H6 Partnership Annual Report 2017

Collective drive to improve the health of women, children and adolescents everywhere

UNAIDS UNFPA unicef UN WOMEN World Health Organization THE WORLD BANK

Contents

Tables

Figures

Boxes

Abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
BEmONC	Basic emergency obstetric and newborn care
C4D	Communication for Development
CEmONC	Comprehensive emergency obstetric and newborn care
CHW	Community Health Worker
EID	Early Infant Diagnosis
EmONC	Emergency obstetric and newborn care
EMTCT	Elimination of mother-to-child transmission (of HIV)
EU	European Union
ENAP	Every Newborn Action Plan
EPMM	Ending Preventable Maternal Mortality
EWEC	Every Woman Every Child
FP	Family planning
GBV	Gender-based violence
GFF	Global Financing Facility
GS	Global Strategy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human resources
HSTP	Health System Transition Plan
HW	Health worker
ICM	International Confederation of Midwives
IMCI/IMNCI	Integrated Management of (Newborn) and Childhood Illnesses
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MNCH	Maternal, Neonatal and Child Health
MNCAH	Maternal, Newborn, Child and Adolescent Health
MNH	Maternal and Neonatal Health
MoH/FMoH	Ministry of Health
MWH	Maternity Waiting Home
NGO	Non-governmental organization
PMNCH	Partnership for Maternal, Neonatal and Child Health
PMTCT	Prevention of mother-to-child transmission (of HIV)
PoC	Point of care
QoC	Quality of care
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RMNCH	Reproductive, maternal, newborn and child health
Sida	Swedish International Development Cooperation Agency
SRMNCAH	Sexual, reproductive, maternal, newborn, child and adolescent health
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and reproductive rights
STI	Sexually transmitted infection
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSG	United Nations Secretary-General
USAID	United States Agency for International Development
WHO	The World Health Organization

Acknowledgements

The H6 Partnership representing UNAIDS, UNFPA, UNICEF, UN Women, the World Health Organization and the World Bank wishes to express deep gratitude to Sweden for generous support to the H6 Joint Programme in 2017 (support from Canada concluded in 2016 as planned). The support received from the Swedish International Development Cooperation Agency (Sida) represents an important contribution and accelerates the implementation of the commitments made to the United Nations Secretary-General's Global Strategy as part of Every Woman Every Child. In 2017, the Sida grant supported the six countries of the H6 Joint Programme: Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe.

We wish to acknowledge the H6 country teams and their efforts, through ownership and leadership of the Ministry of Health, to plan, monitor and implement programmes effectively. We wish to acknowledge the regional and global technical teams and the principals whose support gave shape to the H6 Partnership to become the technical arm of the Every Woman Every Child movement. Special thanks go to the national governments represented by Ministries of Health and implementing partners for their leadership, stewardship and ownership in championing the issues of sexual, reproductive, maternal, newborn, child and adolescent health. Finally, the H6 Partnership wishes to recognize the hard work carried out by health care providers, community leaders and community members, including women themselves, who made possible this impactful, transformative and catalytic programming.

Executive Summary

Demand for technical support from the H6 Partnership has increased significantly in recent years, largely in response to the demand for and proliferation of national-level initiatives in sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH). For example, countries that have developed investment cases for SRMNCAH (under Global Financing Facility Trust Fund support) have relied extensively on the technical support of the H6. This support was supported in part through funding from the H6 Joint Programme. The H6 has an important role to play in ensuring optimum utilization of the financial resources invested in SRMNCAH programmes to achieve results.

The H6 Partnership builds on the progress made towards the Millennium Development Goals (MDGs) and contributes to the collaboration required to support countries as they move forward to achieve the Sustainable Development Goals (SDGs). This joint partnership of six United Nations agencies, functional since 2008, started supporting the UN Secretary-General's Global Strategy for Women's and Children's Health from 2010, and subsequently the updated Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), also known as Every Woman Every Child (EWEC). The H6 Partnership focuses on 75 high burden countries where more than 85 per cent of all maternal and child deaths occur, including the 49 lowest income countries.

The H6 Joint Programme, the operational programme implemented by the H6 Partnership, has received support from Canada and the Swedish International Development Cooperation Agency (Sida) for a total of $99.76 million. The aim is to provide catalytic and strategic support to national health systems to address the root causes of poor maternal and child health outcomes in 10 countries: Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea-Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe, along with global-level activities. Collaboration with Canada started in 2012 and ended in 2016, whereas collaboration with Sida covers 2013 to 2018. Therefore, this report reviews progress for 2017 for Sida support only.

H6 Joint Programme country level progress 2017

During the reporting period, H6 Joint Programme countries completed planned activities. Four countries (Cameroon, Ethiopia, Guinea-Bissau and Liberia) received no-cost extensions for 2017 to complete planned activities, whereas Côte d'Ivoire and Zimbabwe completed activities in the pipeline at the end of 2016. The programme design followed a health systems building blocks strengthening approach. In 2017, activities at country level were confined to evidence-informed upstream work to strengthen national strategies and plans. This improved the service environment of intervention facilities and enhanced skills for 1,227 individuals, to strengthen human resources for health.

Looking at Sida's support from 2013 through 2017, the vast majority of expenditures were made at the country level (87 per cent) compared with the global level (10 per cent), and some 3 per

cent was spent on programme management, monitoring and evaluation. Four outputs account for 81 per cent of country level expenditures: health technologies and commodities, human resources for health, information systems and service delivery. The output receiving the lowest level of investment was health financing, with just 1 per cent of all expenditures.

The partnership's global-level progress

In 2017, the H6 continued to mobilize political support for the Every Woman Every Child movement and for the health targets of the Sustainable Development Goals. Advocacy continued among national governments across the H6 Partnership's 75 focus countries. The end line evaluation findings were effectively disseminated, reaching a variety of stakeholders including development partners and the donor community at the global level, as well as national-level partners in the ministries of health, academia, NGOs and implementing partners, among others. The resource mobilization efforts and discussions were initiated with potential donors for future collaboration.

The H6 Partnership contributed to the implementation of several new global efforts. These included global strategies like the Global Strategy for Women's, Children's and Adolescents' Health; Global Financing Facility (GFF); Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM). H6 further received a five-year extension of collaborative funding from the French Muskoka Initiative for countries of West and Central Africa. Ten million Euros have been allocated for the first year, with budgets for the following years to be decided on an annual basis.

Looking back and moving forward

At country level, the H6 Partnership continued to help advance the goals of Every Woman Every Child, as the constituency with the most extensive reach in countries with a high burden of maternal and child mortality and morbidity. The EWEC Global Strategy is a detailed roadmap for countries to begin implementing the Sustainable Development Goals, reducing inequities, strengthening fragile health systems and fostering multi-sector approaches to end all preventable deaths of women, children and adolescents and ensure their health and well-being. The H6 is the technical arm of the Global Strategy.

The H6 Partnership's strategic interventions for the coming years are underpinned by principles of human rights and gender equality and aligned with the milestones and strategic interventions of the EWEC Result Framework 2020. This aims to harmonize actions across the EWEC ecosystem, which includes the H6, Global Financing Facility and the Partnership for Maternal, Neonatal and Child Health (PMNCH). This will work across sectors and partners engaged in implementing the EWEC Global Strategy, helping to maintain country focus, joint programming and complementarity of existing efforts to magnify results.

Section 1. Progress of the H6 Joint Programme

One of the first and most ambitious operational programmes implemented by the partnership was the H4+ Joint Programme Canada and Sweden, subsequently renamed the H6 Joint Programme. The H6 collaboration with Canada and Sweden mobilized a combined grant of $99.76 million to accelerate progress towards MDG 4 to reduce child mortality and MDG 5 to improve maternal health in 10 countries in sub-Saharan Africa. The grant also enabled H6 partners at the country, regional and global levels to generate and disseminate knowledge and strengthen capacity for achievement of the Millennium Development Goals related to reproductive, maternal, newborn, child and adolescent health (RMNCAH).[1]

In 2016, the H6 collaboration with Canada concluded, as planned. The H6 collaboration with Sida received a no-cost extension for 2017 to complete approved activities at country level and in 2018 to undertake actions on the management responses to the end line evaluation. The programme interventions were divided into two categories of global and country-level activities.

Table 1: Sweden's grant funding for H6 Joint Programme in six countries

Supporting grant funding	Eligible countries
Sweden (Sida)	Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia, Zimbabwe

At the global level, activities generally fall into three types:

- Development and dissemination of global knowledge products, including lessons learned;
- Capacity development initiatives of country teams and key stakeholders from 75 high burden countries in order to strengthen national capacity around the design, implementation and monitoring of RMNCAH strategies;
- Advocacy initiatives for greater action and investment for RMNCAH.

The joint results framework[2] is the basis for joint coordinated implementation. It has four thematic areas (Policy Planning and Costing, Quality, Equality, and Accountability). Each thematic area is further divided into action areas. In the eight action areas, which correspond to four thematic areas, deliverables are associated with the 17 outputs to be achieved by the programme.

[1] SRMNCAH is used for post-2016 new H6 efforts. The H6 Joint Programme interventions were confined to RMNCAH.

[2] The joint results framework was established in 2013 for global-level activities supported under the grant. For country-level activities, a monitoring and evaluation framework is used to track progress following an extended health system building block approach.

The six countries covered through the H6 Joint Programme (Sida) are low-income and lower middle-income and ranked among the lowest in the UNDP Human Development Report, with high maternal, infant and child mortality rates. While all of these countries face some constraints and challenges, each demonstrates the potential for success in reducing maternal and child deaths as well as in expanding provision of integrated services.

1.1 H6 Joint Programme at country level

The programme is designed to provide catalytic and strategic technical support for RMNCAH to strengthen national health systems in line with national health plans through the close collaboration of regional level. The programme design at the country level follows an expanded "health system building block" approach that includes leadership and governance, financing, technologies and commodities, human resources, health information and service delivery, community ownership and demand generation, as well as advocacy for mobilizing commitments and resources. Where possible, existing national platforms for coordination received support to facilitate implementation and provide oversight at the national, provincial and subnational levels.

Five of the six programme countries focus on a subset of health districts with poor RMNCAH outcomes, usually in underserved and hard-to-reach districts, with the exception of Ethiopia.

National-level interventions strengthen policy, strategies, guidelines, procedures and health systems as a whole to create an enabling environment for enhancing access to quality RMNCAH services, as well as to provide strategic support to reinforce management subsystems.

Subnational-level interventions complement or supplement ongoing efforts through catalytic and evidence-based integrated provision of RMNCAH information and services. This informs policy by drawing lessons from the implementation on the ground. Such intervention areas are chosen based on remoteness, geographical inaccessibility, low coverage of health interventions, and representation of marginalized population subgroups.

During programme planning, 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 and morbidity. The local context was prioritized and interventions were rolled-out in a holistic manner. Each country team, under the leadership of the respective Ministry of Health and in consultation with local key stakeholders, identified needs and priority interventions in alignment with the agreed monitoring and evaluation framework. The proposed policy and programme interventions were based on global evidence and evidence from other countries that had demonstrated success in improving health outcomes for women and children. Community participation and demand generation interventions were integrated with supply-side interventions. For the reporting period 2017, the focus was to complete planned activities of the previous year. Hence, interventions covered only the process-intensive outputs

of the programme, focusing on four out of eight that remained incomplete by end of 2016 (Outputs 1, 3, 4 and 6).

Challenges faced in the implementation phase

Countries in the H6 Joint Programme faced challenges during the implementation phase. In all countries, extra efforts and context-specific strategies were deployed to mitigate challenges around weak health management information systems (HMIS), scarcity of skilled providers, the ad hoc management of logistics management information systems, and lack of community ownership of health programmes. In some countries, implementation was hampered by the onset of humanitarian emergencies.

The Ebola crisis emerged in **Liberia** in mid-2014. In response, activities were reprogrammed to focus on reinforcing maternal and newborn health services weakened by the crisis.

In **Zimbabwe**, the challenge was geographic spread, with six intervention districts dispersed along the border of the country. In order to provide supervision and monitor progress, the chain of coordination was ensured at the national, provincial and subnational levels.

Côte d'Ivoire faced a high turnover of health functionaries in the intervention areas. Rigorous in-service trainings were organized to ensure the availability of skilled providers in the identified health facilities.

In **Cameroon**, the intervention districts in the Northern Province were affected by Boko Haram, leading to insecurity and high levels of vacancy among skilled providers. The H6 country coordinator was located in the province for enhanced coordination with authorities and interventions for skills enhancement and community participation that covered the entire range of facilities from health post (grassroots) to secondary-level health facilities. Programmatic support to the communities helped health care providers to overcome threat perception.

Ethiopia struggled with competing priorities on a tight schedule, high staff turnover rates at all levels, and a generally weak system of monitoring and supervision. The focus of the programme was to enhance the skilled human resource base for women and children's health by committing more than half of the available resources (US$ 4.9 million) under the H6 Joint Programme.

A volatile political climate in **Guinea-Bissau** saw the introduction of four successive governments from 2015 onward. The political turnover slowed programme implementation. The H6 support focused on building national capacity with skilled human resources, towards a cadre of RMNCAH service providers.

Output 1: Leadership and governance: Policy-level support to strengthen leadership and governance of national health systems

In each of the six countries, the H6 interventions aligned with the 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 RMNCAH;
- Capacity-building and promoting the use and implementation of evidence-based protocols and standards to improve the quality of RMNCAH services;
- Supporting the development of strategy and policy documents for RMNCAH and the removal of financial barriers to access RMNCAH care services;
- Strengthening and monitoring processes to improve effectiveness as well as accountability, including maternal death surveillance and response (MDSR);
- Supporting Ministries of Health, programme managers and health workers to integrate gender-responsive measures in policy, programming, and service delivery for RMNCAH.

In 2017, key results at the **policy level** included the following:

- **Cameroon** disseminated the national policy on community health;
- **Ethiopia**'s accomplishments included the development of a national strategy to eliminate mother-to-child transmission of HIV, national guidelines on prevention of mother-to-child transmission of HIV (PMTCT) and congenital syphilis, a national roadmap for MNCH quality of care and a plan of action to eliminate preventable obstetric haemorrhage deaths.
- **Guinea-Bissau** reported the development of its National Every Newborn Action Plan (ENAP); national guidelines for the evaluation of the quality of maternal, child and newborn care; and the assessment of equity in immunization in three regions (Gabu, Tombali and SAB) along with recommendations to improve coverage. The Health Sector Coordination Committee at the national level and regional level also received support to function effectively; the committees are under the leadership of senior political representatives (governors and regional secretaries).
- In **Liberia**, the National RMNCAH 2015–2016 operational plan was reviewed and the 2017–18 plan was then developed.

Output 3: Health technologies and commodities: Support for improved service environment (equipment, infrastructure and supplies)

Support under this output aimed to improve the service environment, particularly in reducing stock-out rates for the essential drugs and medicines required for maternal and child health, and provision of essential equipment and supplies for RMNCAH services at intervention facilities.

Referral linkages in all countries were strengthened through improved communication at all levels of initiating and receiving referrals; in addition, provision of ambulances enhanced connectivity between communities and primary and secondary health facilities.

In 2017, progress for an **improved service environment** included the following:

- Blood transfusion bags (10,000) were purchased for use in 30 districts, including support to collection of donor blood and quality assurance in **Côte d'Ivoire**;
- In **Cameroon**, newborn resuscitation kits were distributed to the 91 intervention facilities in the far north region;
- Autoclaves were installed and made operational to ensure the quality of maternal and newborn services in 19 maternity health facilities of **Ethiopia**;
- **Guinea-Bissau** reported procurement and distribution of essential drugs, instruments, and medical consumables to 75 health facilities in seven intervention health regions for the provision of quality mother and child health services;
- Efforts to revive maternal and newborn care in six counties of **Liberia** continued in 2017, where installation of medical equipment finalized in 18 intervention health facilities and a need-based running water supply facility was established at seven intervention health facilities. In six intervention counties, 25 health facilities were made functional for the provision of RMNCAH services, contributing to the Ebola recovery phase of the national health system.

Output 4: Skilled human resources for health

Each H6 Joint Programme country was equally challenged by a scarcity of skilled health care workers for the provision of RMNCAH care (especially in remote geographic areas) to enhance maternal and child survival and health. About one third of the total programmable funds were committed in 2013–2017 to enhance the base of skilled human resources through in-service and pre-service trainings. An increase in deliveries attended by a skilled birth attendant is reported in the intervention facilities of all countries due to an increase in availability of skilled human resources.

In 2017, key results in **human resources for health** included the following:

- During 2017, about **1,227 health functionaries received training** in a wide range of skills in the areas of emergency obstetric and newborn care (EmONC), Integrated Management of Newborn and Childhood Illnesses (IMNCI), family planning, PMTCT, newborn care, community awareness and pre-service training. This includes enhancing quality and capacities of the training institutions and trainers.

Table 2: Training for improved skills and competencies in RMNCAH

No.	Country	Maternal health*	Newborn and infant care	HIV prevention and treatment	Family planning	Youth-friendly health care	Health care management	Community Health Workers	TOTAL
1	Ethiopia	340	64	–	–	–	–	–	404
2	Guinea-Bissau	223	–	–	–	–	–	–	223
3	Liberia	158**	158**	158**	98	–	38	250	544
4	Zimbabwe	–	36	–	–	–	20	–	56
	Total	**563**	**258**	**158**	**98**	–	**58**	**250**	**1,227**

* EmONC/BEmONC/CEmONC, midwifery, MCH aides, SRMNCH, MDR and working with individuals, families and communities approach.

** Joint training for RMNCH

- In **Zimbabwe**, the first national training on the IMNCI Computerized Adaptation and Training Tool (ICATT) was organized in 2017. The aim was to improve the quality of pre-service training for paediatricians and nurse tutors in training schools and to build capacity for programme management among 20 district managers from six intervention districts.

- In **Ethiopia**, the focus was on enhancing the quality of skills enhancement trainings. In training of trainers, a total of 49 trainers participated in an integration of midwifery clinical practicum to improve the quality of hands-on trainings; participants represented midwifery departments of all universities and midwifery clinical practicum hospitals. Similarly, a training of master trainers was held to support the Federal Ministry of Health's (FMOH) objective to ensure compassionate and respectful care; participants represented FMOH, Human Resources Development (HRD) Directorate, regional health bureaus, universities and hospitals.

- In **Guinea-Bissau**, an acute shortage of anesthesiologists in 11 regional hospitals representing the entire country has been overcome by mobilizing an international consultant from Cuba to conduct a rigorous year-long training of 34 nurses as Nurse-Anesthesiologists. At the end of training in April 2017, 32 of the 34 participants succeeded in passing their qualifying exams. Their skilled service provision has increased the capacity of secondary-level health facilities to deliver high-quality comprehensive emergency obstetric and newborn care, and supported a variety of surgical treatments.

- In **Liberia**, activities aimed to enhance the monitoring and supervision of pre-service midwifery training institutions for compliance with the curriculum, standards and national guidelines for midwifery and nursing practice. Logistical, financial and technical support was provided to the Liberia Board for Nursing and Midwifery. An emphasis on coaching and mentoring to improving quality of care for RMNCAH services continued throughout 2017 at intervention facilities in six of country's 15 counties.

An analysis of the M&E framework for 2013–2017 reveals that Ethiopia and Liberia exceeded their targeted training benchmarks for the proportion of health care providers with EmONC skills. In Liberia, at the request of national health authorities, training was also conducted with health functionaries from non-intervention health facilities, helping to compensate for turnover among skilled EmONC providers. Côte d'Ivoire and Zimbabwe fully achieved their training targets. Cameroon fell short of its targets due to the lack of skilled trainers available to impart EmONC training, though it did achieve its targets for the training of community health workers. Cameroon, Côte d'Ivoire, Liberia and Zimbabwe fully achieved their targets for training community health workers for community-based RMNCAH, while Ethiopia and Guinea-Bissau fell short by a small margin.

The H6 Joint Programme has made a significant contribution to improving the capacity of health services staff to provide essential services in RMNCAH, especially, but not only, at the subnational level. The renewed confidence and professional pride that comes alongside gains in skills and competencies were endorsed by the end line evaluation. The end line evaluation also reported that by strengthening confidence and professional pride, capacity development investments also improved the motivation of health services staff.

Output 6: Health service delivery: Improved quality and access to integrated RMNCAH services

H6 supported the provision of skilled human resources, strengthening service environments and referral systems in 452 health facilities in the six countries of the H6 Joint Programme (Sida). Two major achievements were reported by all countries: (1) enhancement of access to quality EmONC services, and (2) integration of PMTCT with the RMNCAH service package at health facilities.

Five of the six H6 Joint programme countries (with the exception of Ethiopia) followed a strategy of targeting a sub-set of health districts with poor outcomes in RMNCAH, usually under-served and hard-to-reach districts.

Table 3: Geographic targeting of H6 Joint Programme countries

Country	Geographic target	Intervention population coverage	Key criteria used for selection
Cameroon	Seven districts in the Far North region out of 189 districts of the country	970,000 people (45% of the total national population)	Low levels of RMNCAH services High incidence of home deliveries High maternal and neonatal death ratios High prevalence of poverty
Côte d'Ivoire	Eight health districts in three regions out of 72 districts of the country	1.4 million people (7% of the total national population)	Poor indicators in maternal and child health Most urgent unmet needs in MNCH
Ethiopia	—	—	No discernible geographic targeting but activities are supported at the district level
Guinea-Bissau	All regions but with special emphasis on 7 out of 11 regions	900,000 people (50% of the total national population)	Highest child and infant mortality ratios
Liberia	Originally three counties with three added later out of 15 counties	642,847 population (17% of the total national population)	Underserved counties Poor geographic access (hard-to-reach) Remote rural populations
Zimbabwe	Six districts out of 40 districts representing all six provinces of the country	1.2 million people (10% of the total national population)	High burden of maternal morbidity and mortality Poor geographic access (hard-to-reach) High levels of poverty and illiteracy One district from each of the six provinces of the nation

In 2017, results in **health service delivery** included the following:

- **Cameroon** focused on facilities in an area facing insecurity through community-based interventions and outreach services.
- **Côte d'Ivoire** successfully integrated family planning, voluntary HIV testing and cervical cancer screening with RMNCAH programme priorities.
- **Ethiopia** reported that 105 patients with obstetric fistula were repaired during 2017 at health facilities in Jimma and Arsi University. Transport was provided for the patients and their guardians to enable them to travel to the health facility and back home after the repair. This has restored the women's good health, and most are now advocates providing information to other women in the community.
- **Guinea-Bissau**'s national healthcare system continued to face many challenges in 2017 due to a dynamic external environment. With H6 support, the country strengthened health facilities to provide services and ensure improved health outcomes and strengthened referral linkages. Nine international experts for obstetric, pediatric and anesthesiology specialists were brought in to build the capacity of national health care providers and improve services for maternal, newborn and child health care. During 2017, the pending refurbishment of intervention facilities was completed in five health facilities, including construction of a maternity waiting home in Buba and in Catio; one surgery room in Buba; and one health centre and a residence for health care providers in Gâ-Para. In addition, a mechanism to conduct client satisfaction assessment was established in Simão Mendes National Hospital, aimed at measuring the level of satisfaction of users (especially women). The results of the assessment were used to inform policymakers about the adverse effect of the user fees for pregnant women, women affected by HIV, and survivors of sexual and gender-based violence.
- In **Liberia**, the programme supported Ministry of Health officials to conduct supportive supervision, coaching and mentoring of skilled providers as well as community cadres. The objective was to ensure that RMNCAH service delivery at the intervention facilities conforms to the quality standards. As a result, the intervention facilities reported a significant upward trend in institutional deliveries attended by skilled providers, from 2,953 in the first quarter of 2017 to 4,642 in the second quarter.

Box 1: "Maternal waiting homes" increase access and save lives in remote districts of Liberia

"Our women used to walk many hours in labour pain just because they wanted to give birth to their babies in the clinic," said Junior, a young man who had carried food for his pregnant wife to the maternal waiting home in Boegeezay, Dodain district, Liberia.

"Some people with pregnant woman even came from a distance farther than ours and they would walk sometimes at night on the rough road with flashlights and in some cases, deliveries took place on the road. The women would be very afraid and tired. Thank God for this programme for helping us with the maternal waiting home to save our women and babies," he said.

For many communities in Liberia, long distances to health facilities and bad road conditions have made it difficult for pregnant women to access the services of skilled healthcare providers for safe delivery. In 2016 and 2017, the H6 Joint Programme, in collaboration with the Ministry of Health, established six maternal waiting homes. The homes are accommodations located near (and linked to) a health facility where women can stay towards the end of pregnancy and/or after birth to enable timely access to maternal health services for delivery or for complications. The homes reduce the risk of presenting late at the health facilities for labour and delivery, thereby reducing maternal and newborn death and disabilities.

The maternal waiting home where Junior's wife rested safely is located in Rivercess county in Boegeezay, Dodain district. Before its establishment, about one fourth of deliveries occurred at home. After its establishment, more than 90 percent of deliveries took place in the Boegeezay clinic (145 deliveries in May and June 2017). Most of the pregnant women who deliver at the health facility are from hard-to-reach communities. Additionally, in two cases, a pregnant woman waiting for the initiation of labour at the maternal waiting home manifested obstetric complications and was referred to and managed in time at the St. Francis Hospital, the only referral hospital in the county. In both cases, the mother and baby survived.

Liberia needs many more such initiatives to assure positive health outcomes for every pregnancy and childbirth.

1.2 H6 Joint Programme at global level

One of the main activities at the global level in 2017 was to facilitate the completion of an **independent evaluation** of the H6 Joint Programme. Once completed, a detailed plan was developed to disseminate findings among key stakeholders at global, regional and country level. First, the methodology and outcomes were shared with evaluation professionals, as shown in table 4. At the global level, stakeholders were informed of results through the side events organized at the PMNCH Board meeting and during the United Nations General Assembly. Management response of the H6 partners to the evaluation's findings and their key recommendations were presented to the UNFPA Executive Board in an informal briefing session. At the country level, stakeholders were encouraged to use the results of the evaluation in their respective country planning process, to integrate its recommendations for action in their future programming.

Table 4: Dissemination of evaluation results, 2017

Stakeholders	Time period	Description
Evaluation professionals	March and May 2017	AfrEA meeting in Kampala, Uganda; and UNEG meeting in Vienna, Austria
Global level: Donors, academicians, private sector, international NGOs and UN Member States	May 2017 to January 2018	PMNCH Board Meeting in Ottawa; UNGA side event in New York; and UNFPA/UNDP/UNOPS Executive Board
Country level: Ministries of health and gender & women's empowerment officials, Donors, H6 regional and country partners, academia, NGOs, other key stakeholders	May 2017 to December 2017	Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Guinea-Bissau, Liberia, Zambia, Zimbabwe

Another major activity at the global level was a **series of consultations** organized with the governments of Ethiopia, Kenya, Liberia and Sierra Leone to produce programming guidance and a conceptual framework for SRMNCAH. The consultations engaged a variety of stakeholders from the health sector (including health service providers), other relevant sectors, women's organizations and United Nations partners. Participants in the consultations were presented with a draft framework and guidance and asked to provide feedback and input about how to support gender equality in SRMNCAH interventions. The drafts were well-received and feedback was subsequently incorporated. The intention is to rollout this new programming guidance and framework in 2018, to support gender-responsive SRMNCAH interventions.

During the UN General Assembly session in September 2017, a **side event** of the H6 Partnership was organized for advocacy on women's, children's and adolescents' health towards mobilizing commitment and support from the Member States, donors and development partners. The event was well-attended and several key stakeholders provided positive feedback on the achievements of the H6.

Section 2. Financial management and coordination of the H6 Joint Programme

2.1 Spending by level and output area

The H6 Joint Programme was designed to operate at three levels:

- **Global and regional level:** This is where members of the global technical team work in consultation with members at the regional level to produce global knowledge products, capacity building initiatives, and advocacy for advancing integrated RMNCAH in the programme countries and other high-burden countries.
- **National level:** This is where programme resources are used to finance the H6 country teams and their activities to strengthen national health systems for SRMNCAH.
- **Subnational level**: This is where the H6 Joint Programme provides technical and financial resources in support of the integrated delivery of health services along the continuum of RMNCAH, as well as engagement at the community level for generating demand for improved services.

Table 5: Expenditures by partner and programme level, H6 Joint Programme, 2013–2017 (US dollars)

Partner	Country level	Global level	Programme management	Total	Percentage of total
UNFPA	19,035,488	1,119,412		20,154,900	38%
UNICEF	10,488,062	1,408,465		11,896,526	23%
WHO	9,713,980	1,486,457		11,200,437	22%
UN Women	3,656,483	405,073		4,061,556	8%
UNAIDS	2,176,95	914,626		3,091,592	6%
Programme management, M&E			1,000,000	1,000,000	2%
Administrative agent charges			525,841	525,841	1%
Total	45,070,978	5,334,033	1,525,841	51,930,852	
Percentage of total	**87%**	**10%**	**3%**		**100%**

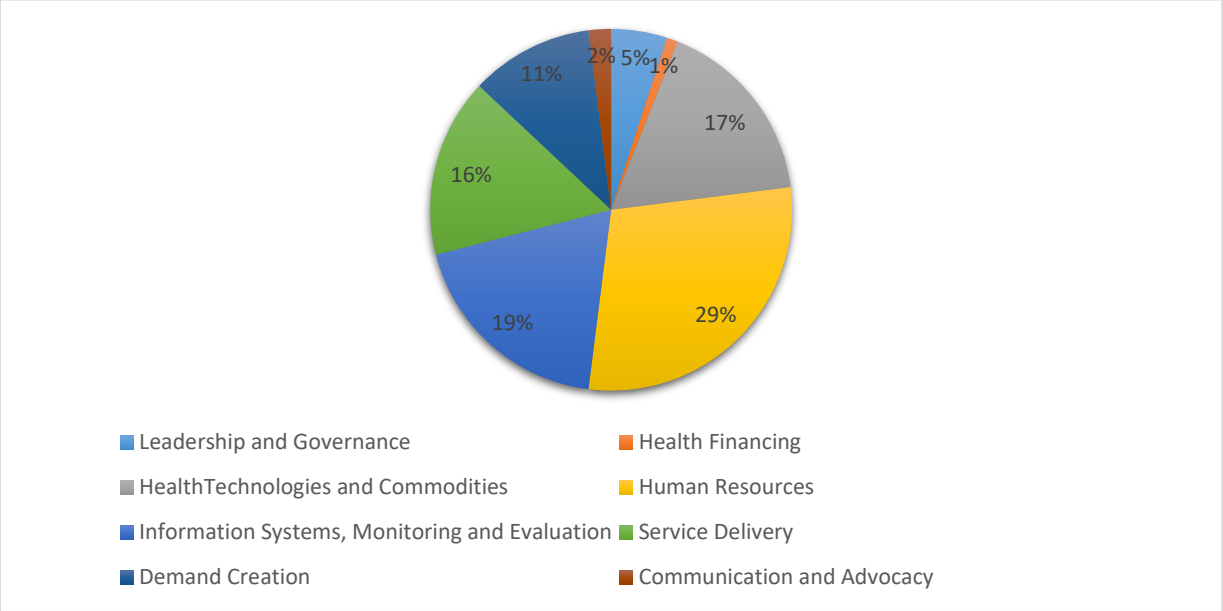
Source: H6 Sida: Final Expenditures, 2013 to 2016 and provisional expenditure 2017.

The breakdown of total Sida support from 2013 to the end of 2017 is as follows: The total expenditure was $51,930,852. Over 87 per cent of all expenditures ($45,070,978) were incurred at country level compared with 10 per cent at the global level ($5,334,033) and 3 per cent on programme management and administrative agent charges ($1,525,841). Programme management includes inter-country meetings, joint missions, annual report, joint steering

committee meetings, mid-term evaluation and end line evaluation. Administrative agent charges pertain to payment to UNFPA to administer the grant.

Country-level expenditures of $45.07 million supported initiatives aimed at eight output areas of health systems strengthening. Most country-level investments were directed at improving the supply of health services and the performance of the public health sector. The six output areas corresponding to the health sector building blocks accounted for 87 percent of all programme expenditures at the country level, while just over 13 percent of expenditures were dedicated to demand creation, communication and advocacy.

Figure 1: Country-level expenditures by output area, H6 Joint Programme, 2013–2017



Four output areas account for 81 per cent of expenditures at country level: human resources for health (29 per cent), information systems and monitoring and evaluation (19 per cent), health technologies and commodities (17 per cent), and support to service delivery (16 per cent).

As part of the H6 Joint Programme, each country planned and made investments as per its identified needs and priorities and to complement existing efforts of its national health system through strategic and catalytic interventions. The health sector building block receiving the lowest level of financial support at country level was health financing, which accounts for only 1 per cent of all expenditures. Four countries reported no programme expenditures in the area of health financing, and two countries (Côte d'Ivoire and Guinea-Bissau) made catalytic investments in health financing.

2.2 At the global level

Programme management

The H6 global technical team provides technical and managerial oversight support for the H6 Partnership. The H6 Joint Programme coordination unit is located at UNFPA and is the administrative agent of the Sida grant. 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 (JSC) meetings and reporting compliance with decisions made. From the inception of the first grant received from Canada in 2011 to date, **15 Steering Committee meetings** have been held; this includes eight held after the grant received from Sida in 2013. The meetings were jointly organized for the Canada and Sida grants until 2016. These meetings addressed appropriation and utilization of funds, reviewed progress and made decisions to enhance the effectiveness of the programme.

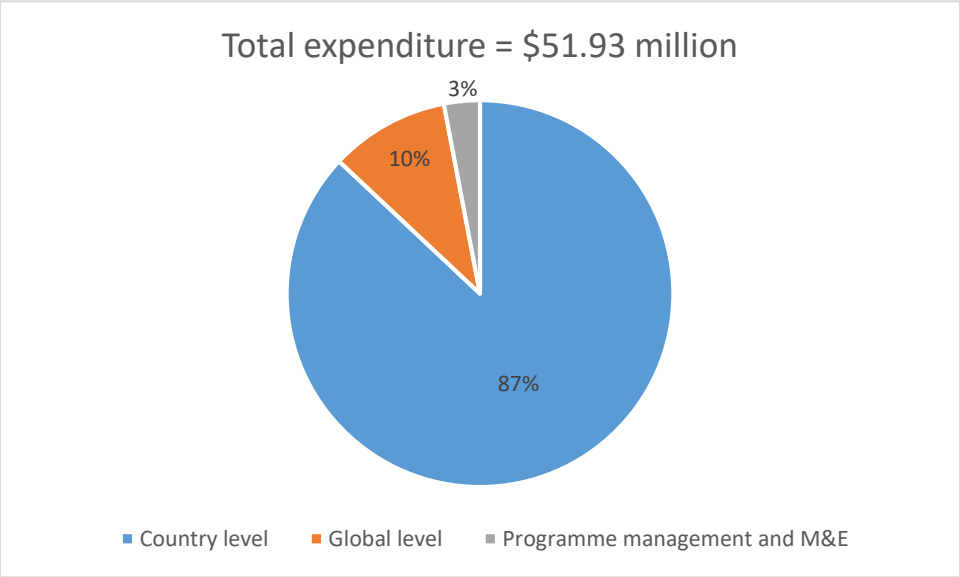
The **annual inter-country planning meeting** started in 2012 when six country teams met in Addis Ababa, Ethiopia, to develop annual work plans with the global and regional teams. Subsequent meetings were held 19 to 21 November 2013 in Freetown, Sierra Leone; 26 to 30 May 2014 at Victoria Falls, Zimbabwe; and 2 to 6 November 2015 in Douala, Cameroon. In the review and planning meetings, countries reflected on the progress made, challenges faced and mitigation strategies deployed by the H6 Partnership, and the global technical team updated participants on recent global and regional developments. These meetings also promoted cross-learning among H6 countries and teams.

Financial management

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

For the Sida collaboration: Of the total $52.58 million received as of 2017 by the H6 Joint Programme, after deducting administrative agent charges, some $52.06 million remained for programming. Of this, $45.07 million was spent at the country level and $5.33 million at the global level. By the end of 2017, the total provisional expenditure was $51.93 million. Country-level programming was prioritized and, as such, the originally agreed ratio was spent at the country level .

Figure 2: Percentage of total funds spent at country and global level, 2013–2017



H6 stakeholder coordination and convening role

The convening role H6 provides is a value-added feature of this unique partnership. From the inception of the H6 Joint Programme, the partners have organized meetings, participated in joint events and joint missions, and organized specialized coordination meetings with evolving mechanisms such as the Global Financing Facility.

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 period 2013–2017, more than 90 teleconferences were organized for the global technical teams represented by all H6 partners and representatives of Every Woman Every Child, resulting in improved coordination, more efficient exchange of information, and harmonized responses on key issues and opportunities. Decisions made during the weekly calls are well-documented for follow-up.

During 2017, H6 global and regional team members participated in joint missions to Côte d'Ivoire, Guinea-Bissau and Liberia. 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 needs and mobilize technical assistance. The missions also organized visits at the subnational 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, facilitated efforts to analyse barriers to and enablers of progress. An assessment of country strengths and opportunities was conducted to define evidence-based corrective actions to address challenges. The role of the H6 in coordinating and convening stakeholders helps countries to sustain their development gains.

2.3 At the country level

Programme management

In each of the six countries in the H6 Joint Programme, one of the H6 agencies has been appointed as the lead agency (table 6). It acts as the H6 focal point, or country coordinator, overseeing and coordinating implementation at the country level. At the country level, the programme is led by the collective efforts of country teams in close collaboration with Ministries of Health.

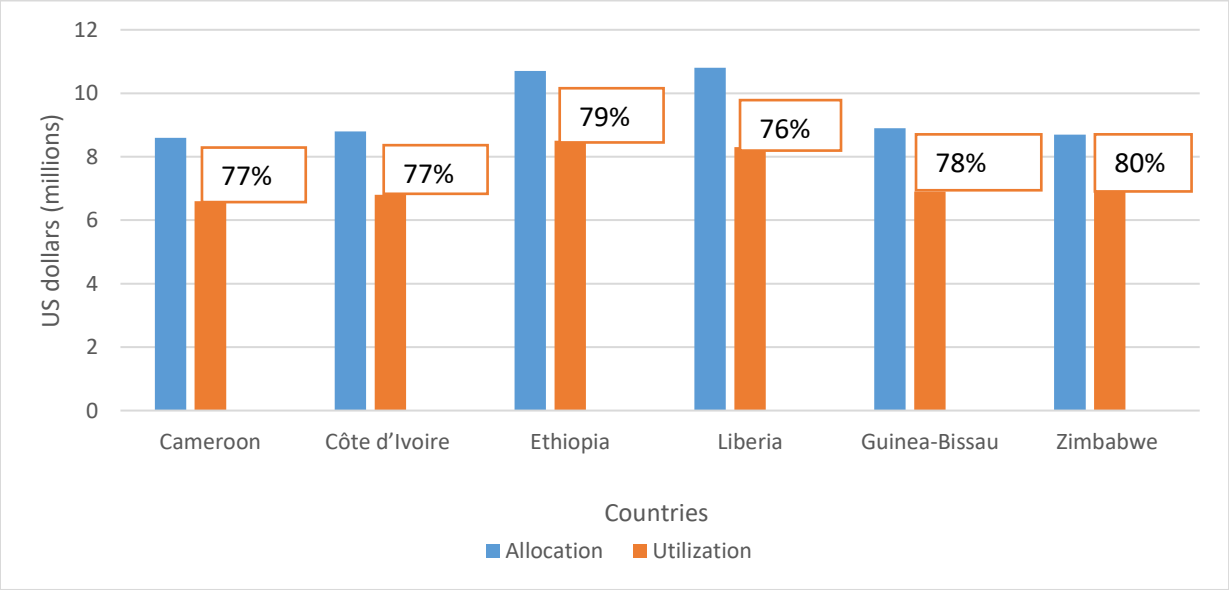
Table 6: Lead agencies in H6 Joint Programme countries

H6 partner agency	Countries
UNFPA	Côte d'Ivoire, Guinea-Bissau and Zimbabwe
UNICEF	Cameroon
WHO	Ethiopia and Liberia

Financial management

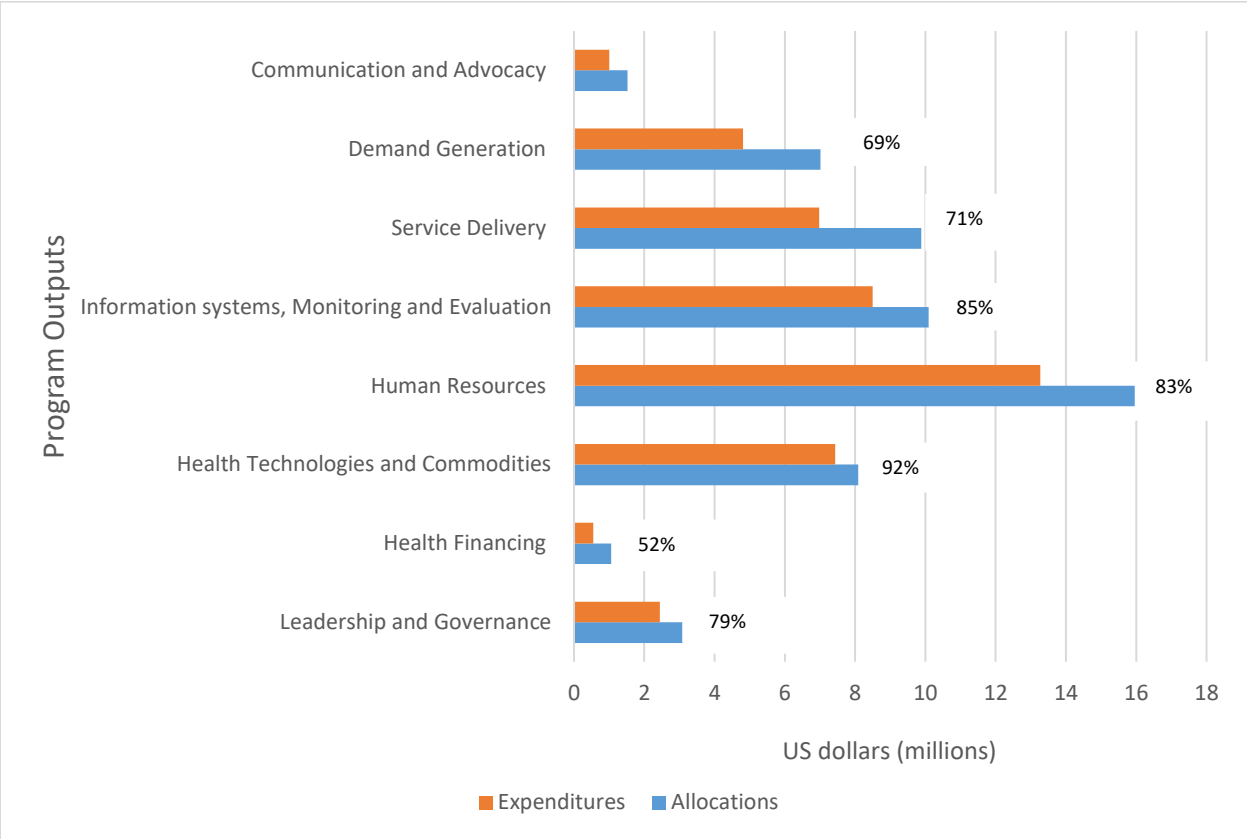
The present trends indicate full utilization of grants received from Sida. The degree to which the allocated budget was utilized, however, varied by country. Figure 3 illustrates the state of finances under Sida's collaboration. An analysis of the total cumulative expenditure incurred against allocation for 2013–17 reveals that average funds utilization rate for all six countries is about 76 percent. In absolute terms, the highest allocation was for Liberia at US$10.8 million, followed by Ethiopia at $10.7 million, Guinea-Bissau at $8.9 million, Côte d'Ivoire at $8.8 million, Zimbabwe at $8.7 million and Cameroon at $8.6 million.

Figure 3: Utilization rate in Sida collaboration countries, 2013–2017



An analysis of the total expenditure against allocation for all six programme countries following H6 Joint Programme outputs is illustrated in Figure 4.

Figure 4: Budget allocation vs. expenditure by output for six countries, with utilization rate, 2013–2017



The highest rate of utilization (92 per cent) was registered in the health technologies and commodities output. This is due to the fact that procurement policies within the UN system are already established. The next-highest rate of utilization (85 per cent) was for strengthening the information system, including monitoring and evaluation, followed by expanding the base of skilled human resources (83 per cent). High priority was assigned to the output of the human resource, given the acute shortage of skilled service providers in programme countries.

In the beginning, the pace of activity implementation and fund utilization was slow, but as the programme went on and protocols were established, the rate of implementation increased. Monitoring activities focused on strengthening the national health management information systems. Maternal death surveillance and response systems were established in all programme countries. The other two areas in which fund utilization was high against allocations were leadership and governance, and service delivery. For the service delivery output, different countries faced context-specific challenges to make facilities operational. Early on, implementation was slow for the service delivery output in 2013, but implementation gained momentum from 2014 onwards, once enablers contributing to service delivery were in place.

Demand creation focused on community-level interventions, which is process intensive. This led to the relatively lower utilization of funds against allocations. Only Côte d'Ivoire and Guinea-Bissau planned interventions under the health financing output. This has a lower rate of implementation because some of the approved activities were later taken over by the European Union (EU) in Guinea-Bissau. During 2017, all planned country level activities were completed.

Section 3. Looking back and moving forward

3.1 H6 Joint Programme contribution 2013–2017

The H6 Joint Programme was designed to enhance policy engagement and capacity development at the national and subnational levels, with a strong geographic focus on a subset of underserved districts or health zones to inform national practice and policies with positive lessons learned. The programme also aimed to support efforts to plan and implement initiatives that are strategic, catalytic and complementary to existing and planned programmes. Complementarity of programming has been achieved in most countries. Similarly, catalytic support improved the effectiveness of other programmes at the subnational level.

At the policy level, each country made perceptible progress with high impact at scale. Examples of achievements include the following: The **Liberia** country team played a pivotal role in supporting the national health systems to manage and revive RMNCAH services during and post-Ebola recovery phases; also, large quantities of much-needed drugs, medicines and supplies were procured and distributed with H6 Joint Programme support. **Côte d'Ivoire** and **Zimbabwe** succeeded in integrating and disseminating clinical protocols and standards to enhance the quality of care. In **Cameroon**, national MDSR guidelines and tools were integrated to enhance accountability in the public health system. **Ethiopia** registered success in contributing a substantive increase in the human resource base for skilled birth attendants. In **Guinea-Bissau**, the country team supported the national health system to improve the skills of the service provider, rejuvenating capacities of individuals and institutions by bringing in international experts to promote evidence-informed and rights-based RMNCAH services.

There were variations in the focus and approach in countries, as national contexts vary from country to country. While programme support was always complementary to efforts by larger programmes in support of RMNCAH, examples of catalytic interventions were significant in each country. The programme made important contributions to significantly increased capacities in EmONC and, at the same time, promoted an integrated package of RMNCAH services at the subnational level. The catalytic impact is evident in the experience of **Côte d'Ivoire**, where annual district planning for integrated RMNCAH services is now spreading in non-intervention districts. All countries reported integration of PMTCT with MNCH care in health facilities. In **Liberia**, programming was reorganized to supplement and complement national efforts to combat Ebola and effectively manage the recovery phase for the health sector. The experience of **Cameroon** is also unique due to its environment of insecurity. A systematic approach was used in Cameroon to enhance access to and utilization of RMNCAH services through community ownership and community support to service providers to ensure their security while working in health facilities located in Boko Haram-affected areas.

In all countries (except Zimbabwe) there was a marked success in shaping pre-service midwifery education. All programme countries have demonstrated a strengthening of accountability through the establishment and institutionalization of MDSR processes. A positive contribution was made to health system capacity through the delivery of services in RMNCAH, including support for skilled human resources; enabling of the service environment with the provision of reproductive health supplies and equipment; and improved leadership and governance by enhancing the managerial capacities of programme and facility managers.

Overall, these efforts taken together contributed to measurably improved access and quality of RMNCAH services, especially at the targeted subnational level. This result is demonstrated by two contributions at a country level that are common but of great significance. First, in all six countries, evidence-based protocols and standards for clinical services were updated with the latest guidelines and protocols Secondly, strategic facilitation and support provided through the H6 Joint Programme was utilized by the governments and other stakeholders in the development of critical national plans and strategies.

Though success was limited in some areas by challenges and factors beyond the countries' control, the H6 Joint Programme made many positive contributions to the capacity of national health systems to deliver services in RMNCAH.

BOX-2-Scale-up of innovations in programme countries

- In Ethiopia, the Government is using a **task-shifting strategy** to provide integrated emergency and obstetrics surgery in previously under-resourced facilities in the country's rural areas and poor communities. This innovation is developing a cadre of mid-level health professionals through graduate-level training at universities throughout the country, increasing the supply of clinicians, addressing the country's skilled human resources shortage and redressing system inequities.
- The second area of focus is **improved clinical practices**. The use of the anti-shock garment has become widespread in the H6 Joint Programme intervention facilities in three focus counties in Liberia (Maryland, Grand Cru and River Gee). The H6 partners have plans to roll out the use of the Non-Pneumatic Anti-Shock Garment (NASG) in three additional counties with the eventual aim to integrate it into national policy.
- Another category is **improving the service environment**, in particular through the provision of solar suitcases. This is being tested in Liberia, where it has helped to ensure more consistent electricity in health facilities. There is a plan to monitor how the installation of solar units affects attendance at facilities, and to use this information to prepare a proposal for additional support in order to install solar suitcases in a wider number of facilities to overcome problems related to irregular electricity supply.

3.2 Sustaining health systems, strengthening gains and transition plans

The positive contribution made by the H6 Joint Programme to enhance the capacity of national health systems to deliver services in RMNCAH especially in underserved and isolated health districts, counties and zones is a core strength of the programme. Sustaining the gains made is a major challenge in all programme countries, however, with adequate funding the most pressing issue.

A funding gap exists even in countries with financing plans. In **Zimbabwe**, for example, the Health Development Fund (HDF) has adopted the H6 approach and some interventions have been integrated into the country's proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria. HDF has taken up interventions to address key areas including obstetric fistula, interventions within MDSR, clinical mentorship on maternal health and strengthening of EmONC services. Despite such positive steps, the available resources are not sufficient to meet funding needs to sustain programme gains.

In **Liberia**, two out of six counties in the H6 Joint Programme have no external support, and domestic resources fall short of the funding required to sustain gains. The Global Financing Facility is a source of support sought by countries such as Cameroon and Liberia. Liberia's RMNCAH investment case seeks to improve the delivery of EmONC services and enhance the delivery of RMNCAH services at community level. In **Cameroon**, the H6 country team proactively shared learning from the programme and integrated suitable interventions into GFF Thematic Fund interventions as well as performance-based financing from the World Bank. This will focus on the selected provinces of the nation and includes the Far North Province where the majority of H6 Joint Programme investments were made.

Working with a variety of international and domestic and private sector funding sources is a strategy actively pursued by the H6. In **Côte d'Ivoire**, the H6 worked with other funding sources to implement activities such as capacity-building of key actors in maternal, neonatal and child health to improve surveillance and response to maternal deaths (Muskoka), distribution of long-lasting impregnated nets (Global Fund) and family planning (French Development Agency). Now, GFF will support Côte d'Ivoire in its third wave and provide an opportunity to sustain H6 Joint Programme gains.

Capacity building must continue in a range of areas from supply management to quality of care in services. In **Ethiopia**, H6 support focused on expanding the skilled human resource base, strengthening in-service and pre-service training facilities, strengthening M&E systems and institutionalizing MDSR and studies to inform policies. Interventions of the H6 Joint Programme yielded a high return on investment, and future activities will benefit from and build on this progress by creating a critical mass of skilled human resources, which will be sustained in part by Ethiopia's domestic resources, GFF and SDG pool funds.

Collaboration remains the key to progress, including at country level. In **Guinea-Bissau**, the H6 Joint Programme was implemented in close collaboration with the Ministry of Health as an institutional partner. Guinea-Bissau is building upon this relationship and undertaking efforts to leverage domestic resources for sustaining programme gains. The programme's gains may be at risk, however, due to the limited presence of international donors and uncertainty around a continued inflow of domestic resources.

Gains made with support from the H6 Joint Programme are at risk given existing resource gaps and uncertainty about support in the future. H6 partners are mobilizing resources in a collective drive to protect and improve the health and well-being of every woman, child and adolescent – especially those who are among the poorest and most vulnerable in the world.

3.3 Lessons learned

The three major roles of the H6 – convening, technical assistance and advocacy – shape several of the lessons learned over the past five years. H6 successfully discharged its convening role by mobilizing country commitments for the updated Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). H6 partners have 46 potential platforms with increasing number of functioning coordination mechanisms in the high burden 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 scope for strengthening H6 coordination in each of the programme countries, including the involvement of national partners and stakeholders. Coordination among technical teams at the country, regional and global level takes a lot of time, but the return on investment is high, as it helps to create synergies and optimize results for SRMNCAH.

As the technical arm of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), the H6 Partnership is moving from the H6 Joint Programme, now concluded, to joint programming for linking evidence to policy and practice at all levels. This requires capacity building and technical assistance to country teams. H6 successfully provided evidence-based technical products or global public goods[3] for RMNCAH, supported the development and operationalization of the Global Strategy, and developed major supporting strategies such as EPMM, ENAP and the Quality of Care Network. 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

[3] A global knowledge product consists of a strategy, conceptual framework, guideline, tool, toolkit, scorecard, manual, policy brief or briefing kit, fact sheet, case study, training materials/course design or approach for improving RMNCAH policy, advocacy and/or programme assessment, design, implementation, monitoring or evaluation. A global knowledge product can also include a peer-reviewed synthesis or journal article that captures programmatic experience or lessons learned. They are designed to be used globally, i.e. to benefit stakeholders beyond the H6 Partnership and to be used across different countries or regions for RMNCAH sector.

technical areas for which less evidence, experience, and dissemination exist (e.g. multi-sectoral action, gender equality and women's empowerment, involvement of adolescents, humanitarian and development nexus). Strategic and catalytic technical support can do more with less.

Regarding its advocacy role, in the past five years, the H6 Joint Programme has raised the profile of neglected areas relevant to the Sustainable Development Goals such as adolescents, newborn care, midwifery, gender equality, and sexual and reproductive health and rights, which were prioritized in the Global Strategy. The repositioning of the H6 process needs continued harmonization and complementarity among three major facets of the EWEC Global Strategy: the Global Financing Facility; the Partnership for Maternal, Neonatal and Child Health; and the H6 Partnership.

The H6 strategic interventions for the coming years (with H6 milestones) are aligned with EWEC Result Framework 2020, which aims to harmonize action across sectors and among all partners engaged in implementing the EWEC Global Strategy. This work is based on the following three principles:

- **Country focus**: H6 will focus on joint technical assistance for strengthening national capacities to operationalize the Global Strategy.
- **Additionality**: The interventions are complementary to existing individual agency programmes.
- **Joint programming**: The interventions will be planned and delivered jointly, while leveraging joint expertise from the H6.

The results that the H6 will contribute to are outlined in the EWEC Framework 2020. This partnership is also an example of UN Reform and will continue to showcase how a UN partnership delivers more than the partners could when working as individual agencies.

Section 4. Working together on the SRMNCAH agenda: contributions of the H6 Partnership

Sections 1, 2, and 3 of this report covered the H6 Joint Programme supported by Sweden. Section 4 moves beyond the joint programme to report progress by the H6 Partnership in a variety of other endeavours, including collaboration with key partners, implementation of other grants, and support to develop several global strategies aimed at improving SRMNCAH in high-burden countries.

By 2017, 60 governments had made commitments to the EWEC Global Strategy (2016-2030), out of which more than 50 per cent (31 of 60 countries) were mobilized by the H6 country teams. The H6 technical teams at global, regional and country levels provided technical support to countries for the development and implementation of national SRMNCAH plans and investment cases.

The French Government has recently renewed its commitment to support the **French Muskoka Fund** for the next five years, starting in 2018. Key areas of technical support in the second phase include maternal and newborn health, child health, youth and adolescents' sexual and reproductive health, family planning and nutrition as well as cross-cutting areas of health system strengthening and gender-based and human rights-based approaches. The geographical scope will be maintained on the current eight French Muskoka Fund target countries (Benin, Chad, Côte d'Ivoire, Guinea, Mali, Niger, Senegal and Togo) to ensure they meet their goals by 2030. This renewed French support offers the opportunity to build on the achievements and lessons learned from the first phase of the French Muskoka Fund partnership and to expand the coordination platform to amplify gains.

The countries of **Arab States** region have received technical assistance from the H6 team to strengthen RMNCAH services in humanitarian settings, assess RMNCAH targets and indicators in line with the Sustainable Development Goals, and strengthen the adoption of surveillance tools at national and subnational levels in line with WHO standards and guidelines to improve measurement of maternal, newborn and child deaths.

The **Quality, Equity, Dignity** (QED) effort unites and builds on the technical and advocacy work of the ENAP and EPMM groups and engages PMNCH partners. It is initially led by nine countries already spearheading efforts. Launched in 2017, QED aims to strengthen national efforts to end preventable deaths by 2030, as envisioned in the EWEC Global Strategy. The interventions include strengthening the capacity of health professionals to plan and manage quality improvement; improving data collection; and increasing access to medicines, supplies, equipment and clean water.

By the end of 2017, 43 countries and territories with a high burden of newborn mortality and stillbirth had finalized national newborn plans or strengthened the relevant components within national health strategies. An additional 24 countries adopted the **Every Newborn Action Plan** (ENAP) tracking tool in 2017, bringing the total to 75 countries. The tracker helps countries identify gaps and establish neonatal mortality and stillbirth reduction targets, which are essential SDG and Global Strategy indicators.

Section 5. Conclusion

Success is evident at policy and programme levels in all of the H6 Joint Programme countries, despite all H6 country teams having encountered dynamic programme environments and external factors beyond their control. Strategic, context-specific and catalytic processes have transformed resources into results over the past five years and set the stage for a sustained positive trajectory in all of the output areas given adequate resources.

Enriched with H6 Joint Programme experiences, H6 country teams actively participated in shaping national health plans. 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. A total of 23,464 health functionaries received training in a wide range of skills in the realms of RMNCAH from 2013 through 2017. This includes enhancing the quality and capacity of training institutions and individual trainers.

The H6 Joint Programme invested in strengthening maternal death surveillance and response systems (MDSR) in government and building capacity among health service managers and health service providers. MDSR represents a critical tool for health systems to effectively engage in efforts to reduce avoidable maternal and newborn deaths. In most of the countries, communities that lived far away from fixed health facilities were identified as a particular target group. The programme aimed to overcome barriers to access, using a range of interventions that targeted distance and isolation. Examples include more and better-trained community health workers who live closer to the community; the construction of maternity waiting homes to enable women (and often their families) to travel to health facilities in advance of their delivery; and support to strengthening outreach services.

There were also efforts to engage with service providers to improve their understanding of gender equality issues. 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, to hold them responsible for reaching groups of people who are marginalized and discriminated against, particularly adolescent girls. During the H6 Joint Programme, the increased engagement of religious and community leaders proved successful in the effort to reverse harmful cultural norms that hinder mothers and children from seeking health care.

The H6 Joint Programme demonstrated a capacity to adjust and respond to changing needs and priorities at the country level, as in the case of the effective responses to the Ebola outbreak. Joint programming of dedicated funds for RMNCAH provided a common purpose for strengthened collaboration and changed the nature of the partnership among country teams. Innovations were supported for scale-up at the national level in a number of countries.

H6 teams achieved a greater level of collaboration at both country and global level, building upon their organization's comparative advantages and complementing the in-house capacities of partner agencies for harmonized response and one voice at the country level.

The programme expanded access to integrated RMNCAH services by consistently targeting service provision to underserved and hard-to-reach areas and marginalized populations by increasing the capacity of health workers, improving infrastructure and strengthening referral and outreach. Value added in support of the Global Strategy has been most evident in the programme's contributions to improved quality and access to integrated RMNCAH services at the country level, and also to increased coherence in policy engagement and advocacy at both country and global levels.

Over the years, H6 has evolved into an entity that is regarded as a role model for UN reform within the UN system as well as outside at the country, regional and global levels. H6 teams at each of these levels were enriched with experience from this impactful programme and remain motivated as well as ready to galvanize the capacities of partners towards building equitable and resilient national health systems. The comparative advantage and in-house capacities of each partner backed up with collective drive provided unique positioning to the H6 Partnership, enabling it to support national health systems in their efforts to meet the needs of millions of women, children and adolescents for health information and services.

……

Appendix 1: Human resources for health: skills enhancement (2013–2017)

No.	Country	Maternal health*	Newborn and infant care	HIV prevention and treatment	Family planning	Youth-friendly health care	Health care management	Health care technologies – CHWs	Total
1	Cameroon	970	398	30	210	–	–	229	1,837
2	Côte d'Ivoire	924	398	63	187	457	143	1463	3,635
3	Ethiopia	3,443	3,197	256	–	–	743	447	8,087
4	Guinea-Bissau	848	–	–	483	140	150	2,221	3,842
5	Liberia	941**	448**	377**	527	159	302	487	2,243
6	Zimbabwe	565	1567	964	-	247	88	425	3,856
Total		7,491	6,008	1,690	1,407	856	1,573	5,237	23,464

* EmONC/BEmONC/CEmONC, midwifery, MCH aides, SRMNCH, MDR and working with individuals, families and communities approach
** Joint training for RMNCH

(Total trained: 7,131 (30%) in 2014; 5,937 (25%) in 2015; 9,169 (39%) in 2016; 1,227 (5%) in 2017 = 23,464 individuals trained.)

Appendix 2: Progress on indicators in the H6 Joint Programme M&E framework (2013–2017)

Note: In the following tables, averages are reported for some indicators in an attempt to make results comparable as some countries outputs have been reported with disaggregated data by districts or facilities based on the country specific practices of data collection. In 2017, Cameroon, Ethiopia, Liberia and Guinea-Bissau received a no-cost extension and completed activities by June 2017. In line with activities carried out in 2017, only relevant output values are changed. N/A signifies not "not applicable" because there was no intervention, "nd" signifies "no data," information is not available.

For the H6 Sida collaboration, baseline data is from the year 2013, which was the first year of implementation of programme interventions.

Output 1. Leadership and governance: Governance and management of health sectors and financing systems are strengthened to that ensure RMNCAH services respond to the needs of women and children

Common indicator 1.1: Proportion of targeted districts that used updated RMNH/HIV national standards and guidelines.*

Cameroon	Côte d'Ivoire	Guinea-Bissau**	Ethiopia	Liberia	Zimbabwe
Baseline: 0% Target: 100% 2017: 95%	Baseline: 0% Target: 100% 2016: 100%	Baseline: nd Target: 100% 2017: 100%	Baseline: 100% Target: 100% 2017: 100%	Baseline: 33% Target: 100% 2017: 100%	Baseline: nd Target: 80% 2016: 100%

*Above reported data of 100% shows that national guidelines finalized and made available to the districts. The extent of use or compliance of above guidelines depends upon improved supervision and monitoring.
** When a region is implementing 60% of national standards, it was considered as achieving the indicator.

Common indicator 1.2: Active coordination and joint mechanisms (planning, procurement and supply management) that bring together donors and partners in RMNCAH are established.*

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: No Target: Yes 2017: Yes	Baseline: Yes Target: Yes 2016: Yes	Baseline: No Target: Yes 2017: Yes	Baseline: Yes Target: Yes 2017: Yes	Baseline: Yes Target: Yes 2017: Yes	Baseline: 0 Target: Yes 2016: Yes

*The institutional arrangements being used by H6 to engage Ministry of Health and other partners vary from country to country. The role of H6 Joint programme is also to actively participate in the existing and/or newly created forums to mobilize commitment and support for RMNCAH.

Output 2. Health financing: Availability of funds and right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care

Common indicator 2.1: National costed RMNCAH plans (including human resources) are developed and based on a comprehensive situation analysis that highlights priorities and gaps

Cameroon	Côte d'Ivoire	Guinea-Bissau*	Ethiopia	Liberia	Zimbabwe
Baseline: N/A Target: N/A 2017: N/A	Baseline: N/A Target: N/A 2016: N/A	Baseline: No Target: Yes 2017: Yes	Baseline: nd Target: Yes 2017: Yes	Baseline: No Target: Yes 2017: Yes	Baseline: N/A Target: N/A 2016: N/A

*There is no unique costed RMNCH plan, but sectorial costed plans such as Every Newborn Action Plan (ENAP) 2017-2021; Strategic Plan strategies ICCM 2016-2020; National Nutrition plan 2016-2020, strategic national plan to fight malaria 2013-2017.

Common indicator 2.2: Proportion of targeted districts that implement innovative approaches to financing (vouchers, funds, cost sharing, etc.)

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: No Target: Yes 2017: Yes	Baseline: 0% Target: 100% (8/8) 2016: 100% (8/8)	Baseline: N/A Target: 100% (11/11) 2017: 100% (11/11)	Baseline: N/A Target: N/A 2017: N/A	Baseline: N/A Target: N/A 2017: N/A	Baseline: N/A Target: N/A 2016: N/A

Output 3. Health technologies and commodities: Commodities and technologies are available in health facilities to deliver comprehensive SRMNCH services to women and their children*

Common indicator 3.1: Proportion of health facilities reporting no stock-out of selected essential medicines for mothers (oxytocin, misoprostol, contraceptives, HIV tests, magnesium sulphate) during the last 3 months (this includes information on preventing stock-outs of contraception and HIV tests)

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: N/A Target: N/A 2017: N/A	Baseline: nd Target: 90% 2016: 86%	Baseline: 9% Target: 100% 2017: 88%	Baseline: N/A Target: N/A 2017: N/A	Baseline: 47% Target: 90% 2017: 92%	Baseline: 77% Target: 90% 2016: 90%

*The source of information is mainly provincial or subnational estimates based on survey or assessments conducted by the Ministry of Health. Therefore, above data does not reflect the exact situation of the health facilities covered by H6 interventions.

Common indicator 3.2: Proportion of health facilities reporting no stock-outs of essential medicines for newborns (bag and masks, suction devices, training manikin) during the last 3 months*

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: N/A Target: N/A 2017: N/A	Baseline: 0% Target: 90% 2016: 79%	Baseline: 9% Target: 100% 2017: 79%	Baseline: N/A Target: N/A 2017: N/A	Baseline: 47% Target: 90% 2017: 97%	Baseline: 30% Target: 70% 2016: nd

*The source of information is mainly provincial or subnational estimates based on survey or assessments conducted by the Ministry of Health. Therefore, the above data does not reflect the exact situation of the health facilities covered by H6 interventions.

Output 4. Human resources for health: Sufficient number and management of skilled human resources to deliver comprehensive RMNCAH services to women and their children*

Common indicator 4.1: Proportion of health care providers trained in programme areas with adequate skills and knowledge according to national norms to provide EmONC services in the targeted districts (training of providers and managers in other RMNCAH areas is also included)

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia**	Liberia	Zimbabwe
Baseline: (14/200) 7% Target: (100/200) 50% 2017: (140/200) 70%	Baseline: 0% Target: (268) 100% 2016: (268) 100%	Baseline: 0% Target: (191) 100% 2017: (191)100%	Baseline: nd Target: (283) 100% 2017: (319/283) 112%	Baseline: (75/236) 30% Target: (236) 100% 2017: (336/236) 142%	Baseline: (75/252) 30% Target: (252) 100% 2016: (252) 100%

*A large number of skills enhancement trainings are going on in each country. Many countries monitored and reported progress on the number of Health functionaries.

** Integrated Emergency surgical officers

Common indicator 4.2: Number of active CHWs/village health workers trained in community-based RMNCAH services, including essential newborn care in the targeted districts during 2013-2016/17

Every country provided training for community-based health workers in 2013-2016/17, thus ensuring that maternal and newborn care will be more readily available, even in remote or underserved communities.

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: 30 Target: 300 2016: 327	Baseline: nd Target: 1417 2016: 1417	Baseline: 893 Target: 2881 2017: 2571	Baseline: nd Target: 514 2016: 447	Baseline: 84 Target: 275 2017: 300	Baseline: 410 Target: 1049 2016: 1049

Output 5. Health information systems, monitoring & evaluation: Functional HMIS, adequate data collection, management, and quality assurance systems to better inform planning processes and decision making, implementation science, research

Common indicator 5.1: Proportion of targeted districts* that have submitted timely and complete reports as per national guidelines and schedules during the last 3 months (*Liberia reported for 26 intervention facilities)

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia *	Zimbabwe
Baseline: 57% Target: 100% 2017: 90%	Baseline: N/A Target: N/A 2016: N/A	Baseline: nd Target: 100% 2017: 100%	Baseline: nd Target: 100% 2016: 72%	Baseline: 47% Target: 100% 2017: 96%	Baseline: 50% Target: 100% 2016: 100%

Common indicator 5.2: Proportion of targeted districts* with established and Functioning Maternal Death Surveillance and Response mechanisms, including Maternal Deaths Reviews (*Cameroon reported on primary and secondary level health facilities from intervention districts and Liberia reported for intervention facilities)

Cameroon*	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia *	Zimbabwe
Baseline: 0% Target: (30) 100% 2017: 87%	Baseline: 62% Target: 100% 2016: 100%	Baseline: 0% Target: 100% 2017: 100%	Baseline: 0% Target: 100% 2016: 72%	Baseline: 17% Target: (26) 100% 2017: 100%	Baseline: 0% Target: 100% 2016: 100%

Common indicator 5.3: Proportion of targeted districts that perform quarterly reviews of HMIS data (with community committees/leaders) to monitor performance and for evidence-based decision making and planning*

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia **	Zimbabwe
Baseline: 0% Target: 100% 2016: (7/7) 100%	Baseline: 0% Target: 100% 2016: (8/8)100%	Baseline: 0% Target: 100% 2016: (7/7)80%	Baseline: nd Target: 100% 2016: 100%	Baseline: 50% Target: (26) 100% 2017: 100%	Baseline: N/A Target: N/A 2016: N/A

* Community engagement processes that require quarterly meetings with community leaders exist but to what extent they are effectively reviewing progress for evidence-based planning can't be established through above data.
** Liberia reported for the intervention area health facilities only.

Output 6: Health service delivery

Common indicator 6.1: Numbers of health care facilities in areas supported by H6 Joint Programme that provided EmONC services in 2013-2016/17 (*Cameroon include health post, primary and secondary facilities for a range of RMNCH services. ** In Guinea-Bissau, 96% of health facilities provided basic and/or comprehensive EmONC services in 2013 but none met EmONC norms and standards. ***For Ethiopia, reported data are from national EmONC NA study 2017).

Cameroon*	Côte d'Ivoire	Guinea-Bissau**	Ethiopia***	Liberia	Zimbabwe
Baseline: 6 Target: 91 2017: 74	Baseline: 10 Target: 54 2016: 54	Baseline: nd Target: 130 2017: 86	Baseline: 33 Target: 300 2017: 261	Baseline: 13 Target: 26 2017: 25	Baseline: 2 Target: 19 2016: 16

Common indicator 6.2: Proportion of ANC and delivery services in targeted districts that provided PMTCT services according to the national guidelines. (*Liberia reported for the intervention facilities)

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia *	Zimbabwe
Baseline: 50% Target: 100% 2016: 99%	Baseline: 49% Target: 100% 2016: 100%	Baseline: 90% Target: 100% 2017: 100%	Baseline: nd Target: 100% 2016: 77%	Baseline: 89% Target: 100% 2017: 100%	Baseline: N/A Target: N/A 2016: N/A

Output 7: Demand, including community ownership and participation					
Common indicator 7.1: Number of active community groups (safe motherhood groups, volunteers, etc.) or rural committees established in targeted districts.					
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**	**Zimbabwe**
Baseline: 0 Target: 1151 2016: 1151	Baseline: N/A Target: N/A 2016: N/A	Baseline: 95 Target: nd 2017: 2132	Baseline: N/A Target: N/A 2017: N/A	Baseline: 84 Target: 300 2017: 300	Baseline: 21 Target: 263 2016: 263
Output 8: Communication (including communication for development) and advocacy					
Common indicator 8.1: Proportion of targeted districts with demonstrable social mobilization programmes that include at least two of the following communication themes: prevention of early pregnancy, expanding knowledge of key family practices, HIV prevention, importance of breastfeeding, and recognition of danger signs during postnatal care for mothers and newborns.					
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**	**Zimbabwe**
Baseline: 28% Target: 100% 2016: 100%	Baseline: N/A Target: N/A 2016: N/A	Baseline: nd Target: 100% 2017: 100%	Baseline: N/A Target: N/A 2017: N/A	Baseline: N/A Target: N/A 2017: N/A	Baseline: nd Target: 100% 2016: 100%
Common indicator 8.2: Number of media and advocacy initiatives executed (include information about any resulting commitments or contributions from governments or partners)					
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**	**Zimbabwe**
Baseline: nd Target: nd 2016: 5	Baseline: nd Target: nd 2016: 18	Baseline: nd Target: 168 2016: 144	Baseline: nd Target: 18 2016: 18	Baseline: N/A Target: N/A 2017: N/A	Baseline: 0 Target: nd 2016: 11

Appendix 3: Key interventions implemented at country level

Key interventions	Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
1) Leadership and governance						
• Support to national task force and policy environment for RMNCAH (including EmONC)	X	X	X	X	X	X
• Supporting adaptation of international guidelines on Quality of Care in RMNCAH	X	X	X	X	X	X
• Midwifery policy and advocacy, support to midwife training and to quality assurance for training	X	X	X	X	X	
2) Health financing						
• Introduction/support to results-based financing			X			
• Supporting pricing incentives and subsidies for RMNCAH services and community health funds		X				
3) Health technologies and commodities, including improved service environment						
• Procurement of training aides for midwives and for EmONC capacity building at facility level	X	X	X	X	X	X
• Provision of equipment, medicines, commodities	X	X	X	X	X	X
• Construction and support of maternity waiting shelters and annexes			X		X	X
• Support to running water and/or solar power for facilities; Water, sanitation and hygiene	X	X	X	X	X	X
4) Human resources for health						
• Strengthening EmONC training and post-training supervision and family planning	X	X	X	X	X	X
• Support for pre-service training of midwives	X	X	X	X	X	
• Support for in-service training (EmONC, IMNCI, FP, PMTCT, task shifting)	X	X	X	X	X	X
5) Health information systems, monitoring & evaluation						
• Strengthening monitoring and evaluation	X	X	X	X	X	X
• Support to establishment and operation (national, provincial, district) of MDSR systems	X	X	X	X	X	X
• Technical advice and support to information management and HMIS	X	X	X	X	X	X
6) Health service delivery						
• Support to national obstetric fistula programme				X		X
• Support PMTCT and pediatric HIV treatment including training and quality assurance	X	X	X	X	X	X
• Support to transportation (motorbikes, bicycles) for community level	X		X		X	X
• Supporting youth friendly services adolescent health and sexuality education	X	X	X		X	X
• Support to IMNCI (including family kits)	X	X	X	X	X	X
• Support national PMTCT and HIV and AIDS plans and programmes	X	X	X	X	X	X
7) Demand including community ownership and participation						
• Support training of community-based health workers and volunteers	X	X	X	X	X	X
• Educational materials for community involvement	X	X	X	X	X	X
• Partnerships with religious leaders			X			X
• Engaging men and boys around RMNCAH activities, gender-based violence, gender equality		X		X	X	X
• Engage traditional leaders in RMNCAH	X				X	
• Supporting training of community group leaders including community-based advocates	X	X	X	X	X	X
8) Communication and advocacy						
• Studies community structures that influence reproductive and maternal health of girls and women	X		X	X		X
• Mass media campaigns on PMTCT	X	X			X	
• Reducing violence against girls and women programme	X	X	X	X	X	

Appendix 4: Key programme activity highlights by country (2013–2017)

Output 1: *Leadership and governance*: Policy-level support to strengthen leadership and governance of national health systems

Cameroon	Over the course of the H6 programme, the National Strategic RMNCH Plan (2014–2020) was finalized and disseminated and the Human Resources Strategy and Plan for Deployment and Retention of Health staff were developed. Updated standards and protocols for IMCI and RMNH/HIV were disseminated in 2014. The Operational Plan for newborn health was developed in 2014 and revised in 2016. National MDSR guidelines and tools were developed in 2015. In 2016, support was extended to the Ministry of Health to scale up the provision of integrated RMNCAH services. The National Policy on Community Health and the referral guide were also developed. In 2017, National Policy on Community Health was disseminated nationwide.
Côte d'Ivoire	Technical support was provided for the development of National Health Accounts, nutrition guidelines, and the institutionalization of MDSR. Family planning and HIV/AIDS strategic documents were produced and disseminated at regional and district level. In 2016, an internal review was conducted of maternal and child health programmes and new tools on antenatal care and treatment of STIs were disseminated with ownership and leadership of the government officials.
Ethiopia	Technical support was provided for the development of RMNCH strategies for 2016–2020 and the Midwifery Roadmap 2015–2025. In 2014, technical support was also provided for the development of the Health Sector Development Plan (HSTP-V) 2016–2020; the National Strategic Plan for EMTCT; and guidelines for MNH care, obstetric protocols, MDSR and gender mainstreaming. In 2016, a national adolescent and youth health strategy (2016–2020) was finalized. During 2017, National Strategy to eliminate MTCT of HIV and National PMTCT and Congenital syphilis guidelines were developed.
Guinea-Bissau	The National Plan of Action for Prevention and Eradication of GBV was validated in 2014 along with the National Gender Policy. H6 supported the development of a policy on free access to health services for RMNCH, HIV and gender-based violence for health facilities at the community level. The H6 team played a critical role in mobilizing the commitment of Guinea-Bissau to the global initiatives "A Promise Renewed" and "Ever Newborn Action Plan." In 2017, National ENAP plan developed and validated. Client satisfaction survey institutionalized in national Hospital to institutionalize accountability mechanism.
Liberia	H6 supported the revision of the National MNCAH, MNDSR and adolescent sexual and reproductive health protocols in 2013. National PMTCT guidelines were revised and the National eMTCT plans were developed. H6 provided technical support for national RMNCAH policy development. In 2016, the GFF Investment Case development was supported, an MNDSR training manual was developed along with a National RMNCAH Annual Operational Plan integrating H6 programme interventions. During 2017, National RMNCAH 2017-18 plan was developed and National HMIS data collection tools were updated.
Zimbabwe	H6 supported guidelines development for National Nutrition Surveillance, Clinical Mentorship and the National Health Strategy. In 2014, H6 facilitated the development and adaptation of guidelines for emergency triage assessment and treatment, PMTCT and pediatric ART and IMNCI training materials. Support was also provided for the development of the Adolescent Reproductive Health Strategy (2010–2015); national PMTCT Strategy (2011–2015), Option B+ Strategy for PMTCT, the New 2013 HIV guidelines and a National Nutrition and Food Policy. In 2016, the EmONC Improvement Plan was finalized, the Child Survival Strategy was revised, and the RMNCAH scorecard was reviewed and adapted for district use.

Output 2: *Health financing*: Addressing financial barriers to RMNCAH

Côte d'Ivoire	Under a national scheme, the H6 Joint Programme supported social franchise schemes by imparting management training and basic supplies to establish for-profit activities to reduce financial barriers to access RMNCH services for seven women's groups composed of 850 members.
Guinea-Bissau	Supported development of national 'free of charge' policy. The policy aimed to eliminate user fees for pregnant women, children under five, and adults over 60. A feasibility study of the free care mechanism was conducted in 2013. The financing needed to replace user fees (e.g. to fund salary incentives and essential drugs) came initially from the H6 Joint Programme in 2014 and an EU-funded RMNCAH programme.

Output 3: *Health technologies and commodities*: Support for improved service environment (equipment, infrastructure and supplies)

Cameroon	In Cameroon with the support of H6, equipment and materials for BEmONC services were provided to 91 health facilities and needs based surgical equipment were provided to five CEmONC centres at district hospitals. Twelve motorcycle ambulances and one normal ambulance were also purchased alongside 95 motorcycles for outreach and supervision activities for the health districts. During programme period, all 91 supported health facilities (health post, primary and secondary level facilities) received essential drugs and supplies even to treat severe malnutrition as well as kits to treat neonatal infections. All intervention (91) health facilities received drugs and supplies during 2017.
Côte d'Ivoire	Eight district health centres and 46 health facilities were provided with equipment and medicine for essential childcare, and 27 facilities received need-based equipment for EmONC. In 2017, blood bags procured and distributed for transfusion (10,000) for use in 30 districts, including support to collection of donor blood and quality assurance towards strengthening of CEmONC services.
Ethiopia	During 2016 procurement was done for equipment for Gondar and Jimma Fistula repair centres. Equipment was also procured for midwifery, anaesthesia and nursing training programmes, which has been distributed to training institutions for the three training programmes. This included four operating tables, 600 blood pressure machines and stethoscopes, six light sources for operations, 10 oxygen concentrators, 50 speculums, 50 resuscitators, and 25 vacuum extractors. Also, 564 anaesthesia and 900 neonatal nursing books were procured and distributed.
Guinea-Bissau	By the end of 2015, six intervention regions had received moto-ambulances. Additionally, medical kits, vaccines, and essential medicines for mothers and children, HIV treatment, EmONC, and infection prevention were procured and distributed. In 2016, monitoring and follow up was intensified to ensure supplies provided to the Ministry of Health reached target regions and were free of cost for women and children.
Liberia	Essential drugs and equipment were provided including high-frequency radios (given to 18 health facilities in three counties); six motorcycles and three bicycles were delivered to programme counties, and 25 'helping mothers survive' kits and simulation materials were provided to 12 nursing and midwifery schools. In 2016, equipment including X-ray machines, ventilators and solar suitcases were supplied to all 26 programme-supported health facilities.
Zimbabwe	All six intervention districts received EmONC commodities for 19 focus health facilities and equipment was provided to refurbish six youth-friendly centres and provide aids for 12 peer educators, allowing all six district hospitals to now provide youth-friendly services. In 2016, a total of 220 Dried Blood Spots (DBS) bundles for EID were procured and distributed; each bundle does 960 tests, giving a total of 211,200 tests.

Output 4: *Human resources for health*: Support for expanding the skilled human resource base

Cameroon	An expert coordinator for training midwives was recruited at the outset of the programme. H6 developed e-learning modules that are being used by midwifery schools in Douala and under extension nationwide. The programme supported training of service providers; as a result, 81 percent of health facilities have skilled human resources with 282 CHWs trained and equipped (bicycle, essential drugs and EFP kit).
Côte d'Ivoire	Training and supervision helped revitalize the practice of prevention of cancer of the cervix by imparting training to 52 service providers. On all sites, 90 percent of the service providers conduct activities according to standards. Some 74 health care providers received intensive competency-based EmONC training for skills enhancement and a total of 268 health functionaries were trained from to make 54 intervention facilities fully functional for essential maternal and newborn care. About 1,417 CHWs received training for awareness generation and enhancing community participation in RMNCAH.
Ethiopia	The focus of the H6 Joint Programme was on expanding human resource base of skilled birth attendants. Some 261 identified health facilities across the country for maternity care were made functional by providing 464 midwives with a three-week competency-based BEmONC training, against a target of 560. Since the H6 programme began, 319 Integrated Emergency Surgical Officers were trained offering life-saving maternity care. It is reported that IESO's are doing 90 percent of emergency procedures and 62 percent is C-sections in the facilities where they are deployed. The programme also supported the training for 367 anaesthetists and 288 mid-level health workers in fistula identification. In 2017, about 404 health functionaries received skills enhancement in-service training.
Guinea-Bissau	In order to strengthen the national health system, H6 recruited eight international experts (three OBGYNs, four paediatricians and one anaesthetist) to deliver CEmONC services and train national providers in two regional hospitals. 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. During the programme period, 42 midwifery tutors received intensive Training of Trainers (six months); seven GP's received training on CEmONC (two months); 34 Nurse Anesthetist trained in hospital attachment (three months).
Liberia	In 2013, the H6 Joint Programme supported 15 BEmONC and three CEmONC facilities of three counties of the south-eastern region. In the post-Ebola recovery phase, the Liberia country team received additional support to revive MNH care in nine facilities of three additional counties, namely Gbarpolu, Grand Cape Mount and Rivercess. With additional funding received in 2015, the revised RMNCAH training target became 536 health functionaries. By the end of 2016, 736 health functionaries (including 200 staff from other than intervention health facilities and counties also benefited from the training). Similarly, 300 community health workers benefitted with orientation on a preventive and promotive aspect of RMNCAH.
Zimbabwe	Zimbabwe is the only country that has opted for in-service training of health care providers. In 2013, when EmONC training was initiated in the country a curriculum of seven days orientation was followed. In 2014, it was found that, 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 that proved successful, prompting the development of National Clinical Mentorship guidelines for MNH. During 2017, Support to Programme management training in the six districts (20 district managers trained) and first national training on the IMNCI Computerized Adaptation and Training Tool (ICATT) for improved pre-service training (participants were paediatricians and Nurse tutors in training schools) was organized successfully.

Output 5: *Health information systems, monitoring & evaluation*: Strengthen programme monitoring and integrating accountability through MDSR

Cameroon	The H6 programme 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 2016 micro plans and elaborated 2017 micro plans.
Côte d'Ivoire	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.
Guinea-Bissau	The National Health Information System was harmonized at the outset of the H6 programme, incorporating indicators of SRMNI (SRH/ HIV/ GBV), disaggregated by sex and age. An MDSR system was established.
Ethiopia	HMIS and data management training was conducted in 2016 along with the quality of care assessments in 29 identified hospitals. A national ANC/PMTCT surveillance system assessment was conducted and the findings were used for surveillance roadmap development. The H6 Joint Programme initiated processes in a partnership with Ethiopian Public Health Institutions. The EPHI analyzed 200 maternal deaths and that informed HSTP-V to strengthen post-partum care as a key maternal health strategy .
Liberia	The programme supported the revision of existing national HMIS tools and programme indicators integrated into national HMIS tools. Health facilities submitted timely and complete reports and according to national guidelines and schedules. Programmes reported as complete and in a timely manner increased from 47 per cent in 2013 to 96 per cent in 2017. The programme invested in establishing and technically supporting the MNDSR process at national level. It also helped to revitalize national commitment to MNDSR following the end of the Ebola Virus Disease (EVD) outbreak. An official MDSR system was set up in 2013 and community-level HMIS indicators were developed and integrated into national reporting systems in 2014. These systems are being scaled up to other facilities in the country with support from the County Health Teams, WHO, UNICEF and UNFPA.
Zimbabwe	Ministry of Health and Child Care (MoHCC) and health authorities in H6 Joint Programme provinces and districts conducted supportive supervision and monitoring visits from 2014 onwards. National coordination meetings on PoC/EID, PMTCT and HIV care were supported at the national and provincial levels. The drafting and printing of a National 2015 HIV/AIDS Report and the Option B+ Interim Review Report were supported.

Output 6: *Health service delivery*: Improved quality and access to integrated RMNCAH services

Cameroon	The referral linkages were strengthened from community level to secondary level facilities. In order to enhance service delivery at the community level, 365 trained CHW referred cases to the health facility in 2016 for malaria (3,103 cases), acute respiratory tract infection/pneumonia (1,743 cases), diarrhoea (1,271 cases), malnutrition (4,968 cases). Also, 727 pregnant women were referred to health centres for obstetric complications and indications. Some 91 health facilities including health posts, primary level and secondary level health facilities were targeted to be made functional. The number of fully functional health facilities increased from six in 2013 to 74 by end of 2017. The proportion of ANC and delivery services in targeted districts that provide PMTCT services as per national norms registered an increase in 99 per cent of facilities, up from the baseline of 50 per cent.
Côte d'Ivoire	In 2016 alone, 40,140 people were sensitized on reproductive health issues and 1,496 clients received contraceptive methods (of which 65 per cent are new users). Some 36 per cent of clients opted for injectables; 15 per cent implants and 48 per cent oral contraceptive

	methods. Also, 499 women underwent screening for cancer of the cervix by IVA, with 1 per cent testing positive; also, 3,669 women opted for voluntary HIV testing, with 1 per cent testing positive. In eight intervention districts, the number of fully functional BEmONC facilities increased from seven to 48 between 2012 and the end of 2016, and the number of fully functional CEmONC facilities doubled from three to six, achieving targets set for the programme. Similarly, intervention facilities offering PMTCT as an integral part of RMNCH services increased from the level of 49 per cent to 99 per cent (54 facilities).
Guinea-Bissau	The country was facing an acute shortage of skilled human resource for health. A two-axis approach was followed. On one side, an international midwifery was engaged to develop pre-service curriculum based on ICM standards and facilitate initiation of midwifery training in two midwifery training schools. The tutors had intensive training (six months) at a national hospital. On another side, international specialists for obstetrics, paediatrics and anesthesiology were engaged to provide services in regional and national hospitals and simultaneously train a range of providers from GPs to nurse anesthesiologist for the provision of EmONC services. In seven intervention regions, the target was to operationalize 120 BEmONC and 10 CEmONC facilities by end of H6 Joint Programme, and about 66 per cent of the target was achieved by end of 2017. In 2017, Refurbishing of Maternity wing of 5 Health facilities and IPC equipment's in 6 Intervention facilities were provided.
Liberia	In 2013, 18 facilities of three counties of the south-eastern region were identified to make operational for EmONC services. But the country witnessed a collapse of services in mid-2014 with the Ebola outbreak. In 2015, it was decided to provide extra funds for covering three more counties with a focus on eight health facilities to make operational for the provision of EmONC services as an effort to support national health system to revive MNH care in the post-Ebola recovery phase. The provision of integrated RMNCAH services was made in all 26 intervention facilities. During 2017, refurbishing of 6 MWH and Improved WASH facilities in 7 Health facilities received support under H6 programme.
Zimbabwe	In the six intervention districts, the strategy was to operationalize at least one CEmONC facility and make 14 BEmONC facilities fully functional by offering all seven signal functions. In 2013, out of 19 intervention facilities, only two facilities were offering all signal functions for EmONC. By the end of 2016, 84 percent of the target facilities had been made fully functional. In 2016 alone, some 929 households were reached with Parent to Child Communication on sexual and reproductive health, with a total of 7,253 'parent person exposures' achieved and 9,965 adolescents reached.

Output 7: *Demand creation*: Building demand and enhancing community participation

Cameroon	Through existing networks of associations and traditional leaders, H6 worked to sensitize groups and individuals on issues of women's rights and RMNCH issues in communities. Some 343 committee members and 264 community leaders received training and 73 associations and two youth centres received materials to support these activities. Communication materials were also disseminated through five advocacy campaigns to increase demand. In 2016, simplified tools were made available to continue to promote MNCH activities improving on past tools.
Côte d'Ivoire	Côte d'Ivoire focused on the creation of several different types of community groups. Husband's Schools were created to promote sexual and reproductive health, seven women's groups benefitted from support to establish profit-making activities to reduce financial barriers, and 43 committees were created to address socio-culture barriers to RMNCH services and improve access. In 2016, partners organized the national week of maternal health reaching 30,664 pregnant women with information on PMTCT, CPN, family planning and key family practices.
Ethiopia	Workshops were conducted on gender mainstreaming and gender-based violence for leaders, policy planners, health training institutions, and health extension workers to help these issues become a standard element of community-based reproductive health care in

	Ethiopia. A safe motherhood advocacy campaign was also conducted at the national level and a stakeholders' meeting was held to identify and document best practices for reducing gender discrimination.
Guinea-Bissau	CHWs were the main drivers of demand creation in Guinea-Bissau throughout the programme period, improving quality of care, free delivery of services and sensitizing communities. In 2016, UN Women also organized five training sessions for CHWs and NGO staff members on SRMNCH, HIV and gender-based violence. The First National Youth Forum for Peer Educators in Reproductive Health was held in August 2016, bringing together 140 peer educators for training in topics like STDs, HIV and AIDS, gender-based violence, family planning and reproductive rights.
Liberia	Demand and community participation was enhanced through the involvement of community groups, community leaders, and 26 adolescent peer groups. Awareness was further raised through radio programmes and parliamentarians were engaged to support RMNCH initiatives. In 2016, 48 community groups participated in training on sexual and reproductive health and reproductive rights, MNH, gender-based violence and masculinity. Through these groups, 27 campaigns and 161 outreach activities were conducted. Overall, these projects aimed at breaking gender barriers and improving community roles and norms as they related to MNH. These efforts have led to an increase in community leader involvement, reporting of gender-based violence, and men accompanying their partners to health facilities.
Zimbabwe	Community work through youth and community leaders helped to raise awareness, participation and service uptake focusing on RMNCH issues. Forty men were trained to increase awareness and mobilize communities on HIV testing, PMTCT and other areas of MNCH. Thirty-three safe spaces for young women were created and three festivals were organized around RMNCH issues. Additional techniques such as road shows, peer groups, and peer-to-peer counselling were also implemented to raise awareness and increase participation in H6 programming.

Output 8: Communication and advocacy, including communication for development

Cameroon	C4D Pools were set up in two districts to increase communication. Women's week celebrations were used as an opportunity to promote women and adolescents. Five high-level ceremonies were also held to raise awareness about activities being run. Seven radio stations agreed to diffuse messaging around RMNCH/PMTCT in local broadcasts. To follow up, listeners clubs were set up in each health district to give feedback on the messages that were broadcast. Finally, community and traditional leaders participated in advocacy training sessions.
Côte d'Ivoire	Communication materials were prepared to promote awareness and treatment around HIV and AIDS, family planning and reproductive health issues. This included television programming, posters, pamphlets, t-shirts, bags and a film.
Ethiopia	Organized by the Ministry of Health regional health bureaus with the support of H6 and other RMNCH partners, a special event focused on RMNCH. It was led by the MCH directorate of the Ministry of Health, and it included a rally, new hospital visit, and a consultative meeting among RMNCHS stakeholders. In other activities, a best practice on midwife exchange and midwife mentoring from St. Paul Hospital and its catchment health centres in Addis Ababa was disseminated in the national RMNCAH-N review meeting in August 2016. In the 2009 Ethiopia fiscal year (2016/17), this was adopted into a national MNH initiative, to be implemented in all zones of the country as a system to improve emergency obstetric referral linkage.
Guinea-Bissau	In 2016, an H6 Newsletter was edited in Portuguese in order to reach more people at the national level, including the regions targeted by the H6 Joint Programme.
Liberia	In Liberia, high-level advocacy meetings were held with parliamentarians at the national, county and district levels and radio talk shows raised awareness. In 2016, H6 produced an

	electronic documentary about programme implementation over the years. The Ministry of Health was supported in conducting advocacy meetings presenting the National Investment Case to health partners, parliament, line ministries and other stakeholders including private companies for possible support; this effort also aimed to push the issues of SRMNCAH high on the national agenda for increased political and national budgetary commitment and support. In 2015, through communications campaigns on HIV and AIDS in 11 regions, the general population, in particular, young men and young women, benefitted from essential information prevention and treatment. Some 12,125 people were voluntarily tested for HIV.
Zimbabwe	A storybook and video documentary was developed around the work being done in Zimbabwe. Community mobilization was also conducted in all six target districts, engaging traditional leaders to raise awareness and utilization of services. H6 also supported a media tour to Chiredzi district that resulted in a number of newspaper articles and radio stories. Materials were produced including stickers (4,000), soldier games (4,000), red roses and ribbons (4,000), t-shirts and leaflets.