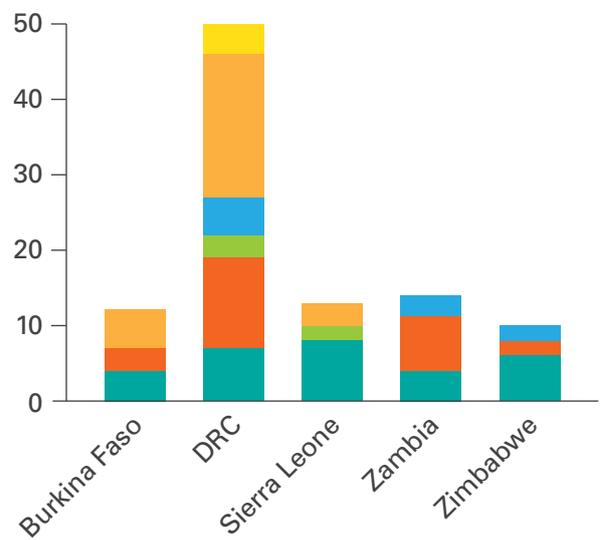


Figure 7: Number of coordination meetings organized with key stakeholders in 2015





Courtesy of H6 country team Zimbabwe

A local community group helps women and families stay healthy

In Zimbabwe's Mbire district, home deliveries are traditional, yet they often result in the death of the mother. To reverse this trend, community groups have been mobilized with support of the H6 Joint Programme.

The project promotes a deeper understanding of the consequences of home deliveries by encouraging forums on reproductive, maternal, neonatal, child and adolescent health.

Over 1,000 traditional leaders have been mobilized to motivate their communities for increased demand for and utilization of integrated RMNCAH and HIV services. By enlisting the collaboration of traditional leaders, community groups motivates pregnant women to register their pregnancies in order to benefit from antenatal care (ANC) services, such as identification of danger signs in pregnancy, risk management of issues such as high blood pressure, STI screening and PMTCT services including HIV counseling and testing and life-long antiretroviral treatment to ensure that children are born HIV-free and mothers lead healthy lives.

Dr. Andrews Chidziva, the Acting District Medical Officer, highlights the positive effects of the community mobilization. *"A lot of women are coming through to register their pregnancies,"* he says, *"I have also witnessed a gradual increase in institutional deliveries."*

At a recent community meeting, a woman called Bandina Matare, described how belonging to such groups can help women overcome the negative effects of traditional practices. *"When a man dies, his wife re-marries, leaving her children behind,"* she said. *"As mothers, we realize that we were leaving our daughters susceptible to abuse and child marriage. Now that we are part of community engagement efforts, we are more knowledgeable."* Even the village headman, Expense M. Gwaze, emphasized how joining community groups has led him to be a leader. *"I presided over a number of disputes regarding gender-based violence in households,"* he said. *"It was impossible to discuss issues concerning a girl child when the parents were unhappy with each other. Community engagement brought us solutions by creating a platform to help us learn and share ideas."* Promoting community practices played an essential role in creating a safe and friendly environment for local awareness raising and discussion.

H6 joint missions

During 2015, H6 global and regional team members participated in joint missions to Côte d'Ivoire, Zambia, Cameroon, Guinea Bissau, Ethiopia, Zimbabwe and DRC. These joint missions promoted interaction among H6 country teams and enabled them to assess programme progress on intervention implementation, coordination mechanisms and innovation and to identify TA needs in order to mobilize support. The missions also organized visits at the sub-national level (in areas of intervention) to observe progress and draw lessons for experience-sharing.

In addition, engagement with key stakeholders, including government representatives, district managers and H6 partners was facilitated and both barriers to progress and enablers of progress were analyzed. An assessment of country strengths and opportunities was conducted to define evidence-based corrective actions to address challenges. Lastly, the added value of the H6 partnership was presented to the development partners and government representatives to sustain programme gains after 2016.

Figure 8: The H6 joint mission process





© UNFPA Ethiopia/Mulugeta Ayene

The H6 joint missions found the following:

1. There is leadership and ownership at the MoH level within the H6 Joint Programme;
2. A structural shift is taking place in each country, revealing opportunities for H6 to provide strategic policy support;
3. The standardization of pre-service training of midwives, the health system-wide integration of quality of care and the institutionalization of accountability mechanisms such as MDSR are on the unfinished agenda of national health systems for post-2015 support.

The lessons learned by the H6 teams drawn from all seven countries visited are as follows:

1. Coordination among technical teams is time-consuming, but it pays rich dividends in the creation of synergies and yields positive results;
2. Modest financial support from donors provides unprecedented opportunities for technical teams to harmonize their response at the global, regional and country levels;
3. Strategic and catalytic support can do more with less;
4. Scale-up must be evidence-based and this warrants more rigorous documentation;
5. The H6 Joint Programme provided flexibility for innovations and allowed communities to connect with health systems; when well-documented, these innovations can have significant impact;
6. Influencing system-wide change through specific area interventions is challenging and requires persistent effort.



Courtesy of H6 country team - Cameroon

Breaking with harmful traditional practices can save lives

She is only 21, but Aissatou Moussa is already a mother of three. Some months ago, she nearly lost one of her children because she refused to visit a local health facility, supported by the H6 Joint Programme. Instead, she clung to local traditions. Her neighbors, trying to help, sacrificed blood to ghosts. But for four days, Aissatou's baby continued to suffer from fever, cough and diarrhoea. Finally, the Community Health Worker in her village convinced her to take the child to the Gazawa Medical Centre. The baby survived; the life-saving treatment was free.

Aissatou was one of many girls in Cameroon who are forced into early marriage and face childbirth with no help but that of a traditional birth attendant, with no care but that of traditional healers and self-medication.

According to a UNFPA report, 25 per cent of teenage girls in Cameroon, like Aissatou, become pregnant.

The H6 Joint Programme supports Community Health Workers who raise local awareness and encourage women to receive antenatal care and deliver their babies in health facilities. The project also equips health centres with medicines and other supplies. The Gazawa Health Centre is among a select few that won the Best Health Centre prize in 2015.

Gaibai Ganava, Chief Health Officer of Gazawa district, has already seen marked improvements in women's health. *"Nowadays, 45 women per month come to the health facility to deliver their babies,"* he says. *"It used to be four per month. The H6 Joint Programme encourages people to attend the centres."*

H6 advocacy and communication at the global and country levels

At the global level

Advocacy and communication played a vital role in mobilizing commitments for the Global Strategy by ensuring a unified vision and message for H6 in tackling the root causes of maternal, newborn, child and adolescent mortality and morbidity, including gender inequalities and socio-cultural and financial barriers.

H6 communications enhanced the visibility of partnerships with more robust and strategic plans and activities, which in turn increased the understanding of the strides made to add value to the international development community, including decision-makers, media, donors, development partners and civil society. Results of H6 communications efforts and support in 2015 include:

1. H6's increased engagement with a number of advocacy communication arms of UN agencies, bi-laterals, civil society organizations and other multi-stakeholder bodies to collaborate on the promotion of UN international days such as World Prematurity Day; the Global Maternal Newborn Health Conference in Mexico City and other international meetings; and ground-breaking reports like The Lancet series on Stillbirths. The global team shared this knowledge with countries and developed social media materials to further align visions and voices;
2. Support for EWEC's plans and activities, including the promotion and support of the launch of the UN Secretary-General's progress report, as well as the renewed Global Strategy for Women's, Children's and Adolescents' Health 2016-2030;
3. Innovative approaches to, and profiles of, those who benefited from partnership activities were documented and curated for social media and for sharing of best practices;

4. Social media activities were introduced and quickly became a major part of the communication and advocacy plan in 2015. This included the creation of the H6 News website h6partners.wordpress.com and increased activity on Twitter and other social media platforms.

At the country level

H6 countries increased their engagements and generated targeted and forward-looking communication plans for 2015. The countries' plans offered many innovative and effective strategies supporting H6 messages about RMNCAH. Some of the results are included below.

In Liberia, a journalists' workshop was conducted on the theme, "Building ownership for a multi-sectoral decentralized HIV and AIDS response in Liberia." Media institutions at national and programme levels were invited to learn about the work of health facilities in providing Basic and Comprehensive EmONC services for the 300,000 inhabitants of the targeted counties. These activities resulted in national newspaper and radio coverage, as well as coverage by online news outlets, all of which published and aired stories about the H6 programme.

To observe the World AIDS Day, H6 Guinea Bissau held a number of events and created materials to raise awareness of HIV by disseminating prevention messages on HIV & AIDS, including the human rights of PLHIV; strengthening the engagement of the national authorities and increasing the number of people who know their HIV status. Through their efforts in 11 regions, the general population, in particular young people of both sexes, benefitted from essential information on HIV & AIDS. Around 12,125 people were voluntarily tested for HIV. In addition, during

World AIDS Day commemorative activities, about 500,000 condoms were distributed.

In the DRC, the communication programme's goals were to organize mobilization for MNCH/HIV/FP through NGO networks to raise awareness about (a) information and services for family planning; (b) knowledge of danger signs during pregnancy and childbirth; (c) the care of the newborn at home; and (d) reproductive health and substance abuse among teenagers and young people in Orientale and Bas Congo. Through collaborative efforts with NGOs, messages about Family Planning reached 2 million people through various communication channels (radio, markets, community networks, churches, neighborhoods, panels held along major roads, etc.). In addition, 25 large tarpaulins and 105 posters with Family Planning messages were produced and displayed throughout Kinshasa and more than 10 radio and television programmes on the issue of maternal and child health were aired;

In Zambia, H6 supported drama performances about the harmful consequences of early marriage, targeting adolescents and women of child-bearing age in communities and schools in the Chama and Chadiza districts. Through this innovative programming, an increased number of women

were able to access Long Lasting Reversible Contraceptives (LARC). The performances were presented to 2,472 adolescents (1,176 girls, 1,296 boys) in schools of Chama and Chadiza districts; and 676 young men and women (316 and 360, respectively) out of school.

In Côte d'Ivoire, media orientation and gender workshops on high-impact interventions for maternal and child health were conducted through the H6 AIDS Initiative. The workshop helped 34 male and three female reporters (from 17 health districts where H6 AIDS programmes are implemented) to learn about and disseminate information on these high-impact health interventions. The local radio reporters from the targeted health district areas were not only encouraged to talk to their listeners about the importance of the health of mother and child, but also to work with health officials as partners for the dissemination of awareness messages;

In Sierra Leone, 28 journalists from different media houses were oriented on the response of the Joint Programme to the reduction of maternal and child deaths in the country. This was followed by two TV discussions on the causes of maternal and child deaths and Joint Programme response depending on the different mandates of different agencies.

Figure 9: H6 news website



<http://everywomaneverychild.org>

Democratic Republic of the Congo



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Panos Pictures,
Democratic Republic
of the Congo

Men and boys help improve the environment for maternal and children's health

In the Democratic Republic of Congo, 100 traditional chiefs and community leaders have pledged to improve the health of mothers and babies.

A process of open dialogue helped identify 50 traditional chiefs and 50 community leaders who are committed to promoting women's rights, preventing HIV/AIDS and combating gender-based violence. World AIDS Day 2015 provided an opportunity for the anti-AIDS club in Tumikia, Mosango region (which had recently received support from UN Women), to organize a series of activities led by the Sector Chief and several community and traditional leaders. During 16 days of awareness-raising, participants were educated about the causes, transmission

and prevention of HIV. The local radio station encouraged people to attend, to voluntarily monitor their HIV status and to discuss ways to change their lifestyle.

In a region where sexual and gender-based violence are still a part of life, 2,000 young men were educated about the need for communities to uphold women's rights. Six hundred young boys and girls came together to focus on the theme, "Commitment to stop violence against women," and many pledged to fight child marriage and sexual violence.

No fewer than 72 men's and boys' clubs were set up to support women's rights, two in each health area. Working with local women, their members created a synergy that led to the promotion of women's rights.





Looking back and moving forward in 2016

Lessons learned - H6 Joint Programme (2011-2015)

Some of the lessons learned by H6 during the past five years cover three major roles – convening, technical and advocacy – played by the collaborative activities. H6 successfully discharged its convening role by mobilizing country commitments for EWEC, facilitating the mobilization of additional resources and establishing H6 coordination mechanisms for 35 countries. Joint programming and joint funding yielded more efficient results regarding collaboration at the country level, as joint programming provides a unifying and common purpose. However, there is a scope for strengthening H6 coordination in all countries, including the involvement of national partners and stakeholders.

In its technical role, H6 successfully provided evidence-based technical products (Global Public Goods) to support the development and operationalization of the Global Strategy; developed major supporting strategies and reports, i.e., EPMM, ENAP, the State of the World Midwifery report, etc.; better aligned technical support and maintained its focus on the most

deprived areas for programmatic interventions in Joint Programme countries. There is scope for better utilization of complementary resources and expertise, intensification of technical capacity-building at the country level, building more sustainable institutional capacity and paying closer attention to technical areas for which less evidence, experience and dissemination (multi-sectoral action, involvement of adolescents, etc.) exist.

Regarding its advocacy role, the H6 initiative in the past five years has raised the profile of neglected areas such as adolescents, newborn care, midwifery, equality and reproductive rights which were prioritized in the Global Strategy. Multiple joint, high-profile advocacy events have been organized; national media and communication strategies have been developed in order to influence the shaping of new funding mechanisms, i.e., RMNCAH trust fund, GFF, etc. The repositioning of the H6 process focuses on emerging and sensitive topics as necessary, involving additional partners and other sectors to better link regional initiatives.



Courtesy of H6
country team -
Zambia

Better service and trained female birth attendants bring women to health centers for safe deliveries

“Before the Joint Programme project, our main challenge was a lack of skilled birth attendants,” says the male director of a rural health centre in Luvuzi in Zambia’s Lukulu district. *“I am qualified as an Environmental Health Technician, in charge of public health in the community. But I was also responsible for all the deliveries!”* explains the director with relief. *“Today, the centre has a qualified midwife. This has not only increased the number of women who deliver at the health facility,”* he explains, *“but the women are more comfortable with a female than a male attendant. And they learn from her. She is very skilled and even takes time to share new skills with me. The impact of the H6 support can be felt. In 2011 we had two maternal deaths, but we have not had any since then.”*

“The H6 Joint Programme sponsored me for a midwifery course,” explains the midwife in charge of the rural health centre in Lukona, in Sierra Leone’s Kalabo district. *“Before acquiring these midwifery skills, I couldn’t manage complicated pregnancies. Now I can handle all issues related to pregnancy and childbirth. In a typical month, I handle up to 30 deliveries. Before the training, I referred most of the cases to Kalabo, which is 60 km away on a sandy road. The trip was expensive for the women, who had to feed themselves and travel back on their own after delivery. This discouraged some of them from coming to our facility, since they knew they would be referred.”*

H6 Joint Programme allows underserved populations to gain access to skilled birth attendants which in turn increases safe deliveries.

Guinea-Bissau



Overcoming obstacles to reach every women and every child

In the remote region of Bijagós, a boat is the only means of transport among a string of coastal islets. Some communities become completely cut off during the rainy season and access to basic services is always a challenge. Inorey is a typical community. There is no electricity, no piped water and no mobile phone network; the nearest health centre is several miles away. To reach Inorey, after leaving the boat on the beach, one walks four kilometers along a narrow path through the forest.

Djuco (not her real name) is an experienced and committed nurse who works in Inorey to promote the community's health and is now more empowered than ever to do so. *"Now that we have medicines through H6 funds, things are much better. Before, we had nothing to offer people, now we have better beds for women, better working conditions and we can assist pregnant women and children, because we have the essential medicines,"* she says.

Djuco works closely with community health agents who liaise with the communities and help identify those who need health care. Thanks to the H6 Joint Programme, a system was put in place that provides free access to medicines and health care for pregnant women and children under five years of age. Thousands of certified medicines are procured, brought to the country by Joint Programme partners and then distributed through the Ministry of Public Health to all of the 75 health facilities in the seven regions covered by the H6 Joint Programme--even the most remote ones like Inorey.

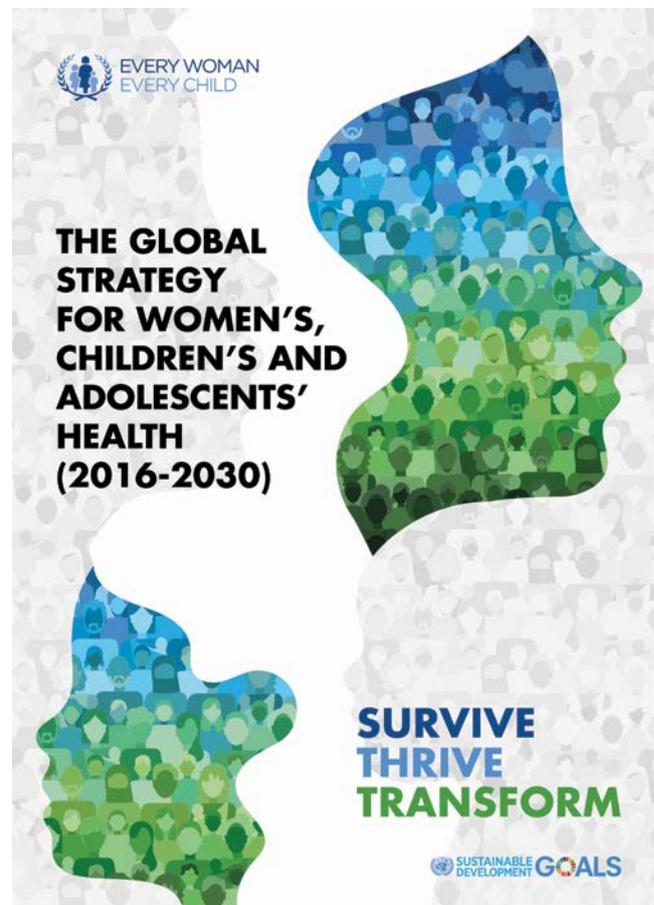
Courtesy of H6 country team
- Guinea Bissau

H6 in support of the Global Strategy

In order to support EWEC GS 2.0, H6 will provide and facilitate evidence-based technical support to develop, implement and monitor RMNCAH policies, strategies/plans, and Investment Cases; facilitate convergence and support nationally-led efforts to align partners on national priorities; support linkages and foster coordination across sectors. Four countries covered during the first wave of GFF are DRC, Ethiopia, Kenya and Tanzania, and an additional eight countries will be taken up under the second wave. GFF focuses on the development of Investment Cases for RMNCAH, the mobilization of their financing improving health financing strategies and expanding global public goods.

While developing future plans, H6 will pay attention to adolescents, fragile settings, multi-sectoral responses and changing contexts (devolution/decentralization). Where geographic scope is concerned, focus will be placed on high-burden countries for intensified joint response. Immediate next steps in repositioning H6 include country engagement to accelerate progress in RMNCAH, support for the development and implementation of RMNCAH strategies/plans/ Investment Cases, maximizing H6 support and inputs in existing platforms for priority areas (i.e., adolescents) and mobilizing country-level commitments, such as EWEC GS 2.0, World Health Assembly, Women Deliver, etc.

Figure 10:
Every Woman Every Child GS 2.0



Strategic intervention transforming challenges into opportunities

Elizabeth is an orphan who was raised by her uncle in Bombali District in Northern Sierra Leone. When she turned 13, Elizabeth's uncle forced her to marry Mathew Conteh, a 35-year old schoolteacher in their village. The uncle received the bride price.

Elizabeth was still a child, but she was not without advocates. In her village there is a Husband School, a project supported by the H6 Joint Programme through FINE (the Fambul Initiative Network for Equality. Fambul means family in Krio.)

The Husband School sensitizes men on the importance of family planning and reducing gender-based violence. It provides a meeting space where respectable married men, role models in their communities, can come together to discuss how to change deep-rooted socio-cultural norms and harmful traditional practices, such as Female Genital Mutilation/Cutting and child marriage.

Members of the Husbands School uncover problems relating to sexual and reproductive health and gender-based violence, which are then reported back to Male Peer Educators (MAPES) in the Peer Educators Network (PEN) for immediate action. During one of the sessions at the Husband School, Elizabeth's situation was brought to the attention of the group. After much deliberation, the matter was taken up by MAPES, PEN, the Ministry of Social Welfare, Gender and Children's Affairs and the Family Support Unit of the Sierra Leone Police. The allegations were investigated and confirmed and Elizabeth's uncle was asked to return the bride price. Then, in the presence of the entire community, he formally annulled the marriage.

As a result of this intervention, Elizabeth was removed from her uncle's custody and re-enrolled in school in the care of her teacher, Mrs. Mariatu Sesay, who is now her foster parent.



Courtesy of H6 country team - Guinea Bissau



Looking back and moving forward in 2016

H6 Joint Programme plans for 2016

The H6 Joint Programme's plans for 2016 include the consolidation of programme gains and the undertaking of advocacy efforts for sustaining gains through available opportunities. Priority interventions such as skills enhancement of human resources, strengthening of HMIS, institutionalization of MDSR, support for the development of national RMNCAH plans and strategies and the documentation of community-level interventions will be shared at the development partners' forums at the country level. Also a priority is active participation in upstream work to strengthen national health systems' strategies, including new opportunities provided by GFF, etc.

Both the H6 Canada and the H6 Sida collaborations are scheduled to end in 2016. The plans include undertaking advocacy for mobilizing resources to continue and further enhance the interventions initiated under H6, particularly regarding strategic support at the policy level, standardization and quality improvement of pre-service midwifery education and training; supporting QoC interventions, protocols and standards, IPC, connecting data to action, promoting data-led decision-making and data management; informing policy on learning through, and documenting, evidence of change.

Finally, the End Line Evaluation of the H6 Joint Programme is planned during 2016 and preparations for it were made in 2015. The Euro Health Group has been identified as the independent evaluation agency. The TOR of the End Line Evaluation is in Appendix 4. Timely and complete sharing of information with the evaluation team, facilitating field missions and on-line assessments by the evaluation team are top priorities in 2016.

From 2016 onwards, H6 will continue its primary role of improving reproductive, maternal, newborn, child and adolescent health by providing technical leadership with state of the art knowledge and skills, as well as technical support on how to strengthen health systems and address socio-cultural determinants.



Conclusion

The focus of the H6 Joint Programme is to accelerate progress to meet MDGs 4 and 5 by reducing maternal and child mortality and morbidity. Despite delays in the initial phases of implementation during 2012-13, largely due to a late start in activities, programme implementation rates began to pick up the pace in 2013. The year 2015 registered steady progress in almost all H6 Canada and Sida collaboration countries. The results from 2014 began revealing themselves in 2015.

The guiding principles for 2015-16 planning and implementation were based on lessons learned during the mid-term review, such as screening the programme environment in each country, weaving challenge mitigation strategies into programme design, and better aligning interventions to inform policy, demonstrate results, consolidate programme gains and engage key stakeholders to scale up successful interventions.

The possibility for a positive trajectory towards achieving programme outputs depends on the extent to which resources are transformed into results. Though programme environments are dynamic and often subject to external factors, success has been noticeably achieved at policy and programme levels in all countries.

At the policy level, the development of RMNCAH national plans and strategies is supported in all countries to create an enabling environment to ensure access to quality RMNCAH services. H6 teams in the DRC, Cameroon and Ethiopia played active roles in the development of GFF Investment Cases. In DRC and Burkina Faso, advocacy initiatives resulted in the long-awaited commitment of domestic resources for contraceptives.

The issue of scarce skilled human resources received attention during the early phases of planning the H6 Joint Programme, resulting in the capacity development of 29,784 personnel representing various health functionary categories, ranging from doctors to CHWs. In Burkina Faso, evidence- and competency-based modular training for MNH now drives national training institutions, whereas in Zimbabwe, mentorship programmes support health care providers as they hone newly acquired skills under the supportive supervision of experts. Sequential differential strategies in Zambia engage retired midwives to revive health facilities

and incrementally replace them with newly-trained midwives, resulting in an improved service environment. In Guinea Bissau, in order to deal with the vacuum in skilled human resources, international experts have been engaged to develop the capacity of local staff and simultaneously provide critical care necessary to reduce the burdens of mortality and morbidity.

Enriched with H6 Joint Programme experiences, H6 country teams actively participated in shaping national health plans. In Ethiopia, an analysis of MDSR data revealed a big gap in post-natal care, informing the design of improved HSTP-V maternal health strategies. Safe motherhood requires a functioning health care system that supports the critical elements of care: appropriate drugs, technology and skilled providers. Liberia's country team proved that in the Ebola recovery phase, access to and availability of MNH care in the intervention facilities resulted in a steep increase in institutional deliveries, reviving health facilities for the communities. In Côte d'Ivoire, efforts to disseminate national strategies, guidelines, protocols and standards have markedly enhanced the capacity of duty-bearers towards more effective implementation of policies and evidence-based programming.

Civil society and communities have an essential role to play in demand-generation and promotion of community ownership, as it becomes crucial to hold those with power accountable and, more importantly, responsible for the most marginalized, most discriminated-against groups, particularly adolescent girls. In Sierra Leone, capacity building of CHWs to reconnect families with health facilities ran smoothly during the post-Ebola response phase. Similarly, in Guinea Bissau, Zambia and Zimbabwe, the increased engagement of religious and community leaders to reverse harmful cultural norms that hinder mothers and children from seeking health care proved successful.

The global-level initiative to build capacities and use a knowledge base approach to managing the RMNCAH sector was pivotal in providing a solid foundation for evolving national health systems for equitable, quality and universal RMNCAH care. The lessons learned by H6 reinforced what was already known: the entrenched gender inequalities and harmful cultural practices that destabilize efforts cannot be ignored. Despite the challenges, progress towards the MDGs was

indeed accelerated. Partnerships were forged and vulnerable women and children were reached.

With the advent of the SDGs and the shifting of structures and demographics, new doors of opportunity have opened for national efforts to create resilient health systems at global, regional and country levels. Health architectures will readjust to better respond to the health needs of women, children and adolescents. Meanwhile, the unfinished agenda of the H6 Joint Programme to promote quality of care and accountable systems and processes and standardize pre-service quality education for midwives must be addressed, supported and reinforced.

It is time for H6 to continue to build upon past experiences, galvanize the capacities of the partners involved and revamp key players to make the EWEC GS 2.0 a tangible reality. The most vulnerable women, children and adolescents still need to be reached during the SDG era.







Leveraging resources creates synergy

Despite registering noticeable downward trends in maternal mortality during the MDG era, still obstetric fistula remains one of the main complications of childbirth in Ethiopia.

It is estimated that up to 3,500 women develop fistula every year, whereas some 37,000 cases remain untreated.

As part of Ethiopia's new Health Sector Transformation Plan, a strategy to eliminate obstetric fistula from the country between 2015 and 2020 was set in motion. To make this possible, the Ministry of Health took the innovative step of "piggybacking" on the national polio campaign conducted in February 2015 in response to a polio outbreak in Ethiopia and the global polio eradication initiative. The polio campaign team checked for obstetric fistula cases at each household they visited as part of the polio campaign. Simple tools, translated into local languages, were used to orient health functionaries at different levels. This was followed with house-to-house surveys on fistula cases covering 99.7 per cent of households. Through this campaign, 2,497 suspected fistula cases were identified and mapped. All of the suspected patients were linked to fistula treatment centers for screening and the confirmed cases were treated. An additional 372 uterine prolapse cases identified in Amhara Region were referred to health facilities for treatment.

Building upon existing polio campaigns' momentum, hope was restored among young, despairing women. The efforts served a prime example of synergy creation in order to deliver more with less.





Appendix 1: Specific H6 achievements in 2015 at the country level H6 Canada collaboration¹²

¹² All national RMNCAH indicators have been taken from *Countdown to 2015 - A Decade of Tracking Progress for Maternal, Newborn and Child Survival*.

Burkina Faso



Joint Programme focus regions:

2 regions out of 13



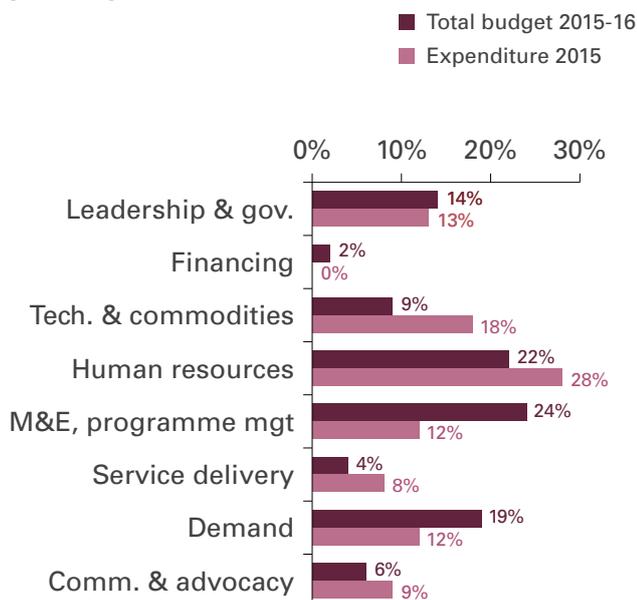
Population covered by Programme:

2.9 million
(16% of total)

Budget 2015-16: **US\$ 2.8 m**

Expenditure 2015: **US\$ 1.46 m (52%)**

Budget allocation and expenditure per output (2015)



National RMNCAH indicators:

MMR (per 100,000 live births): **371**

Total fertility rate: **5.4**

Adolescent birth rate (per 1,000 girls): **136**

Infant mortality rate (per 1,000 live births): **61**

Neonatal mortality rate (per 1,000 live births): **27**

Skilled attendant at delivery: **66%**

Health expenditure (per capita): **US\$ 109**

RMNCAH expenditure:

34% (Govt.), 33% (OOP), 31% (External sources)

Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- Coordination of RMNCAH group action on financial and programming gaps;

- Review of Human Resource development plan 2016-18;

- Institutionalization of modular EmONC and IMCI training at National School of Public Health.

At the programme level:

Health financing: Enhanced access by addressing financial barriers for EmONC and institutional deliveries by supporting national subsidy strategy.

Health technologies and commodities:

CHWs in nine health districts of the two intervention regions were equipped with electric thermometers, scales and accessory packages for home-based newborn care; 142 professionals were trained in logistics management on the CHANNEL software. Supplies for deliveries and for intensive newborn care provided to the health training centres of the two regions.

Human resources for health:

Trained: 498 pre-service midwifery students in EmONC/FP/PMTCT at the National School of Public Health. In-service training of 20 doctors in essential surgery; 20 service providers in EmONC, 52 at the IMCI clinic and 893 at the IMCI community; 468 CHWs in newborn care at home; 25 national and regional tutors, 364 health agents (in all the health districts of the two target districts); 591 community-based workers (in 4/9 of the health districts) in home based newborn care.

Health Information Systems, Monitoring and Evaluation:

Fourteen core administrators were trained in the performance score chart for maternal, neonatal and infantile reproductive health. Capacities of national coordination team members built in their access to geo analysis of EmONC with the support of two facilitators from WHO, Geneva. Monitoring of activities in one of the health districts, North region. Training of 50 hospital agents in the implementation of EMONC monitoring. Improved weekly surveillance of maternal deaths and of the stock levels of reproductive health products.

The programme encouraged three out of the nine health districts to supervise health workers in IMCI, prenatal consultation and PMTCT clinics, as well as encouraging the group of districts and regions to carry out integral supervision on reproductive health/family planning.

Health service delivery:

National FP week organized with 56,632 newly recruited users (8 per cent of whom are new users), for a revival of FP. Provision of FP services and referrals, delivery services through sponsorship network of children and the women's groups of PLAN Burkina. Sixteen successful operations on victims of obstetrical fistula. Treating of 28,957 obstetrical complications in 2015 compared to 28,249 in 2014 with CFR of 1.4 per cent compared to 1.6 per cent in 2014. 984 (950 women and 34 men) parents engaged in dialogue with adolescent children resulting in 74 sexually-active adolescents (39 boys and 35 girls) tested for HIV and registration of 18 new adolescent users of contraceptive methods. Training of 20 people in charge of the provincial coordinates of FEBAH on the SRH/FP allowed the implementation of informative activities for 2,881 handicapped persons in specialized centres and schools of FEBAH (1,300 women and 1,581 men). 1,127 handicapped clients were referred by organizers of CORAH (the Regional Association of Handicapped Advocacy) to health courses for SR/FP services: 369 for FP, 403 for the management of STIs and 355 for HIV screenings. 212 new handicapped users of FP services registered.

Demand, including community ownership and participation:

H6 Joint Programme contributed to the review and nation-wide adoption of the IFC frame models (working with individuals, families and communities). Educational conversations, film projections, drill theatres, health fairs known as 'Djanjoba' and TV and radio series were produced. More than 700,000 people were reached by the advocacy activities and C4D, predominantly women (63 per cent). 34 new Husband Schools and 10 additional health tutoring courses were established, bringing the total number to 44 Husband Schools in 13 health promotion centres covering 408 men. The 117 model husbands of the ten original schools each assigned a friend the name "Zoa Songo" to mentor on how to become a model husband. The 49 educational dialogues and the 459 house visits reached 514 men, 654 women as well as 1,909 husbands and 2,056 wives. More than 1,440 pregnant women who delivered at health promotion centres were accompanied by a man and 71 men accompanied their wives to FP sessions.

Communication and advocacy:

On the political level, the maintenance of the budgetary policy intended for the purchase of contraceptive products totaling 375 million CFA francs was certified with an additional 50 per cent reduction in the price of contraceptives. A documentary on the modular tutoring of midwifery students was produced.

Democratic Republic of the Congo



Joint Programme focus regions:

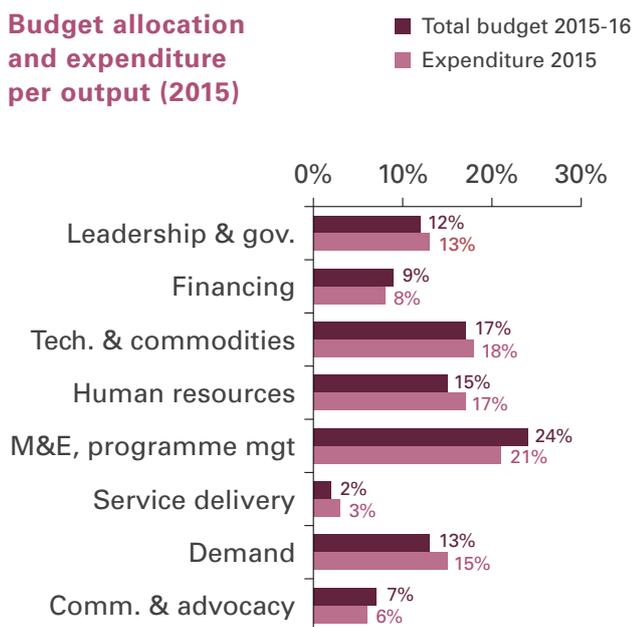
9 districts of 3 regions



Population covered by Programme: 1.5 million (2% of total)

Budget 2015-16: US\$ 3.01 m
Expenditure 2015: US\$ 2.37 m (79%)

Budget allocation and expenditure per output (2015)



National RMNCAH indicators:

MMR (per 100,000 live births): 693

Total fertility rate: 5.9

Adolescent birth rate (per 1,000 girls): 135

Infant mortality rate (per 1,000 live births): 75

Neonatal mortality rate (per 1,000 live births): 30

Skilled attendant at delivery: 80%

Health expenditure (per capita): US\$ 26

RMNCAH expenditure:

5% (Govt), 33% (OOP), 35% (External sources)

Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- Mobilizing political commitment to the EWEC Global Strategy 2.0;
- Facilitated implementation of

a strategic plan for Family Planning 2014-2020;

- Planning of the long-term GFF investment framework and financing strategy has begun.
- The MNCAH documents of standards and directives were updated by following activities: 1) the popularization of MNCAH standards, 2) the

consolidation and capacity-strengthening of MNCAH service providers, 3) the introduction of chlorhexidine gluconate 7.1 per cent for umbilical care, 4) the adoption of the standards, directives and users' guides of the amoxicilline dispersible tablet 250 mg of the magnesium sulphate, of female condoms and of dexamethasone;

- Supported identified health districts to develop operational Plan of Action (PAO).

At the programme level:

Health financing: The mutual funds offices (health insurance) at the provincial centre of the mutual funds (CPAM) and National Union of Midwives and Delivery Doctors (UNAAC) at Bandundu received IT tools and solar equipment.

Health technologies and commodities: National health system received needs-based supplies of oxytocin, magnesium sulphate, misoprostol, and quick screening syphilis and HIV tests. Eighteen health facilities received kits of supplementary equipment for midwives, 80 kits for Caesarian deliveries, 888 boxes of delivery kits, 106 boxes for repairing the perineum and the uterine neck and three maternity wards equipped with hospitalization bed for post-partum care. Team managers of health centres were given motorcycles to transport samples and insure the early diagnosis of HIV of exposed children. Health districts of Kenge, Bandundu and Nzanza were provided with three ambulances for improved referral.

Human Resources for Health: Capacity building of two pre-service midwifery schools through the supply of didactic material followed by training of 15 tutors on pedagogical techniques with use of didactic materials; 20 tutors trained in EmONC. Training of 40 midwives as service providers of EmONC; 21 midwives to offer integral services during Family Planning. EmONC training of 50 service providers (doctors, nurses and midwives) from health districts

Bandundu and Mbanza-Ngungu. At the central level, 26 tutors were trained and Bandundu and Bas Congo (Kongo Central) provinces provided 16 EmONC training tutors who received mentoring support through a team of four tutors and supervisors. 225 service providers received mentoring support. 105 service providers trained in the provision of FP services. Training of managers of the MoH on the use of the Logiciel Tier-Net for follow-up of the elimination of new pediatric infections of HIV and congenital syphilis by 2030. Training of 25 service providers on the rational use of medicines for Kenge, Boki, Popikabaka, Kimbu and Mwela-Lwemba districts.

Health Information Systems, Monitoring and Evaluation: Health products reviewed in Matadi, Nzanza, Mbanza-Ngungu and Bandundu to assess supply chain. Monitoring and actualization of cartography of services for RMNCH and EMTCT. Key HIV indicators for maternal and infantile health have been taken into account in developing the scorecard. Framework of surveillance and response of maternal deaths: More than 40 per cent of health districts in the country systematically record cases of maternal deaths on a daily basis on MDSR. Emphasis on the daily notifications of maternal and perinatal deaths and response in the health districts of the intervention areas.

Health Service Delivery: 1,045,753 of the new users of FP are registered. For the prevention of the transmission of HIV, adolescent sexual reproductive health (ASRH) supported, especially in the youth centers in Bomoto and Coulibaly of Kinshasa and the Matadi of Kongo Central. 491 cases of sexually transmitted

infections were treated in Bomoto, Kinshasa. 40 health centres supplied with HIV intrans, especially rapid screening tests for HIV. Three structures, including two youth centres and one health centre, offered health services for adolescents and youth, in particular the CJ Sidiki Coulibaly and CJ Bomoto and the CS Etonga of the Nsele health district in Kinshasa. PMTCT integration: at least five structures per health district from the nine targeted districts.

Demand, including community ownership and participation: Communities trained in the recognition of maternal death danger signs and surveillance at the community level, organized themselves for emergency evacuations, contribution of household chores during emergency management and the organization of mutual funds. Three big markets of Kinshasa have benefitted from awareness surrounding HIV and voluntary screening. Community activities strengthened in the health districts of Kenge and Mosango through the recruitment of volunteers for UN Women. Capacities of 27 managers and civil servants of the public administration strengthened in HIV and SGBV as well as 60 magistrates, 10 judiciary police officers and 10 chiefs of community radio on HIV & AIDS. 1,420 distribution agents at community level continue to offer FP community services.

Communication and advocacy: US\$2,500,000 spent for purchase of contraceptives for the first time in the history of the government, with the aim of increasing FP services. The activities of the CARMMA launched in 2013 continue to be held in three provinces, as all the partners align themselves with governmental priorities.

Sierra Leone



Joint Programme
focus regions:

2 districts
out of 13



Population covered by Programme:
750,000 (12% of total)

National RMNCAH indicators:

MMR (per 100,000 live births): **1,360**

Total fertility rate: **4.5**

Adolescent birth rate (per 1,000 girls): **131**

Infant mortality rate (per 1,000 live births): **87**

Neonatal mortality rate (per 1,000 live births): **35**

Skilled attendant at delivery: **60%**

Health expenditure (per capita): **US\$ 228**

OOP expenditure as % of total exp. on health: **61%**

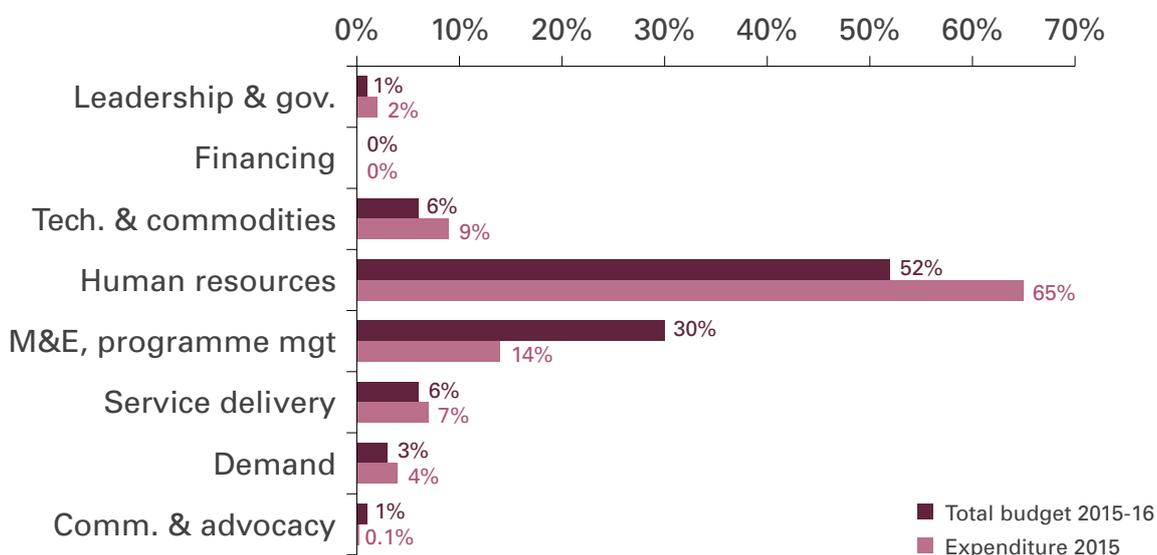
Budget 2015-16:

US\$ 2.8 m

Expenditure 2015:

US\$ 1.46 m (52%)

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- The development of a process to review the Reproductive and Child Health Policy and Strategy with the national MoH;
- Provided technical support for development of the post abortion guideline;
- H6 supported the development of MDSR guideline.

At the programme level:

Health financing: H6 partners supported the MoHS to secure funding from donors for the implementation of RMNCAH activities for the nine month National Health Recovery Plan.

Human Resources for Health: The H6 Joint Programme supported the strengthening of one of the midwifery schools in Freetown, training of medical doctors in Nigeria and training of MCH aides within the country. Midwifery school curriculum reviewed for improvement. The Joint Programme supports in-service training, including Maternal Newborn and On the Job Training (OJT) which was resumed in October 2015 with the training of 200 tutors. During 2015, 27 pre-service midwives supported by the Joint Programme completed training and were deployed to different facilities to provide services; 106 new students were admitted. 740 MCH Aides oriented on MCH, 133 HW's on maternal health, 2,100 community volunteers oriented on MNH.

60 service providers were trained in the provision of adolescent-friendly health services and six facilities upgraded to meet the need for youth-friendly services in two districts of Port Loko and Pujehun. 250 service providers trained in HIV counseling and testing for pregnant women and adolescents. Over 28,000 pregnant women and adolescents benefited from outpost HIV testing conducted in different communities. 2,100 CHWs in the two districts were trained in MNC, IMNCI, Ebola awareness, in the provision of services to children under 5 years of age, and institutional delivery through referrals.

Health Information Systems, Monitoring and Evaluation: 26 M&E and data entrants trained in data collection and analysis, mainly in key indicators of RMNCH; Collated and analyzed data has been shared with different partners for future planning of activities related to RMNCAH (m-health).

Health service delivery: The H6 Joint Programme strengthened the referral system by providing 10 motorbikes and ambulances to transport patients referred from hard-to-reach communities. Adolescent Friendly Health Centres established to increase adolescents' use of health services, particularly sexual health, HIV preventive services and family planning. In 2015, 720 mothers were referred to the hospital and 820 sick children were referred to Pujehun Maternity Hospital from hard-to-reach areas using the existing referral system. The Joint Programme supported the provision of IPC supplies to public health units in Pujehun and Portloko districts.

Demand, including community ownership and participation:

At the community level, functional PEN (Peer Educators Network) centres were set up, serving as resource centres for SRH issues with over 335 peer educators working in Husband Schools. 100 adolescent peer educators were sensitized to promote the uptake of health services. The Joint Programme trained community extension workers and Community Advocacy Groups (CAGs) to refer cases to health facilities when appropriate, to increase community awareness on family planning and to provide condoms for Ebola survivors within their communities. 188 CAGs have been directly supported by the Joint Programme. Support for the development, testing and dissemination of Behavioral Change and Communication tools on reducing teenage pregnancy and raising awareness on the issue.

Communication and advocacy: 28 journalists from different media houses were oriented on MNH, resulting in enhanced coverage of RMNCH in print and electronic media. Two TV discussions were held on MNH care.

Zambia



**Joint Programme
focus regions:**

**5 districts
out of 103**



**Population covered by Programme:
643,000 (5% of total)**

National RMNCAH indicators:

MMR (per 100,000 live births): 224

Total fertility rate: 5.3

Adolescent birth rate (per 1,000 girls): 145

Infant mortality rate (per 1,000 live births): 43

Neonatal mortality rate (per 1,000 live births): 21

Skilled attendant at delivery: 64%

Health expenditure (per capita): US\$ 192

OOP expenditure as % of total exp. on health: 28%

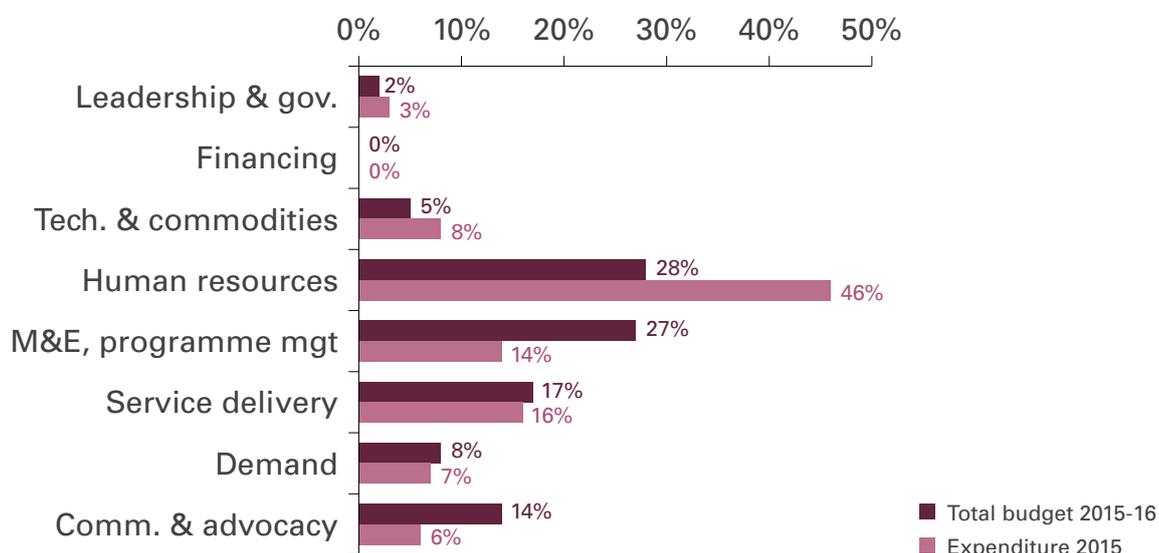
Budget 2015-16:

US\$ 2.6 m

Expenditure 2015:

US\$ 1.21 m

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- The MoH authorized Community Based Distributors to offer Depo Provera (DMPA) to clients in the community;
- RMNCH partners adopted “Mama Kit” in 19 districts -EU & RMNCH trust fund and MOH call partners to promote Mama Kits following the evidence generated;
- Development and update of management of pediatric HIV manual.

At the programme level:

Health technologies and commodities:

90 delivery sets, 120 baby cots, 10 incubators, 10 oxygen concentrators and suction machines, five vacuum extractors and five autoclave machines were procured and distributed to implementing health facilities in Chadiza, Chama, Lukulu, Kalabo and Serenje districts.

Human Resources for Health:

91 per cent (64/70) of targeted nurses trained as midwives in pre-service institutions and deployed to district hospitals and selected health centres in the five districts to improve EmONC services. 14 retired midwives were contracted, resulting in an increased proportion of health care workers providing EmONC services in the targeted districts.

15 District Managers from the five Joint Programme districts were oriented in MDSR. 20 health care providers acquired skills to provide Long Acting Reversible Contraceptive (LARC) family planning methods in five districts’ health facilities to improve family planning uptake. 39 health workers were trained in IMCI; 45 in EmONC skills; 22 in essential newborn care and 24 in PMTCT option B+ from Serenje, Chama and Chadiza districts.

Health Information Systems, Monitoring & Evaluation:

Monitoring capacity in Chadiza, Chama, Kalabo, Lukulu and Serenje was strengthened during quarterly joint monitoring missions and visits of the monitoring institution INESOR (Institute of Economic and Social Research). Results and ongoing achievements in improving maternal and child health services for the Joint Programme project in the five districts were documented.

Health service delivery:

District and facilities monitoring and mentorship visits were conducted, and the performance at each level discussed. Two maternity waiting shelters furnished in Chama and Lukulu; EmONC equipment (40 surgical kits) procured and distributed to EmONC facilities. Six delivery rooms (maternity annexes) and four maternity waiting shelters rehabilitated with solar panel sets in six facilities to provide lighting, all towards improved service delivery. All Joint Programme districts supported to conduct integrated outreach services for SRH & MNCAH services on a quarterly basis.

Demand, including community ownership and participation:

SMAGs and CHW were provided with bicycles, t-shirts, torches, gumboots and other materials to facilitate their work in the communities and to be easily identified by community members. Community RMNCAH services were strengthened in 2015 as more CHW and volunteers were trained, reaching more communities with messages and services. Community-based family planning volunteers (40), SMAG members (100), community essential newborn care (40) and traditional leaders and chiefs (125) were oriented on RMNCAH.

Communication and advocacy:

Provincial and district medical health offices sensitized stakeholders on MNCAH and the importance of reducing maternal deaths and advocated for strengthening the multi-sectoral response through provincial and district development coordination committee meetings to allow discussions on actions to address low performance for MCH indicators such as immunization and the importance of improving MNCAH outreach services in the communities.

Zimbabwe



Joint Programme focus regions:

6 districts out of 63



Population covered by Programme:
1.2 million
(10% of total)

National RMNCAH indicators:

MMR (per 100,000 live births): 470

Total fertility rate: 3.9

Adolescent birth rate (per 1,000 girls): 120

Infant mortality rate (per 1,000 live births): 47

Neonatal mortality rate (per 1,000 live births): 24

Skilled attendant at delivery: 80%

External assistance (RMNH per annum): US\$ 179 m

ODA maternal/neonatal health (per live birth): US\$ 46

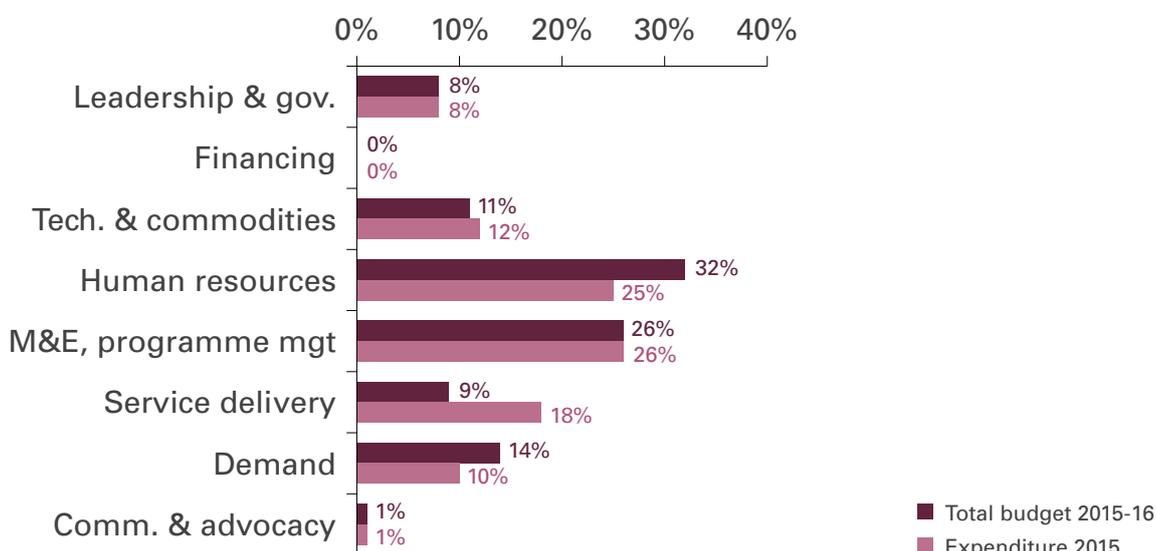
Budget 2015-16:

US\$ 5.2 m
(\$4.6 m Sida, \$0.6 m Canada)

Expenditure 2015:

US\$ 3.4 m
(\$2.92 m Sida, \$0.53 m Canada)

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- National nutrition communication strategy and surveillance guidelines developed;
- Clinical mentorship guidelines on Maternal Health developed and disseminated;
- EmONC training assessment in Joint Programme districts completed.

At the programme level:

Health technologies and commodities:

Support was provided to PMTCT and early infant diagnosis to prompt ART initiation for infants. 220 dried blood spot bundles for early infant diagnosis and 120 packs of Point of Care (PoC) reagents were procured and distributed. These procurements enabled 211,200 EID tests and 12,000 HIV tests through PoC machines. Essential MH medicine and commodities were procured for delivering EmONC services at health facilities in Joint Programme districts.

Human Resources for Health:

Training of 300 CHWs in infant feeding and counseling; 40 nurses in pediatric ART; 60 nurses in counseling and EID testing; 70 nurse tutors in EmONC; four doctors and 11 nurses in refresher EmONC and MVA training; 80 nurses in IMNCI; 150 medical students in computerized package of IMNCI; 60 nurses in ETAT at referral centres and 39 in WHO growth standards; 42 RH managers were trained in RMNCAH and five RH officers/nurses/midwives

in that field, in the QoC assessment tool. 40 doctors and 60 nurses were mentored in MH in three supported provinces (Midland, Mashonaland West and Matebeleland North). 152 HMIS focal persons from two provinces, Manicaland and Masvingo, were trained in HMIS.

Health Information Systems, Monitoring & Evaluation:

An electronic maternal and perinatal death database system has been developed and is being piloted in two Joint Programme provinces, Manicaland and Masvingo. Maternal death audit reviews were conducted in all six Joint Programme provinces. MoHCC and health authorities in Joint Programme provinces and districts conducted supportive supervision and monitoring visits. National coordination meetings on PoC/EID, PMTCT and HIV care were supported at the national level and in Mashonaland Central province. The drafting and printing of a national 2015 HIV/AIDS report and the Option B+ interim review report were supported.

Health service delivery:

Two obstetric fistula camps were organized in Chinhoyi Provincial Hospital where 78 cases were repaired. 10 doctors and 10 nurses were trained in such surgery and pre- and post-operative care. Parent to Child Communication (PCC) on the SRH package was developed, printed and implemented as part of the PCC programme in Hurungwe district. Outreach sessions on the MNCAH service delivery package were conducted in Binga and Chipinge districts. Five health facilities were renovated in three Joint Programme provinces for delivering improved MH services.

Demand, including community ownership and participation:

40 men were trained in HIV testing and counseling, PMTCT and other areas of MNCAH in Chipinge and Chiredzi districts. Thirty-three safe spaces (Pachoto groups) for young women were formed in three districts, Chiredzi, Chipinge and Mbire, with a membership of 8,095 young women for discussing SRHR issues, including their own needs. Three district-level stakeholders' meetings were conducted where young girls and women discuss face to face with authorities the challenges faced when accessing SRHR services. Three district festivals were organized for young women to participate in and learn about RMNCAH issues. 1,752 people attended the festivals, including several young girls. 32 male community-based advocates were trained, working with 60 female community-based advocates trained in 2014 to encourage communities to seek health services in facilities, to prevent gender-based violence and to educate women on the advantages of early booking for ANC. 3,295 men and women in Chipinge, Chiredzi and Mbire were reached through community forums with information on MNCAH, SRHR and HIV services, including gender-based violence.

Communication and advocacy:

A video documentary, Joint Programme IEC materials, including banners, posters, pull-up banners, stickers and visibility items such as hats and T-shirts were distributed in Joint Programme provinces and districts. Health, gender and human rights information kits were developed. Joint Programme information was posted on social media and covered in print media.



The background of the page is a photograph of people wearing traditional African clothing. The clothing features vibrant colors like blue, red, and green, with intricate patterns and embroidery. The image is partially obscured by a large, semi-transparent purple rectangle that contains the main text.

Appendix 1: Specific H6 achievements in 2015 at the country level H6 Sida collaboration

Cameroon



Joint Programme
focus regions:

7 districts
out of 174



Population covered by Programme:

0.97 million
(4 per cent of total)

National RMNCAH indicators:

MMR (per 100,000 live births): 470

Total fertility rate: 4.6

Adolescent birth rate (per 1,000 girls): 128

Infant mortality rate (per 1,000 live births): 57

Neonatal mortality rate (per 1,000 live births): 26

Skilled attendant at delivery: 64%

Health expenditure (per capita): US\$ 138

OOP expenditure as % of total exp. on health: 61%

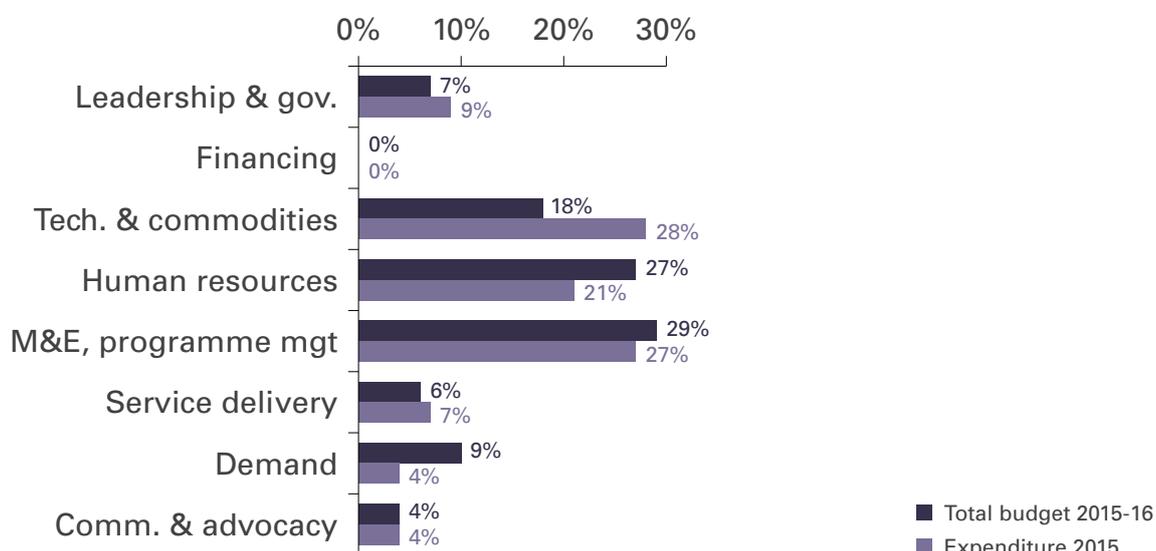
Budget 2015-16:

US\$ 3.7 m

Expenditure 2015:

US\$ 1.84 m

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- The dissemination of a Strategic National Plan 2014 – 2020 for RMNCH;
- National MDSR guidelines and tools developed.

At the programme level:

Health technologies and commodities:

RMNCAH-related equipment and materials and blood transfusion kits for 30 health facilities. Resuscitation kits for newborns and medical kits for neonatal infection care and management were procured. Essential drugs for the treatment of 25,000 cases of children suffering from diseases associated with malnutrition, along with Community Health Workers' kits were provided. An ambulance for emergency transportation was provided for Koza health district.

Human Resources for Health:

Developed e-learning Modules for Midwifery schools in Douala and a nation-wide expansion is ongoing; 23 teachers and 49 students were trained in the e-learning system. 35 other midwifery teachers received competency-based training. Seven training institutions were equipped with mannequins, computers and supplies. The Joint Programme supported the strengthening of service provider capacities by training 40 in ANC, BEmONC and

PMTCT, 75 in FP, 121 in IMCI and 90 health workers in NBC. At the community level, activities have been launched in two health districts with 147 CHWs trained and equipped (bicycles, essential drugs and EFP kits) to implement essential family practices and distribute packages and home treatment for simple cases of malaria, diarrhea, ARI and case referrals. Two mentor visits were organized for 30 health facilities.

Health Information Systems, Monitoring & Evaluation:

The project continued to support 30 regional districts using integrated tools for monitoring and evaluation, including routine maternal and neonatal deaths surveillance. Seven districts and 64 health areas evaluated their 2014/15 micro plans and elaborated 2016 micro plans. Clinical maternal and neonatal death reviews/surveys were routinely conducted in 30 regional health districts (30 HDs recording maternal deaths and 26 implementing MDSR). In 2015, 10 death review committees were organized. In 2013, two studies were conducted to evaluate progress; a rapid assessment of the implementation of the recommendations was carried out in 2015 on gender-related barriers, assessment of quality of care and client satisfaction. National specialized institutions (Cellule d'Information Sanitaire/ MoH) have been recruited to support Monitoring and Evaluation of the project, including data collection and analysis to inform decision-makers.

Health service delivery:

Strengthened referral; 91 facilities providing MNCH care: 189 CHWs provided services to 15,209 children under age 5; malaria cases (11,026), diarrhea (1,777), ARI (2,406), malnutrition (273), pregnant women (1,402), in their villages situated over 5 kms from health integrated centres. Seven districts conducted outreach activities and supervision in remote areas with funds provided by the Joint Programme; 95 motorcycles were provided for outreach services and rapid intervention in case of terrorist attacks.

Demand, including community ownership and participation:

For adolescent and youth health, three counseling units on RMNCAH and PMTCT were created. The system of recognition awarded good performance in the area of RMNCAH in 2015; 13 health facilities in the seven health districts received recognition awards.

Communication and advocacy:

The contract with seven radio stations is ongoing with trained broadcasters diffusing messages on RMNCAH/PMTCT in several languages. A follow-up committee was created in every health district to give feedback on broadcasting. Social mobilization and communication was routinely done by 90 per cent of health facilities on various themes. Two videos documenting the activities were produced for advocacy support.

Côte d'Ivoire



Joint Programme
focus regions:

8 districts
out of 72

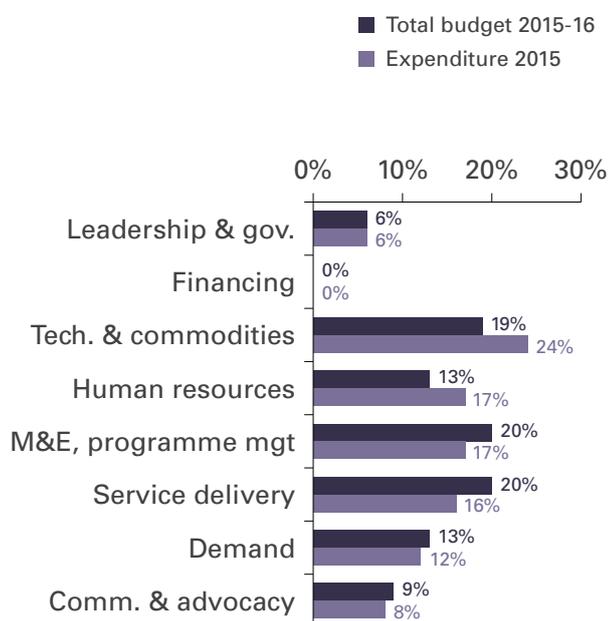


Population covered by Programme:
1.4 million
(7% of total)

Budget 2015-16: **US\$ 5.0 m**

Expenditure 2015: **US\$ 2.21 m**

Budget allocation and expenditure
per output (2015)



National RMNCAH indicators:

MMR (per 100,000 live births): **645**

Total fertility rate: **4.9**

Adolescent birth rate (per 1,000 girls): **125**

Infant mortality rate (per 1,000 live births): **67**

Neonatal mortality rate (per 1,000 live births): **38**

Skilled attendant at delivery: **59%**

Health expenditure (per capita): **US\$ 172**

OOP expenditure as % of total exp. on health: **51%**

Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- Mobilizing political

commitment to the Global Strategy for women's, children's and adolescents' health (Strategy 2.0);

- Supported printing and dissemination of key strategic

documents on FP, HIV, GBV, adolescent/youth health, EmONC, ICM norms;

- Supported review of eight district operational plans for Maternal and Child Health.

At the programme level:

Health technologies and commodities:

The health centres of eight health districts were provided with essential newborn care drugs and supplies. 27 health facilities including 21 first contact and six referrals received free medical equipment for the supply of obstetric and neo-natal emergency quality care. Three referral facilities (Katiola, Touba and Odienné) provided responsive care and blood bags for the treatment of bleeding and anemia cases. 18 health centers were provided with equipment to offer integrated health services of FP, ANC, PMTCT and cervical cancer screening. 26 motorbikes and helmets and 89 bikes were provided for community-based distribution agents for the distribution of products and to improve community mobilization.

Human Resources for Health:

146 supervisors were deployed to internship training sites at schools for the use of Helping Mothers Survive techniques along with technical supervision. 30 supervisors and school club leaders were trained in sexual and reproductive health (teenage pregnancy) in order to conduct peer educator-led activities on sensitive topics. 87 health care providers were trained in visual inspection

of acetic acid/Cryotherapy for the screening and treatment of precancerous lesions. 16 health centres integrated the screening of precancerous lesions into their routine activities and protocols. 50 health care providers in eight health districts strengthened their capacities in BEmONC in preparation for effective management and quality of obstetric emergencies; the

supervisions have shown that 95 per cent of health care providers trained in 2013-2014 effectively apply the EmONC skills. 100 people were trained in how to medically and psychologically care for gender-based violence cases. 16 supervisors and 47 CBD agents in the villages' health facilities in Katiola district were trained.

Health Information Systems, Monitoring and Evaluation:

The monitoring of the use of SMS technology (Smartphone) showed that 71 per cent of health districts reported at least one maternal death case. Quality assurance assessment tools were adapted to ensure their utilization to offer quality maternal and child health care. Three districts (Katiola, Dabakala, Niakara) implemented the bi-annual monitoring of the Minimum Activities Package and the essential family practices that identify bottlenecks and their causes while analyzing the different paths taken and favouring local solutions. Four joint missions were organized to monitor the functioning of local committees and health facilities on the prevention of harmful socio-cultural practices.

Health service delivery:

25 health care providers were oriented in the use of the recommendations guide for the clinical practice of EmONC. 11 health trainings were reorganized to offer quality integrated services in family planning, ANC, CPoN, PMTCT, and cervical cancer. 69 free consultations on FP, ANC, screening of cervical precancerous lesions and PMTCT, (a) raised the awareness of 20,000 men and women on the use of sexual and reproductive health services, as well as those on FP and HIV&AIDS; (b) offered

contraceptive methods to 5,688 women of whom 88 per cent were new recipients; (c) screened 3,312 women for cervical cancer and 5,721 for HIV. The various performance-based finance documents were put together with the support of two national consultants.

Demand, including community ownership and partnership:

18 women's groups and 20 Community-Based Distribution Agents benefited from funding for their income-generating activities through "social franchises." 20 Husband Schools were created in the health districts of Niakara (2), Sakassou (5), Samatiguila (2), Touba (5) and Minignan (6) with husband models to promote reproductive services.

Communication and advocacy:

3,447 radio spots were broadcast on four local radio stations in Malinké, Baoulé and Tagouanan. An orientation workshop was held for men and women in the media in the regions in question on H6 interventions in Côte d'Ivoire. 16 film screenings on maternal health were shown in eight districts (Katiola Dabakala Niakara, Sakassou, Bouaké, Minignan, Odienné and Touba) in order to raise awareness of 3,619 people and women of child-bearing age in rural areas about frequenting health centres. 37 media professionals from 17 districts were oriented in the H6 initiative and also had their capacities strengthened on the promotion of high-impact interventions.

Ethiopia



Joint Programme
focus regions:

All 9 regions



Population covered by Programme:

0.97 million
(4 per cent of total)

National RMNCAH indicators:

MMR (per 100,000 live births): **353**

Total fertility rate: **4.3**

Adolescent birth rate (per 1,000 girls): **71**

Infant mortality rate (per 1,000 live births): **41**

Neonatal mortality rate (per 1,000 live births): **28**

Skilled attendant at delivery: **16%**

Health expenditure (per capita): **US\$ 69**

OOP expenditure as % of total exp. on health: **35%**

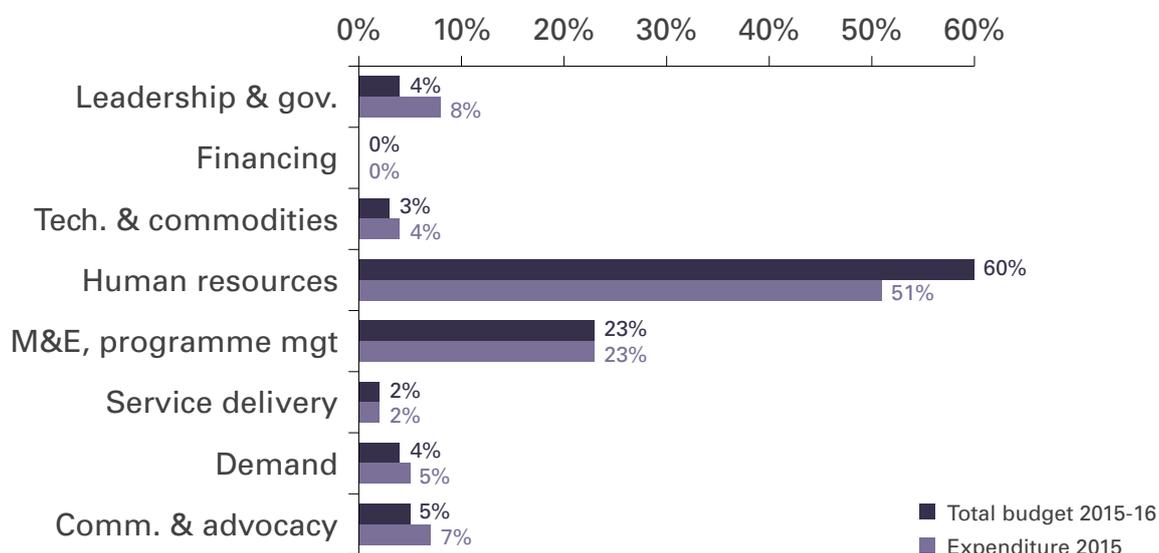
Budget 2015-16:

US\$ 5.0 m

Expenditure 2015:

US\$ 2.38 m
(48%)

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- Obstetric fistula elimination strategy (2015-2020) and training materials for middle level health care providers were developed;
- Midwifery Road Map (2015-2025) with costing was developed;
- Public Health Emergency Management (PHEM) implementation manual for MDSR was developed to facilitate the integration of MDSR within the IDSR (Integrated Disease Surveillance and Response)/ PHEM system.

At the programme level:

Human Resources for Health:

72 health workers in Oromia and SNNPR (South Nations, Nationalities and Peoples region) were trained in women-friendly service delivery. Another 60 Health Extension Workers and 10 district officers within Women Affairs and Social Security in SNNPR were trained in GBV psycho-social support. A total of 464 midwives and nurses working in maternal, delivery and neonatal units in 295 health centres received competency-based training in BEmONC during 2015. Four BEmONC training sites were added in Oromia Regional State, increasing the total standardized BEmONC training sites nationally to 19. A total of 578 staff (137 physicians and 297 nurses) received skills upgrade training at teaching hospitals with Neonatal Intensive Care Unit (NICUs).

600 health care providers were trained in essential newborn care. 252 Integrated Emergency Surgical Officers were trained in Mekelle, Hawassa, Harumaya and Jimma Universities. They were deployed to various primary health care facilities to provide emergency obstetric care. 46 tutors and senior midwives were trained as trainers in coaching and mentoring and they will continue to train other senior midwives to mentor new graduates. Competency-based integrated and comprehensive training packages in line with EMTCT were developed. Training of trainers on the revised guidelines (2015) with focus on Early Infant Diagnosis was given to 30 health care workers from all regions.

Health Information Systems, Monitoring & Evaluation:

MDSR tools were distributed and trainings were provided for 243 PHEM and MCH officers from remote pastoralist regions in the country. Self-assessment on quality maternal and newborn health care was conducted in 30 hospitals in the country and a national review meeting for dissemination of results was held in April 2015. The MidTerm Review of the EMTCT strategy was completed and disseminated and the findings used to revise a new strategy. A national ANC/PMTCT surveillance system assessment was conducted and the findings were used for surveillance road map development. Mother baby cohort-based reporting of PMTCT services was institutionalized in all government health facilities. A national study on the acceptability of male midwives was conducted and findings disseminated among key stakeholders.

Health service delivery:

EmONC services were provided in more than 54 per cent of Ethiopia's health facilities (n=3,500) with all signal functions. Midwifery standards were disseminated to 695 midwives. The aim of the standards is to improve quality of midwifery services in all health facilities. 240 health extension workers were trained from Gondar and Jimma catchment areas to identify fistula patients and refer them to fistula centres. Additionally, 65 health workers were trained to identify and screen fistula patients.

Demand, including community ownership and participation:

65 HEWs in SNNPR and 62 HEWs in Oromia, 300 members of women's groups in SNNPR and 157 in Oromia were trained in community mobilization, behaviour change skills, gender equality, male engagement, sexual and reproductive health and prevention of GBV and harmful traditional practices. 80 community conversation facilitators in SNNPR (40 female; 40 male) and 41 in Oromia (24 female; 17 male) were trained to facilitate community conversations.

Communication and advocacy:

A safe motherhood advocacy campaign was conducted at the national level. Consultation meetings with relevant stakeholders were held in both target regions to identify and eventually document best practices for reducing gender discrimination and harmful practices, as well as increasing healthcare demand among women.

Guinea-Bissau



Joint Programme
focus regions:

7 regions
out of 11



Population covered by Programme:
0.9 million
(60 per cent of total)

National RMNCAH indicators:

MMR (per 100,000 live births): **549**

Total fertility rate: **4.8**

Adolescent birth rate (per 1,000 girls): **137**

Infant mortality rate (per 1,000 live births): **60**

Neonatal mortality rate (per 1,000 live births): **40**

Skilled attendant at delivery: **45%**

Health expenditure (per capita): **US\$ 79**

OOP expenditure as % of total exp. on health: **43%**

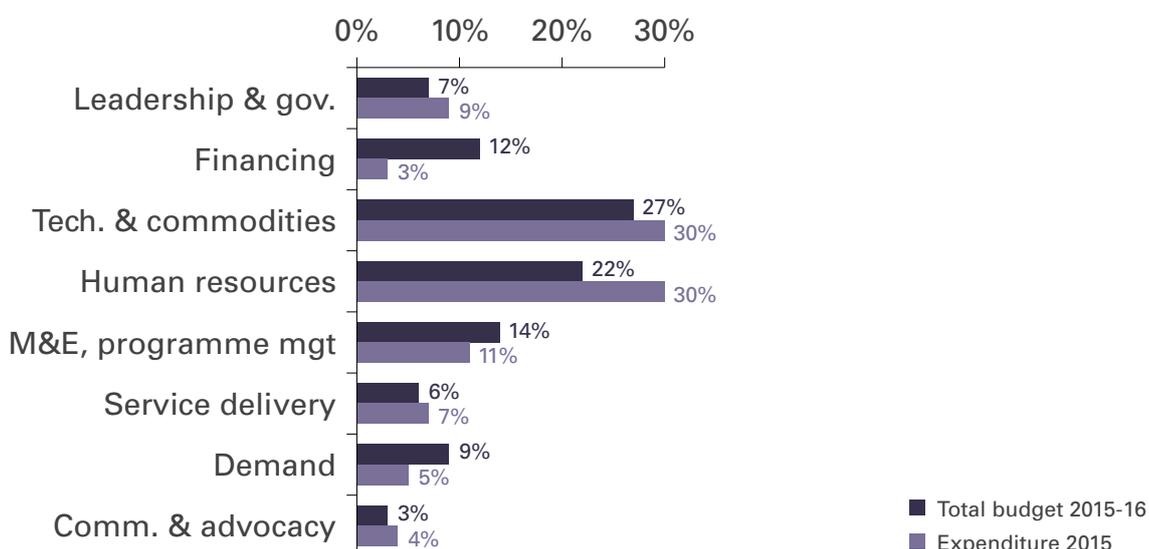
Budget 2015-16:

US\$ 5.02 m

Expenditure 2015:

US\$ 2.57 m

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided support for:

- Review of emergency obstetric and newborn care standards and integration of gender rights dimension was completed;
- HIV&AIDS guidelines as per WHO norms were updated;
- Development of policy on free access to health services for reproductive, maternal, newborn and child health, HIV and gender-based violence at health facilities, at the community level.

At the programme level:

Health technologies and commodities:

Maternal and child health medicines, PMTCT, GBV and infection prevention materials in 75 facilities, EmONC equipment, internet/ phone communication for regional directorate provided. The Joint Programme procured and distributed medical kits, vaccines and essential medicines for mothers and children, HIV treatment, emergency obstetric and newborn care and infection prevention.

Human Resources for Health:

Supported the national medical school for training of midwives and nurses on emergency obstetric and newborn care and provided in-service training on emergency obstetric and newborn care, MDSR, ANC, HIV and gender-based violence. Eight international experts were contracted to train health professionals in emergency obstetric and newborn care. Support for national health school for set-up of training of nurses and midwives, training of health providers: 40 in BEmONC, 73 in ARV treatment and PMTCT, 270 in RMNCH including FP.

Health Information Systems, Monitoring and Evaluation:

Improved data collection/ analysis and establishment of MDSR system. Joint field missions in 7 regions, one national HMIS review meeting held.

Health service delivery:

Renovated maternities and surgical theaters strengthened the referral system with the supply of ambulances, motorbikes, drugs and PHC equipment/material. Recruited 8 international experts (3 OBGYN, 4 pediatricians & 1 anesthesiologist) for delivery of CEmONC and training of national providers at national and 2 regional hospitals. Strengthen referral (30 motorbike ambulance, 3 ambulances).

Demand, including community ownership and participation:

Training of 772 CHW for awareness generation and community participation trained on MNH from 2 H6 regions; 1,000 basic information posters on maternal health made available to health facilities. Provided food support for functioning of maternity waiting homes.

Liberia



Joint Programme
focus regions:

6 SE counties
out of 15



Population covered by Programme:
642,847
(17% of total)

National RMNCAH indicators:

MMR (per 100,000 live births): **725**

Total fertility rate: **4.6**

Adolescent birth rate (per 1,000 girls): **147**

Infant mortality rate (per 1,000 live births): **53**

Neonatal mortality rate (per 1,000 live births): **24**

Skilled attendant at delivery: **61%**

Health expenditure (per capita): **US\$ 88**

OOP expenditure as % of total exp. on health: **26%**

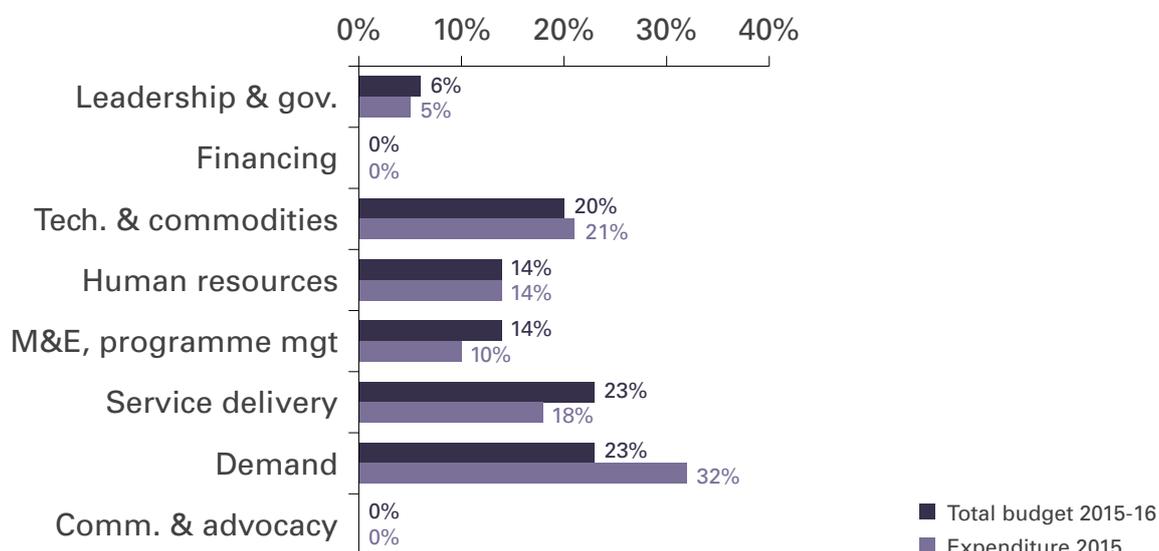
Budget 2015-16:

US\$ 6.99 m

Expenditure 2015:

US\$ 2.85 m

Budget allocation and expenditure per output (2015)



Key achievements in 2015:

At the policy level:

H6 provided technical support for:

- An integrated 2016 work plan for the SRMNCAH division at the MOH was developed;
- National supply chain and Health Management Information System (HMIS) was strengthened;
- Developed national MNDSR guidelines and protocols.

At the programme level:

Health financing:

During the period of review, the programme provided technical and financial support for the assessment and development of the national investment plan for national health system.

Health technologies and commodities:

Anti-shock garments were provided to programme facilities to aid in the management of intra and postpartum haemorrhage, resulting in the increase in lives of women saved from 22 in 2014 to 38 in 2015. IPC materials, including personal protective equipment, were delivered to health facilities. EmONC drugs, medicine and supplies including delivery kits supplied for 18 facilities. 12 midwifery schools equipped with essential teaching-learning aides including human skeleton, Mama Natalee, partograph chart, pregnancy calculators etc.

Human Resources for Health:

Eighty midlevel service providers were trained in 193 skilled providers and 36 Reproductive Health services supervisors trained in EmONC,

including essential newborn care, Infection Prevention and Control (IPC) and the provision of logistics to enhance their performance. Additionally, 175 community frameworks, 36 community health committee members and 87 midlevel service providers were trained in HBMNC and given essential tools for performing their duties. The programme recruited, retrained and deployed 9 retired and newly graduate midwives in 6 Joint Programme supported health facilities. Youth volunteers were also deployed to Joint Programme counties to support supply chain and M&E. Performance based incentives were provided to active community health volunteers, including 110 trained traditional Midwives.

Health Information Systems, Monitoring and Evaluation:

The programme supported the revision of existing national HMIS tools and programme indicators integrated into national HMIS tools. Establishment of MDSR at national, county, district and health facility levels. Health facilities submitted timely and complete reports and according to national guidelines and schedules, programs reported as complete and in a timely manner increased from 47% to 67% in 2014 and 2015 respectively. The programme has engaged community health volunteers and various community leaders to support the reporting of maternal and newborn deaths at their respective levels, providing them with reporting tools and other materials including rain gear, flashlights and IPC materials to facilitate their job.

Health service delivery:

In three counties, 18 health facilities supported by H6 Joint Programme reported

recovery of MNH care. ANC 4 visits increased from 39.3% (12,335/31,467) in 2014 to 49% (15,750/32,142) in 2015. Similarly, facility deliveries increased from 33.5% (9,487/28,321) in 2014 to 50.0% (14,464/28,928) in 2015 respectively. Kangaroo Mother Care (KMC) units made three programme referral hospitals functional. The number of preterm and low birth weight infants saved, inside Joint Programme supported health facilities, increased from 11 to 21 in 2014 and 2015 respectively. Joint Programme facilities in three counties were provided with functioning maternal and perinatal death and response mechanisms. H6 Joint Programme provided 3 ambulances for referral of MNH cases.

Demand including community ownership and participation:

175 community health workers, including Trained Traditional Midwives, were trained and equipped to conduct community based SRMNAH activities including FP commodities distribution. 26 adolescent peer groups were established in 26 catchment communities, peer-to-peer support was provided and adherence training and awareness activities were conducted. Journalists from three community radios in each programme county and two national radios were trained on SRMNAH reportage. 36 Community Committees Chairpersons were trained and provided with tools to facilitate delivery of their tasks in ensuring services utilization. Eight newspapers, one national radio (Front Page Africa, The Catalyst, The People, Insight, In Profile Daily, Heritage, The People, Daily Observer and Equatorial Latitude Broadcasting Cooperation) and one online news medium, "Allafrica.com" published and aired stories on the Joint Programme.

Appendix 2: Human Resources for Health: Skills re- enhancement 2015

| Country | Maternal health ¹³ | Newborn and infant care | HIV prevention and treatment | Family Planning | Youth-friendly health care | Health care management | Community Health Workers | TOTAL |
|--------------------|-------------------------------|-------------------------|------------------------------|-----------------|----------------------------|------------------------|--------------------------|---------------|
| Burkina Faso | 538 | 643 | 857 | | | | 893 | 2,931 |
| Cameroon | 667 | 90 | | | | | | 832 |
| Côte d'Ivoire | 244 | | 63 | 87 | 30 | | 163 | 587 |
| DRC | 270 | 270 | | 105 | | 25 | 61 | 731 |
| Ethiopia | 865 | 1,178 | 30 | | | | 447 | 2,520 |
| Guinea-Bissau | 383 | | | 343 | | | | 726 |
| Liberia | 193 | | | | | 21 | | 214 |
| Sierra Leone | 133 | 740 | 250 | 188 | 60 | | 2,100 | 3,471 |
| Zambia | 87 | 40 | 24 | 60 | | 15 | 280 | 506 |
| Zimbabwe | 105 | 341 | 140 | | 40 | 42 | 390 | 1,058 |
| Grand total | 3,485 | 3,302 | 1,364 | 858 | 130 | 103 | 4,334 | 13,576 |

¹³ EmONC/BEmONC/CEmONC, midwifery, MCH aides, SRMNCAH, MDSR, IFC approach.

Appendix 3:

Joint Programme innovations completed and planned

| COMPLETED | |
|------------------|--|
| Canada | |
| Burkina Faso | <ul style="list-style-type: none"> • Sharing of healthcare costs (national cross-subsidization for delivery and EmONC) • Husband Schools |
| DRC | <ul style="list-style-type: none"> • Competency-based EmONC training • Midwives responding to obstetric emergencies in Bandundu |
| Sierra Leone | <ul style="list-style-type: none"> • Using civil society in monitoring the supply chain management to improve the accountability |
| Zambia | <ul style="list-style-type: none"> • Hiring retired midwives to run health facilities • Implementation of non-monetary incentives (Mama Kits) to increase institutional delivery |
| Zimbabwe | <ul style="list-style-type: none"> • Use of social media to reach young people with information and education on SRH • Use of PoC PIMA CD4 count machines |
| Sida | |
| Cameroon | <ul style="list-style-type: none"> • Prepositioning of obstetric kits |
| Ethiopia | <ul style="list-style-type: none"> • Integrated Emergency Surgical and Obstetric Officers (IESO) |
| Zimbabwe | <ul style="list-style-type: none"> • Use of social media to reach young people with information and education on SRH • Use of PoC PIMA CD4 count machines |
| ONGOING | |
| Sida | |
| Cameroon | <ul style="list-style-type: none"> • Free phone network for referral between facilities |
| Cote d'Ivoire | <ul style="list-style-type: none"> • Husband Schools • Community-based Family Planning |
| Guinea Bissau | <ul style="list-style-type: none"> • Maternity waiting homes keeping women on higher risk nearby health facilities |
| PLANNED | |
| Sida | |
| Ethiopia | <ul style="list-style-type: none"> • Linking door-to-door polio campaign to obstetric fistula • Mother-baby cohort for PMTCT Monitoring and Evaluation |
| Liberia | <ul style="list-style-type: none"> • Use of motorcycle wagons for the transportation of RH commodities to nearby health facilities. |

Appendix 4: End Line Evaluation – Joint Programme Canada and Sida collaboration

Specific Objectives of the Evaluation

The specific objectives are to:

- Assess the relevance of the objectives and the approach of the H4+ JPCS at global, regional, national and sub-national levels, including its role and positioning within the context of other partnerships and platforms;¹³
- Assess the effectiveness and efficiency of the implementation of the H4+ Joint Programme (Canada, Sweden) (H4+ JPCS) at global, regional, national and sub-national levels; also, but not exclusively, with regard to:
 - Achievements of the programme regarding the strengthening of national health systems at policy and programme level in the ten programme countries;
 - Improvements in the delivery of a comprehensive package of reproductive, maternal, newborn and child health services to the population in intervention areas in the ten programme countries;
- Assess the sustainability of the results achieved by the H4+ JPCS 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 maternal and children's health programming, awareness raising products, and technical guidance on RMNCAH;
- Assess the extent to which issues of gender equality, social inclusion and equity have been taken into consideration;
- Identify lessons and good practices from the implementation of the H4+-JPCS, and opportunities to improve both the cooperation between the six agencies and their support aimed at the improved delivery of the comprehensive package of services and support in RMNCAH, in a set of concrete and actionable recommendations.

Evaluation Object and Scope

The H4+ joint programme, financed by Canada and Sweden sits within a set of policies and strategic frameworks, namely:

- The H4+ partnership, whose consolidation and actions the H4+ JPCS was meant to support;
- The Secretary General's Global Strategy for Women's and Children's Health and the associated global initiative "Every Woman, Every Child" (EWEC) that came to serve as the strategic framework for the H4+ partnership.

Indicative Deliverables and Time Schedule

All evaluation deliverables will be drafted in English (see Annex 2) to the exception of the executive summary of the final evaluation report and of the evaluation brief which will be produced in English, French and Spanish versions.

¹³ Such as the Partnership for Maternal and Newborn Health (PMNCAH), the International Health Partnership (IHP+), the RMNCAH Steering Committee, the Innovation Working Group, the independent Expert Review Group.

Table: Indicative time schedule of the End Line Evaluation

| Evaluation phases and stages | Deliverables | Dates | Meetings |
|--|---|-------------------------------------|---|
| Preparatory phase | | | |
| Consultations and documentary research with a view to drafting the terms of reference | Terms of reference | May – June 2015 | |
| Start of tendering process | | July 2015 | |
| Review of technical proposal (joint EMG/ERG) | | October 2015 | |
| Review of financial proposal | | October 2015 | |
| Contracts Review Committee | | November 2015 | |
| Contract award | | End of November 2015 | |
| Inception phase | | | |
| Kick-off of evaluation | | Mid-December 2015 | Kick-off meeting (team leader) (with reference group) |
| Structuring stage (preliminary desk study) | | January 2016 | Internal team meeting (proposed) |
| Exploratory mission Evaluation Team Leader | Chapter in inception note: data availability at country level / implications for evaluation methodology | February 2016 (first half) | |
| Reporting stage (part 1) | Inception report (draft) Presentation of the draft inception report | February 2016 (second half) | Joint evaluation reference group meeting (team leader + at least one team member) |
| Reporting stage (part 2) | Final inception report | March 2016 (first half) | |
| Data collection phase | | | |
| Desk study | | | |
| Compilation and analysis of secondary data / information Analysis of available secondary data and information | No official deliverable (instead evaluators ensure compilation of information in evaluation matrix) | March (second half) 2016 – May 2016 | Consultation meeting between Sweden / Sida, Canada DFATD and evaluation team (video conference) |
| First country mission (pilot) | Country visit #1 (pilot) | June 2016 | |
| | Debriefing presentation to national ERG of pilot country Pilot country case study note (draft) | June 2016 | Exit meetings in H4+ coordinating agency (team leader + team members) |

| Evaluation phases and stages | Deliverables | Dates | Meetings |
|---|---|---|---|
| Field study and online survey | | | |
| First country mission (pilot) | Presentation of country case study note | June – July 2016 | Joint reference group meeting (video-conference with team leader and team members) |
| | Pilot country case study note (final) | July 2016 (end of month) | |
| Missions to remaining 3 countries selected for field-based country case studies | 3 Country visits | August-September 2016 | |
| | Debriefing presentations to country offices (PowerPoint) | At end of each country visit | Exit meetings in the relevant H4+ coordinating agencies (team leader + team members) |
| | Country case study notes (draft) | 2 weeks after end of country visit | |
| | Presentation of the results of the data collection and preliminary findings to the reference group (PowerPoint) | October 2016 (first half of month) | Joint reference group meeting (team leader + core team members) |
| Preparation, dissemination and analysis of online survey | Survey questionnaire Sampling frame | May – September 2016 Reporting phase | |
| Reporting phase | | | |
| | Draft final report | December 2016 (first half of month) | |
| | Presentation of the draft final report to the joint evaluation reference group and H4+ Steering Committee (PowerPoint) | December 2016 (middle of month) | Joint evaluation reference group meeting with H4+ Steering Committee (team leader + at least one team member) |
| | Final report | February 2017 | |
| Management response | | | |
| | Management response | March 2017 | Coordinated by joint EMG, in collaboration with joint ERG |
| Dissemination | | | |
| | Evaluation briefs (English, French, Spanish) French and Spanish versions of the executive summary of the final evaluation report | March 2017 April 2017 | Presentation by team leader and joint EMG |
| | Presentation of the evaluation results (PowerPoint) to the stakeholder workshop | | |

Appendix 5:

List of countdown countries/ High burden countries and H6 countries

75

Countdown countries where more than 95% of all maternal and child deaths occur

| | |
|--|-----------------------|
| Afghanistan | Lao PDR |
| Angola | Lesotho |
| Azerbaijan | Liberia |
| Bangladesh | Madagascar |
| Benin | Malawi |
| Bolivia | Mali |
| Bostwana | Mauritania |
| Brazil | Mexico |
| Burkina Faso | Morocco |
| Burundi | Mozambique |
| Cambodia | Myanmar |
| Cameroon | Nepal |
| Central African Republic | Niger |
| Chad | Nigeria |
| China | Pakistan |
| Comoros | Papua New Guinea |
| Congo | Peru |
| Côte d'Ivoire | Philippines |
| Djibouti | Rwanda |
| DRC | Sao Tome and Principe |
| Egypt | Senegal |
| Equatorial Guinea | Sierra Leone |
| Eritrea | Solomon Islands |
| Ethiopia | Somalia |
| Gabon | South Africa |
| Gambia | South Sudan |
| Ghana | Sudan |
| Guatemala | Swaziland |
| Guinea | Tajikistan |
| Guinea Bissau | Tanzania |
| Haiti | Togo |
| India | Turkmenistan |
| Indonesia | Uganda |
| Iraq | Uzbekistan |
| Kenya | Vietnam |
| Korea, Democratic People's Republic of | Yemen |
| Kyrgystan | Zambia |
| | Zimbabwe |

35

Countries reporting either having a dedicated H6 country team or having H6 as part of a UN coordinating team

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|--------------------------|
| Afghanistan |
| Bangladesh |
| Burkina Faso |
| Burundi |
| Cameroon |
| Central African Republic |
| China |
| Comoros |
| Côte d'Ivoire |
| Djibouti |
| DRC |
| Eritrea |
| Ethiopia |
| Guinea Bissau |
| Haiti |
| Indonesia |
| Kenya |
| Lao PDR |
| Lesotho |
| Liberia |
| Madagascar |
| Mali |
| Mauritania |
| Mozambique |
| Nepal |
| Nigeria |
| Senegal |
| Sierra Leone |
| Swaziland |
| Tajikistan |
| Togo |
| Uganda |
| Vietnam |
| Zambia |
| Zimbabwe |

12

Countries covered under GFF wave I and II

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|------------|
| Bangladesh |
| Cameroon |
| DRC |
| Ethiopia |
| India |
| Kenya |
| Liberia |
| Mozambique |
| Nigeria |
| Senegal |
| Tanzania |
| Uganda |

10

Countries participating in the H6 Joint Programme—Canada and Sweden

| |
|---------------|
| Burkina Faso |
| Cameroon |
| Côte d'Ivoire |
| DRC |
| Ethiopia |
| Guinea Bissau |
| Liberia |
| Sierra Leone |
| Zambia |
| Zimbabwe |



Appendix 6: RMNCH knowledge products and global public goods (2011-2015)

| Year | Product | Agency | Link |
|--|--|--------|---|
| Thematic area 1: Policy, planning and costing | | | |
| Area 1: Mapping/monitoring of global and country activities within the broad H4+ scope of work and implementation of the Global SRMNCH Strategy 2011-12. | | | |
| 2012 | Mapping of major global MNH initiatives and agreed list of H4+ priority countries developed. | UNICEF | Report with no link |
| 2013 | Final version of tool for rapid assessment of RMNCH interventions and Commodities (RAIC) disseminated. | UNICEF | H4+ activities disseminated during the 2013 Global Newborn Health Conference (GNHC) in Johannesburg, SA; http://newborn2013.com |
| | Every newborn bottleneck analysis (BNA) tool used during country consultations on newborn care. | UNICEF | Bottleneck analysis tool for ENAP disseminated through website and during country (at least 5 countries) and regional (Asia, Africa) newborn consultations www.everynewborn.org https://www.dropbox.com/s/t4a8rw3m87mmdbg/Every-Newborn-Bottleneck%20Analysis%20tool-12-August-2013.pdf?dl=0 |
| 2014 | Strategic goals, targets and objectives for ending preventable maternal, newborn and child deaths defined up to 2030. | WHO | Every Newborn An Action Plan to End Preventable Death (2014) https://www.everynewborn.org/every-newborn-action-plan/ |
| | RMNCH quality of care scorecards using DHS and MICS data for 74 priority countries. | WHO | Maternal, newborn, and child health scorecards (2016) http://www.who.int/maternal_child_adolescent/documents/countries/indicators/en/ |
| 2015 | <ol style="list-style-type: none"> 1. Revision of Lives Saved Tool for updating the OneHealth and LiST instruments. 2. Policy briefs and guidance published 3. a) Core competencies in adolescent health and development for primary care providers and to assess the adolescent health and development component in pre-service education; b) A standards-driven approach to improve the quality of health-care services for adolescents; c) Building an adolescent competent workforce; d) Preterm guidelines; e) Maternal and peripartum sepsis guidelines; f) Newborn resuscitation; g) Feeding low birth weight babies; h) Guidance note on improving quality of paediatric care; | WHO | <p>LiST: Lives Saved Tool www.livessavedtool.org</p> <ol style="list-style-type: none"> a) Core competencies in adolescent health and development for primary care providers including a tool to assess the adolescent health and development component in pre-service education of health-care providers (2015) http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf?ua=1&ua=1 b) A standards-driven approach to improve the quality of health-care services for adolescents (2015) http://apps.who.int/iris/bitstream/10665/184035/1/WHO_FWC_MCA_15.06_eng.pdf c) Building an adolescent competent workforce (2015) http://apps.who.int/iris/bitstream/10665/183151/1/WHO_FWC_MCA_15.05_eng.pdf d) WHO recommendations on interventions to improve preterm birth outcomes (2015) http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf?ua=1 e) WHO recommendations for prevention and treatment of maternal peripartum infections (2015) http://apps.who.int/iris/bitstream/10665/186171/1/9789241549363_eng.pdf f) Guidelines on basic newborn resuscitation (2012) http://apps.who.int/iris/bitstream/10665/75157/1/9789241503693_eng.pdf?ua=1 g) Breastfeeding of low-birth-weight infants (2015) http://www.who.int/elena/titles/supplementary_feeding/en/ h) Improving paediatric quality of care at first-level referral hospitals (2015) http://www.who.int/maternal_child_adolescent/documents/paediatric-hospital-care-quality/en/ |

| Year | Product | Agency | Link |
|------|--|--------|---|
| 2015 | 1. Use of amoxicillin for treatment of pneumonia . 2. ENAP Progress Tracking Tool revised, used and data collated from 16 of the 28 ENAP high burden countries. Bottle neck Analysis and situation assessments in Iraq, Nepal and Malawi. | WHO | 1. Revised WHO classification and treatment of childhood pneumonia at health facilities (2015) http://apps.who.int/iris/bitstream/10665/137319/1/9789241507813_eng.pdf 2. Every Newborn Progress Report (2015) https://www.everynewborn.org/wp-content/uploads/2015/05/Every-Newborn-Progress-Report-May2014.pdf |
| | Adapting CHW training packages to integrate actions for HIV and TB – policy brief. | UNAIDS | https://www.dropbox.com/sh/rzxuhrwzh72iukp/AABTTHZ2eMGxyj8JQ5VGE6B0a?dl=0 |
| | Guidance note on strategic planning for ending preventable maternal, newborn and child, mortality. | WHO | https://www.dropbox.com/s/a9nd0dr1kmv208o/WHO%20Guidance%20Note%20on%20Strategic%20Planning%20for%20Ending%20preventable%20Maternal%2C%20Newborn%20and%20Child%20Mortality.pdf?dl=0 |

Area 2: Develop and/or cost RMNCH modules of national health plans, and rapidly mobilize new or additional resources.

| | | | |
|------|---|----------|---|
| 2012 | Toolkit for RMNCH strategic planning, implementation, monitoring and reviews. | WHO | http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf |
| | Checklist for the rapid review of RMNCH plans. | UNICEF | Link yet to be developed |
| 2013 | RMNCH Policy Compendium developed. | WHO | A Policy Guide for Implementing Essential Interventions for Reproductive, Maternal, Newborn and Child Health (RMNCH) (2014) http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf OneHealth Tool http://www.internationalhealthpartnership.net/en/tools/one-health-tool/ Compilation of WHO recommendations on maternal, newborn, child and adolescent health (2013) http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/ |
| | Strategic planning with specific focus on RMNCH continued through the One Health tool for planning and costing. | | |
| | Technical guidelines for Maternal Death Surveillance and Response produced. | | |
| | WHO recommendations on maternal, newborn, child and adolescent health compiled. | WHO | Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death (2013) http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/ |
| | H4+ 2013 Annual Report published | UNICEF | H4+/EWEC high-level stakeholders meeting convened in May 2013 www.everywomaneverychild.org |
| | Factsheets with MNH coverage indicators developed for all H4+ Canada countries (as well as over 20 high-burden countries) and posted on EN website. | UNICEF | https://www.dropbox.com/sh/k0ulxntr5xrbq7/AACKya3lwvxvOXcLVkq2uRjkXa?dl=0 |
| 2015 | Joint publication in the British Medical Journal - through the EWEC workstream on social determinants of health - Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era | UN Women | Article is accessible at: http://www.bmj.com/content/351/bmj.h4213 |
| | Global Citizen Reporter Advocacy training– for Sub Saharan Africa and South Asia | UN Women | http://www.citizens-post.org/news/2015/8/19/citizen-reporter-training-in-uganda |

| Year | Product | Agency | Link |
|------|---|----------|---|
| 2015 | <ol style="list-style-type: none"> Briefing Kit for Sexual and Reproductive Health and Rights in South Asia Briefing Kit for Sexual and Reproductive Health and Rights in Sub-Saharan Africa Policy Brief – Sexual and Reproductive Health Rights; the Case for Engaging Citizens in Policymaking | UN Women | <p>http://whiteribbonalliance.org/wp-content/uploads/2016/03/Briefing-Kit-SRHR-in-South-Asia.pdf</p> <p>http://whiteribbonalliance.org/wp-content/uploads/2016/03/Briefing-Kit-SRHR-in-Sub-Saharan-Africa.pdf</p> <p>http://whiteribbonalliance.org/wp-content/uploads/2016/03/Policy-Brief-SRHR-The-Case-for-Engaging-Citizens-in-Policymaking.pdf</p> |
| | <ol style="list-style-type: none"> In 2015 – Strategic goals, targets and objectives for ending preventable maternal, newborn and child deaths defined up to 2030 as part of the Global Strategy. Revision of reference data for Lives Saved Tool completed for updating of the OneHealth and LiST instruments. Under the GFF umbrella, A multi-stakeholders meeting, “From ‘shopping lists’ to investment plans: Supporting countries to develop and finance sound investment plans for women’s, children’s and adolescents’ health” organized in June 2015, to inform the development of the TA agenda around RMNCAH investment plans and TA coordination. The following Policy briefs and guidance published <ol style="list-style-type: none"> Core competencies in adolescent health and development for primary care providers; A tool to assess the adolescent health and development component in pre-service education; A standards-driven approach to improve the quality of health-care services for adolescents; Building an adolescent competent workforce; Preterm guidelines; Maternal and peripartum sepsis guidelines. newborn resuscitation; Feeding low birth weight babies; Improving quality of paediatric care; Use of amoxicillin for treatment of pneumonia; Adapting CHW training packages to integrate actions for HIV and TB; and Guidance note on strategic planning for ending preventable maternal, newborn and child, mortality. global convening of stakeholders and subsequent action planning informed Agenda for Zero Discrimination in Health Care, launched by UNAIDS jointly with the Global Health Workforce Alliance, | WHO | <ol style="list-style-type: none"> The Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016 - 2030) http://globalstrategy.everywomaneverychild.org/ LiST Lives Saved Tool http://www.livessavedtool.org/ How can health ministries present persuasive investment plans for women’s, children’s and adolescents’ health? (2015) http://www.who.int/bulletin/online_first/15-168419.pdf Core Competencies in adolescent health and development for primary care providers (2015) http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf?ua=1&ua=1 <ol style="list-style-type: none"> A standards-driven approach to improve the quality of health-care services for adolescents (2015) http://apps.who.int/iris/bitstream/10665/184035/1/WHO_FWC_MCA_15.06_eng.pdf Building an adolescent competent workforce (2015) http://apps.who.int/iris/bitstream/10665/183151/1/WHO_FWC_MCA_15.05_eng.pdf WHO recommendations on interventions to improve preterm birth outcomes http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf?ua=1 WHO recommendations for prevention and treatment of maternal peripartum infections (2015) http://apps.who.int/iris/bitstream/10665/186171/1/9789241549363_eng.pdf Guidelines on basic newborn resuscitation (2012) http://apps.who.int/iris/bitstream/10665/75157/1/9789241503693_eng.pdf?ua=1 Breastfeeding of low-birth-weight infants (2015) http://www.who.int/elena/titles/supplementary_feeding/en/ Improving paediatric quality of care at first-level referral hospitals (2015) http://www.who.int/maternal_child_adolescent/documents/paediatric-hospital-care-quality/en/ Revised WHO classification and treatment of childhood pneumonia at health facilities (2014) http://apps.who.int/iris/bitstream/10665/137319/1/9789241507813_eng.pdf Caring for the sick child in the community Adaptation for high HIV or TB settings CHW Manual (2014) http://www.who.int/maternal_child_adolescent/documents/9789241548045.pdf Ending Preventable Maternal and Newborn Mortality and Stillbirths Effective |

| Year | Product | Agency | Link |
|------|---|--------|--|
| 2015 | and convening joint actions by key partners: communities, member-states, professional healthcare associations, donors, UN | WHO | <p>interventions and strategies (2015) http://www.everywomaneverychild.org/images/07_Ending_Preventable_Maternal_andNewborn_Mortality_and_Stillbirths.pdf</p> <p>J) From Shopping List to Investment Plans: Supporting Countries to Develop and Finance Sound Investment Plans for Women's, Children's and Adolescents' Health. https://www.dropbox.com/s/6c3xauvs9apyga5/WHO%20From%20Shopping%20List%20to%20Investment%20Plan.pdf?dl=0</p> |

Thematic Area 2: Quality

Area 3: Support countries' scale up of quality RMNCH service delivery in line with domestic priorities, ensuring linkages with Malaria and HIV and strengthening consolidated Procurement Systems Management

| | | | |
|------|---|--------|---|
| 2011 | The UN Commission on Life-saving Commodities for Women and Children, which includes H4+partners as members created a list of 13 key commodities and medical devices has been identified for MNH/FP; draft report with recommendations is available. | UNICEF | Draft Report with Recommendation, with no link |
| 2013 | MNH communication for development (C4D) guide drafted. | UNICEF | <p>ENAP disseminated through various websites and global and regional meetings/conferences. http://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/index.html https://www.dropbox.com/s/xursbkezagn6i5o/5-C4D-MNCHN_FINAL-WEB-v3.pdf?dl=0</p> |
| | Final list of essential medical devices for Maternal and Newborn Health compiled. | UNICEF | http://www.who.int/medicines/areas/policy/12-IPC_InteragencylistMandMD.pdf |
| | DIVA Procurement and Supply tool (final version) available | UNICEF | Link yet to be developed |
| 2014 | 1. MDSR sub-regional workshop held in Libreville on 24-27 June for eight countries - AFRO/CA (Angola, Burundi, Cameroon, Chad, Congo, Gabon, DRC, Sao Tome & Principe). | WHO | 1. these are meetings, with private reports. No links available. |
| | 2. Core set of indicators of quality of MNCH care in facilities published. | | 2. Consultation on Improving measurement of the quality of maternal, newborn and child care in health facilities (2014) http://apps.who.int/iris/bitstream/10665/128206/1/9789241507417_eng.pdf |
| | 3. QoC panel published in Countdown 2014 Report. | | 3) Fulfilling the Health Agenda for Women and Children: The 2014 Report (2014) http://www.countdown2015mnch.org/documents/2014Report/The2014report/Countdown_The_2014_Report_final.pdf |
| | 4. BJOG supplement on QoC in MNH to be published in August (WHO staff co-editor and WHO staff contributors). | | 4. https://www.dropbox.com/s/rdoeu9rfyk29zuk/QOC%20During%20Labor%20and%20Birth.pdf?dl=0 |
| | 5. Meta review on QoC assessments in MNCH published. | | 5. confidential report. |
| | 6. QoC core indicators pilot tested in Uganda and Tanzania. QoC field testing manual/operations drafted. | | 6. Global Monitoring of Implementation of Maternal Death Surveillance and Response (MDSR) (2015) http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/global-monitoring/en/ |
| | 7. MDSR implementation monitoring tool drafted. | | 7. TA provided, mission reports available if needed. |
| | 8. Technical support provided to DRC (strategy development), Zambia (GAPPD and home-based newborn care), Zimbabwe (Quality of care), Burkina Faso (community services and GFATM proposal). | | |

| Year | Product | Agency | Link |
|------|---|--------|---|
| 2014 | <p>9. Contributed, with H4+ agencies and country partners, to development of guide providing for safe delivery and newborn care in the context of an Ebola outbreak.</p> <p>10. The mHealth Assessment and Planning for Scale tool was developed and launched, to provide mHealth implementers and countries successfully and sustainable scale their innovations.</p> | WHO | <p>8. The H4+ partnership Joint support to improve women's and children's health http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf</p> <p>9. mHealth maps toolkit http://who.int/life-course/publications/mhealth-toolkit/en/</p> |
| | <p>1. Support provided to strengthen H4+ coordination activities;</p> <p>2. Maintain strong partnership with the Every Newborn Group (WHO, UNFPA) to advocate for strengthening of MNH activities</p> | UNFPA | Report with no link |
| | <p>1. ENAP developed and disseminated;</p> <p>2. development of draft C4D strategy;</p> | UNICEF | https://www.dropbox.com/s/xursbkezagn6i5o/5-C4D-MNCHN_FINAL-WEB-v3.pdf?dl=0 |
| | <p>1. Organization of two regional workshops (Dakar, Arusha) on C4D and MNH to strengthen country planning and implementation;</p> <p>2. Support provided to countries, in collaboration with the global Chlorexhidine Working group (Commodity Working Group), to strengthen procurement, supply management and use of chlorexhidine (Pakistan, Sierra Leone, Ethiopia, Liberia, DRC, Malawi, Bangladesh, Kenya, Nigeria).</p> <p>3. QoC workshop to develop pool of QOC experts organised for 15 countries: Bénin, Botswana, Burkina Faso, Côte d'Ivoire, Ethiopia, Malawi, Mali, Mozambique, Niger, South Africa, South Sudan, Togo, Uganda, Zambia, Zimbabwe.</p> | WHO | <p>1. workshop reports, with no link.</p> <p>2. mission reports, with no link</p> <p>3. workshop report, with no link</p> |
| 2015 | <p>1. Feasibility of WHO indicators of QOC for MNCH care in facilities tested in DRC, Chad, Tanzania, Zambia and Zimbabwe.</p> <p>2. Qualitative study to understand challenges in monitoring QOC conducted in DRC and Tanzania.</p> <p>3. In depth evaluation of MDSR implementation conducted in Guinea and Burkina Faso.</p> | | <p>1. Feasibility of WHO indicators of QOC for MNCH care in facilities https://www.dropbox.com/s/2merq2gxd4iox2h/WHO%20QOC%20Indicators%20Final.pdf?dl=0</p> <p>2. Qualitative study to understand challenges in monitoring QOC https://www.dropbox.com/s/aekm22ilkiwz3c4/WHO%20Report%20QOC%20Field%20Report%20Final.PDF?dl=0</p> <p>3. https://www.dropbox.com/s/kvawqq8l45m5b17/WHO%20Time%20to%20Respond%20-%20MDSR.pdf?dl=0</p> |
| | <p>4. First global report on MDSR implementation published.</p> <p>5. Case studies documenting successes and challenges in MDSR implementation published.</p> <p>6. Global workshop on MDSR convened in Vancouver in Oct 2015.</p> <p>7. National capacity building for quality of care assessment and improvement</p> | WHO | <p>Maternal Death Surveillance and Response website http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/</p> <p>4. Full List of MDSR case studies http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/en/</p> <p>5. Department of MCA Progress Report 2014-15 (2015) http://apps.who.int/iris/</p> |

| Year | Product | Agency | Link |
|------|--|--------|--|
| 2015 | <p>in Congo, Malawi, Swaziland and Tanzania. DRC.</p> <p>8. IMPAC guidelines updated with latest WHO recommendations.</p> <p>9. MMR Estimates published November 2015 following extensive country consultations and follow up with H4+ countries, an implementation of a refined methodology that favoured closer following and better use of country-level data.</p> | WHO | <p>bitstream/10665/205631/1/9789241510356_eng.pdf</p> <p>6. A conversation with the special rapporteurs (2016)</p> <p>http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1</p> |
| | <p>1. ENAP partnership maintained and strengthened;</p> <p>2. ENAP Progress Report published and launched at WHA in May 2015. Two side events organized to update on progress;</p> <p>3. Technical support provided to countries to develop newborn strategies and scale up plans;</p> <p>4. H4+ and other countries supported to submit abstracts and participate in the Global Maternal Newborn Conference in Mexico.</p> <p>5. List of essential MNCH medicines printed and disseminated;</p> <p>6. Specific technical inputs provided to revise patient guidelines and country recommendations in response to reports of CHX drops being used by mothers for newborns eyes in Nigeria;</p> <p>7. "Global Standards for Quality Health Care Services for Adolescents" published;</p> <p>8. Final draft of all 7 modules of the Essential Childbirth Care (ECBC) course completed;</p> | | <p>1. ENAP Progress Report (2015)</p> <p>http://www.who.int/life-course/news/enap-press-release/en/</p> <p>2. Global Maternal Newborn Conference website www.globalmnh2015.org</p> <p>3. Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health (2014)</p> <p>http://www.who.int/medical_devices/md_maternal_v12_web.pdf</p> <p>4. Global standards for quality health care services for adolescents</p> <p>http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/</p> <p>5. Essential Newborn Care Training course</p> <p>http://apps.who.int/iris/bitstream/10665/70540/3/WHO_MPS_10.1_Training_file_eng.pdf</p> |

Area 4: Address the urgent need for skilled health workers, particularly midwives and other related cadre of personnel, including community health workers, and related modalities for maximizing delivery, such as task-shifting.

| | | | |
|------|---|----------------|---|
| 2012 | "Global Standards for Quality Health Care Services for Adolescents" | WHO and UNAIDS | www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/ |
| | Midwifery Services Framework (draft). | UNFPA | http://internationalmidwives.org/projects-programmes/midwifery-service-framework.html |
| 2014 | High Burden Countries Initiative (HBCI) – Technical Guidance and ongoing country Midwifery workforce assessments. | UNFPA | http://www.icsintegrare.org/wp-content/uploads/2016/02/SRMNAH-Handbook.pdf |
| 2015 | <p>1. Midwifery Service framework developed, printed and disseminated.</p> <p>2. Development of the CHW's RMNH training guidance.</p> <p>3. Assessments initiated of Midwifery Workforce (MWA) in Mozambique and The Tanzania report, final, is still with the government for Final approval. No other workforce assessment is planned at this stage.</p> | UNFPA | <p>1. ICM Midwifery Service Framework</p> <p>http://www.internationalmidwives.org/assets/uploads/documents/Manuals%20and%20Guidelines/MSF%20for%20field-testing,%2017Mar15.pdf</p> <p>2. Developed with WHO as indicated by WHO</p> <p>3. Report in progress of finalization;</p> <p>4-5. SoWMy Report</p> <p>http://www.unfpa.org/sowmy</p> |

| Year | Product | Agency | Link |
|---|--|-------------------|---|
| 2015 | <p>4. development and release of SoWMY report in June 2014.</p> <p>5. The SoWMY report disseminated in 26 countries for advocacy to mobilise political and administrative support for Education, Regulations and associations of midwives.</p> | UNFPA | |
| <p>Area 5: Support countries to address demand-side barriers to access to services, especially for the marginalized and most vulnerable, particularly through community engagement, and community health workers.</p> | | | |
| 2012 | <p>1. Three regional workshops for dissemination of MWA organised at Bangkok (Asia & Pacific region), Dakar (West and Central Africa) and Cairo (Arab states);</p> <p>2. Three regional gap analysis workshop - first at Senegal for Senegal, Chad, Mauritania, Mauritius and Guinea cockery, second at TOGO for Mali, Niger, Ivory Coast, Benin, Burkina feso and Togo and Kenya organised;</p> <p>3. Midwifery service framework field tested at Lasotho and Bangladesh;</p> <p>4. Quality of care during childbirth: evidenced based statements, inputs, outputs and outcomes developed on experience of care (respect and dignity, communications, emotional support) to ensure updated tools align to QoC midwifery</p> | UNFPA | <p>1. Workshop reports with no link</p> <p>2. Regional workshop report with no link</p> <p>3. Midwifery Service Framework Field Test Framework with no link</p> <p>4. Link yet to be developed</p> |
| | Project briefs developed and disseminated. | UNFPA | http://www.slideshare.net/EveryWomanEveryChild/h4-activities-and-plans |
| 2013 | Strategic communications and advocacy platforms in place. | UNFPA | <p>https://docs.google.com/file/d/1hjoGHMzIDtbFBeujX90iRC9sTi3hjzazOTmZL_sJzTgmV1Kq5GMyBlkkTiw6/edit</p> <p>http://intearare.es/?p=1363</p> |
| 2014 | RMNH training guidelines for CHWs developed. | UNFPA | A mapping of existing training tools for CHWs in SRH/MNH is available on the WHO website. |
| | Development of Zero Discrimination in Health Care and putting human rights on fast track. | UNAIDS | http://www.unaids.org/en/resources/presscentre/featurestories/2016/march/20160301_health-settings |
| | The mapping of tools to assess and address HIV-related stigma and discrimination in health care. | UNAIDS | https://www.dropbox.com/s/9tfrutxuiqzxm2c/UNAIDS%20-%20Human%20Rights%20Mapping%20Tools%20S%26D%20in%20healthcare%20settings%20-%20draft.pdf?dl=0 |
| 2015 | The Legal Barriers/Age of Consent Advocacy Pack The Age of Consent Reform Advocacy Pack for Legal Barriers to Access Health Services, including HIV testing and treatment | UNAIDS and UNICEF | Semi-public link. Request access through http://dev.ecp-geo.nam.org.uk/ |
| | <p>1. Country case study fact sheets published and disseminated for Burkina Faso, Cameroon, Serra Leone, Zambia and Zimbabwe. Liberia under development.</p> <p>2. An integrated C4D guide on MNCH prepared and rolled out in multiple countries.</p> | UNICEF | http://www.who.int/maternal_child_adolescent/documents/imci_community_care/en/ |

| Year | Product | Agency | Link |
|--|---|--------|--|
| Thematic Area 3: Equality | | | |
| Area 6: Tackle the root causes of maternal, newborn and child mortality and morbidity, and HIV including gender inequality, low access to education (especially for girls), child marriage and adolescent pregnancy. | | | |
| 2015 | <ol style="list-style-type: none"> 1. Three modules (first draft) have been developed by WHO to help RMNCH teams to support community groups, using participatory learning with women's groups, to improve maternal and newborn health. The modules describe the roles and responsibilities of programme manager, supervisor and facilitator (community health worker) and will be included in the existing WHO/UNICEF manual 'Caring for Newborns and Children in the Community'. 2. draft Gender Equality Framework for RMNCAH developed and under review through key stakeholders. 3. Set of modules developed in partnership with WHO, Women and Children First and UNICEF for Improving quality of maternal and newborn health to women's groups in rural settings. Ongoing participatory review with women networks in Ethiopia, Bangladesh, Cote d'Ivoire and priority Global Plan countries. 4. Developed and finalised of the 'Planning handbook for caring for NB and children in the community. 5. Three modules (first draft) have been developed to support community groups, using participatory learning with women's groups, to improve maternal and newborn health. The modules describe the roles and responsibilities of programme manager, supervisor and facilitator (community health worker) and will be included in the existing WHO/ UNICEF manual 'Caring for Newborns and Children in the Community'. | WHO | <ol style="list-style-type: none"> 1. Caring for newborns and children in the community (2015) http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/ 2. Gender and RMNCAH: A framework for action (2015) http://genderandaids.org/rmncah/wp-content/uploads/2016/05/Gender-and-RMNCAH-Framework.pdf 3. Caring for newborns and children in the community (2015) http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/ 4. Positive health, dignity and prevention for women and their babies http://www.gnpplus.net/resources/treatment-literacy-guide-for-pregnant-women-and-mothers-living-with-hiv-2/ 5. Caring for the newborn at home Caring for newborns and children in the community http://www.who.int/maternal_child_adolescent/documents/caring-for-the-newborn-at-home/en/ |
| | Literacy and advocacy kit to specific country contexts and to support pregnant and breastfeeding women groups and networks of women living with HIV, in communities with limited levels of literacy. Tool 1 and 2 | UNAIDS | <p>Tool 1. (under review) and Tool 2.</p> <p>http://www.gnpplus.net/treatment_literacy_for_pregnant_women_and_mothers_living_with_hiv/; http://www.gnpplus.net/assets/wbb_file_updown/5325/Facilitators%20Manual%20English%20Treatment%20literacy%20PMTCT.pdf</p> <p>http://www.gnpplus.net/assets/wbb_file_updown/5325/FlipChart%20English%20Treatment%20literacy%20PMTCT.pdf</p> <p>http://www.gnpplus.net/assets/wbb_file_updown/5325/Poster%20English%20Treatment%20literacy%20PMTCT.pdf</p> <p>http://www.gnpplus.net/assets/wbb_file_updown/5325/Guide%20Animatrice%20Francais%20Treatment%20literacy%20PMTCT.pdf</p> <p>http://www.gnpplus.net/assets/wbb_file_updown/5325/FlipChart%20Francais%20Treatment%20literacy%20PMTCT.pdf</p> <p>http://www.gnpplus.net/assets/wbb_file_updown/5325/Poster%20Francais%20Treatment%20literacy%20PMTCT.pdf</p> |

| Year | Product | Agency | Link |
|------|---|----------|---|
| 2015 | Annotated bibliography of community-based delivery service costing methodologies compiled and to be published in 2016 | UNAIDS | https://www.dropbox.com/s/venqy077vadm2c9/UNAIDS%20Annotated%20Bibliography%20of%20Community%20Based%20Costing%20Methodologies.docx?dl=0 |
| | Two Community Engagement Indicators developed by CEWG | UNAIDS | https://www.dropbox.com/s/7dhsqyrtcvtyz6/UNAIDS%20-%20CE%20Indicators%20for%20pilot%20test%2013.10.2015%20Cote%20d%27Ivoire%20NCPI%20EMTCT%20validation.doc?dl=0 |
| | People Living with HIV E-analysis tool for the Stigma Index methodology developed to empower networks of PLHIV to analyse and clean up data and generate further analysis through RMNCAH lens | UNAIDS | Semi-public link. Request access through http://dev.ecp-geo.nam.org.uk/ |
| | Global Consultation with Adolescent and Youth Leaders in Harare, Zimbabwe. Goal: a roadmap that helps take the All In response process forward in the 25 focus countries. | UNAIDS | https://www.dropbox.com/s/s1m8xohxg1c1crl/UNAIDS%20-%20Brief%20All%20In%20Report%20-%20Harare.docx.pdf?dl=0 |
| | Draft Gender Equality Conceptual Framework for RMNCAH developed - global / Regional consultation held. Finalization after consultation planned for Women Delivers Conference | UN Women | http://genderandaids.org/rmncah/ |

Thematic Area 4: Accountability

Area 7: Strengthen monitoring and evaluation systems to ensure availability of credible data in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health

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| 2011 | A tool for rapid assessment of national (and district) RMNCH plans has been drafted based on how to conduct a Joint Assessment of a National health Strategy (JANS), drawing from country experience. | UNICEF | Link yet to be developed |
| 2012 | Capacity strengthening in 3 SIDA countries focused on strengthening the capacity of national programme managers | UNICEF | Workshop report with no link |
| 2014 | Technical support provided to countries to assess barriers and challenges to increase demand for MNH during regional C4D workshops at West, Central and Southern Africa | UNICEF | Workshop report with no link |
| 2015 | <ol style="list-style-type: none"> 1. BMC Supplement published highlighting the bottlenecks and recommendations for overcoming for nine high impact maternal-newborn interventions. 2. ENAP Progress Tracking Tool revised, used and data collated from 16 of the 28 ENAP high burden countries. 3. Support was provided to Bottle neck Analysis and situation assessments in Iraq, Nepal and Malawi. Based on this work, Nepal and Malawi have developed their National Plans for newborn care and Iraq is in progress. 4. The m-health interventions and Rapid-Pro for community reporting | UNICEF | <ol style="list-style-type: none"> 1. BMC Supplement https://www.everynewborn.org/wp-content/uploads/2015/09/Overview-of-Series.pdf 2. Bottle Neck Analysis https://www.dropbox.com/s/t4a8rw3m87mmdbg/Every-Newborn-Bottleneck%20Analysis%20tool-12-August-2013.pdf?dl=0 3. ENAP Progress Report https://www.dropbox.com/sh/0qu8lx8uf5vv7fz/AACr5W2mVeTbq3mLpeaZBV1ea?dl=0 (5) Link yet to be developed |

| Year | Product | Agency | Link |
|------|---|--------|------------------------------|
| 2015 | were documented and disseminated included on pregnancy and newborn care and on Ebola at different fora including Mexico GMNH Conference. | UNICEF | |
| | Di-Monitring tool modified and face to face training of all 10 country teams organised in May 2015 at Cote D'Ivoire for francophone countries and in Zambia for anglophone countries. | UNFPA | Training report with no link |

Area 8: Documentation, evaluation, and sharing of best practices of the H4+ mechanism and country efforts

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| 2011 | H4+ undertook a survey of 57 countries who have made commitments to the Global Strategy, to assess progress, gaps, country needs as well as explore the role of H4+ partners in supporting implementation of the commitments. | WHO | http://www.who.int/reproductivehealth/global_strategy_women_children/en/index.html |
| 2012 | Mapping of progress and needs in implementation of country commitments: Survey of 53 countries committed to the Global Strategy. | WHO | http://www.who.int/reproductivehealth/global_strategy_women_children/WHO_H4-report_tables.pdf |
| | Country profiles including baseline information in areas according to H4+ scope of work. | WHO | https://docs.google.com/file/d/1hjoGHMzIDtbFBeujX9OiRC9sTi3hjzazOTmZl_sJzTgmV1Kq5GMyBlkkTiw6/edit |
| | A matrix for data analysis reflecting the H4+ scope of work and SharePoint site and web site. | WHO | http://workspace.who.int/sites/H5/default.aspx |
| 2013 | H4+ progress report 2013 developed, acknowledged by member states and partners and by the independent expert group on Women's and Children's health. | WHO and UNFPA | http://www.everywomaneverychild.org/images/content/files/9789241506007_eng.pdf |
| 2014 | <ol style="list-style-type: none"> 1. Survey of H4+ support to countries updated to reflect Global H4+ Results Framework finalized in 2014, including a section on value added of H4+ mechanism, as well as achievements and challenges. 2. Survey disseminated to 58 countries, 44 of which completed the survey including all Canada-funded countries. 3. Data to form the base of H4+ 2014 Progress Report and serve as a baseline for future monitoring of H4+ support. | WHO and UNFPA | The H4+ partnership Joint support to improve women's and children's health Progress report (June 2014) http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf |
| 2015 | <ol style="list-style-type: none"> 1. Survey of H4+ support to countries in 2014, responded to by 62 countries, provided an overview of H4+ coordination, functionality, and activities in 2014; looked across 2013 and 2014 to examine the trajectory of H4+ work overtime. 2. Offered insight the post-2015 development agenda initiatives by documenting H4+ lessons learnt on interagency collaboration and joint implementation. | WHO and UNFPA | The H4+ partnership Joint support to improve women's and children's health Progress report (June 2014) http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf |

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How the H6 partnership provides joint support to improve women's and children's health

