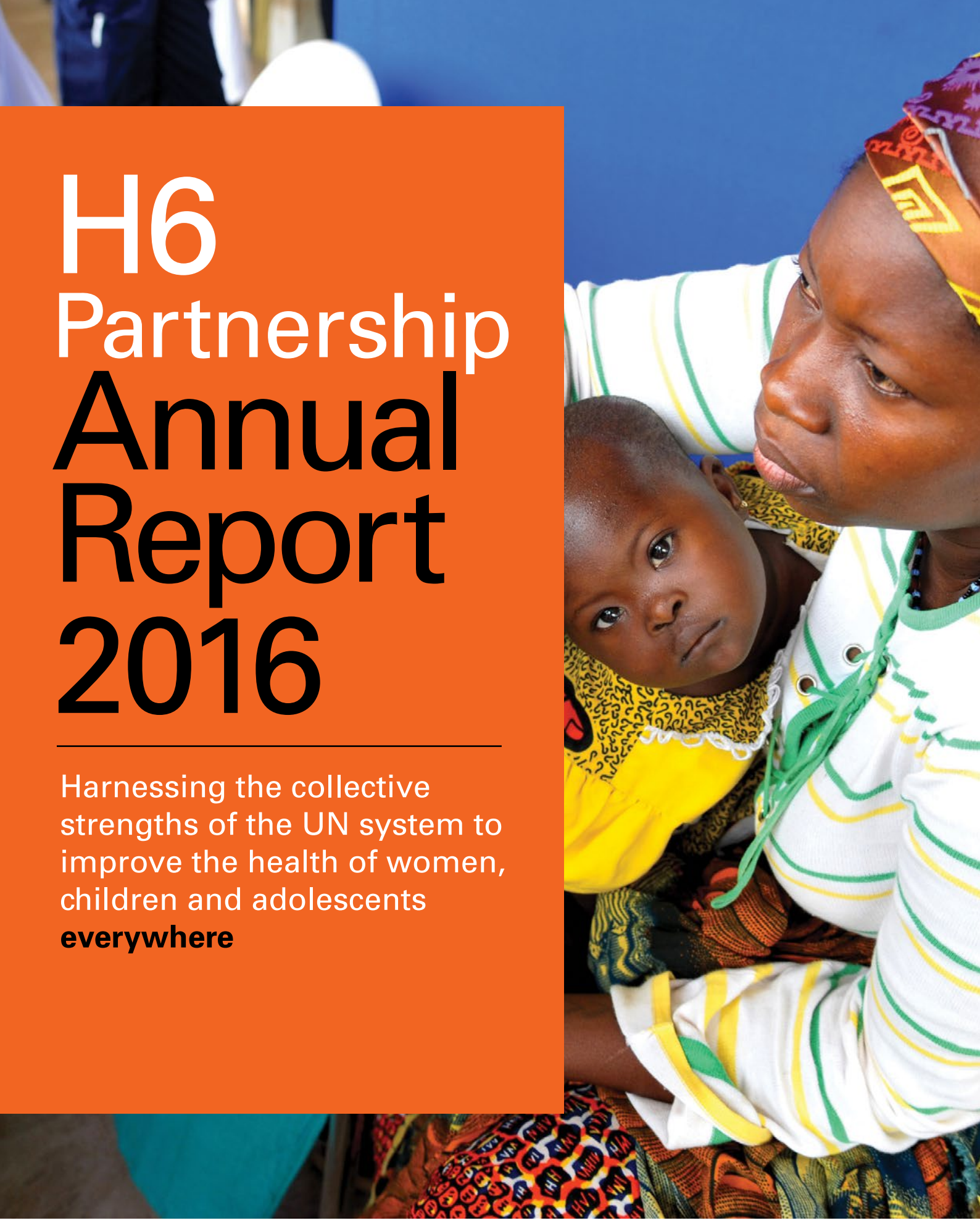
H6 Partnership Annual Report 2016

Harnessing the collective strengths of the UN system to improve the health of women, children and adolescents **everywhere**



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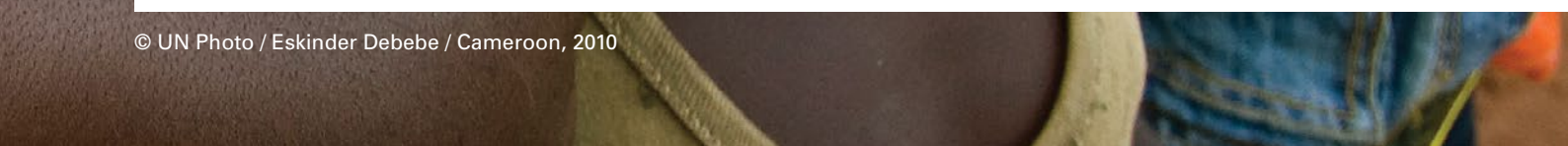


Abbreviations

ASRH	Adolescent sexual and reproductive health
BMC	British medical journal
CAG	Community Advocacy Group
CHW	Community Health Worker
DRC	Democratic Republic of the Congo
DFATD	Department of Foreign Affairs, Trade and Development (Canada)
EmONC	Emergency Obstetric and Newborn Care
EMTCT	Elimination of Mother-To-Child Transmission (of HIV)
ENAP	Every Newborn Action Plan
EPMM	Ending Preventable Maternal Mortality
EWEC	Every Woman Every Child
GBV	Gender-based violence
GFF	Global Financing Facility
HMIS	Health management information system
ICM	International Confederation of Midwives
IMNCI	Integrated Management of Newborn and Childhood Illnesses
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MNCH	Maternal, Newborn and Child Health
MNCAH	Maternal, Newborn, Child and Adolescent Health
MNDSR	Maternal and Neonatal Deaths Surveillance and Response
MoH/FMoH	Ministry of Health

PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of mother-to-child transmission (of HIV)
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
Sida	Swedish International Development Cooperation Agency
SMAG	Safe Motherhood Action Group
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health
TBA	Traditional birth attendant
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
USAID	United States Agency for International Development
WHO	World Health Organization

The choice of acronym may reflect its usage at a particular time. In order to maintain uniformity for the H6 Joint Programme, the report most often uses RMNCAH.

MNCH
In 2008, the H4 Partnership started working together on Maternal, Newborn and Child Health.

RMNCH
In 2010, reproductive health was added, and the acronym became RMNCH after the launch of the United Nations Secretary-General's global strategy of Every Women Every Child.

RMNCAH
Later in 2013, the adolescent health component was integrated, with an 'A' to make RMNCAH.

SRMNCAH
As of 2016, sexual health was added in the continuum of care, which is also in keeping with the 2030 Agenda. The H6 Partnership now works in SRMNCAH.

Acknowledgements

The six United Nations agencies of the H6 Partnership – UNAIDS, UNFPA, UNICEF, UN Women, the World Health Organization and the World Bank – wish to express their deepest gratitude to Canada and Sweden for their generous support to the H6 Joint Programme, through Global Affairs Canada (formerly DFATD) and Sida, the Swedish International Development Cooperation Agency. This support is an important contribution towards improving Sexual, Reproductive, Maternal, Newborn, Adolescent and Child Health (SRMNACH) and accelerating the implementation of the commitments made to the United Nations Secretary-General's Global Strategy as part of Every Woman Every Child, particularly in the 10 countries supported by the H6 Joint Programme: Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Ethiopia, Guinea-Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe.

We wish to acknowledge the H6 country, regional and global teams for their efforts in planning, monitoring and implementing programming across the world. This includes the principals whose support gave shape to the partnership to become the technical arm of the Every Woman Every Child movement. Additionally, the H6 wishes to thank the national governments represented by their Ministries of Health as well as our implementing partners for their leadership, stewardship and ownership in championing the issues of SRMNCACH. Finally, H6 wishes to recognize the hard work accomplished by health care providers, community leaders and community members who make possible this impactful, transformative and catalytic programming.

This report is dedicated to Dr. Babatunde Osotimehin, the late Executive Director of the United Nations Population Fund. The world has lost a great leader and champion for the health and rights of women and girls worldwide. Dr. Osotimehin was a driving force in the success of the H6 Joint Programme and his belief in the positive power of collaboration remains an inspiration.

"I believe that through H4+ in the way we are working together, we can make a difference."

Dr. Babatunde Osotimehim
Executive Director of UNFPA

Executive Summary

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 UN agencies has been functioning since 2010 as the technical arm of UN Secretary-General's Global Strategy for Women's and Children's Health, and subsequently the updated Global Strategy for Women's, Children's and Adolescent's Health (2016–2030) – also known as the Every Woman Every Child movement. It 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.

This report reviews progress in 2016 and since the inception of the H6 Joint Programme collaboration with Canada and Sweden (Sida).[1] Findings are featured from a recent evaluation of this programme, which mobilized $99.76 million to provide catalytic and strategic support to national health systems to address the root causes of poor 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.

Of note in 2016 is a change of name. The H4+ partners renamed their coalition the H6 Partnership, reflecting the full commitment and equal engagement of all six member organizations.

Country level progress with the H6 Joint Programme

The programme's results (outputs) are based on the health system building block approach, which 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. For example, the H6 Joint Programme has worked at the policy level in all 10 programme countries to create an enabling environment in order to ensure access to quality care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) by developing sector national plans, strategies and integration of evidence informed protocols and standards. In another example, the issue of scarce human resources for health was identified early and addressed from 2011 through 2016, the H6 Joint Programme supported the training of a total of 43,009 personnel ranging from specialized doctors to community health workers (CHWs).

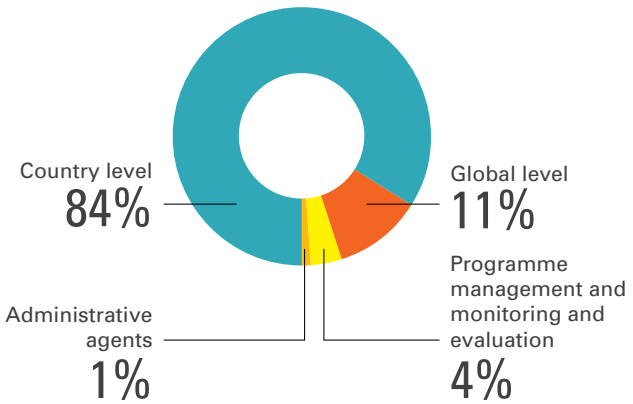
[1] The H6 Joint Programme was originally named the H4+ Joint Programme Canada and Sweden (Sida) 2011–2016.

Additional highlights of country-level programming include the institutionalization of Maternal Death Surveillance and Response (MDSR) systems in the 10 countries; strengthening of Emergency Obstetric and Newborn Care (EmONC) through training for health workers; and an improved service environment including strengthening of referral systems, demand generation and creating community participation methods. Context-specific and strategic advocacy efforts were deployed to promote commitment for resources and strengthening structures, systems and procedures for the national health systems.

The vast majority of expenditures in the H6 Joint Programme were made at the country level (84 per cent) compared with global level (11 per cent), and some 4 per cent was spent on programme management and monitoring and evaluation.

Four outputs account for 75 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 2 per cent of all expenditures. Implementation rates for planned activities across the 10 countries averaged 77.5 per cent. Allocated budget utilization rates averaged 73 per cent for 2011–2016 period.

H6 expenditures 2011-2016



The partnership's global-level progress

As a result of H6 advocacy, adolescent health features prominently in the updated Global Strategy for Women's, Children's and Adolescent's Health (2016–2030), along with the multi-sectorial aspects of RMNCAH in humanitarian settings. This strategy will frame and guide the work plan of the H6 as the world moves forward with the Sustainable Development Goals.

At global and regional level, the H6 Joint Programme was successful in the development, dissemination and capacity building of country teams for global public goods pertaining to the RMNCAH sector. This included supporting and promoting evidence-informed, rights-based and results-oriented policies and programme interventions to improve the health of women, children and adolescents, which ensures their active engagement in programmes.

The H6 continued to mobilize political support for the Every Woman Every Child movement, as the technical arm of the Global Strategy, with its operational framework as well as its indicator and monitoring framework. The H6 also mobilized support for the health targets of the Sustainable Development Goals. Advocacy continued among national governments across the partnership's 75 focus countries.

The H6 Partnership contributed to several innovative global efforts. These included global strategies like the Global Strategy for Women's Children's and Adolescent's Health, Global Financing Facility (GFF), Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM). The H6 also promoted a nine-country network on quality of care and worked with collaborative funding sources – the French Muskoka initiative and RMNCH Trust Fund.

Looking back and moving forward

At both the global and country level, H6 has been successful in its goal to help strengthen health systems and services in relation to SRMNCAH. Supported efforts, especially at the subnational level, have helped improve the accessibility and quality of services. The H6 Joint Programme has made particular strides in reaching geographically isolated, marginalized and underserved areas and population subgroups.

A recently completed independent evaluation found that the H6 Joint Programme interventions contributed to strengthening health systems for RMNCAH at both national and, particularly, sub-national levels especially through improvements in EmONC and MDSR, leading to improved service quality and access; were catalytic and aligned with national priorities; added to the strengthening of national health systems and improved significantly the quality and nature of the partnership among the six UN agencies. While all of the 10 participating countries faced constraints and challenges, each demonstrated the potential for success in reducing maternal and child deaths and expanding the provision of integrated RMNCAH services.

Lessons learned include the critical importance of addressing the social and structural determinants of SRMNCAH by balancing supply side and demand side interventions. Lessons learned also underscore the need for a collective approach to tackling the broader impediments to the health sector, including weak health financing and human resources, and the need to focus on adolescents' sexual and reproductive health and reproductive rights.

Despite challenges, progress towards the Millennium Development Goals was accelerated, partnerships were forged and vulnerable women and children were reached with life-saving information and services by the H6 Joint Programme. Looking forward, the H6 can continue to build on lessons from the past and build on the strengths of member organizations to achieve the Sustainable Development Goals, notably Goal 3 for good health and well-being and Goal 5 for gender equality, as well as the related goals outlined in the Global Strategy. However, as funding ends, participating programme countries must develop and implement transition plans to maintain the gains achieved through this programme. As the programme comes to an end, the end line evaluation warns that the gains in the quality of care in reproductive, maternal, newborn, child and adolescent care are at risk.

H6 members

The synergy of the H6 members: Specialized expertise in working together on the global agenda for sexual, reproductive, maternal, newborn, child and adolescent health

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

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

UNICEF, the United Nations Children's Fund, is the lead UN agency for advocating for the protection of children's rights to help meet their basic needs, including health, and to expand their opportunities to reach their full potential.

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

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

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

Introduction: The H6 Partnership

The H6 Partnership harnesses the collective strengths of the UN system to reach every woman, child and adolescent. The six UN agencies of this global health partnership are UNAIDS, UNFPA, UNICEF, UN Women, World Health Organization and the World Bank Group. The H6 partners work together to provide technical support to 75 countries with high burdens of maternal and child mortality and morbidity in their efforts to implement the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and the 2030 Agenda for Sustainable Development. The major initiative is the H6 Joint Programme carried out in 10 countries with support from Canada and Sweden.

H6 highlights

2008

- UNFPA, UNICEF, the World Health Organization and the World Bank launch the H4 Partnership as a joint effort to leverage the core competencies of each partner along the continuum of care for maternal, newborn and child health.

2010

- H4 takes a lead role in promoting the Every Woman Every Child movement, which is initiated by the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health.[2]
- The focus of H4 broadens in 2010 to include reproductive health in order to help countries implement the integrated Global Strategy package of reproductive, maternal, newborn and child health (RMNCH).
- H4 assumes the role of supporting 75 high burden countries (the Countdown 2015 countries) where more than 85 per cent of all maternal and child deaths occur, including the 49 lowest income countries.
- UNAIDS joins the partnership in 2010 and UN Women joins in 2012. The partnership is renamed as H4+.

2011

- H4+ supports efforts to accelerate progress towards the Millennium Development Goals, especially reducing child mortality (MDG 4) and improving maternal health (MDG 5); also integral to this work are efforts to combat HIV and AIDS, malaria and other diseases (MDG 6) and the promotion of gender equality and women's empowerment (MDG 3).
- Canada and Sweden provide grants to accelerate MDG progress in 10 high burden countries in the partnership's major initiative, the H4+ Joint Programme Canada and Sweden (2011-2016).
- The H4+ partners form teams at global and country levels that leverage their respective strengths to provide well-coordinated technical assistance in the development and implementation of national plans for Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNCAH).

[2] The joint results framework was established in 2013 at the request of Canada and Sweden for global-level activities supported under the grant. For country-level activities, a monitoring and evaluation framework was used, as reported in Annex 2.

"The H6 mandate is to leverage the collective strengths and distinct advantages and capacities of each of the six health agencies in the UN system to support countries with high burdens of maternal, child and adolescent mortality and morbidity in their efforts to improve the survival, health and well-being of women, newborns, children and adolescents."

The H6 Announcement
4 March 2016

Post-2015

- UN agencies are called on to be 'fit for purpose' and to 'Deliver as One', which means common country programming under national leadership and in line with the principles of aid effectiveness, i.e. improved relevance, alignment, harmonization, managing for results and mutual accountability – all qualities facilitated by H4+ activities.
- Unprecedented levels of coordination are required to implement the Sustainable Development Goals. Many of SDGs adopted in 2015 relate to sexual, reproductive, maternal, newborn, child and adolescent health.
- An evaluation recommends that as the technical arm of the Global Strategy, the partnership clarify its purpose, structure and value proposition within the context of the Global Strategy and the Sustainable Development Goals.

2016

- The UN Secretary-General launches an updated global health strategy, the Global Strategy for Women's, Children's and Adolescent's Health 2016–2030, which frames and guides the work plan of the H6.
- H4+ Partnership changes its name to the H6 Partnership to reflect the full participation and commitment of all six member organizations to leverage their respective areas of expertise and longstanding relationships with counterparts at the global, regional, national and subnational levels.
- In order to give equal emphasis to sexual health in the RMNCAH agenda, it was integrated into the continuum of care and the acronym became SRMNCAH.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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 Sweden (2011–2016), 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 RMNCAH related goals of the MDGs.

This section describes key highlights from 2016 and presents progress made under the Canada and Sida grant since its inception.

Three types of activities are generally carried out at the global level:

- 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[3] is the basis for jointly and closely coordinated implementation. It has four thematic areas (Policy Planning and Costing, Quality, Equality, Accountability), with eight action areas and 17 outputs to be achieved. Each thematic area is further divided into action areas. There are eight action areas, and corresponding to these areas, deliverables associated with the 17 outputs to be achieved by the programme.

The 10 countries in the H6 Joint Programme are low-income and low-middle income and ranked among the lowest in UNDP's Human Development Report 2013, 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.

Table 1: Canada and Sweden grant funding for H6 Joint Programme 10 countries

Supporting grant funding	Eligible countries
Canada	Burkina Faso, Democratic Republic of the Congo, Sierra Leone, Zambia, Zimbabwe
Sweden (Sida)	Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia, Zimbabwe

[3] The joint results framework was established in 2013 at the request of Canada and Sweden for global-level activities supported under the grant. For country-level activities, a monitoring and evaluation framework was used, as reported in Annex 2.

Programme design and intervention areas

The programme is designed to provide catalytic and strategic support to the RMNCAH component towards strengthening national health systems in line with national health plans. 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 are strengthened to facilitate implementation and provide oversight at the national, provincial and subnational levels.

Nine of the 10 programme countries focus on a subset of health districts with poor RMNCAH outcomes, usually in underserved and hard-to-reach districts; the exception is Ethiopia. Table 2 summarizes the criteria used in each country to identify subnational programme intervention areas.

National-level interventions strengthen policy, strategies, guidelines and procedures 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. Such interventions 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 Ministry of Health and in consultation with 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 evidence from other countries that had demonstrated success in improving health outcomes of women and children. The community participation and demand generation interventions were integrated with supply side interventions.

"The H4+ focus on maternal mortality reduction, newborn survival, the prevention of mother to child transmission (PMTCT) and adolescent health was consistent with the Liberia National Health Strategy and are clearly identified in the 2011-2015 Roadmap as high priorities."

Ministry of Health Technical Team
Liberia, June 2016

Table 2: Geographic and population coverage at subnational level in H6 Joint Programme countries

COUNTRY	GEOGRAPHIC TARGET	INTERVENTION POPULATION COVERAGE	KEY CRITERIA USED FOR SELECTION
Canada collaboration			
Burkina Faso	• Nine health districts in two regions out of 13	• 2.9 million population (16% of national population)	• High maternal, newborn and infant mortality from two regions with poor RMNCH indicators
Democratic Republic of the Congo	• Nine health zones in three provinces	• 1.5 million population (2% of total national population)	• At least two H6 agencies already present • Able to complement existing programmes • Accessible from the capital
Sierra Leone	• Two districts out of 13 districts. (originally all 13 districts until 2014)	• 750,000 population (12% of total national population)	• Focus on underserved and vulnerable pregnant women and adolescents
Zambia	• Five of 11 worst-performing districts out of 103 in the country	• 643,000 population (5% of total national population)	• Poor maternal health indicators. • Poor geographic access (hard-to-reach) • Lowest levels of donor support. • High poverty levels
Zimbabwe	• Six districts out of 40 districts representing all six provinces of the country	• 1.2 million population (10% of 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
Sweden (Sida) collaboration			
Cameroon	• Seven districts in the Far North region out of 189 districts of country	• 970,000 population (45% of 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 country	• 1.4 million population (7% of 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 district level
Guinea-Bissau	• All regions but with special emphasis on seven regions	• 900,000 population (50% of total national population)	• Highest child and infant mortality ratios
Liberia	• Originally three counties with three added later	• 642,847 population (17% of total national population)	• Underserved counties • Poor geographic access (hard-to-reach) • Remote rural populations

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 overcome 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.

Liberia and **Sierra Leone** had to deal with the Ebola crisis mid-2014. In response, activities were reprogrammed to focus on reinforcing maternal and newborn health services weakened by the crisis.

In **Democratic Republic of the Congo**, the government decentralized the health governance structure in early 2015, which in turn delayed the mid-phase of the programme. However, decentralization ultimately strengthened coordination at the provincial and national levels.

In **Zambia**, high poverty levels and low availability of skilled providers posed challenges in hard-to-reach intervention districts. In response, a sequential strategy was deployed to engage retired midwives who were later replaced with newly trained midwives.

In **Zimbabwe**, six intervention districts were located on the border of the country and were geographically dispersed. In order to provide supervision and monitor progress, the chain of coordination was strengthened at the national, provincial and subnational levels.

Burkina Faso and **Côte d'Ivoire** had to deal with a high turnover of health functionaries in 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 in security and high levels of vacancy among skilled providers. The H6 coordinator was located in the province for enhanced coordination with authorities, skills enhancement interventions and community participation interventions that covered the entire range of facilities from health post (grassroots) to secondary-level health facilities. The 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.

Guinea-Bissau experienced a volatile political climate from 2015 onwards, with the introduction of four successive governments. The political turnover slowed programme implementation.

H6 Joint Programme at global level

Only 11 per cent of financial resources in the H6 Joint Programme are for global-level activities, which was a decision made early on at the design stage, in order to keep the focus of interventions at the country level. At the global level, programme activities aimed to generate and disseminate global knowledge products for the RMNCAH sector.

This led to a clear benefit of the H6 Joint Programme, that is, a increasingly collaborative approach to developing and disseminating global knowledge products.

One partner usually leads the process, while others contribute to the development and dissemination. For the advocacy role, H6 partners work together to successfully advocate for the inclusion of adolescent health, the multi-sectorial dimensions of RMNCAH, and humanitarian settings within the context of the updated Global Strategy of Every Women Every Child. Additionally, the H6, both as a partnership and as a Joint Programme, helps improve inter-agency collaboration at the global level. This trend towards increasing collaboration was a highlight of H6 achievements.

"Collaboration among partners has much improved. There is a much greater expectation that the partners will develop elements in common rather than separately. There is now an assumption of collaboration that did not exist eight years ago (when H4 was originally founded)."

Global Stakeholders, H6 End Line Evaluation Volume II, 2016

The global-level activities of the H6 Joint Programme aim to contribute to the H6 joint results framework. Activities undertaken through the H6 Joint Programme at the global level that follow the H6 joint results framework for global interventions are presented in Appendix 1.

Regarding global-level activities, key achievements from 2011 to 2016 against the deliverables of results framework under each thematic area are as follows:

Thematic Area 1: Policy planning and costing

Countries received support to identify and address systems constraints to improved RMNCAH health, and to implement responsive initiatives that are evidence-driven and performance-based. A major achievement during 2011-2016 under this thematic area is capacity building of countries to use the Every Newborn bottleneck analysis tool and the revision of the Every Newborn Action Plan (ENAP) progress tracking tools used in 16 of 18 high burden countries.

The guidance note developed on strategic planning for ending preventable maternal, newborn and child mortality paved way for developing the Ending Preventable Maternal Mortality (EPMM) strategy. A policy guide jointly developed with Partnership for Maternal, Newborn and Child Health (PMNCH) for implementing essential interventions for RMNCAH was widely disseminated. This contributed to development of RMNCAH policy briefs on new and programmatic guidance; building of country capacity for applications; and provision of global/regional technical assistance to countries to conduct needs assessment and promote evidence-based planning.

Thematic Area 2: Quality

The focus under this thematic area is to support countries to scale up quality RMNCAH service delivery in line with domestic priorities, ensuring linkages with malaria and HIV and strengthening consolidated Procurement Management Systems. The feasibility of WHO indicators of quality of care for MNCH care in facilities were tested in Chad, DRC, Tanzania, Zambia and Zimbabwe. This was followed by national capacity building for quality of care assessment and improvement in Congo, DRC, Malawi, Swaziland and Tanzania. This process culminated in the development of a global network for improving quality of care for maternal, newborn and child health, towards achieving universal health coverage of recommended MNCH interventions by H6 partners in early 2017.

A midwifery service framework was developed in collaboration with the International Confederation of Midwives (ICM), then field-tested in Bangladesh, DRC and Lesotho and widely disseminated among priority countries. In 2014, *The State of the World's Midwifery* report was developed to support advocacy initiatives to strengthen midwifery services through dissemination and follow up in 26 priority high burden countries with a focus to enhance standardization of education, support for association building and improving service environment for midwives. The validation of elimination of mother-to-child transmission of HIV and syphilis has further strengthened prevention of mother-to-child transmission (PMTCT) programme criteria, including dedicated focus to advancing human rights, gender equality and community engagement. Five countries have been validated for having eliminated vertical transmission of HIV and/or syphilis.

This resulted in the development of tools and approaches and the capacity building of national institutions for conducting quality of care assessments, implementing activities and monitoring programme performance.

Thematic Area 3: Equality

The focus of these interventions is to promote knowledge and capacities to tackle the root causes of maternal, newborn and child mortality and morbidity, and HIV including gender inequality, low access to education (especially for girls), child marriage and adolescent pregnancy. Discrimination in healthcare is prevalent and is a major threat to equality.

An *Agenda for Zero Discrimination in Health Care* was launched, convening stakeholders for coordinated inter-sectoral actions at global, regional and country levels to enhance leadership and accountability and scale-up what works. Several global knowledge products were developed and disseminated to help RMNCAH teams to promote community and women's group participation for newborn and child care:

- a literacy and advocacy kit to support pregnant and breastfeeding women's groups and networks of women living with HIV in communities;
- an annotated bibliography of community-based service delivery costing methodologies; and
- a draft gender equality conceptual framework for RMNCAH.

This contributed to strengthening the development, implementation and monitoring of community-based reproductive, maternal, newborn, child and adolescent health interventions to facilitate the achievement of desired behaviour and social change objectives towards increased utilization of RMNCAH services.

Thematic Area 4: Accountability

Initiatives in this area strengthen monitoring and evaluation systems to ensure availability of credible data in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health. The Maternal Death Surveillance and Response technical guidance was developed and issued.

Related efforts included capacity building of 23 countries and organization of a regional team to roll out Maternal Death Surveillance and Response, which entailed establishing institutional mechanisms and developing the capacity of key functionaries for consistent processes. This was followed by publication of the first global report on MDSR implementation in high burden countries. Support was provided to bottleneck analysis for newborn care and situation assessments conducted in Iraq, Malawi and Nepal. Based on this work, several countries have developed their national plans for newborn care. The BMC Supplement, one of a series of papers for Every Woman Every Child, was published to highlight the bottlenecks and recommendations for overcoming nine high impact maternal-newborn interventions. This contributed to establishing a system of maternal death surveillance and review at the country level and resulted in health system strengthening through an increased focus on evidence-informed quality in programme implementation processes.

Global knowledge products

There are 60 knowledge products presented in Appendix 1 that represent a considerable body of valuable work produced during some five years of operational activity from 2012 through 2016, much of which has been duly recognized by country teams. The World Health Organization produced the majority of the 60 global knowledge products (32), followed by UNICEF (10), UNFPA (7), UNAIDS (8) and UN Women (3). The majority of items produced were guidance documents (21), followed by tools/toolkits (15), policy briefs (7) training materials (9), articles (5) and programmatic frameworks (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 partners and to be used across different countries or regions for RMNCAH sector.

The global knowledge products produced under the H6 Joint Programme were created through a collaborative process. They usually had a single lead partner as the main author, but one or more H6 partners contributed to its development and dissemination.

Some of the global knowledge products used widely in the H6 Joint Programme countries include the following:

- **Policy and advocacy:** RMNCH policy compendium, *The State of the World's Midwifery* report, the British Medical Journal Supplement on MNCH;
- **Planning tools:** Mapping of tools to assess and address HIV-related stigma and discrimination in health care and e-repository;[4] Every Newborn Action Plan (ENAP) and related guidelines, tools, reports, case studies; guide providing for safe delivery and newborn care in the context of an Ebola outbreak;
- **Guidelines:** Technical guidance for Maternal Death Surveillance and Response; Caring for newborns and children in the community; Maternal, newborn and child health score cards: Meta review on Quality of Care standards in MNCH; and RMNH training guidelines for community health workers;
- **Training material:** Communication for development (C4D) training modules.

The knowledge products created, disseminated and placed in public domain aim to add value to the ongoing efforts to enhance evidence-informed, rights based, client-centred and results- oriented practices in the RMNCAH sector.

[4] *www.zeroHIVdiscrimination.com*

Newborn in-home care in Burkina Faso

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Community health workers like **Kadidia Ouedraogo**, who is from a village in the Central North region of Burkina Faso, conduct home visits after a baby is born to teach families about caring for newborns at home and about health care practices for mother and baby, during pregnancy and after childbirth. Kadidia received training in newborn care in September and October 2015, and within weeks she had started implementing the strategy, after the district supplied her with the necessary tools. When interviewed in May 2016, she was tracking more than 20 pregnant women; she made the visits as taught and was able to follow up with several newborns after they were born.

Kadidia discovered that the families she visited were happy to receive information about the importance of antenatal consultation and about the signs of danger among pregnant women and newborns. *"Thanks to the training that I did, a woman who was suffering from bleeding three months into her pregnancy consulted a health professional. She had started bleeding before I met her family but her parents didn't know it was a sign of danger. Thanks to my advice the woman saw a doctor soon after and her pregnancy was saved,"* she said. For Kadidia, the implementation of the strategy of newborn in-home care has proven its importance and she is committed to furthering it.

H6 Joint Programme at country level

The H6 involvement at the country level included work at both policy and programme levels that focused on strengthening national health systems. The progress is analyzed against agreed indicators and presented in a matrix in Appendix 2. Country-level accomplishments are presented under eight outputs:

Output 1: Leadership and governance

Output 2: Health financing

Output 3: Health technologies and commodities

Output 4: Human resources for health

Output 5: Information systems, monitoring & evaluation

Output 6: Health service delivery

Output 7: Demand creation

Output 8: Communication and advocacy

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

In all countries, the H6 interventions were 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 the RMNCAH sector;
- Capacity-building and promoting the use of evidence-based protocols and standards to improve the quality of RMNCAH services;
- Supporting the development of strategy and policy documents for RMNCAH sector and the removal of financial barriers to access RMNCAH care services;
- Strengthening and monitoring processes to improve effectiveness as well as accountability, including MDSR;
- Supporting the preparation of national health accounts to strengthen accountability;
- Supporting Ministries of Health, programme managers and health workers to effectively integrate gender-responsive measures in policy, programming and service delivery for RMNCAH.

Key results at policy level include mobilizing political commitment for the updated Global Strategy in Côte d'Ivoire, DRC and Zambia and providing technical support in the development of the GFF investment case in Cameroon, DRC, Ethiopia and Liberia. Progress at policy level also included development of the triannual national human resource development plan in Burkina Faso, as well as support for development of the post-Ebola national recovery plan in Sierra Leone and Liberia. There was also development of a national RMNCH free care policy in Guinea-Bissau and support in Burkina Faso, along with development of key health sector plans, strategies and integration of protocols and standards in the national guidelines of all 10 programme countries.

"Before H6, everyone worked in an isolated way, in their own corner… we didn't know what the other was doing. Since this programme was funded, we work more directly together."

H6 Country Team Member, Burkina Faso, May 2016

Output 2: Health financing: Addressing financial barriers to RMNCAH

The H6 Joint Programme interventions to address financial barriers were catalytic, need-based and complementary of ongoing support in the RMNCAH sector at country level.[5] The interventions aimed to remove financing barriers for target populations, primarily for reducing the direct costs of RMNCAH services for users.

In DRC, vouchers were distributed through Family Kits, enabling women to access basic RMNCAH services at subsidized cost. The programme activities also focused on supporting voluntary community health insurance schemes ('mutuelles de santé') in some of the intervention districts by strengthening their management capacities reaching beneficiaries. Support for the development of national health accounts was provided to enhance accountability of governance for health. In Cameroon, the programme supported the consolidation and expansion of the strategy of pre-positioning obstetric kits in 30 health facilities through the training of service providers and provision of delivery kits, Caesarean kits and emergency suitcases. These kits are offered to pregnant women at a subsidized cost for delivery and C-section, thus increasing access by reducing barriers linked to direct payment of health care services.

In Côte d'Ivoire, under a national scheme, the H6 Joint Programme supported social franchise schemes by imparting management training and basic supplies to set-up for profit activities to reduce financial barriers to access RMNCAH services for seven women's groups composed of 850 members. A voucher scheme for providing in-kind services to teenage girls, pregnant women, mothers and newborns was tested in two districts of Sierra Leone for in-kind health support.

A significant achievement reported by Burkina Faso, Guinea-Bissau and Zambia was the development of a national 'free of charge' policy and the facilitation of its implementation in the H6 programme intervention area.

- In **Zambia**, during 2011–2012, technical and financial support was provided to the Ministry of Health and the Ministry of Community Development, Mother and Child Health to develop a national strategy for healthcare financing and design a social health insurance policy by tracking resources for women's and children's health through national health accounts.

- The H6 team supported the development of the national 'free of charge' policy in Burkina Faso. The national strategy to subsidize deliveries in **Burkina Faso** allows providing EmONC services without prepayment and at a subsidized cost of 80 per cent for C-sections, thereby removing the bottlenecks linked to direct payment of health care services. In four out of five Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities participating in the intervention, 80 per cent cost-sharing resulted in coverage of 78 per cent of cases requiring C-section delivery in the catchment area of these facilities.

- The 'free of charge' national policy in **Guinea-Bissau** was spearheaded by the H6 country team, working closely with other partners. The policy aimed to eliminate user fees for pregnant women, children under five and adults over 60. Under the H6 Joint Programme a feasibility study of the free care mechanism was conducted in 2013. This 'free of charge' policy process (including research, advocacy, planning and cost modelling) was signed into practice through a Ministry of Health decree. The financing needed to replace user fees (for example, to fund salary incentives and essential drugs) came initially from the H6 Joint Programme in 2014 and an RMNCAH programme funded by the European Union (EU). However, EU funding soon absorbed all the costs and covered the whole country from early 2015.

[5] Ethiopia, Liberia and Zimbabwe did not conduct any interventions under Output 2.

Output 3: Health technologies and commodities: Support for improved service environment

(equipment, infrastructure and supplies)

Maternity waiting shelters

Maternity waiting shelters (sometimes called mother waiting homes) have emerged as one of the main achievements of the H6 Joint Programme, and are a significant aid to increasing opportunity to reach the underserved with quality services. The maternity waiting shelters that already existed in target communities were dilapidated, poorly equipped and had unsafe structures.

Under the H6 Joint Programme, building or refurbishing maternity waiting shelters was undertaken in most countries and they consistently attracted a positive response from communities. For example, in DRC, Guinea-Bissau, Liberia, Zambia and Zimbabwe, the development of maternity waiting homes attached to district hospitals and primary health facilities was credited with increasing access to facilities. This increase in access contributed to reducing time lost in reaching an appropriate health facility, one of the major delays responsible for maternal deaths.

The process of refurbishing the maternity waiting shelters often contributed to strengthening community engagement. They created an effective bridge between advising women to attend the health facility and the challenges faced due to poor infrastructure or road connectivity, lack of facility-managed referral transportation available when needs arise, and long distances.

COUNTRY EXAMPLE

Women's Action Group in Zimbabwe

Gladys Mudzviti, 28, is married and has three children. She has been married for more than eight years and lives with her family in ward 24 of Chiredzi District in Zimbabwe's Masvingo Province. Ever since she joined the women's forum and started receiving information from the Women's Action Group (WAG) in 2015, her life and that of her family began to change for the better.

Prior to her involvement with WAG, Gladys struggled with the emotionally abusive way that her husband treated her. She had a difficult experience, especially during her first pregnancy when she delivered her first child at home. As a mother who was looking forward to having her first baby, she wanted to deliver safely at a hospital. However, her husband would not allow her to register her pregnancy or deliver at a hospital. *"When I got pregnant with my first child,"* Gladys said, *"my husband would not go with me for an HIV test or to register the pregnancy as we had been taught to do by WAG in 2014. He asked me to go get tested for HIV alone. He used to say those who are pregnant are the ones who go for testing and he would depend on my results to know his status."*

In February 2015, Gladys received calendars from WAG through a community-based advocate from her village. The calendar gave information about registering pregnancy and delivering at the health facility. *"The calendar was a turning point for me as it helped to open a discussion around the issues that I had failed to convince my husband about,"* she said. After receiving the calendar, Gladys' husband changed and he also started attending WAG meetings. In March 2015, they went for HIV testing together and were both found negative, which also helped her husband to change his attitude towards extramarital affairs. Gladys safely delivered her third child at the clinic in September 2015. *"There were so many dangers associated with home deliveries but I had no option as I had to respect my husband,"* she said. Gladys is happy about the change and looks forward to delivering at the clinic if they have another child. Her husband continues to contribute to change in their community by openly discussing the importance of HIV testing and safe delivery at hospitals.

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. Referral linkages in all countries were made more effective 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. Progress during 2011-2016 also included refurbishment of health facilities for ancillary services like running water, sanitation, provision of solar lamps and selective refurbishment of examination rooms, labour rooms and operation theaters. Needs-based repair of maternity waiting shelters (box 2) was taken up by the H6 Joint Programme at subnational level. Several countries were prioritized for needs-based support for distribution of drugs, medicines and supplies received from other sources to strengthen logistics and supply management system, namely Burkina Faso, Côte d'Ivoire, DRC, Liberia and Sierra Leone. Burkina Faso, DRC and Zambia made progress towards targets set in the M&E framework for the H6 Joint Programme, though did not achieve them. For example, in Burkina Faso about 12 per cent of facilities had sufficient stocks of maternal health medicines in 2013, which increased to about 90 per cent by 2016. In the same period, the essential medicine and supplies for newborn care increased from 40 per cent to 65 per cent. The target was not fully achieved but availability of essential drugs and medicines increased considerably in the intervention facilities. Similarly, DRC increased the number of facilities with availability of essential drugs and medicines for maternal and newborn health at 36 per cent from 13 per cent, falling short of their target. However, as mentioned earlier, DRC reported major bottlenecks in logistics and supply management nationwide.

Despite these challenges, other countries achieved significant successes. In Liberia, only 47 per cent of facilities in the H6-supported intervention area reported no stock-out of essential maternal and newborn health in 2013, which increased to 81 per cent for maternal and 96 per cent for newborn health. The country received large quantities of the essential drugs and medicines from several donors in post-Ebola phase. The H6 Joint Programme supported transportation and distribution of drugs, medicines and supplies in all of Liberia's 15 counties. In Zimbabwe, during the H6 Joint Programme period, 90 per cent of intervention health facilities reported no stock-out for essential maternal health care drugs and medicine, registering an improvement from the baseline of 77 per cent facilities with no stock-outs.

"Various equipment and supplies have been procured and distributed by the Federal Ministry of Health. The equipment and supplies enabled integrated emergency surgical officers to provide emergency obstetric care. Supervisory visits have confirmed that there are reduced referrals to specialized hospitals and health facility deaths have also reduced where these officers have been deployed."

Global Stakeholders, H6 End Line Evaluation Volume II , 2016

Maternity facilities are available day and night with solar suitcases in Liberia

In rural Liberia, most primary health facilities struggle with the electricity supply, including those supported by the H6 Joint Programme. This is particularly true at night when most deliveries occur. Midwives striving to make delivery safe for mothers and newborns often use their cell phone flashlights to offer health services in these poorly electrified facilities. In 2016 the H6 programme, through the Ministry of Health and county/district health teams, installed solar suitcases as back-up electrification at the maternity wards in 26 health facilities and other facilities as requested by the county/district health teams. These health facilities can now provide backup and emergency obstetric services both at night and during storms. Demand for services has increased since the installation of the solar suitcases as services are available day and night. Also, 115 health workers at the 25 health facilities (county health technicians and clinic officers, midwives and security staff and others) received training to maintain and operate the solar suitcases and to manage the backup electricity device.

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

Pre-service midwifery training

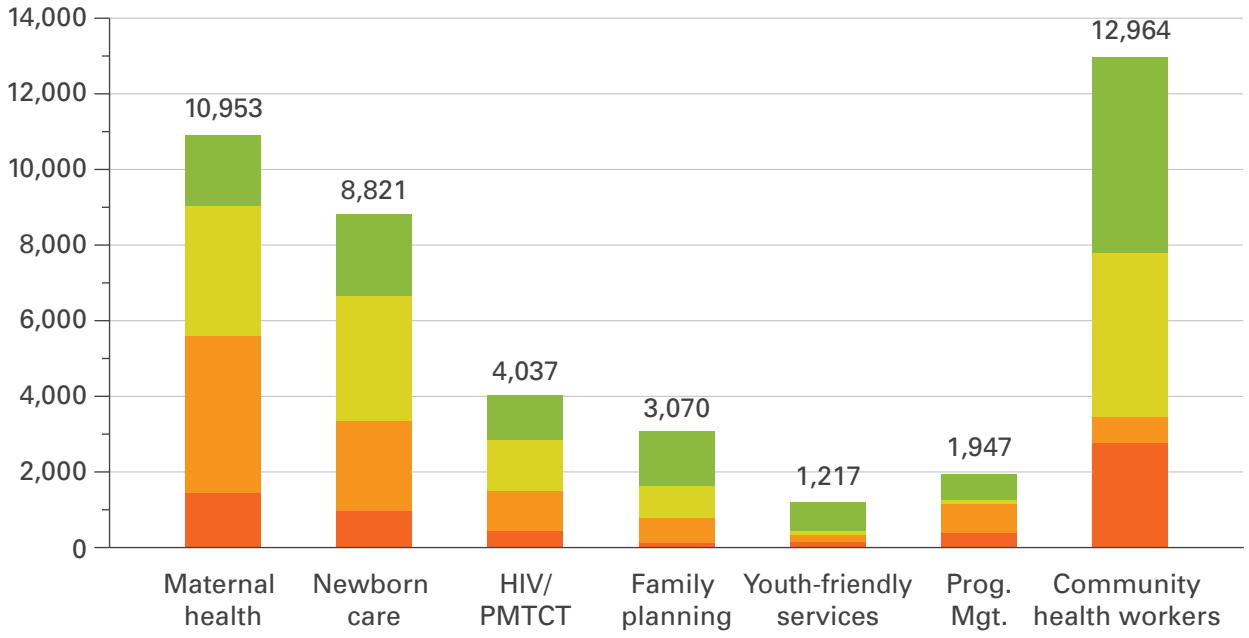
Maternal and child mortality is concentrated in sub-Saharan Africa where there are only 1.3 per cent of the world's health care workers available for the people who experience 25 per cent of the global disease burden. Midwives can deliver 87 per cent of all essential sexual, reproductive, maternal and newborn health care services. Yet only 42 per cent of the world's health care providers with midwifery skills work in the 73 countries where more than 90 per cent of all maternal and newborn deaths and stillbirths occur. Thus training new midwives and reinforcing the skills of the existing ones remained a priority strategic intervention of the H6 Joint Programme.

The intervention supported by the H6 Joint Programme included strengthening of quality pre-service midwifery education through skills enhancement training for capacity building of tutors, provision of teaching aids in pre-service institutions and provision of support to pre-service students undergoing training programmes. This support included the refurbishment of schools, revision of curriculum and standardization of training programmes. In addition to programme-level progress, work was undertaken at policy level to increase advocacy among policy makers towards the standardization of training curriculum following the International Confederation of Midwives standards and integrating midwifery in national plans and strategies. For example, Ethiopia developed an overarching strategy document, the national midwifery roadmap for 2015-2025, to guide relevant government bodies towards effective planning and implementation of midwifery training programmes to ensure the presence of a skilled birth attendant (SBA) at birth for every pregnancy and childbirth.

Pre-service midwifery training received support in all countries except Zimbabwe. In Guinea-Bissau, international experts were arranged to design curriculum, build capacities of tutors and initiation of a national midwifery programme to address the scarcity of skilled human resource required to make its health system functional. In Zambia, the national government has decided to standardized curriculum of pre-service training to overcome variations in the midwifery skills for the professionals coming out from different training streams. DRC has many different curricula for midwifery in the country ranging from one to three years. Because of this inconsistency, under-skilled midwives are also counted as skilled birth attendants. While use of skilled birth attendants at delivery is reported to be quite high at 80 per cent, the maternal mortality rate also remains high above 700 per one hundred thousand live births.

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. About 29 per cent of the total programmable funds were committed through 2016 to enhancing the skilled human resource basis 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. A total of 43,009 health functionaries received training in a wide range of skills in the realms of 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. Progress in 2016 is presented in Appendix 3.

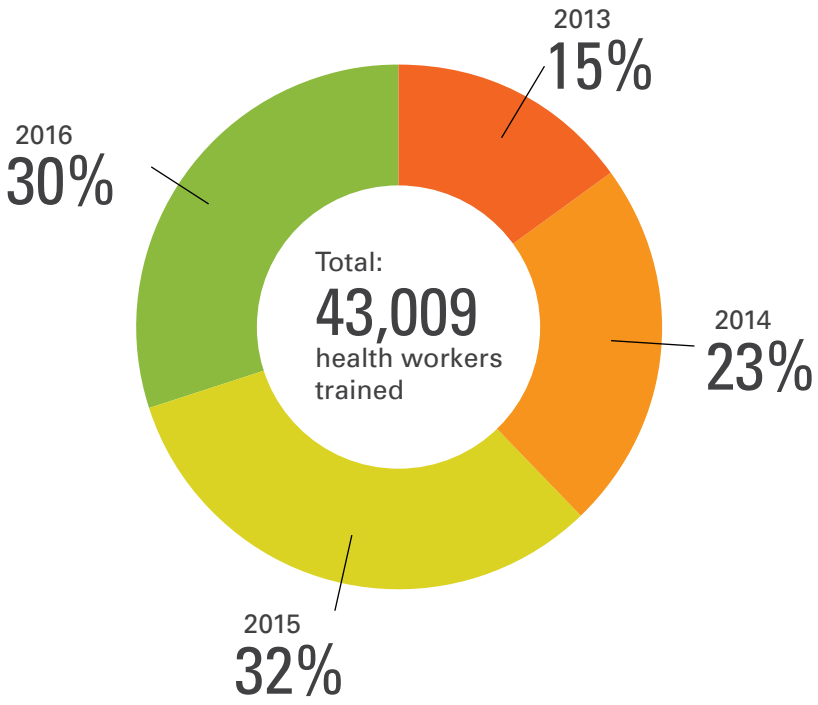
Figure 1: **Increase in human resources for health, by area, 2013–2016**



A total of 43,009 health functionaries

over four years received training to enhance a wide range of skills through initiatives supported by the H6 Joint Programme.

Figure 2: **Percentage of health workers trained by year, 2013–2016**



In 2013, the pace of imparting skills-based trainings to a variety of health care providers in the range of RMNCAH services started gaining momentum. By 2014, all programme countries attained the desired pace to fill gaps in the performance of health care providers. In 2015, Sierra Leone and Liberia organized the training of a large number of community health workers to contribute to the post-Ebola recovery phase to bring back individuals and communities to make use of care at health facilities. At the same time, results of the investment in pre-service training of midwives started contributing to the skilled human resource base of each country. The protocols and standards for quality of services were also reinforced to institutionalize quality of care in the national health system and sustain the gains already achieved. The programme countries have also invested in pre-and post-testing (and in follow up) of training. Effective follow up and assessment of the impact of training took place in the Burkina Faso, DRC, Ethiopia, Zambia and Zimbabwe. Post-tests and follow-up missions to assess competencies and skills often reported positive gains as a result of training.

There were some negative results, however. In the DRC, for example, post-training reviews and supervision reports noted deficiencies in the use of the partograph, and use of less effective practices in newborn care. In Zimbabwe, training and review reports also made negative observations on the use of the partograph. The same reports noted deficiencies such as the non-availability of standard delivery kits, the general condition of labour and delivery wards, and the lack of post-partum haemorrhage packs. In Sierra Leone in 2015, the H6 heads of agencies noted that most of the in-service training programmes in the districts were not supported by supervision and mentoring, leading to enhanced focus for supportive supervision following trainings. Importantly, in both the DRC and Zimbabwe, training review and supervision reports included recommendations for refresher training and increased supportive supervision and mentoring. In Zimbabwe, the review teams also engaged directly in refresher training of staff to help correct the deficiencies they had observed. The mentorship programmes of DRC and Zimbabwe are outcomes of actions on post-training assessment and follow up. This has been scaled up by the national health system of Zimbabwe to cover entire nation. The range of training organized by programme countries are illustrated in Table 3.

"The H4+ approach enables the agencies to work together and put resources together. It was also catalytic in the sense that the agencies also mobilized their own funds for RMNCAH in addition to the H4+ Canada funds. The partners coordinate their work through the Health Sector Coordinating Committee (CNP-SS) commissions, for example UNICEF, UNFPA and USAID for commodities."

Senior Ministry of Health official,
DRC, August 2016

COUNTRY EXAMPLE

Transformative impact of community health workers in Cameroon

Several years ago, the maternity health centre in Guidiguis, a village in the Far North district of Cameroon, was shut down because no one was using it. But then, last year, traditional authorities advocated for its reopening, after seeing a sudden increase in demand for prenatal and postnatal health services in the district.

Across the area, which is inhabited by sorghum farmers, grazers and micro-business owners, antenatal consultations and vaccination records are going up, reversing a trend in the area that local health workers and community leaders describe as "exceptional". The town's traditional leader, Lamido Alioum Amadou, says that times are changing: "Maternal, infant and neonatal health has moved forward here in Guidiguis. Even husbands are now supporting their wives to give birth in the nearest health centre," he says.

The transformation is the result of the work of community health workers (CHW) – volunteers who have been trained and equipped to conduct door-to-door education as well as diagnosis and home treatment of simple malaria, diarrhea and respiratory tract infections, and to spot children with malnutrition. They encourage pregnant women, nursing mothers and children to use mosquito nets, and promote essential family practices. They also offer hospital referrals and help people access medical assistance. CHWs are present in seven health districts across the Far North, a region that is notorious for its poor maternal and neonatal health indicators.

This community health worker initiative was introduced in the region as an innovation in 2013. Since then, health facilities say they have seen the numbers of pregnant women seeking antenatal and the use of skilled birth attendants births go up, while maternal and neonatal mortality are declining. "People have understood and now believe how important the hospitals are, especially for maternal and infant health," says Amadou, one of the trained CHWs.

An analysis of the M&E framework reveals that Burkina Faso, DRC, Zambia, Ethiopia and Liberia achieved more than their targeted training benchmarks for the proportion of health care providers with EmONC skills. In Liberia, at the request of national health authorities the training was also imparted to the health functionaries from non-intervention health facilities in the counties where interventions were carried out. In the remaining four countries, extra trainings were organized to compensate for turnover of skilled EmONC providers. Zimbabwe and Côte d'Ivoire fully achieved their targets. Sierra Leone could not achieve its target for skills enhancement on EmONC as trainings were suspended in 2014-2015 due to the Ebola outbreak. Guinea-Bissau fell short of its target as it took considerable time in the initial stage to mobilize international exports to initiate trainings in 2013. In Cameroon, the scarcity of human resources to impart EmONC trainings resulted in falling short of reaching the targets. At the same time for Sierra Leone, Zambia, Zimbabwe, Cameroon, Côte d'Ivoire and Liberia targets for training community health workers for community based RMNCAH were fully achieved. In the cases of DRC, Guinea-Bissau and Ethiopia, the achievements for community health worker trainings are marginally short of reaching the targets. In Burkina Faso, initial delay in starting CHW trainings resulted in a shortfall in performance.

The H6 Joint Programme has made a significant contribution to improving the capability of health services staff to provide essential services in RMNCAH, especially but not only at the subnational level. The renewed confidence and professional pride which comes alongside the gains in skills and competencies was observed and reported by the end line independent evaluation team during interviews, observations and focus group discussions with health services staff in all four field country studies. By strengthening confidence and professional pride, capacity development investments also addressed the motivation of health services staff.

"Basic EmONC training has resulted in fewer maternal complications and infant deaths. High-risk cases are referred to the district hospital, while others can be managed by the health centre."

Kariangwe Mission Hospital, Zimbabwe, July 2016

Table 3: Training for improved skills and competencies in RMNCAH supported by the H6 Joint Programme

TRAINING INTERVENTIONS	Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe	Cameroon	Côte d'Ivoire	Ethiopia	Guinea-Bissau	Liberia
National/provincial EmONC instructors trained or recruited	X	X	X	X	X	X	X	X	X	X
Provincial/district/facility health service staff trained in Comprehensive and Basic EmONC (doctors, nurses, midwives)	X	X	X	X	X	X	X	X	X	X
Competency-based training of midwives	X	X	X	X	X	X	X	X	X	X
Health service staff trained in Helping Babies Breathe		X								X
Health service staff trained in use of the partograph and when/how to initiate referral	X	X	X	X	X			X		X
Health service staff trained in Kangaroo Mother Care		X								X
Service providers, including community-based distributors trained in family planning	X	X	X	X	X	X		X	X	X
Community Health Workers (CHWs) and Health Volunteers trained in antenatal care, family planning and nutrition	X		X			X		X	X	X
Health service staff trained in integration of HIV in RMNCH, PMTCT and paediatric antiretroviral therapy	X	X		X	X	X		X	X	
Health service staff trained in Integrated Management of Newborn and Child Illnesses (IMNCI) and Infant and Young Child Feeding (IYCF)	X			X	X	X	X	X	X	
Health service staff trained in infection prevention and control for pregnant women in the context of the Ebola Virus Disease	X		X					X	X	X
Health service staff trained in identification, referral and treatment of obstetric fistula	X				X			X		
Provincial/district/facility health service staff trained in youth-friendly services			X	X	X	X	X			X

Output 5: Information systems, monitoring & evaluation: Strengthening programme monitoring and integrating accountability through MDSR

The major support under this output was to strengthen data management systems at the subnational level in the intervention area to initiate and establish data-led decision-making processes. In all programme countries, a key challenge was to collect data through weak health management information systems (HMIS). Advocacy efforts at the national level were made to improve data collection tools and investment was made at national, provincial and district levels to enhance capacity of monitoring officers and programme managers for improved data management. The second major area of investment was to establish and institutionalize the maternal death surveillance and response mechanism towards integration of accountability mechanisms in the public health system all programme countries during 2012–2016.

Under this output, two indicators were tracked. The first relates to proportion of districts that submit timely and complete HMIS report following national guidelines during the last three months. The second is the proportion of intervention districts with a functional MDSR system. Except for Ethiopia and Liberia, all countries achieved programme targets. In Ethiopia, for reporting on these indicators, all maternal health facilities of the nation were covered. As a result, only 72 per cent of the target could be achieved. In Liberia, during 2015, three additional counties were covered to intensify support to country in the post-Ebola recovery phase. Only one intervention facility out of 26 total intervention facilities of six countries failed to achieve targets set under this output.

In almost all countries there have been issues around data recording, management and use of data in decision making. In Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Liberia and Zambia, the national government was engaged to build the capacity of the intervention facilities for recording, compilation, analysis, reporting and use of data in decision making at all levels. In Zimbabwe, the support at the national level for a monitoring expert resulted into establishing processes and integrate use of data by the RMNCH secretariat. In almost in all countries, training sessions were organized to build capacity of key officials and health care providers to strengthen HMIS and promote evidence-based management. In Liberia, as a rapid response to the recovery phase of Ebola, H6 provided support to revive the health system's HMIS. Some countries, however, faced significant challenges. In Sierra Leone, for example, a plan to use mobile devices to support public health (m-health) nationwide was delayed when, in early 2013, the national HMIS cell ceased to function for some time following an administrative enquiry.

Strengthening accountability through Maternal Death Surveillance and Response

Support to the establishment, strengthening and operation of systems for maternal and newborn death surveillance and response at national, provincial and district level has been a core element of H6 Joint Programme. It has also been one of the most significant areas of contribution to results at country level towards infusion of accountability in national health systems.

In 2013, technical guidelines for MDSR were developed as a part of H6 Joint Programme global-level activities followed by training of regional and country facilitators from 23 countries. Subsequently, all 10 H6 Joint Programme country teams received orientation in November 2013 that contributed to augmenting MDSR establishment and institutionalization processes.

MDSR systems were strengthened in three main ways. First, support was given towards the establishment of policies for MDSR. This included advocacy for new MDSR policies, support in the establishment of government policy and the creation of committees at different levels. Secondly, capacity building of key functionaries to make institutional mechanisms functional for MDSR was prioritized. And third, H6 provided support in the implementation phase from national level to the grassroots level, working with health facilities and community groups in intervention areas to initiate reporting, review and response for maternal and newborn deaths.

In Zimbabwe, for example, the H6 Joint Programme engaged in support to MDSR. At the national level, the programme provided support to the development and finalization of national Maternal and Neonatal Deaths Surveillance and Response (MNDSR) guidelines; development of a national MNDSR data base; roll out of an electronic system for gathering and centrally analyzing MNDSR data and establishment of a national MNDSR committee.

In Ethiopia, all 236 surveillance officers and facility surveillance focal people received training and MDSR is now integrated into all government health facilities (more than 3,700 facilities nationwide) in addition to community-based surveillance mechanisms.

In Côte d'Ivoire, Cameroon and Guinea-Bissau, the notification of maternal deaths was integrated into the national surveillance tools, making it compulsory for the community and for health care facilities to notify national authorities of all maternal deaths.

In all H6 Joint Programme countries, technical and financial support was provided for the development, multiplication and distribution of notification tools and training of the health technicians at all levels on the surveillance and response of maternal deaths.

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 515 health facilities in all of the 10 H6 Joint Programme countries. Two major achievements were reported by all countries. The first was the enhancement of access to quality EmONC services and the second, the integration of PMTCT with the RMNCAH service package at health facilities. Gaps in provision of critical services were identified in the early phase of the H6 Joint Programme to provide strategic and catalytic support as reported in Table 4.

The positive contribution made by the H6 Joint Programme to health system capacity to deliver services in RMNCAH, especially in districts, underserved counties and health zones, hard-to-reach and inaccessible areas is a strength of the programme. The end line evaluation reported that the gains in the quality of care in RMNCAH are at risk as the programme comes to an end. These risks arise on the supply side in relation to the capacity of health services to provide quality care in RMNCAH. On the demand side, the risks arise from the potential rapid drop-off of community engagement activities and the breakdown of levels of trust attained with a significant contribution by the programme. Conscious efforts with H6 country teams are being made to develop and execute transition plans in a timely manner to sustain programme gains.

In all countries, integration was affected in a number of ways including through policy, programming and training. Efforts were made to integrate critical RMNCAH services within health facilities in order to increase access for users. A good example of this is the significant effort made to integrate PMTCT and pediatric antiretroviral therapy into maternal and newborn services in facilities in target districts. Similarly, in many countries like Burkina Faso, Côte d'Ivoire and DRC, family planning was integrated with the RMNCAH service package. In Burkina Faso, the baseline for deliveries attended by skilled birth attendants in the Central North region was 69.8 per cent and in the North region 62.7 per cent; this has increased to 88 per cent and 93 per cent respectively, fully achieving targets for 2016.

Similarly the use of modern methods of contraception (CPR) in the Central North region was 9.3 per cent and in the North region 10.4 per cent yet this has improved to 36.4 per cent and 29.7 per cent respectively, though remains short of achieving the target of 40 per cent by 2016. DRC faced challenges in achieving its targets due to high turnover rates of health care providers. Sierra Leone also faced challenges with the outbreak of the Ebola virus; however, by engaging the force of community health workers, significant process was achieved. By the end of the programme, H6 was able to revive and maintain EmONC services in nine health facilities in two intervention districts.

Zambia deployed a context-specific technique, using a differential strategy for the provision of services through engaging retired midwives, when 33 retired midwives were hired to make 30 intervention health facilities functional 24-hours a day seven days a week. Simultaneously, nurses working in maternity care units were sent for a one-year training to upgrade their midwifery skills. The trained nurses upgraded as midwives replaced the retired midwives gradually and now health facilities are fully functional. This has led to initiating discussions around retirement age of midwives in the country. The Government of Zambia has increased retirement age from 55 years to 62 years for the midwives. In Zimbabwe, significant work has been done to integrate PMTCT services and timely reporting of dried blood samples for early infant diagnosis (EID). Cameroon targeted facilities in an area facing insecurity through community-based interventions and outreach services. Côte d'Ivoire likewise achieved success through integrating family planning, voluntary HIV testing and cervical cancer screenings within RMNCAH programme priorities.

Guinea-Bissau's national healthcare system faced many challenges due to a dynamic external environment. Efforts were made to strengthen health facilities for the provision of services and to ensure improved outcomes. Referral linkages were strengthened and nine international expert for obstetric, pediatric and anesthesiology specialists were brought in to build capacity of the national health care providers and improve services for maternal, newborn and child care. The challenge is to sustain programme gains in resource constrained setting of the nation.

Table 1: Canada and Sweden grant funding for H6 Joint Programme 10 countries

Country	Needs study	Needs identified
Burkina Faso	EmONC and reproductive health (RH) needs assessments	• Poor geographic and facility coverage of EmONC
Democratic Republic of the Congo	EmONC Needs Assessment	• Health zones with no EmONC services • Deficiencies in equipment for EmONC • Skills deficit in human resources
Sierra Leone	Mapping needs of RMNCAH services during Ebola Virus Disease recovery	• Infrastructure to be improved • Increase availability of essential medicines and supplies • Training and supportive supervision
Zambia	Review of achievements in reducing maternal, neonatal and child morbidity and mortality	• Shortage of skilled health personnel • Low rate of skilled birth attendance • Poor family planning services • Weak EmONC services • Limited use of referrals • Lack of maternity waiting shelters
Zimbabwe	National integrated health facility Assessment and H4+ quarterly planning meetings	• Poor availability of EmONC supplies and equipment • Weaknesses in commodity availability • Underutilized youth-friendly corners
Cameroon	National study of distribution of health workers in remote areas Qualitative rapid assessment study on barriers related to gender inequality and social-cultural norms and practices faced by women in health care settings Client satisfaction survey to evaluate care and services provided at health facility level in the implementing health districts	• Need to increase staffing and redeployment to remote/inaccessible areas • Need to address barriers related to gender inequality faced by women in health care settings, focusing on social and cultural norms and practices • Need to improve the satisfaction level of clients and services provided at health facility level
Guinea-Bissau	Gap Analysis of MCH Aides Curriculum	• Gaps in family planning, gender-based violence (GBV), adolescent health, PMTCT and EmONC
Liberia	Situation Analysis for RMNCAH	• Poor utilization of facilities • Under-served geographic areas • Lack of female empowerment • Harmful cultural traditions and practices

Improved access to quality EmONC: H6 makes significant contribution to reducing maternal and child mortality

In every one of its 10 countries, the H6 Joint Programme was engaged in efforts to strengthen EmONC. At the national level, support was provided for the development of national EmONC needs assessments, plans and guidelines as well as for the revision of pre-service training curricula and supporting national and provincial level pre-service and in-service training institutions for doctors, nurses and midwives.

The H6 Joint Programme invested in support for the training of health facility staff in Basic and Comprehensive EmONC. In most programme countries, this support to training was also accompanied by provision of training equipment (mannequins) and decision aides such as the partograph. In addition, all 10 countries received support in procuring and distributing need-based essential medicines for EmONC, including oxytocin and misoprostol to be compliant with clinical protocols. This combination enhanced skills and improved the service environment, and allowed service providers to make better decisions on referrals and to provide prompt services to avoid the second and third of the "three delays" contributing to preventable maternal deaths.[6] In some cases, like in Cameroon, Côte d'Ivoire, Liberia, Guinea-Bissau and Zimbabwe, this has included the refurbishment or construction of health facilities. Resources were also committed to improve referral linkages, for example through the provision of transport services and communication tools.

In Zambia, six ambulances, two motor boats, 10 motorbikes and 41 radios were provided, strengthening referral systems to reduce delays in EmONC treatment. However, poor road connectivity contributing to transportation issues remains an important bottleneck to effective referrals in many countries.

As a result of these efforts, tangible results were reported by all countries. The enhanced number of facilities offering the full range of EmONC services lead to improved coverage and quality of care (both due to the skills of providers and availability of medicine, supplies and equipment). Referrals were made more efficient, and policies were strengthened. In Ethiopia, 319 integrated emergency surgical officers received a three-year-training to ensure provision of comprehensive EmONC services in 101 maternity facilities. These facilities represent one third of all designated maternity health facilities in the nation.

The improved access to quality EmONC services in all 10 countries represents one of the most significant achievements of the H6 Joint Programme.

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

COUNTRY EXAMPLE

Saving babies born with complications in Ethiopia

When **Betselot Addisu** of Ethiopia was born prematurely at around seven months of pregnancy with an extreme low birth weight of 700 grams, no one thought she would live another day. She was delivered by operation at a private hospital to save her mother who was in critical condition with severe high blood pressure. Betselot was immediately taken for incubator treatment, to simulate the warmth of her mother's womb, for 12 days then referred to a hospital.

Betselot was admitted to the advanced Neonatal Intensive Care Unit (NICU) at Yekatit 12 College Hospital with severe anaemia and the onset of damage to the intestinal tract (necrotizing enterocolitis), which is the second-most common cause of mortality in premature infants. At the hospital, Betselot received close attention and care from the unit's special newborn clinical nurses and doctors, particularly Dr. Mulualem Gesesse, the only neonatologist practicing at the hospital. Betselot stayed under NICU until she was discharged at the age of 61 days when her weight increased from 700 grams to 1,100 grams, with no sign of infection. She was able to breathe on her own and was tolerating oral feedings.

The referral service of the Yekatit 12 College Hospital NICU, which serves a population of 4 million, was strengthened under the H6 Joint Programme. According to Mr. Abrham Adane, the Neonatology Case Team Coordinator, as a result of the advanced newborn care service, newborn survival is showing some improvement in the past few years.

At the age of 20 months, in April 2015, Betselot visited the hospital with her parents, Mrs. Wubeshet Gezaw and Mr. Addisu Mengeste, at the invitation of Dr. Mulualem. She is an active and bright toddler. She walks, tries to communicate with her parents and she looks very happy. Her parents say they are astonished by how their daughter thrived through their prayers and the support of all staff at Yekatit 12 College Hospital. ''We were not thinking that our first born will survive," Wubeshet said.

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

H6 country teams invested in community engagement and mobilization using a wide range of strategies and approaches. UN Women supported the development and operation of community-based organizations engaged in addressing issues of girls and women's empowerment and adolescents' sexuality. UNAIDS focused strongly on the use of mass communications (e.g. mass media, printed material, radio programming) while UNFPA worked more directly through support to community groups (e.g. peer educators, traditional and religious leaders, police). UNICEF also provided direct support to community organizations, especially to combat gender-based violence and to promote community practices for enhancing child survival. The World Health Organization provided most of its support to supply side efforts, but also engaged with communities on MDSR.

Reaching end users among vulnerable, marginalized, underserved or neglected groups was a challenging process requiring multiple levels of engagement. Community engagement was given varying degrees of support in H6 countries. The combined investment in building community demand across the 10 countries averaged 11 per cent of all expenditure (Figure 4). However, this masks a significant variation across the 10 programme countries. In Ethiopia, 2 per cent of H6 Joint Programme expenditures were targeted towards community demand, while in Liberia it was 27 per cent (almost three times higher than the average of 11 per cent). Cameroon, Guinea-Bissau, Sierra Leone and Zambia all spent less than 10 per cent while Burkina Faso, Côte d'Ivoire, DRC and Zimbabwe spent between 10 and 13 per cent.

In all countries, efforts were made to increase demand through engaging communities to promote participation. DRC and Zimbabwe engaged community and political leaders. Liberia and Sierra Leone used community workers to raise awareness about RMNCAH issues. In Sierra Leone traditional birth attendants (TBAs) were trained as Community Wellness Advocates to promote MNCH, refer clients for institutional delivery and provide information about family planning and gender-based violence.

Ethiopia and Zambia created community action groups and Cameroon and Guinea-Bissau used multiple channels to enhance community partnerships and ownership. In Guinea-Bissau, for example, community advocacy activities to promote voluntary HIV testing among couples including awareness raising, counseling and free testing services received positive response from the community.

The H6 Joint Programme has been able to implement some important demand side interventions that have been effective, with practical approaches to reaching marginalized communities and increasing access to vital RMNCAH services. In Liberia, CHWs were retrained to accompany pregnant women to health facilities; Mama kits were distributed in Zambia; maternity waiting shelters were constructed in Guinea-Bissau, DRC, Liberia, Zambia and Zimbabwe; and community and religious leaders were engaged in Liberia, Zambia and Zimbabwe. However, with a few exceptions, these demand side activities were not well documented and formally assessed. This led to limited opportunities to demonstrate how to make progress around demand creation for integrated RMNCAH services.

"The H4+ project has really improved things in this area. As Safe Motherhood Action Groups (SMAGs), our work has been made easier because we have been given bicycles and as such we have been able to reach a lot of people. More women are now having live births as a result of delivering at the health facility. About four years ago, maternal and neonatal births were really bad in this community and many people blamed it on witchcraft but today I can testify that that is a thing of the past. As SMAGS we have been sensitizing the community and H4+ has contributed a great deal."

Community Health Worker, Serenje, Zambia, July 2016

COUNTRY EXAMPLE

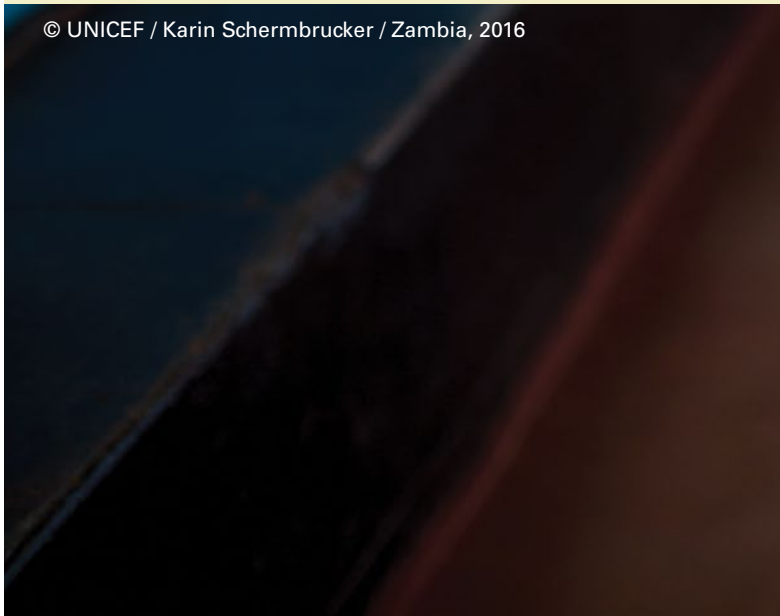
Safe Motherhood Action Group in Zambia

In Zambia, members of the **Safe Motherhood Action Group (SMAG)** are changing behaviour in their communities. Two members of such a group associated with the Chadiza Rural Health Hospital, Eastern Province, speak to the impact of their work.

A male group member helped a couple living with HIV achieve better health: *"A couple who had tested HIV positive in the catchment did not want to go back to the hospital for medication. Their health condition started to deteriorate and I went there to encourage and educate them about the importance of treatment. I personally persuaded and brought them to the clinic. Until now they are on medication and their health conditions have improved,"* he said.

A female SMAG member addressed reproductive health issues: "*Another mother had an abortion but did not want to go to the hospital, but after I counselled her she came to the hospital and now has been able to get pregnant again and delivered her baby,"* she said.

Guidance from both a male and a female SMAG member encouraged an adolescent to seek health care: *"An 18 year-old in-school girl with HIV was pregnant and did not know what to do. I encouraged her to go to the hospital for medication. A female SMAG encouraged her also to go to the hospital where she enrolled in antenatal care, delivered and was then admitted back into school,"* the male group member said.



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Output 8: Communication and advocacy: Global and country level

At the global level

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

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

- The H6 Partnership increased its engagement with a number of advocacy communications arms of UN agencies, bi-laterals, civil society organizations and other multi-stakeholder bodies to collaborate on the promotion of UN International Days such as World Prematurity Day, the Global Maternal Newborn Health Conference in Mexico City, the Women Deliver conference and other international meetings – as well as ground-breaking reports like The Lancet's Series on Ending Preventable Stillbirths. The H6 global technical team[7] shared this knowledge with countries and developed social media materials to further align visions and voices.

- Communication and advocacy has focused on support for the plans and activities of the Every Woman Every Child movement, including promotion and support for the launch of the UN Secretary-General's progress report and the updated Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).

- The H6 has promoted innovative approaches to, and profiles of, those who have benefited from partnership activities, which were documented and curated for social media and for sharing of best practices.

[7] The H6 Global Technical Team provides technical and managerial oversight support for the H6 partnership.

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

Figure 2: The H6 News Site: *h6partners.wordpress.com*

At the country level

H6 Joint Programme countries increased their engagement and generated targeted and forward-looking communication interventions, offering many innovative and effective strategies supporting H6 messages about RMNCAH. In Burkina Faso, H6 successfully advocated to maintain the national budget line with a commitment of 375 million CFA of domestic resources towards contraceptives and to mobilize donor funding for the remaining interventions. This resulted in a 50 per cent reduction in the out-of-pocket cost of contraceptives. In DRC, high-level advocacy support resulted in $2.5 million (US dollars) being spent by the national government on contraceptives, for the first time in DRC, as well as in the development of the country's family planning vision 2030. However, advocacy efforts could not yield results in case of the bill on reproductive health law for receiving approval of the DRC's National Assembly.

In Côte d'Ivoire, eighteen radio professionals were trained and received materials for the production of broadcast programming on the promotion of RMNCAH. The local radio reporters from the targeted health district areas were not only encouraged to talk to their listeners about the importance of the health of mother and child, but also to work with health officials as partners for the dissemination of awareness messages. This facilitated awareness generation processes and demand for services in the intervention communities. Also, in Sierra Leone, journalists were trained on how to report about RMNCAH issues. This has resulted in expanded coverage of RMNCAH issues in the print and electronic media.

In Zambia, the advocacy initiatives were successful for seeking concurrence of key stakeholders to provide comprehensive sexuality education, targeting adolescents and women of child-bearing age in communities and schools in the Chama and Chadiza districts.

Ethiopia ran a safe motherhood campaign in the month of Tirr (January-February 2016) with the main theme of providing "Respectful and compassionate maternity care". Maternal health was also the focus of visual and print communications in Guinea-Bissau in 2016, where H6 also supported the production, printing and distribution of communication materials about gender-based violence, discrimination against people living with HIV, family planning, female genital mutilation (FGM), forced and/or early marriage.

In Zimbabwe, advocacy was conducted to improve the effectiveness of training programmes by incorporating mentorship of trainees. This became a part of the national strategy for human resources in health.

"The H4+ country team has good relations with the Ministry of Health at a senior level. The team reports close coordination and a high level of collaboration. National health authorities report that the process of consultation and coordination of H4+ joint programming was effective in avoiding or eliminating overlap and duplication of efforts."

Evaluation Reference Group-Liberia, 2016

Addressing the root causes of gender inequality

Gender inequality is often an underlying cause of poor maternal health outcomes. The H6 Joint Programme assigned priority by taking an active approach through supply side (systems and inputs) and demand side (community engagement and women's empowerment). Adverse effects on women's access to healthcare are linked to socio-cultural practices that discriminate against women and girls, including unequal relationships, limited financial autonomy and the prioritization of male health. Addressing these root causes can improve RMNCAH outcomes.

- **Burkina Faso** – Gender mainstreaming was encouraged through a 2016 event with the theme of "Agricultural entrepreneurship of women: obstacles, challenges and perspectives." In previous years, Burkina Faso has also addressed gender through advocacy for laws prohibiting violence against women and girls (passed in 2015), rural credit associations for women (2014) and Husband Schools to enhance male participation.

- **DRC** – H6-supported gender equality interventions worked with community leaders and members, both men and women. In 2016, DRC organized women's cooperatives around income generating activities to create mutual health insurance as well as 72 clubs reaching 3,000 men and boys to promote women's rights and reproductive rights.

- **Sierra Leone** – With support from H6, the Ministry of Social Welfare, Gender and Children's Affairs worked on a community empowerment project mobilizing traditional birth attendants (TBAs) around issues of gender-based violence and reproductive health for community advocacy and outreach. Community Advocacy Groups (CAGs) have engaged in community outreach in their respective communities – making referrals, promoting family planning awareness and addressing problems of gender-based violence.

- **Zambia** – Activities in 2016 raised awareness among traditional leaders on gender-based violence and the human rights of girls and women in five implementing districts. Since the start of the programme, Zambia has emphasized the involvement of men as volunteers in order to promote male involvement and participation in MNCH programming.

- **Zimbabwe** – The focus of H6 interventions has been on gender mainstreaming in health and community activities to address root causes and structural barriers that affect the health of girls and women. Men were trained as community-based advocates in the three districts. The community-based advocates were empowered on effectively engaging communities on RMNCAH and safe spaces (forums) were created in the communities for adolescents and young women for confidence-building activities, engagement and information-sharing.

- **Cameroon** – A strategic document guiding a gender approach for MNC mortality reduction programmes was developed. In the Far North region, the poorest in the country, H6 has supported efforts to address the root causes of low utilization of health facilities and lack of health-seeking behaviour. Some 73 women's groups received technical and material support to develop income-generating activities and to promote RMNCAH.

- **Côte d'Ivoire** – As part of the 'Husband Schools' initiative, communities in 35 villages were sensitized to promote gender equality. Further, training modules for community actors about the socio-cultural barriers to PMTCT were made available.

- **Guinea-Bissau** – The H6 programme supported development of a comic book about gender-based violence in 2016. It was written in the most widely spoken language, Creole, and featured drawings by one of the most well-known comic-book authors in the country. This book aimed to sensitize men about the urgent need to end violence against their female partners.

- **Ethiopia** – The Ministry of Health developed a manual on "Gender Mainstreaming in the Health Sector." The manual was introduced through a series of workshops covering all eight regional states across the nation to sensitize all cadres of health workforce.

- **Liberia** – Meetings and group discussions were held in Liberia in 2016 to address gender roles, gender equality and gender-based violence, engaging both young men and traditional leaders. Community leaders are now involved in the dialogue on women's rights, women are coming forth to report cases of abuse, and men are accompanying their partners to the health facilities for pre- and post-natal visits and routine immunization visits.

Innovations and scaled up interventions at country level

One of the pillars of H6 is to promote local solutions to the challenges and barriers faced by enhancing RMNCAH quality of care. Between 2013 and 2016, country-led strategies have proven to be catalytic as well as inspirational for other countries. Innovations and lessons developed in one location have been shared across nine of the countries in the H6 Joint Programme through the H6 annual inter-country meetings and through H6 information sheets. Successful innovations have been incorporated into successive work plans, laying the foundation for sustainable ongoing interventions.

Context-specific strategies

This progress has been achieved through context-specific strategies that can be grouped into four categories.

The first area is training, which has been used in innovative ways. Competency-based EmONC training was conducted in DRC, for example. The H6 Joint Programme supported the development of training materials that laid the foundation for expanding quality MNH care beyond the targeted regions. The competency-based manual is now used by all development partners, resulting in a harmonized approach. The H6 Joint Programme funding also helped create a national three-year midwife education curriculum following ICM standards which was officially adopted by a ministerial decree. The new curriculum was integrated in 38 training institutes and, in 2016-17, H6 is planning to support eight training institutes to contribute to the training of teachers, of internship mentors and of clinical trainers.

Similarly, Ethiopia and Zimbabwe have both used training-based innovations. 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. In Zimbabwe, clinical mentorship and supportive supervision was developed and implemented.

The second strategy represents non-monetary incentives, which have been used to increase demand for services. In DRC, Family Health Kits were piloted and implemented in Mbanza-Ngungu and then extended for four other health zones. The government (supported by UNICEF) decided to implement the pilot approach in other health centres in the country in partnership with the World Bank, the Global Fund, the European Union and Gavi, the Vaccine Alliance.

Liberia and Zambia used Mama Kits to encourage institutional delivery. Mama Kits are collections of useful baby items including hats, diapers, blankets, petroleum jelly, plastic bath tubs and other products. They were given to women who had attended antenatal services and delivered in a facility in both Liberia and Zambia. Mama Kits were appreciated by the communities, midwives, mothers, health volunteers as well as senior Ministry of Health officials, other cooperating partners and H6 partners themselves. Based on the evidence generated in Zambia, RMNCAH partners adopted Mama Kits in an additional 19 districts supported by EU and RMNCH Trust Fund support, while Ministry of Health officials mobilized other partners to scale up Mama Kits in other parts of the nation.

The third area 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). 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.

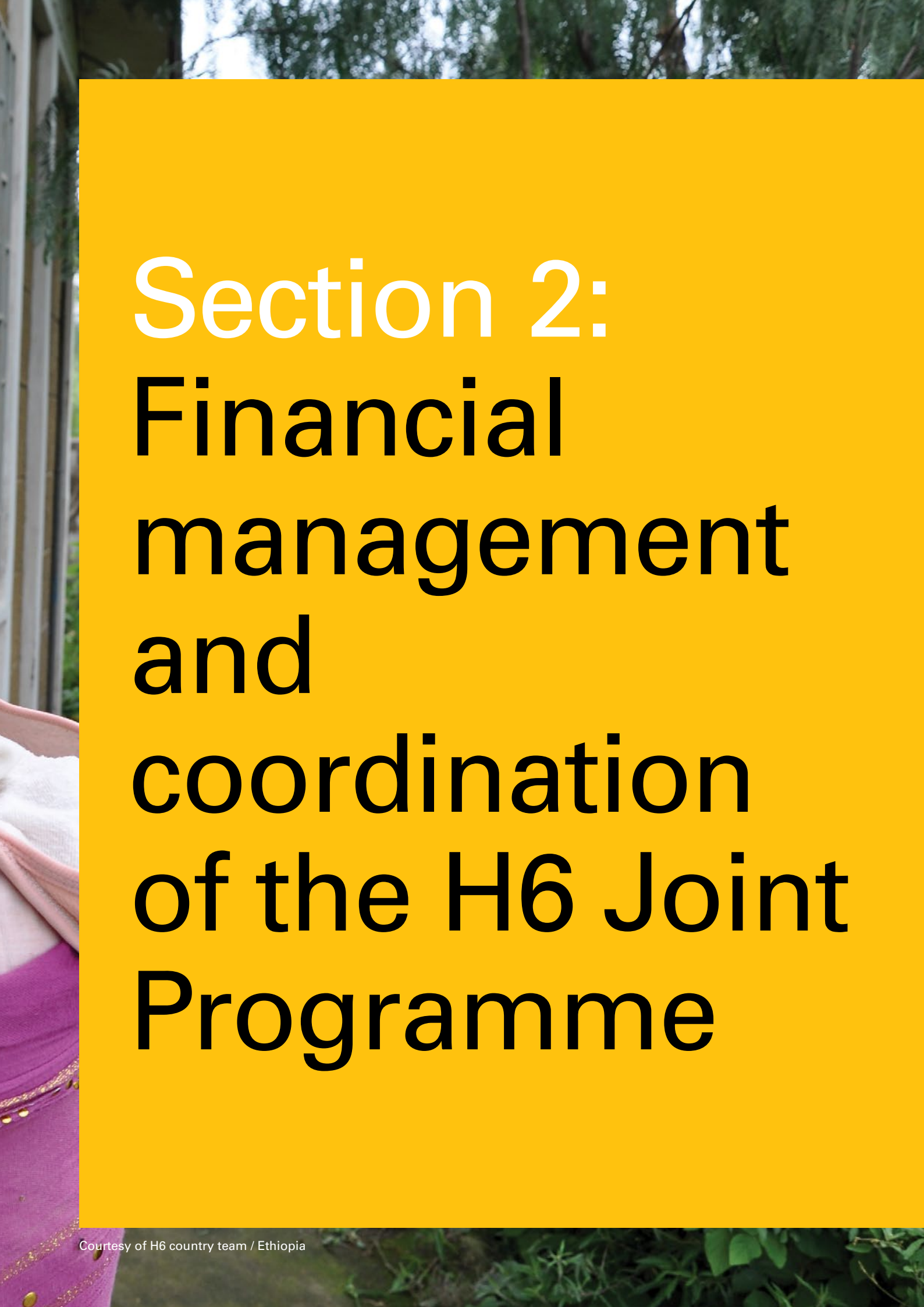
The fourth category is improving the service environment, in particular through the provision of solar suitcases. This is being tested in Liberia, where it has helped to ensure more consistent electricity in health facilities. There is a plan to monitor how the installation of solar units affects attendance 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 problem related to irregular electricity supply.

In addition, Zambia used a differential strategy to overcome a shortage of human resources through the recruitment of retired midwives. Although this innovation was widely appreciated by stakeholders, there is no funding allocated in the public budget as it is not permissible by the regulations. However, the government has changed policy and extended retirement age to 62 from 55 years to keep skilled midwives in the workforce. In the Eastern Province, Sida is funding a replication of a package of H6 interventions including funding for contracts for retired midwives (one midwife per district).

"The EU Millennium Development Goals Initiative (MDGi) programme has adopted the Mama Kits and the government will also incorporate [them] into the next budget, it says."

Senior Ministry of Health Officials, Zambia, July 2016

© UN Photo / Basile Zoma / Côte d'Ivoire, 2012



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

Courtesy of H6 country team / Ethiopia

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 to produce global knowledge products, capacity building initiatives and advocacy for advancing integrated RMNCAH in the 10 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.
- **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 community level for generating demand for improved services.

Table 5: H6 Joint Programme expenditures by partner and programme level, 2011 to 2016
(US dollars)

Partner	Country level	Global level	Total	Percentage of total
UNFPA	32,038,360.25	2,061,039.45	34,099,399.70	36%
UNICEF	20,765,035.02	3,861,402.82	24,626,437.84	26%
WHO	21,330,233.00	3,691,552.00	25,021,785.00	26%
UN Women	3,385,294.51	258,787.07	3,644,081.58	4%
UNAIDS	2,045,671.00	617,783.00	2,663,454.00	3%
Programme management, M&E	—	—	3,900,474.00	4%
Administrative agent charges			997,629.57	1%
Totals	79,564,593.78	14,391,038.34	94,953,261.69	100%
Percentage of total	84%	11%	100%	

Source: H6 Canada and Sida: Final Expenditures, 2011 to 2015 and provisional expenditure 2016.

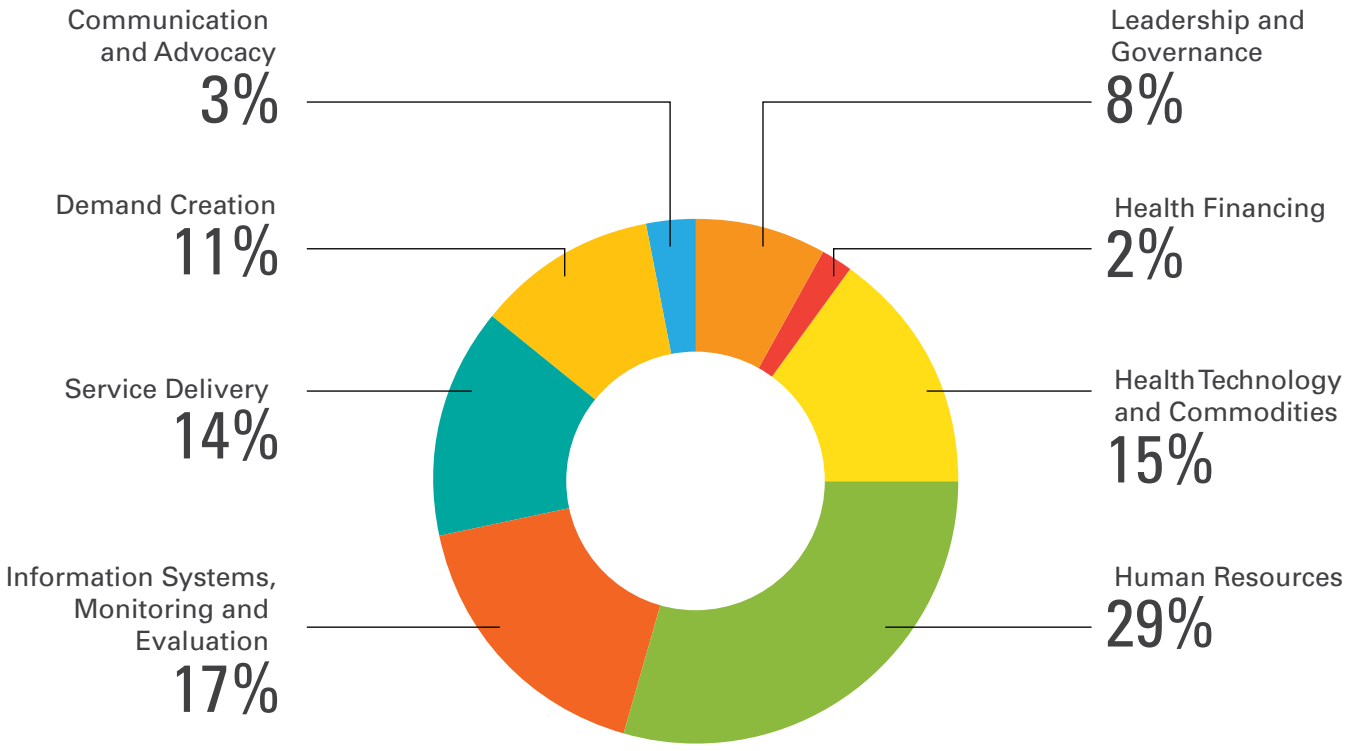
Expenditures for the programme reveal that to the end of 2016, just over 84 per cent of all expenditures were incurred at country level compared with 11 per cent at global level and 4 per cent on programme management including monitoring and evaluation. UNFPA, UNICEF and the World Health Organization accounted for 88 per cent of total expenditures in the same time period.

From 2011 to the end of 2016, the H6 Joint Programme spent $79.5 million at country level on initiatives aimed at eight output areas of health systems strengthening. The majority of H6 Joint Programme country-level investments have been 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 86 per cent of all programme expenditures at country level, while just over 14 per cent of expenditures were dedicated to demand creation and communication and advocacy.

Four output areas account for 75 per cent of expenditures at country level: human resources for health (29 per cent), information systems and monitoring and evaluation (17 per cent), health technologies and commodities (15 per cent), and support to service delivery (14 per cent).

As stated earlier, each country planned and made investment as per existing gaps and to provide strategic and catalytic support to complement existing efforts of the national health systems. The health sector building block receiving the lowest level of financial support at country level has been health financing, which accounts for only 2 per cent of all expenditures. Three countries reported no programme expenditures in the area of health financing, and only four countries (Burkina Faso, DRC, Guinea–Bissau and Sierra Leone) made catalytic investments in health financing, which accounts for more than one per cent of total programme expenditures at country level.

Figure 4: H6 Joint Programme country-level expenditures by output area, 2011–2016



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 Canada and Sida grants. A team of professionals provides guidance, support and facilitation to H6 country teams to develop needs-based and context-specific work plans, in addition to monitoring programme progress and reporting results.

The H6 coordination unit is responsible for organizing Joint Steering Committee (JSC) meetings and reporting compliance with decisions made. From inception to date, a total of 14 Steering Committee meetings have been held. From 2013 onwards, after receiving Sida support, all the following eight Steering Committee meetings were jointly held for the Canada and Sida grant. Two Steering Committee meetings were organized annually, one in person and one via teleconference. These meetings were held to discuss appropriation and utilization of funds, review progress and make decisions to enhance the effectiveness of the programme.

The annual inter-country planning meeting started in October 2011 in Ouagadougou, Burkina Faso, when global, regional and five country teams (with support from Canada) met to develop annual work plans. Following that inter-country planning and review, meetings were held from 29 October to 3 November 2012 in Lusaka, Zambia; 19 to 21 November 2013 in Freetown, Sierra Leone; 26 to 30 May at Victoria Falls, Zimbabwe; and 2 to 6 November 2015 in Douala, Cameroon. In the review and planning meetings, the global technical team updated participants on recent global and regional developments following a reflection with countries on their implications for the H6 partnership. These meetings also promoted cross-learning among H6 countries and teams.

"The programme was able to respond to changing needs. For example, in 2015, UNAIDS had to re-programme activities together with the MoH to align to the new HIV/AIDS national strategic plan 2015–2017. This was discussed with and approved by the Global Technical Team in Douala in November 2015."

H6 country team member
Côte d'Ivoire, 2016

Financial management

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

- **For the Canada collaboration:**

  Of the total $47.18 million received as of 2016 by the H6 Joint Programme, after deducting administrative agent charges, some $46.71 million remained for programming. After deducting programme management and M&E expenditure, net funds available for programming were $43.52 million. Of this, 34.45 per cent was utilized by UNFPA, 30.75 per cent by UNICEF and 34.81 per cent by the World Health Organization. By the end of 2016, $46.54 million had been spent at the global ($9.05 million) and country ($37.49 million) levels.

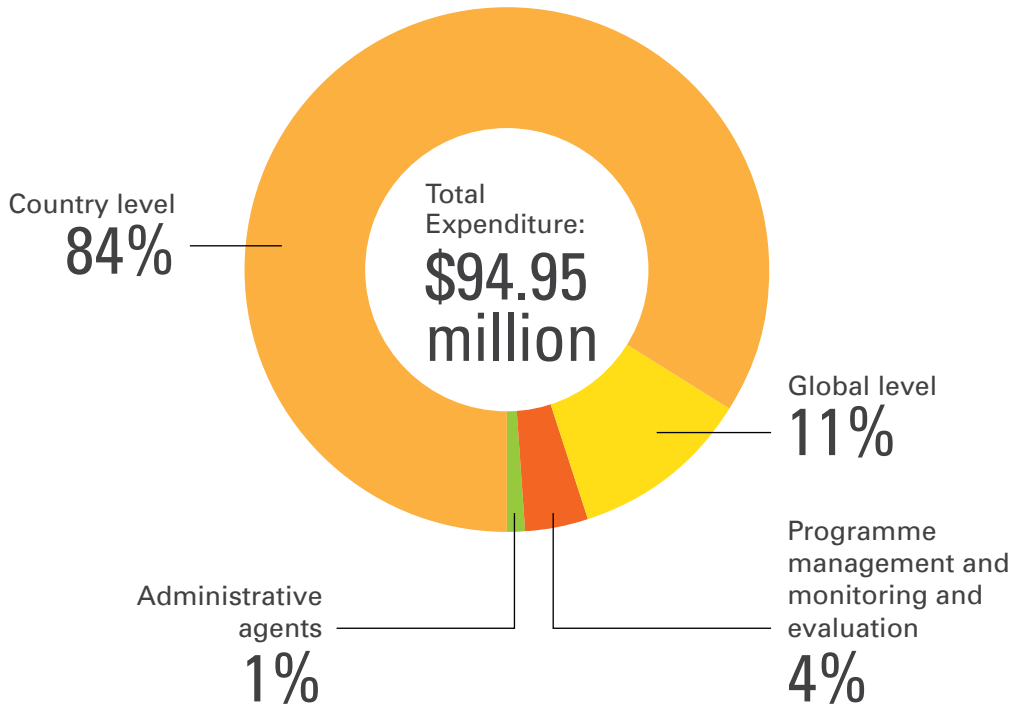
- **For the Sida collaboration:**

  Of the total $52.58 million received as of 2016 by the H6 Joint Programme, after deducting administrative agent charges, some $52.06 million remained for programming. Of this, $42.1 million was spent at the country level and $5.34 million was spent at the global level. By the end of 2016 the total expenditure was $47.42 million. A plan was outlined to utilize the remaining $4.64 million by the end of 2017.

From 2011 to 2016, about $94.95 million was spent including $47.01 million in funding from Canada and $47.94 million in funding from Sweden (Sida). Out of this, 84 per cent was spent at country level, 11 per cent for global-level activities and 4 per cent expenditure was incurred for programme management and M&E activities (which includes inter-country meetings, joint missions, annual report, joint steering committee meetings, and mid-term as well as end line evaluation). The remaining one percent was spent on paying administrative charges to administrative agents (AA).

Country level programming was prioritized and, as such, a larger portion than originally agreed ratio was spent at the country level rather than at the global level.

Figure 5: Percentage of total funds spent at country and global level, 2011–2016



H6 stakeholder coordination and convening role

The convening role of H6 provides an edge to this unique partnership. From the inception of 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 2013–2016, more than 77 H6 teleconferences were organized for the global technical teams represented by all H6 partners and representatives of Every Woman Every Child for improved coordination, more efficient exchange of information, and harmonized responses to key issues and opportunities. Decisions made during the weekly calls were well-documented for follow-up.

H6 global and regional team members participated in joint missions to Côte d'Ivoire, Zambia, Cameroon, Guinea-Bissau, Ethiopia, Zimbabwe, DRC and Liberia in 2015 and 2016. 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 need 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 was facilitated with key stakeholders including government representatives, district managers and H6 partners. Both barriers to progress and enablers of progress were analyzed. An assessment of country strengths and opportunities was conducted to define evidence-based corrective actions to address challenges. The added value of the H6 programme was presented to the development partners and government representatives to sustain programme gains.

"The initiative is an 'eye opener' for me. It can solve many, many issues in country.' The joint missions are the most useful activity. Lala [UNAIDS Regional Advisor] was invited to participate in three missions (Guinea-Bissau, Côte d'Ivoire and the DRC) and each one was very valuable in terms of communication, collaboration and unified programme advice and support to the countries."

H6 Regional Team, UNAIDS, 2016

At the country level

Programme management

In each of the 10 programme countries, 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.

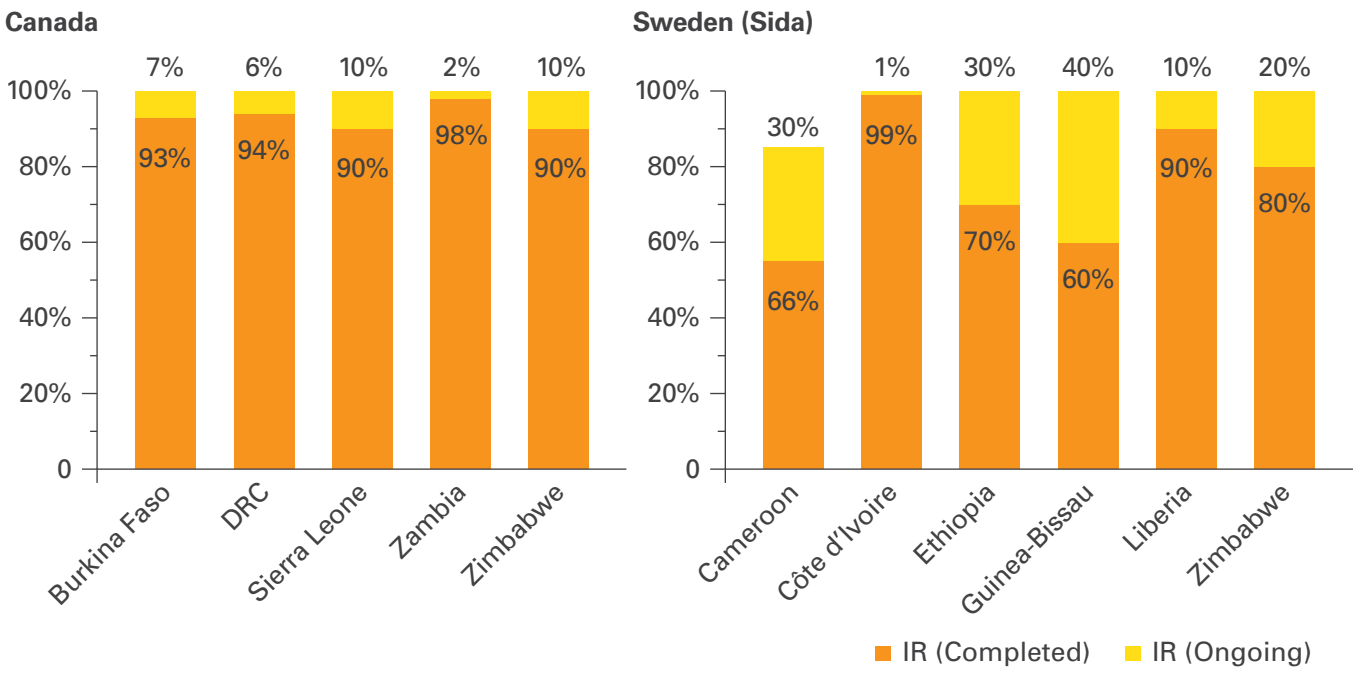
For the countries of the Canada collaboration, **192 activities** were planned for the two years 2015 and 2016. Of those, 177 were completed and 15 are ongoing. The activity completion rate of 2015 and 2016 was 92 per cent overall.

For countries of the Sida collaboration, **324 activities** were planned in 2015 and 2016. Of those, 256 (79 per cent) were completed and 68 activities (21 per cent) are ongoing. Implementation rates for completed and ongoing activities were high in all six countries, averaging 77.5 per cent. They ranged from 99 per cent in Côte d'Ivoire, 90 per cent in Liberia, 66 per cent in Cameroon, 70 per cent in Ethiopia, 80 per cent in Zimbabwe to 60 per cent in Guinea-Bissau. A no-cost extension was approved by the H6 Steering Committee for Liberia, Ethiopia, Cameroon, Guinea-Bissau and the global-level activities of UN Women up to 30 June 2017.

Table 6: H6 lead agencies in H6 Joint Programme countries

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

Figure 6 & 7: H6 Joint Programme activity implementation rate (IR), 2015 and 2016



Financial management

The present trends indicate full utilization of grants received from Canada and Sida. The degree to which the allocated budget was utilized, however, varied by country.

Figure 8 illustrates the state of finances under Canada's collaboration. It illustrates budget utilization by country for the entire period of 2011 to 2016, showing an average utilization rate of 73 per cent. Broken down by country, the data reveals that Zambia utilized 84 per cent, Burkina Faso 78 per cent, DRC 75 per cent, Sierra Leone 68 per cent and Zimbabwe 61 per cent of the funds against approved annual work plans during this period.

Figure 8: Financial progress in Canada collaboration countries, 2011–2016

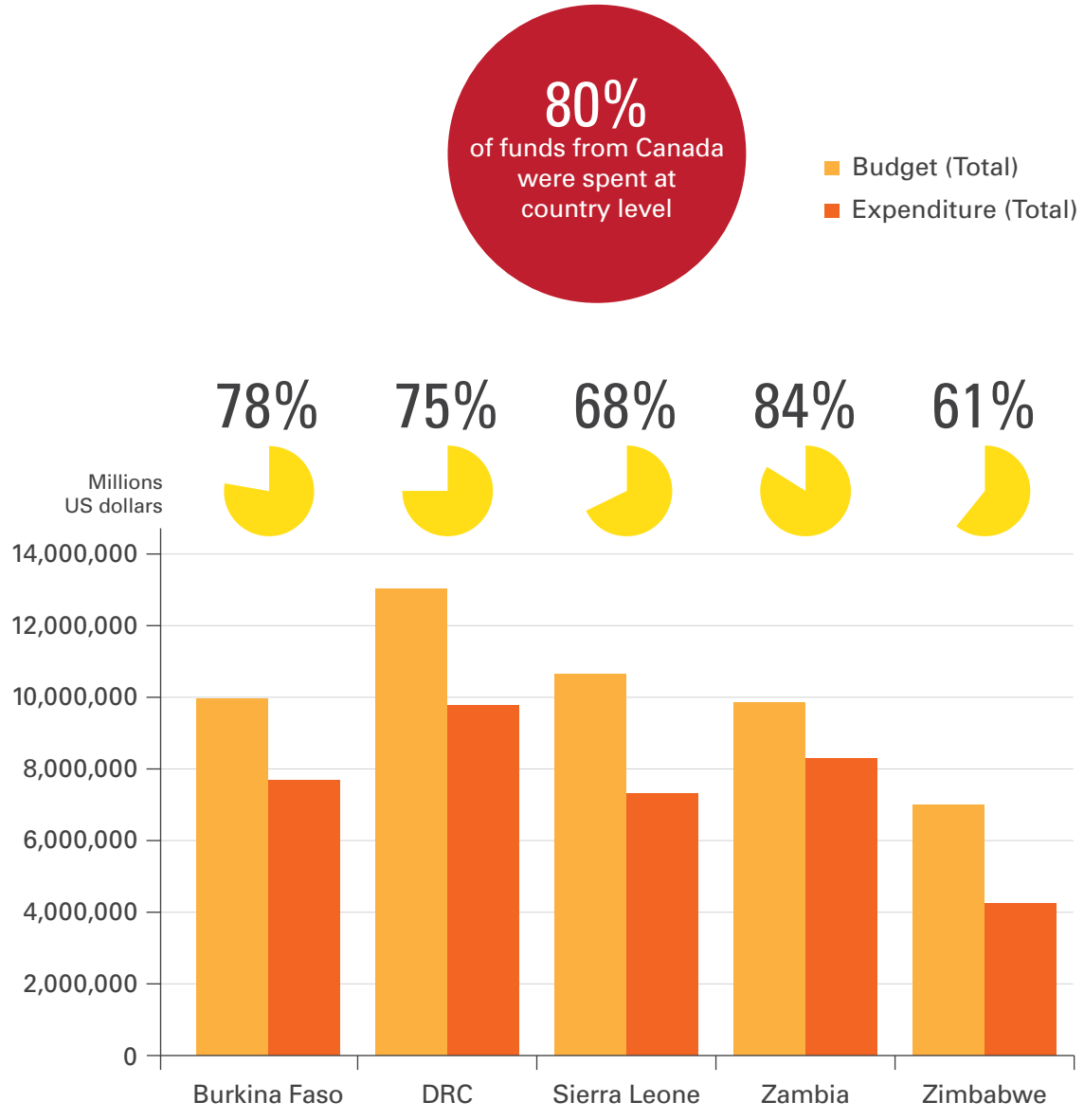
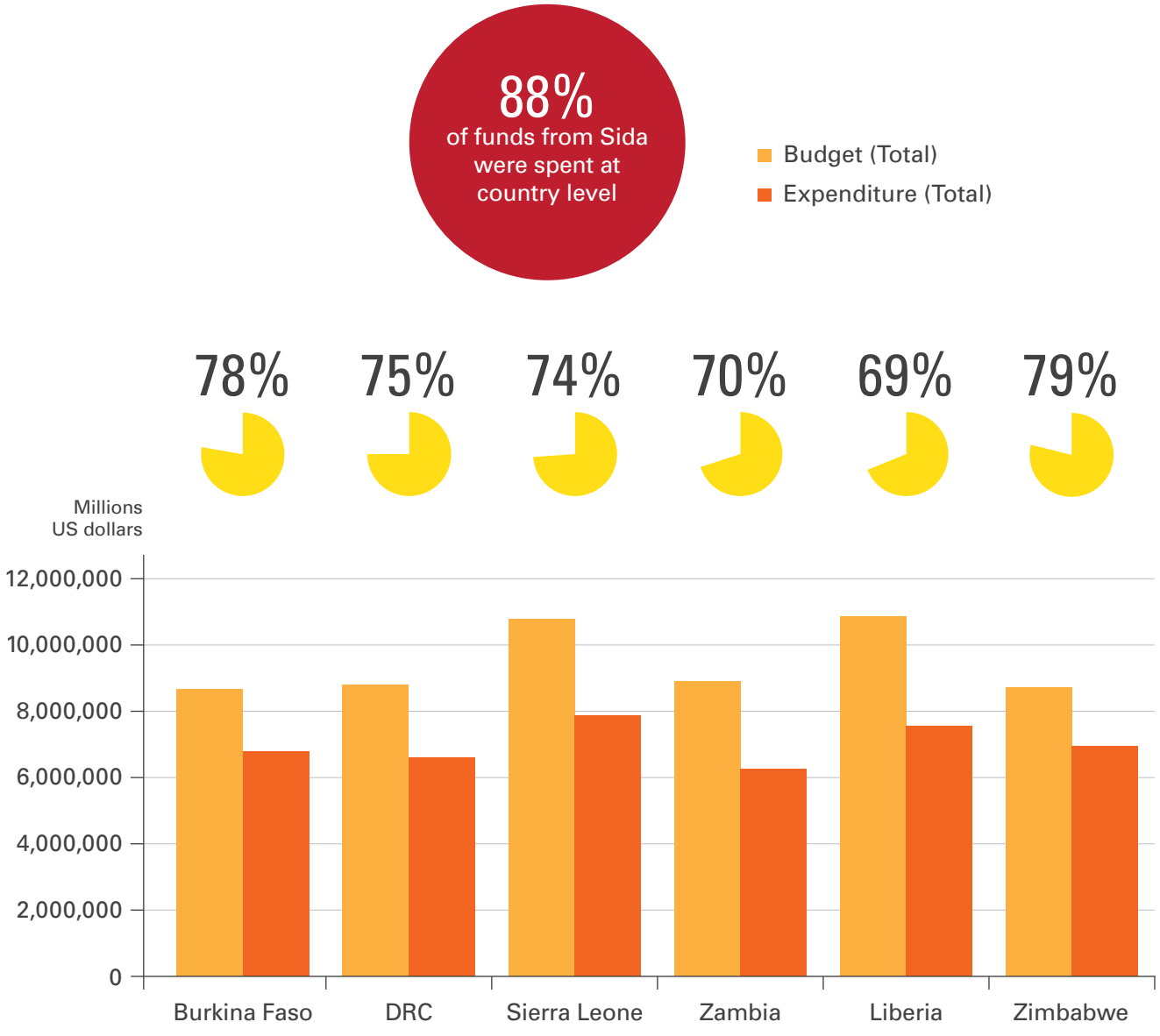


Figure 9 illustrates the state of finances under Sida's collaboration. Some 88 per cent of the programmable funds were dedicated to the country-level activities. Compared with the previous year, the pace of implementation increased in 2015-16, when all six countries attained an average 87 per cent expenditure against a budget of $30.48 million. The total provisional expenditure reported through 2016 for country and global level activities was $48 million against a total grant of $52 million. Overall for 2013-2016 average expenditure was 74 per cent against allocation, ranging from 69 per cent in Liberia to 79 per cent in Zimbabwe.

Figure 9: Financial progress in Sida collaboration countries, 2013–2016



An analysis of the total expenditure against allocation for all 10 programme following H6 Joint Programme outputs is illustrated in Figure 10.

The highest rate of utilization was registered in health technologies and commodities output. This was due to the fact that procurement policies within the UN system were already established. Expanding base of skilled human resources is the next most-utilized category. This is because high priority was assigned considering 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 and demand creation were the other two areas in which funds utilization was high against allocations. Monitoring activities focused on strengthening the national HMIS systems. Success was achieved in established MDSR systems in all programme countries. Demand creation was focused on community level interventions. For the service delivery output, different countries faced context-specific challenges regarding facility operations. Early on (2012-2013) implementation was slow for this output of service delivery but implementation gained momentum from 2014 onwards once factors contributing to service delivery were in place. Health financing has a lower rate of implementation because some of the approved activities were later taken over by the European Union in Guinea-Bissau and delays were experienced in implementing activities in DRC and Burkina Faso during initial years of programme.

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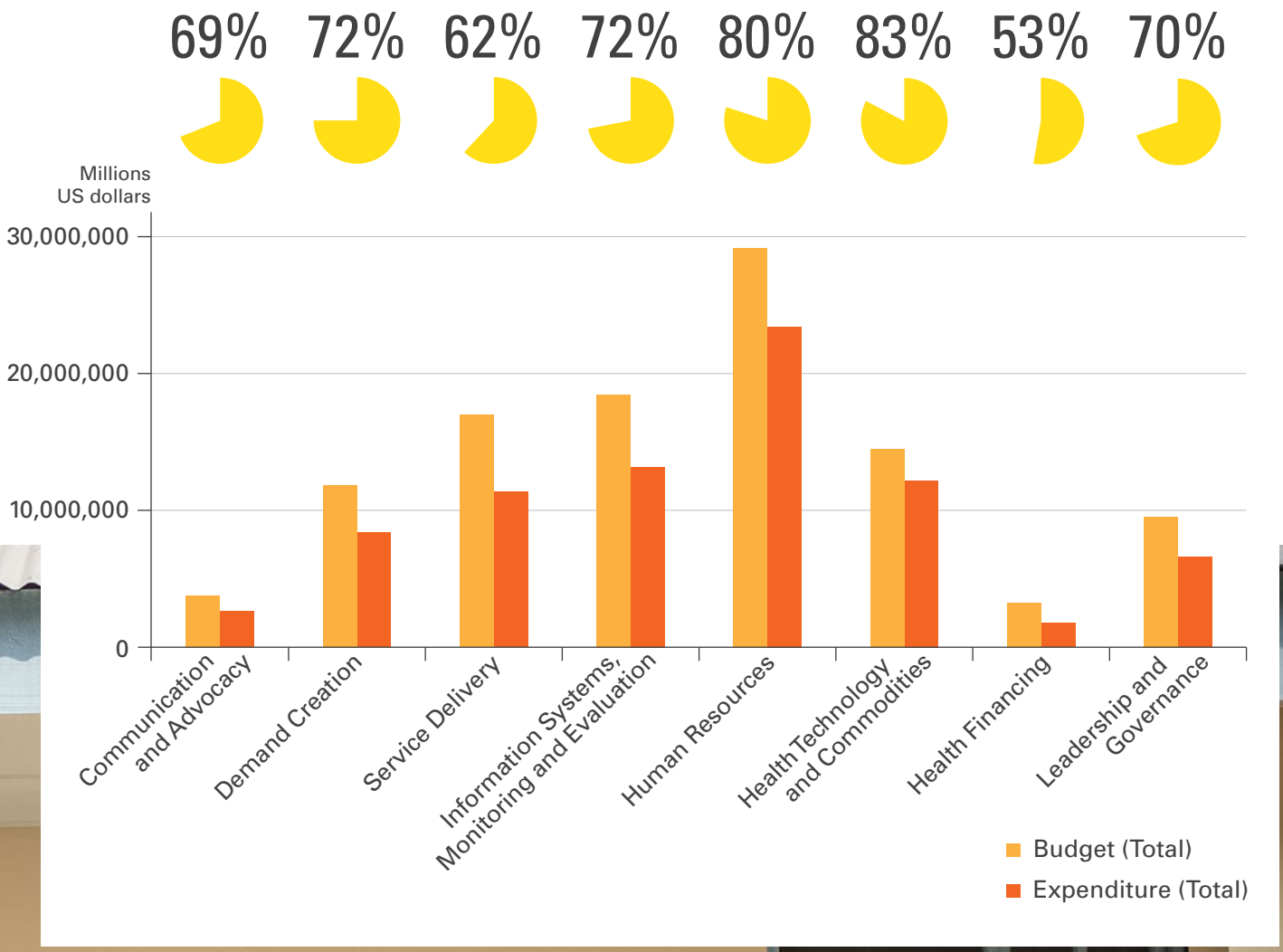
Figure 10: **Budget allocation vs. expenditure by output for 10 countries, 2012–2016**



Section 3: Looking back and moving forward

H6 Joint Programme contribution (2011-2016)

The programme has sought to strengthen national health systems in the 10 countries by supporting initiatives aimed at improving all health systems building blocks along with community participation and demand generation. Within each of these building blocks, programme support has been directed to interventions aimed to improve RMNCAH policies, programmes and services. At global and regional level, the H6 Joint Programme was successful in the development, dissemination and capacity building of country teams for global public goods pertaining to the RMNCAH sector. This included supporting and promoting evidence-informed, rights-based and results-oriented policies and programme interventions to improve the health of women, children and adolescents, which ensures their active engagement in programmes. The H6 played a crucial role in the development of updated Global Strategy (2016–2030) and subsequently mobilizing political commitment and developing operational framework and tools to facilitate planning and implementation by countries.

To demonstrate change, the focus of programme was at country level. At country level, the programme has applied a consistent approach to supporting national health systems while adjusting interventions for country context, needs and priorities. The H6 Joint Programme design followed the strategic approach of Every Woman Every Child (2010). As a result, six strategic interventions were followed by countries based on the national context and complimentary to ongoing efforts of the RMNCAH sector. These included:

1. Positive alignment with national plans and priorities for the health sector, especially as they relate to RMNCAH strategies and programmes;

2. Use of consultative planning and needs identification processes with country leadership and ownership and subnational participation;

3. Investments aimed at expanding the base of skilled human resources through building skills and capacities of individuals and institutions at national and subnational level, especially in EmONC and integrated RMNCAH services to accelerate progress of MDG 4 and 5;

4. Investments in support of integrated package of RMNCAH service delivery through provision of essential supplies, equipment and, improvements to the service environment. This approach was aimed at improving quality of care in RMNCAH, both nationally and in targeted districts and health zones;

5. Promote local initiatives for innovative solutions of programme issues through flexibility in funding;

6. Efforts to build capacity and strengthen data-led decision making by supporting need based improvements in HMIS and MDSR to infuse accountability in public health systems.

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 make 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 subnational level.

At the policy level each country made perceptible progress. Some selected achievements reported by country teams include development of national human resource development plans (2016-18) and capacity building of national schools of public health for competency-based trainings in Burkina Faso. DRC reported success in advocacy to mobilize domestic resources for the procurement of contraceptives and standardizing national pre-service midwifery curriculum following ICM standards. Sierra Leone and Liberia country teams played pivotal roles in supporting the national health systems to manage and revive RMNCAH services during and post-Ebola recovery phases. In Liberia, a huge trench of in-kind support was received in terms of drugs, medicines and supplies that were distributed with H6 programme support. Zambia was successful in initiating advocacy that culminated in the standardization of pre-service curriculum for midwives and enhancing retirement age for the midwives. Zimbabwe and Côte d'Ivoire succeeded in integrating and disseminating clinical protocols and standards to enhance quality of care. National MDSR guidelines and tools were integrated in Cameroon to enhance accountability of public health system. Ethiopia registered success in contributing substantive increase in the human resource base for use of skilled birth attendants. Finally, Guinea-Bissau team supported national health system to rejuvenate capacities of individuals and institutions related to skills of service providers by bringing in international experts to promote evidence informed and rights oriented RMNCAH services.

There were variations in the focus and approach in countries as national contexts vary from country to country. While programme support was almost always complementary to efforts by larger programmes in support of RMNCAH, examples of catalytic interventions were significant in each country. About one third of the financial resources and a major part of energies were invested in capacity building of individuals and institutions for skilled human resources for health for provision of RMNCAH. In some countries, the H6 Joint Programme specifically aimed to change the national landscape of skilled providers, as in Ethiopia. In some countries, such as Guinea-Bissau, a strategic approach to address an issue was aimed at a specific geographic area but it had a snowball effect for the entire country. Efforts to build capacity for service providers at the local level were effective and were followed up by continued testing and in-service supervision. The programme made important contributions to significantly increased capacities in EmONC and, at the same time, promoted an integrated package of RMNCAH services at subnational level as evidenced from 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 facilities. In Burkina Faso, the programme demonstrated the successful integration of family planning in the package of RMNCAH. Zambia demonstrated a sequential strategy to enhance use of skilled birth attendants (SBA), improve referrals and simultaneous community ownership – all of which resulted in higher service utilization of health facilities even in high poverty and remote districts. In Liberia and Sierra Leone, 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; therefore a systematic approach was used to enhance access to and utilization of RMNCAH services. In all countries except Zimbabwe, marked success is registered in shaping pre-service midwifery education.

"In answer to the question 'Did the nurse treat you with respect and courtesy?' all but one of the 40 responses in the exit interview conducted by the evaluation team were positive."

Exit interview from River Gee County, Liberia,
H6 Joint Programme End Line Evaluation Volume II, June 2016

All 10 programme countries have demonstrated a strengthening of accountability through the establishment and institutionalizing MDSR processes. A positive contribution was made to health system capacity through the delivery of services in RMNCAH, especially in underserved and isolated health districts, which is one of the strengths of the programme.

Taken together, these efforts had the effect, especially at the targeted subnational level, of contributing to evident improved access and quality of RMNCAH services. This is backed up by two contributions at country level that are common but of great significance. First, in all 10 countries, evidence-based protocols and standards for clinical services were adapted in health system. Secondly, strategic facilitation and support was provided in developing critical national plans and strategies.

However, each country encountered challenges and faced factors beyond their control that limited success in some areas. The positive contribution made by the H6 Joint Programme to health system capacity to deliver services in RMNCAH, especially in underserved and isolated health districts, counties and zones, is one of the programme's strengths. Paradoxically however, this strength makes one of the programme's potential weaknesses even more consequential. The gains in the quality of care in RMNCAH are at risk as the programme comes to an end. Now the biggest challenge among all of the H6 countries is to develop and implement a "transition plan" to address sustainability. In 2017, conscious efforts are being made in all countries to sustain programme gains. Furthermore, the funds currently pledged for continuing this programme are far less than what is required. Unless additional donor funding is identified, the future is not clear for sustaining hard-won gains and scaling up these innovations.

Lessons learned

The lessons learned over the years of the H6 Joint Programme are drawn from implementation experiences and the end line evaluation findings; such lessons need to be factored in future programming of H6 partnership. This would pave the way to enhance effectiveness and efficiency of future endeavours.

- The 'transition plans' need to be well-woven, to plan and implement programmes that target national and subnational strengthening of health service provision. This requires greater engagement and ownership by policy makers to commit domestic resources as well as by donors and development partners present in the countries.

- Priority action on the social and structural determinants of health and well-being are warranted by the Sustainable Development Goals. This requires the development and promotion of people-centric strategies. Thus, well-sequenced and coordinated support has to balance between demand side and supply side interventions towards engaging individuals and communities to address barriers to access quality services, including sociocultural barriers.

- The broader impediments to the health sector and beyond – including weaknesses in human resources for health, health financing and the general enabling environment – needs collective drive and priority action for transforming weak health systems into resilient ones.

- Adolescents are the biggest population cohort and need attention particularly for RMNCAH programming at the country level. Key aspects of sexual and reproductive health and rights including family planning need prioritization for those left behind, especially young women and girls. To this effect, there is a need to mobilize commitment and support both at global and at country level in the promotion and dissemination of evidence-based and comprehensive approaches to meeting the needs of adolescents, including young women and girls.

- Efforts are required to strengthen the capacity of national authorities to lead programme coordination mechanisms maintaining a chain of coordination to optimize results.
  The development partners have a critical role to facilitate processes that ensure coordination mechanisms reach to the subnational level and include all implementing partners and local health service facilities.

- The repositioning of the H6 process focuses on emerging and sensitive topics as necessary, involving additional partners and other sectors to better link regional initiatives. This requires the development of a clear definition of the regional dimension of its work and corresponding roles and responsibilities for regional offices in supporting country teams.

- In supporting the innovation action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), H6 partners should support systematic approaches to 'linking evidence to policy and practice'. This requires capacity building and technical assistance to country teams.

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. The efforts were initiated in the planning stage of 2015 annual work plan to integrate transition plans to sustain programme gains. Some of the country team's efforts received positive responses and some are in the pipeline. However, sustaining gains made is a major challenge in all programme countries, with adequate funding the most pressing issue.

A **funding gap** exists to sustain gains even in countries with financing plans. For example, in Zimbabwe, the Health Development Fund (HDF) has adopted the H6 approach and some interventions have been integrated in the country's Global Fund proposal. HDF has taken up interventions to address key areas including obstetric fistula, an electronic database for MDSR, interventions within MDSR, clinical mentorship on maternal health and expansion of the management of violence and aggression (MVA). Still, the available resources are not sufficient to meet funding needs to sustain programme gains.

Two out of six H6 Joint Programme counties of Liberia are left with no **external support** and domestic resources fall short of the requirement. The Global Financing Facility is a source sought by countries such as Cameroon and Liberia. In Cameroon, the H6 country team proactively shared learnings from the programme and integrated suitable interventions in the GFF Thematic Fund and 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. Liberia's RMNCAH Investment Case seeks to improve the delivery of EmONC services and enhance the delivery of RMNCAH services at community level.

Working with a variety of international and **domestic and private sector funding sources** is a strategy actively pursued. In Côte d'Ivoire, the H6 worked with other funding sources to implement activities such as the capacity-building of key actors in maternal, neonatal and child health in surveillance and response to maternal deaths (H6 and Muskoka), foreign consultations with a distribution of nets MILDA (Global Fund) and family planning (French Development Agency).

In Burkina Faso, the **national budget** will sustain some of the programme gains. The budget supports funding for childbirth and EmONC, free preventative healthcare for women, free care for management of serious malaria cases with pregnant women and children under five, the provision of contraceptives and PMTCT services.

Capacity building must continue, from supply management to quality of care in services. In Ethiopia, H6 support was 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. Capacity building of individuals and institutions are self-sustaining activities whereas Ethiopia's domestic resources, GFF and SDG pool funds will help to sustain returns on the investments of the H6 Joint Programme.

In Sierra Leone, H6 country team has received funding from the United Kingdom (DFID) to strength the national health system. This includes RMNCAH services under the Saving Lives Programme (2016-2021) jointly implemented by UNFPA, UNICEF and the World Health Organization, which builds on the experiences and interventions of the H6 Joint Programme.

"[H4+] has taught us how to be accountable not just with H4+ but also with others. Also, an improvement in terms of focus – more focus on delivery. Undertaking the Bottleneck Analysis was important. Now we need to do this with our own funding."

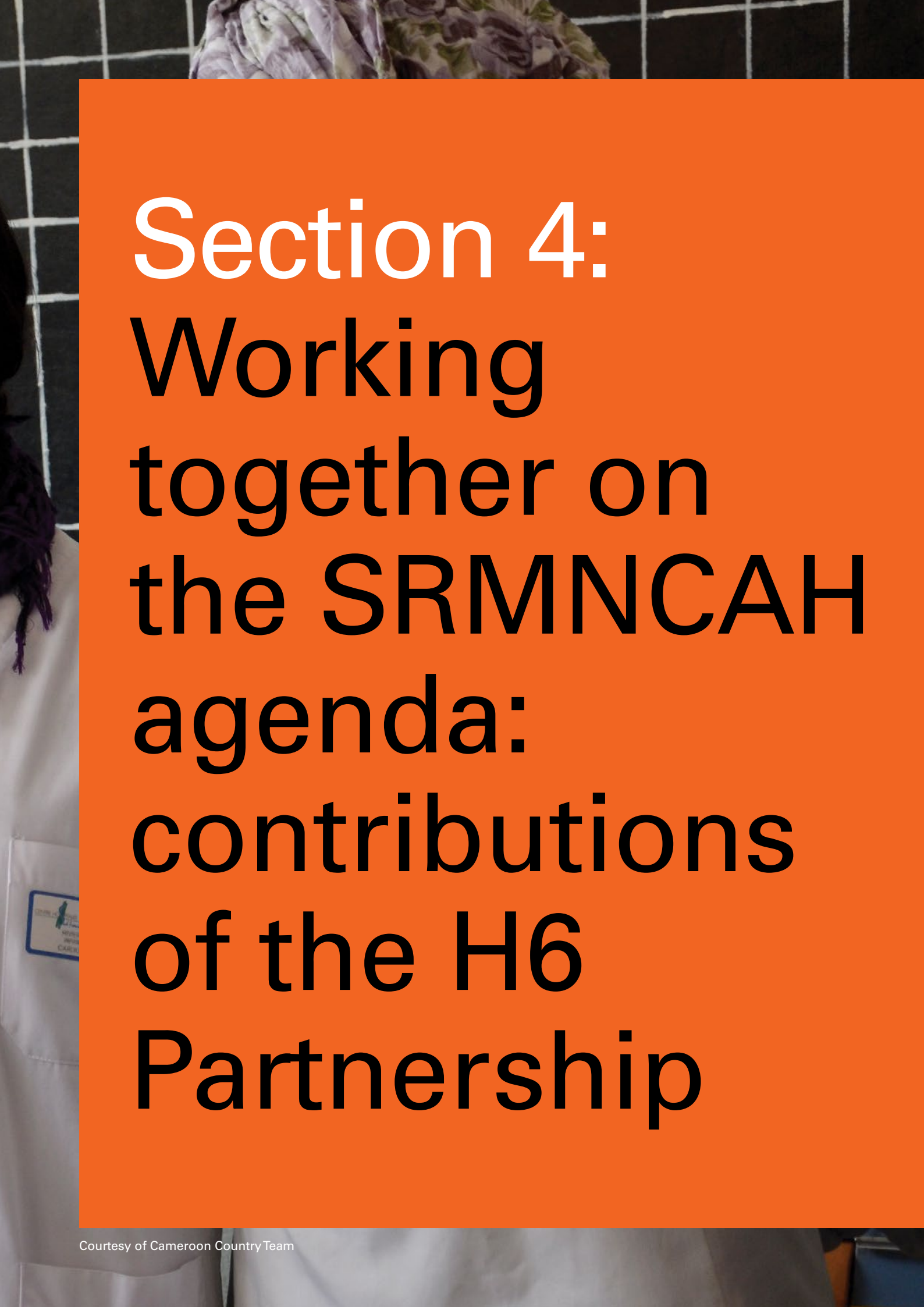
Senior officials, Ministry of Health, Zambia

Collaboration remains the key to progress, including at country level. In Guinea-Bissau, the H6 Joint Programme has been implemented in close collaboration of the Ministry of Health as institutional partner. Guinea-Bissau is building upon this relationship, as well as the efforts that are being made to leverage domestic resources for sustaining programme gains. At present, only the EU is a donor in the health sector and the country is experiencing uncertainty around continued inflow of domestic resources. The H6 country team is planning to reach out to potential donors to **mobilize resources** towards maintaining the pace of programme interventions at least for a few years to cover gaps created by the external political environment for the RMNCAH sector.

Collaboration is also critical in DRC, where the H6 country team played a major role in enhancing the cohesion of the agencies. Moreover, in GFF investment cases, H6-supported interventions in family planning, nutrition and other selected areas have been integrated, which is a step towards sustaining some gains.

The efforts of H6 country team in Zambia is working to tap existing opportunities including the Health Result Group of the UN Sustainable Development Goal Partnership Framework and the Cooperating Partners Group for Health, which has a subgroup on RMNCAH. Zambia is in the process of developing its 7th National Development Plan, National Health Strategic Plan and the National AIDS Strategic Plan 2017-2021. H6 partners are working towards integrating H6 Joint Programme interventions into the evolving national plans.

The H6 Joint Programme gains are at risk given uncertainty and existing resource gaps. There is an urgent need to reach out to present and potential donors to mobilize resources to further 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.



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

Courtesy of Cameroon Country Team

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

In 2016, the transition from the Millennium Development Goals to the Sustainable Development Goals was a central theme in the activities. The H6 continued to contribute to the development of systems and processes to support the implementation of the updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). As part of the Every Woman Every Child movement, the H6 is supporting countries in developing and implementing evidence-based policies and costed plans.[8]

The H6 Partnership contributed to several innovative global efforts. These included global strategies like the Global Strategy for Women's Children's and Adolescent's Health, Global Financing Facility, Every Newborn Action Plan, and Ending Preventable Maternal Mortality. The H6 also promoted a nine-country network on quality of care and worked with collaborative funding sources – the French Muskoka initiative and RMNCH Trust Fund.

60 governments and 110 organizations have made commitments to the Global Strategy, pledging more than $25 billion towards the health and well-being of women, children and adolescents.

[8] *http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf*

Global Strategy for Women's, Children's and Adolescents' Health

The H6 Partnership continues to function as the technical arm of the updated Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). In September and November 2016, the H6 organized a series of regional consultations around the Global Strategy, including two workshops in Africa with Ministries of Health and programme managers. The consultations informed the development by the World Health Organization Regional Office for Europe of a strategy on women's health and well-being as well as an action plan, the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind.[9] In 2016, the H6 continued to promote the **operational framework** for the Global Strategy, which offers guidance and options for countries that are translating the strategy into national and subnational operations, starting with the period 2016–2020 and building on current country-level plans. Developed by the H6, the operational framework is organized around the nine action areas of the Global Strategy and includes examples of country experiences, as well as a rich repository of operational tools.

The World Health Organization, on behalf of the H6 and in collaboration with other partners, conducted technical reviews and consultative processes in 2016 to create the **indicator and monitoring framework** for the Global Strategy.[10] The monitoring framework consists of 60 indicators and aims to minimize the reporting burden on countries by aligning the global reporting requirements with 34 indicators that already existed within the Sustainable Development Goals. The additional 26 indicators that are specific to the operational framework draw from established global SRMNCAH initiatives. Together, the 60 indicators provide sufficient depth and breadth for tracking progress against the goals and targets of the Global Strategy.

Throughout 2016, the H6 prepared a **new toolkit**[11] to support implementation of the Global Strategy. Published in April 2017, the toolkit will support decision makers, health professionals and government officials as they develop and implement investment plans for women's, children's and adolescents' health. The toolkit is an ongoing effort to consolidate and systematize a vast array of existing evidence-based tools and resources, establishing a core set of tools to support countries.

The Global Strategy **progress report** is coordinated by the Partnership for Maternal, Newborn and Child Health (PMNCH) with H6 as a major contributor; it will be prepared in 2017 with support from UN Member States.

Mobilizing political momentum and commitments in support of the Global Strategy and its advocacy umbrella, the Every Woman Every Child movement, remains a key priority. As of March 2017, 60 governments and 110 organizations have made official commitments to the Global Strategy, pledging more than $25 billion towards the health and well-being of women, children and adolescents. Significantly, 35 countries have included specific commitments related to adolescent health.

[9] Adopted by the WHO Regional Committee for Europe. Available at: *http://www.euro.who.int/__data/assets/pdf_file/0018/314532/66wd13e_SRHActionPlan_160524.pdf*

[10] Available at: *http://www.who.int/life-course/publications/gs-Indicator-and-monitoring-framework.pdf* (accessed on 17 March 2017).

[11] The toolkit is available at *http://www.everywomaneverychild.org/h6-toolkit/*. See also an introduction to the toolkit at *http://www.everywomaneverychild.org/2017/04/21/toolkit-to-support-the-implementation-of-the-ewec-global-strategy-at-country-level/*.

H6 role in developing the updated Global Strategy

Building on progress made through the Every Woman Every Child movement, in September 2015 the UN Secretary-General launched an updated Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). The World Health Organization, with the other H6 partners, coordinated the content development and writing of the updated Global Strategy, collaborating with several institutions and individual experts.

The process of developing this new roadmap involved many stakeholders. The H6 partners coordinated and supported the various Global Strategy development work streams, as well as Member State consultations on the development of the Global Strategy, including global discussions at the Sixty-eighth session of the World Health Assembly in May 2015, the 41st G7 summit in June 2015 and the 132nd Inter-Parliamentary Union Assembly in April 2015. In addition, UNICEF led the facilitation processes along with H6 partners to develop a five-year operational framework to accompany the Global Strategy. UNFPA, on behalf of H6, mobilized political commitments from 31 countries with high burdens of maternal and child mortality and morbidity in 2015 and that work resulted in an additional 10 commitments in 2016. Finally, the H6 prepared a toolkit[12] to support implementation of the updated Global Strategy.

Working together on the SRMNCAH agenda

Global Financing Facility

In 2016, the Global Financing Facility[13] increased the number of countries supported through the GFF Trust Fund from an initial four front-runner countries to 16 countries. The H6 continued to help GFF countries develop investment cases in line with the GFF business plan, which places great emphasis on the development of country-led, prioritized and costed RMNCAH investment cases. The H6 supported efforts in areas including equity analysis and prioritization, costing of the plans, analysis of available national resources, as well as support for specific technical areas such as adolescent health and civil registration and vital statistics. The GFF Technical Working Group, a team led by the World Health Organization and composed of technical experts from the H6 and other constituencies represented in the investors' group, continued to coordinate follow-up and technical assistance in the development of RMNCAH investment cases.

The Global Financing Facility is a multi-stakeholder partnership to raise resources from private capital markets to help close the global financing gap for investments in maternal, adolescent and child health. It was launched in July 2015 and is housed at the World Bank.[14]

[12] *http://www.everywomaneverychild.org/h6-toolkit/*

[13] *http://www.worldbank.org/en/news/press-release/2015/07/13/global-financing-facility-launched-with-billions-already-mobilized-to-end-maternal-and-child-mortality-by-2030*

[14] *https://www.globalfinancingfacility.org/introduction*

Every Newborn Action Plan

The Every Newborn Action Plan, launched in 2014, provides a roadmap of strategic actions and evidence-based solutions to prevent newborn deaths and stillbirths. In 2016, the Every Newborn Management Team, led by H6 members WHO, UNICEF and UNFPA, endorsed the Every Newborn Results Framework 2017 to 2018. It sets out activities to accelerate national efforts to reduce maternal and newborn deaths and stillbirths, and sustain progress towards the Every Newborn 2020 Global and National Milestones endorsed by 194 countries at the World Health Assembly in 2014. To date, 48 countries with the highest burden of newborn mortality have finalized national newborn plans or strengthened the relevant components within national health strategies (table 7). In addition, 14 countries are currently undertaking actions to strengthen newborn health in their national health strategies, namely Azerbaijan, the Central African Republic, Chad, Guinea-Bissau, Iran, Lesotho, Mozambique, Republic of Moldova, Pakistan, Sierra Leone, South Sudan, Syria, Zambia and Zimbabwe. Intercountry meetings to strengthen the implementation of the action plans were held in 2016 in the Eastern Mediterranean and Southeast Asia regions, along with 24 countries in West and Central Africa.

Table 7: Status of integration of the Every Newborn Action Plan into national health strategies (as of 31 January 2017)

Region	
Southeast Asia	Bangladesh**, Bhutan**, India**, Indonesia**, Myanmar*, Nepal**, Sri Lanka**, Timor-Leste*
Eastern Mediterranean and North Africa	Afghanistan*, Egypt*, Iraq, Jordan, Lebanon, Morocco*, Pakistan (Punjab)*, Palestine*, Sudan**
Africa	Angola*, Benin, Burkina Faso*, Cameroon*, Côte d'Ivoire*, Democratic Republic of the Congo*, Djibouti, Ethiopia**, Ghana*, Guinea*, Kenya*, Liberia*, Malawi*, Mali*, Mauritania*, Niger*, Nigeria**, Rwanda*, Senegal*, Tanzania**, Uganda*
Western Pacific	Cambodia, China*, Lao PDR, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Thailand, Viet Nam*

* Plan includes a Newborn Mortality Reduction (NMR) Target;
** Plan includes a NMR and a Stillbirth Reduction Target (SBR)

Ending Preventable Maternal Mortality

Following the publication of the Ending Preventable Maternal Mortality Strategy, the EPMM working group developed a comprehensive monitoring framework. UNFPA, WHO and UNICEF contributed to the framework, which subsequently became part of the H6 work plan. This activity is divided into two phases, the results of the first phase (Phase I) was published in 2015 and focused on measures to address the direct causes of maternal mortality set of 12 core metrics for global monitoring and reporting.[15] The set of EPMM core metrics from Phase I informed the development of the Indicator and Monitoring Framework for the Global Strategy published in February 2016. In 2016, the EPMM working group completed the second phase (Phase II), to describe indicators to address the direct causes of maternal mortality categorized into 11 themes that highlight the social, political and economic determinants of maternal health and survival. Phase I can be seen as broadly aligned with the pillar of 'survive' and Phase II with 'thrive' and 'transform' of the updated Global Strategy 2016–2030.

Following rigorous consultations, 150 subject experts representing 78 organizations agreed on 25 indicators across six categories as the final set of core indicators for Phase II. The iterative process also identified and prioritized an additional 30 indicators that require further research before they can be recommended for global monitoring and national reporting. To ensure transparency of this process, a manuscript has been submitted for publication.

Working together on the SRMNCAH agenda

Improving the quality of care for mothers and newborns

The World Health Organization continued in 2016 to develop the evidence base to improve the quality of care for maternal, newborn and child health (MNCH). The publication of WHO standards for maternal and newborn care[16] was followed by the synthesis of the evidence of effective implementation strategies and development of an implementation guidance to operationalize the standards. This represents a major contribution towards the global goal of universal health coverage of recommended MNCH interventions.

Following these developments, nine countries launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health (MNH Quality of Care Network) in February 2017.[17] The Network – which is supported by WHO, UNICEF, UNFPA and other partners – aims to support every pregnant woman, newborn and child with good-quality care in health services, and to halve maternal and newborn deaths and stillbirths in health-care facilities within five years in the nine participating countries. The Network is supported by a learning platform managed by the World Health Organization, which facilitates an exchange of information and joint learning.

[15] Moran AC, Jolivet RR, Chou D, Dalglish SL, Hill K, Ramsey K, et al. A common monitoring framework for ending preventable maternal mortality, 2015-2030: phase I of a multi-step process. BMC Pregnancy Childbirth. 2016; 16:250.

[16] *http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/*

[17] *www.qualityofcarenetwork.org*

Working together on the SRMNCAH agenda

The French Muskoka initiative

The French Muskoka Initiative is a grant implemented in 11 countries by the H6 partners UNFPA, UNICEF, UN Women and WHO.[18] The total investment in this initiative for 2012–2018 was 95 million euros (19 million euros per year) from the French Ministry of Foreign Affairs, and an additional 1.5 million euros per year from the UNICEF French National Committee to implement essential family health practices. The initiative plays a catalytic role at the regional level, as well as strengthening national health systems and enhancing the planning, coordination and implementation of high-impact interventions for women and children in maternal health, family planning, sexual and reproductive health for youth and adolescents, infant and child health, nutrition and community health. In recent years, the French Muskoka initiative has supported quality of care assessments at the facility-level in seven countries across West and Central Africa.[19]

[18] Benin, Burkina Faso, Côte d'Ivoire, Chad, DRC, Guinea, Haiti, Mali, Niger, Senegal, and Togo

[19] Benin, Burkina Faso, Chad, Congo, Côte d'Ivoire, Mali and Niger

RMNCH Trust Fund

In 2016, RMNCH Strategy and Coordination Teams (SCT) worked with country teams to accelerate programme implementation in 19 countries across sub-Saharan Africa and Asia.[20] Seven RMNCH SCT joint monitoring missions were organized in programme countries to discuss progress and challenges to implementation, conduct policy dialogue informed by the RMNCH commodities landscape analysis, and initiate transition plans to sustain programme gains with key stakeholders.

In Mauritania, the RMNCH Trust Fund rapidly deployed technical assistance for an in-depth analysis of the national RMNCAH landscape, including a mapping of financial resources. This effort was in support of the H6 partnership and in collaboration with the Ministry of Health (MoH), civil society organizations and the private sector.

The second half of the year involved preparing for the transition of the RMNCH Trust Fund efforts through country platforms that could provide long-term support to the implementation of the 2030 Agenda for Sustainable Development. At the end of 2016, the RMNCH Trust Fund's global and associated country grants came to an end. The remaining fund balance ($6.3 million) was made available for re-programming in 2017. For countries in receipt of support from both the RMNCH Trust Fund and the GFF, the re-programmed funds support GFF investment cases. In addition, the reprogrammed funds supported three 'Global Public Goods': mainstreaming and implementing the RMNCH landscape synthesis; supply chain strengthening; and mainstreaming the Life-Saving Commodities Practitioners' Network.

The RMNCH Trust Fund was established in 2013 by UNICEF, UNFPA and the World Health Organization with funding from the Governments of Norway and the United Kingdom (DFID), to finance high-impact interventions already in national health plans to reduce maternal and child deaths. Also in 2013, the RMNCH SCT efforts were aligned with the H6 approach, which has further strengthened coordination among the H6 partners in their joint efforts to provide guidance to countries and helped harmonize reporting at the global level.

[20] Afghanistan, Bangladesh, Benin, Burkina Faso, Cameroon, DRC, Ethiopia, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Pakistan, Senegal, Sierra Leone, Tanzania, Uganda and Zambia.

Looking ahead to the 2030 Agenda

The 2030 Agenda gives equal emphasis to sexual health in the RMNCAH agenda, and the commitment of the H6 Partnership is now to sexual, reproductive, maternal, newborn, child and adolescent health –with an 's' for 'sexual' added to the updated acronym SRMNCAH.

Going forward, the H6 will continue to support global efforts and to play a major technical role in support of the Every Woman Every Child movement and the implementation of the Global Strategy. The role of the H6 is three-fold, focused on technical capacity, convening stakeholders and advocating for SRMNCAH.

Technical role of the H6: This involves providing evidence-based technical assistance for developing, implementing and monitoring SRMNCAH national plans and investment cases; developing and disseminating 'global public goods' such as SRMNCAH technical guidance and tools, with a particular focus on improving quality of care in terms of both the provision and experience of care; documenting best practices and lessons learned in SRMNCAH; supporting operational research for improving access to quality SRMNCAH to the ones left furthest behind.

Convening role of the H6: This involves supporting nationally-led efforts to mobilize and coordinate stakeholders behind national SRMNCAH priorities. Such efforts facilitate convergence of SRMNCAH global and regional initiatives such as (among others), the GFF Trust Fund, Ending Preventable Maternal Mortality, Every Newborn Action Plan, MNH Quality of Care Network, Health Data Collaborative and FP2020.

Advocacy role of the H6: This involves mobilizing high-level stakeholders for SRMNCAH and advocating for high-impact, cost-effective, right-based and evidence informed interventions to drive national action and results. This includes mobilization of high-level political commitments for SRMNCAH and participation in global and regional bodies and events including the UN General Assembly and African Union, among others.

The H6 is targeting specific objectives in supporting countries developing and implementing evidence-based policies and costed plans. It will become increasingly important to effectively coordinate the multiple global and regional initiatives in SRMNCAH and to respond to growing requests from countries for integrated SRMNCAH technical assistance – roles central to the H6. The extension of the GFF trust fund to 30 additional countries is expected to contribute to this increasing need for technical support in SRMNCAH. The H6 Partnership is the only platform of the Every Woman Every Child architecture that can leverage its presence at country, regional and global levels to support the operationalization of the Global Strategy.

The H6 Partnership is the only platform of the Every Woman Every Child architecture that can leverage its presence at country, regional and global levels to support the operationalization of the Global Strategy.

The H6 at country level: Coordination and collaboration are key.

In 2016, 46 of the 75 high burden countries (61 per cent) had a functional H6 coordination mechanism.

In each of these countries, one of the six member organizations coordinates the partnership to facilitate the provision of joint technical support and advocacy for SRMNCAH at the country level, serving as Chair on a rotating basis (usually every two years). The World Health Organization chairs H6 in 18 countries, UNFPA in 14, UNICEF in 10, UNAIDS in two, and the World Bank Group in one country. Also during 2016, a process was undertaken to review the coordination at country level in order to strengthen it and to encourage rotation of the Chair of the partnership

The H6 at regional level: Activities in 2016 included a focus on strengthening the H6 Partnership at the regional level. In Western and Central Africa,[21] H6 was launched in March 2017 and serves as the technical platform on SRMNCAH of the broader Harmonization for Health in Africa (HHA). In North Africa and the Middle East,[22] H6 was launched in February 2017 and supports countries in strengthening the resilience of their health system.

The H6 at global level: The Chair rotates every two years among the six members of the H6 Partnership, with the Principal of the H6 Chair serving as H6 Representative in the Every Woman Every Child High-Level Advisory Group. UNAIDS has been Chair at the global level since January 2016. At all three levels, the H6 Partnership will continue in the coming years to support the operationalization of the Global Strategy through strategic interventions that aim to strengthen SRMNCAH policies and financing, multi-stakeholder engagement, governance and accountability and technical capacity for improving health workforce, commodities, supplies and service delivery for SRMNCAH.

At present, countries are moving forward in the operationalization of the Global Strategy and as H6 partners are increasingly mobilized for technical support beyond their respective strategic plan. More countries, for example, are benefiting from the GFF Trust Fund. To keep pace, additional dedicated resources will need to be mobilized to effectively bring together the complementary mandates and in-house technical leadership, capacities and experience of the six partner organizations at national, regional and global level.

Guinea-Bissau

[21] West and Central Africa region for UNFPA and UNICEF, and some countries of the WHO Regional Office for Africa

[22] Arab States region for UNFPA, Middle East and North Africa region for UNICEF, WHO Eastern Mediterranean Office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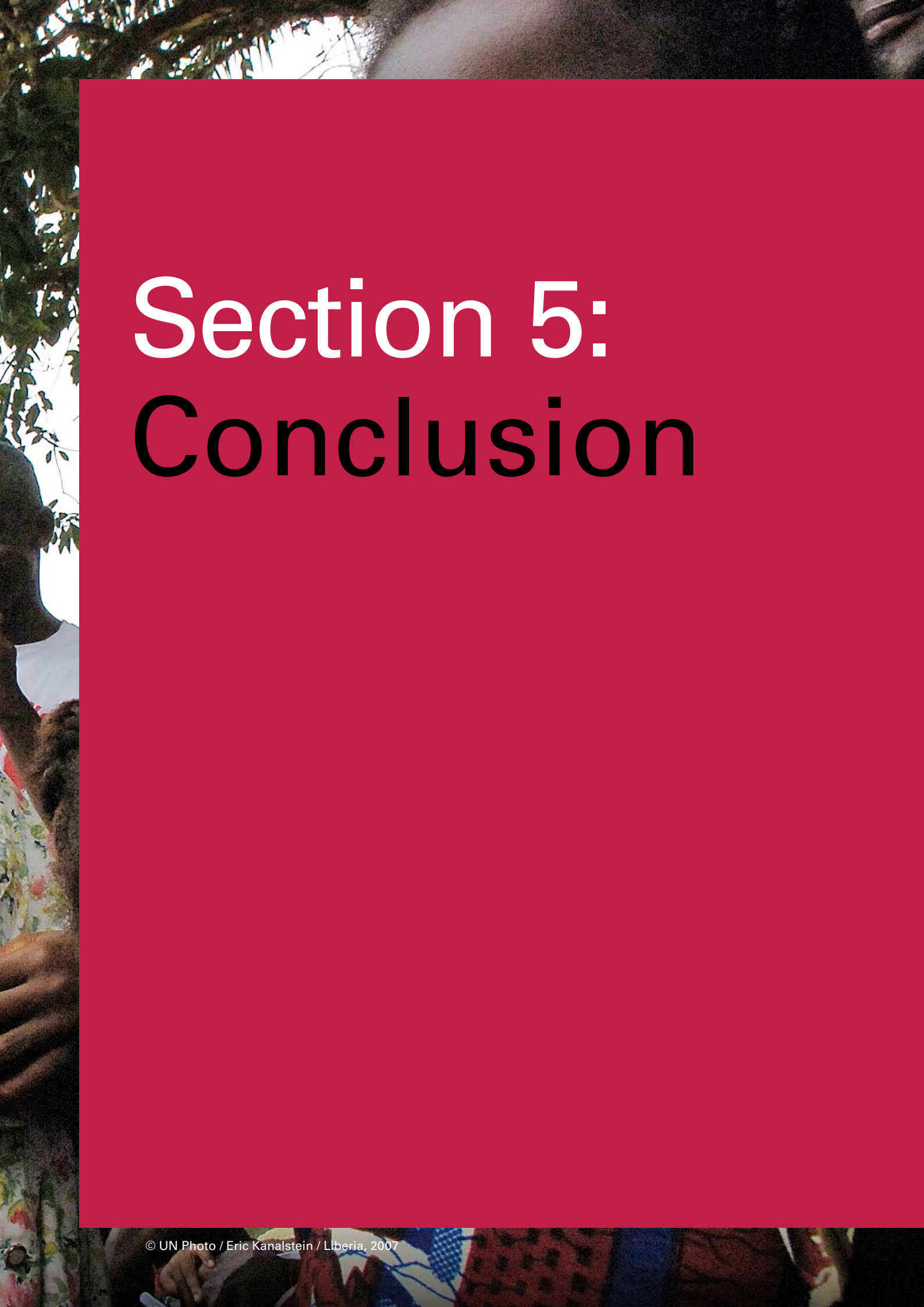

Section 5: Conclusion

Despite some delays early in programme implementation in 2012 and 2013, which were largely due to time consumed in putting processes in place, programme implementation rates reached a steady pace in 2014 onwards. An end line evaluation was commissioned in early 2016 to investigate progress of the programme and draw lessons for future programming. By the end of 2016, the H6 Canada collaboration's funding had concluded and, by mid-2017, the H6 Sida collaboration interventions will also expire. The results of collective drive and collaborative efforts began revealing themselves in 2016.

After a midterm review in 2013, corrective measures were taken based on findings that emphasized the importance of key actions:

- going deeper rather than spreading thin;
- properly screening the country context and RMNCAH landscape in each country;
- introducing strategic, focused, complementary and catalytic interventions to address existing programme gaps;
- weaving challenge mitigation strategies into programme design;
- better aligning interventions to inform policy; and
- engaging key stakeholders to scale up successful interventions that demonstrate results.

These actions facilitated turn-around management of H6 Joint Programme. The H6 country teams received regular facilitation, communication and need-based support to overcome barriers, and supportive H6 joint missions helped maintain high moral and motivation among country teams to achieve programme objectives.

Success has been noticeably registered at policy and programme levels in all countries, though all H6 country teams have encountered dynamic programme environments and were often subject to uncontrollable and external factors. The possibility for a positive trajectory towards achieving programme outputs depends on the extent to which strategic, context specific and catalytic processes transform resources into results.

The independent end line evaluation found that the H6 Joint Programme contributed to health system strengthening for RMNCAH at national and subnational levels across all elements of health system building blocks. Capacity and quality of care in RMNCAH improved noticeably, particularly in EmONC as well as MDSR, and these interventions were complementary, catalytic and aligned with national priorities. 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.

The H6 Joint Programme demonstrated a capacity to adjust and respond to changing needs and priorities at country level, as in the case of effective responses to changing conditions due to the Ebola outbreak. Joint programming of dedicated funds for RMNCAH provided a common purpose to strengthened collaboration and changed the nature of the partnership among country teams. Innovations were supported for scale up at 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 country level. Global-level interventions developed useful, high-quality global knowledge products for the RMNCAH sector and widened participation in the global agenda-setting process for the updated Global Strategy, continuing its leading role in the Every Woman Every Child movement. Value added in support of the Global Strategy has been most obvious when contributing to improved quality and access to integrated RMNCAH services at country level and to increased coherence in policy engagement and advocacy at both country and global level.

While all of programme countries face some constraints and challenges, each has demonstrated the potential for success in reducing maternal and child deaths and expanding provision of integrated RMNCAH services. However, this paradoxically is also one of the greatest risks as funding ends and H6 Joint Programme countries must develop and implement transition plans to maintain gains achieved through the programme.

Efforts to improve the health of women, children and adolescents need to be intensified in a multi-sectoral approach with equal emphasis on the social and structural determinants of health. While MDG 4 and 5 were partially achieved, the 2030 Agenda and its Sustainable Development Goals demand greater ownership, leadership and stewardship of national health systems. Health architectures will readjust to better respond to the health needs of women, children and adolescents. Meanwhile, the H6 has an unfinished agenda to promote quality-oriented, rights-based, equitable sexual, reproductive, maternal, newborn, child and adolescent health care for all – and future action on this agenda requires a collective drive and leveraging of the energies of partners and stakeholders to support country initiatives. It is time for H6 to build upon past experiences, galvanize the capacities of the partners involved and revamp key players to make the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) a tangible reality.

H6 country, regional and global teams enriched with experience from this impactful programme and motivated with its concrete results are well-positioned to support national health systems for meeting the needs of millions of women, children and adolescents for health information and services. The focus on high burden countries remains valid for the 2030 Agenda. The targets are demanding but not impossible to achieve in order to ensure universal access to sexual, reproductive, maternal, newborn, child and adolescent health care for women, children and adolescents during the era of the Sustainable Development Goals.

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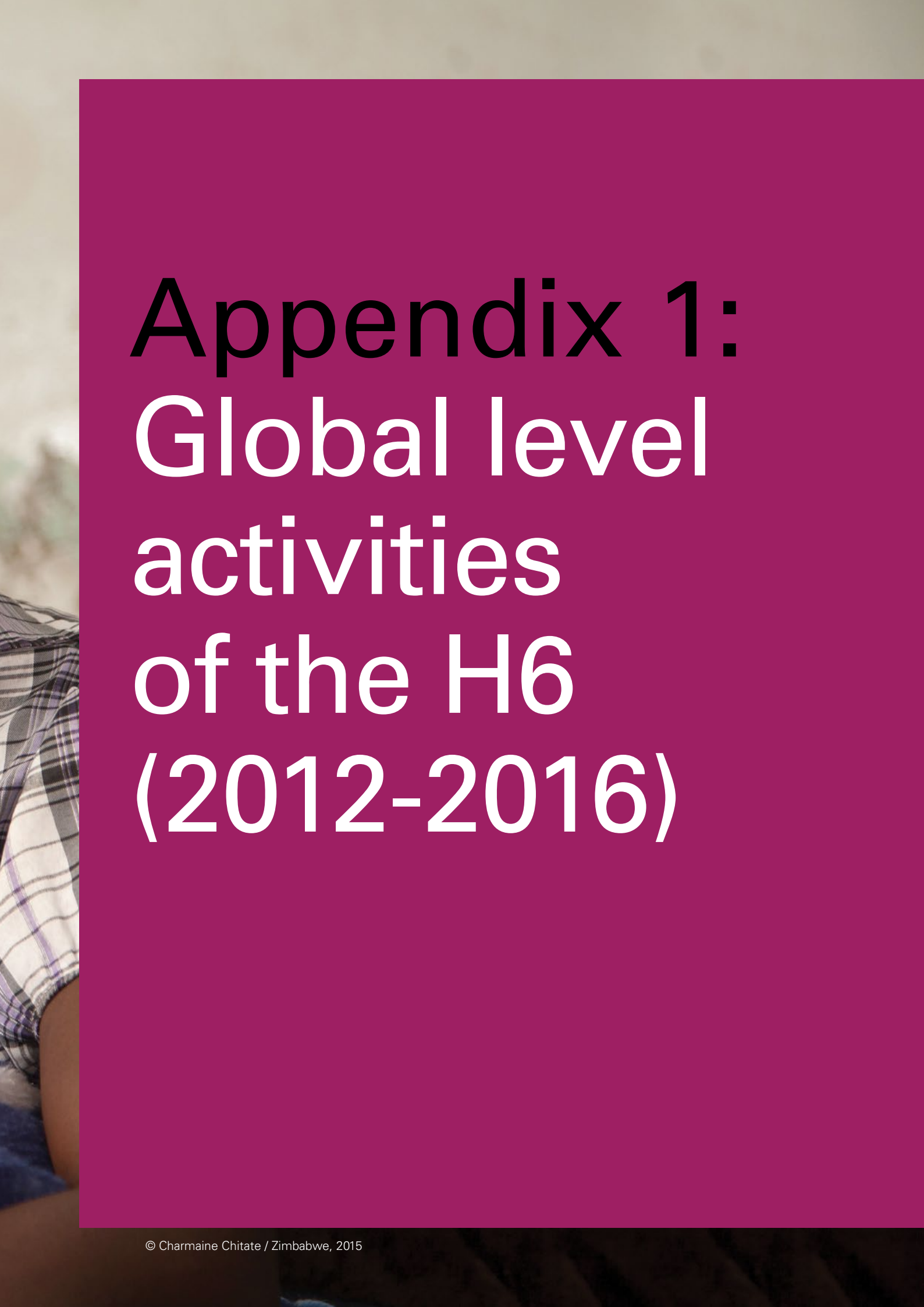
DR Congo



Appendix 1: Global level activities of the H6 (2012-2016)

Year	Description	Category	Lead Agency	Link
Thematic area 1: Policy, planning and costing				
Topic 1: Provide support to countries to identify and address systems constraints to improved RMNCH health, which are MDG- and performance-based				
Output 1a: Needs assessment completed and other related assessments (e.g. Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages). Output 1b: Health plans / legal frameworks developed/revised based on findings of the assessments.				
2012	Mapping of major global MNH initiatives developed.	Documentation	UNICEF	Report with no link
2013	Rapid Assessment tool of RMNCH Interventions and Commodities (RAIC) disseminated.	Capacity Building	UNICEF	H4+ activities disseminated during the 2013 Global Newborn Health Conference (GNHC) in Johannesburg, SA *http://newborn2013.com/*
	Every Newborn Action Plan (ENAP) bottleneck analysis (BNA) tool used during country consultations on newborn care.	Capacity Building	UNICEF	Bottleneck analysis tool for ENAP disseminated through website and during country (at least 5 countries) and regional (Asia, Africa) newborn consultations *www.everynewborn.org* *http://www.healthynewbornnetwork.org/hnn-content/uploads/Every-Newborn-BNA-tool-12-August-2013-1.docx*
2014	Strategic goals, targets and objectives for ending preventable maternal, newborn and child deaths defined up to 2030.	Global Knowledge Product	WHO	Every Newborn: An Action Plan to End Preventable Deaths (2014) *http://www.everynewborn.org/Documents/Every_Newborn_Action_Plan-ENGLISH_updated_July2014.pdf*
	RMNCH quality of care scorecards using DHS and MICS data for 74 priority countries.	Global Knowledge Product	WHO	Maternal, newborn and child health scorecards (2016) *http://www.who.int/maternal_child_adolescent/documents/countries/indicators/en/*
2015	Revision of Lives Saved Tool for updating the OneHealth and LiST instruments.	Global Knowledge Product	WHO	LiST: Lives Saved Tool *www.livessavedtool.org*
	Guidance note on strategic planning for ending preventable maternal, newborn and child mortality.	Global Knowledge Product	WHO	Ending Preventable Maternal, Newborn and Child Deaths: A policy brief to inform the updating and development of strategies and plans of action *https://www.dropbox.com/s/a9nd0dr1kmv208o/WHO%20Guidance%20Note%20on%20Strategic%20Planning%20for%20Ending%20preventable%20Maternal%2C%20Newborn%20and%20Child%20Mortality.pdf?dl=0*
2016	Technical Orientation organized for EWEC GS.2.0 and the GFF.	Capacity Building	WHO	Report with no link
	Developed pre-qualified pool of twenty six senior experts on country investment planning processes for EWEC GS2.0.	Capacity Building	WHO	Report with no link
	Development of a RMNCAH toolkit, the Implementation Toolkit in Support of the Global Strategy for Women's, Children's and Adolescents' Health.	Global Knowledge Product	WHO	Implementation toolkit in support of the Global Strategy for Women's, Children's and Adolescents' Health *http://www.everywomaneverychild.org/h6-toolkit/*

Year	Description	Category	Lead Agency	Link
Topic 2: Develop and/or cost RMNCH modules of national health plans, and rapidly mobilize new or additional resources.				
Output 2a: Priority countries have costed and developed RMNCH and related HIV components included in their health plans. Output 2b: Effective coordination of RMNCH partners and alignment to a national RMNCH plans is strengthened.				
2012	Toolkit for RMNCH strategic planning, implementation, monitoring and reviews.	Global Knowledge Product	WHO	Costing Tools Guide *http://www.who.int/pmnch/knowledge/publications/costing_tools/en/*
	Checklist for the rapid review of RMNCH plans.	Documentation	UNICEF	Link yet to be developed
2013	RMNCH Policy Compendium developed.	Global Knowledge Product	WHO	A Policy Guide for Implementing Essential Interventions for Reproductive, Maternal, Newborn and Child Health (RMNCH) (2014) *http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf*
	Strategic planning with specific focus on RMNCH continued through the OneHealth Tool for planning and costing.	Global Knowledge Product	WHO	OneHealth Tool *http://www.internationalhealthpartnership.net/en/tools/one-health-tool/*
	WHO recommendations on maternal, newborn, child and adolescent health compiled.	Global Knowledge Product	WHO	Compilation of WHO recommendations on maternal, newborn, child and adolescent health (2013) *http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/*
2015	Joint publication in the British Medical Journal, through the EWEC workstream on social determinants of health: "Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era".	Global Knowledge Product	UN Women	Article is accessible at: *http://www.bmj.com/content/351/bmj.h4213*
	Citizen Reporter advocacy training for sub-Saharan Africa and South Asia.	Capacity Building	UN Women	Citizen Reporter Training *http://www.citizens-post.org/news/2015/8/19/citizen-reporter-training-in-uganda*
	1) Briefing Kit: Sexual and Reproductive Health and Rights in South Asia. 2) Briefing Kit: Sexual and Reproductive Health and Rights in Sub-Saharan Africa 3) Policy Brief: Sexual and Reproductive Health and Rights: The Case for Engaging Citizens in Policymaking.	Global Knowledge Product	UN Women	1) *http://whiteribbonalliance.org/wp-content/uploads/2016/03/Briefing-Kit-SRHR-in-South-Asia.pdf* 2) *http://whiteribbonalliance.org/wp-content/uploads/2016/03/Briefing-Kit-SRHR-in-Sub-Saharan-Africa.pdf* 3) *http://whiteribbonalliance.org/wp-content/uploads/2016/03/Policy-Brief-SRHR-The-Case-for-Engaging-Citizens-in-Policymaking.pdf*
	In 2015, strategic goals, targets and objectives for ending preventable maternal, newborn and child deaths were defined up to 2030 as part of the Global Strategy.	Global Knowledge Product	WHO	The Global Strategy for Women's, Children's, and Adolescents' Health (2016 - 2030) *http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf*
	Revision of reference data for Lives Saved Tool completed for updating of the OneHealth and LiST instruments.	Global Knowledge Product	WHO	LiST Lives Saved Tool *www.livessavedtool.org*

Year	Description	Category	Lead Agency	Link
2015	Under the GFF umbrella: A multi-stakeholders meeting, "From 'shopping lists' to investment plans" was organized in June 2015, to inform the development of the TA agenda around RMNCAH investment plans and TA coordination.	Global Knowledge Product	WHO	From 'shopping lists' to Investment Plans: Supporting Countries to Develop and Finance Sound Investment Plans for Women's, Children's and Adolescents' Health" *https://www.dropbox.com/s/6c3xauvs9apyga5/WHO%20From%20Shopping%20List%20to%20Investment%20Plan.pdf?dl=0* How can health ministries present persuasive investment plans for women's, children's and adolescents' health? (2015) *http://www.who.int/bulletin/online_first/15-168419.pdf*
	The following policy briefs and guidance were published: a) Core competencies in adolescent health and development for primary care providers; b) A tool to assess the adolescent health and development component in pre-service education; c) A standards-driven approach to improve the quality of health-care services for adolescents; d) Building an adolescent competent workforce; (e) Preterm guidelines; f) Maternal and peripartum sepsis guidelines; g) Newborn resuscitation; h) Feeding lowbirth weight babies; i) Improving quality of paediatric care; j) Use of amoxicillin for treatment of pneumonia; k) Adapting CHW training packages to integrate actions for HIV and TB; l) Ending Preventable Maternal and Newborn Mortality and Stillbirths Effective interventions and strategies.	Global Knowledge Product	WHO	a-b) Core Competencies in adolescent health and development for primary care providers (2015) *http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf* c) A standards-driven approach to improve the quality of health-care services for adolescents (2015) *http://apps.who.int/iris/bitstream/10665/184035/1/WHO_FWC_MCA_15.06_eng.pdf* d) Building an adolescent competent workforce (2015) *http://apps.who.int/iris/bitstream/10665/183151/1/WHO_FWC_MCA_15.05_eng.pdf* e) WHO recommendations on interventions to improve preterm birth outcomes *http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf?ua=1* f) WHO recommendations for prevention and treatment of maternal peripartum infections (2015) *http://apps.who.int/iris/bitstream/10665/186171/1/9789241549363_eng.pdf* g) Guidelines on basic newborn resuscitation (2012) *http://apps.who.int/iris/bitstream/10665/75157/1/9789241503693_eng.pdf?ua=1* h) Breastfeeding of low-birth-weight infants (2015) *http://www.who.int/elena/titles/supplementary_feeding/en/* i) Improving paediatric quality of care at first-level referral hospitals (2015) *http://www.who.int/maternal_child_adolescent/documents/paediatric-hospital-care-quality/en/* j) Revised WHO classification and treatment of childhood pneumonia at health facitilties (2014) *http://apps.who.int/iris/bitstream/10665/137319/1/9789241507813_eng.pdf* (k) Caring for the sick child in the community: Adaptation for high HIV or TB settings CHW Manual (2014) *http://www.who.int/maternal_child_adolescent/documents/9789241548045.pdf* l) Ending Preventable Maternal and Newborn Mortality and Stillbirths Effective interventions and strategies (2015) *http://www.everywomaneverychild.org/images/07__Ending_Preventable_Maternal_andNewborn_Mortality_and_Stillbirths.pdf*

Year	Description	Category	Lead Agency	Link
Thematic Area 2: Quality				
Topic 3: Support countries' scale up of quality RMNCH service delivery in line with domestic priorities, ensuring linkages with Malaria and HIV and strengthening consolidated Procurement Systems Management				
Output 3a: Standards of care across the RMNCH continuum are updated across priority countries, also including a focus on deaths by HIV or Malaria. Output 3b: Efforts to scale integrated service delivery packages (including elements of gender-based violence prevention and management, family planning, HIV, other STIs/syphilis, malaria and related health services) are supported in priority countries. Output 3c: Access to essential RMNCH and related HIV/STI medicines and supplies is scaled up in priority countries. Output 3d: Updated RMNCH guidelines are developed and disseminated in priority countries.				
2011	The UN Commission on Life-saving Commodities for Women and Children, which includes H4+partners as members created a list of 13 key commodities and medical devices has been identified for MNH/FP; draft report with recommendations is available.	Documen-tation	UNICEF	Draft Report with Recommendation, with no link
2013	MNH communication for development (C4D) guide drafted.	Global Knowledge Product	UNICEF	ENAP disseminated through various websites and global and regional meetings/ conferences. *http://www.healthynewbornnetwork.org/resource/every-newborn-action-plan/* *https://www.dropbox.com/s/kqsn63hkpul35xi/C4D-MNCHN%20Guide.pdf?dl=0*
	Final list of essential medical devices for Maternal and Newborn Health compiled.	Global Knowledge Product	UNICEF	H+ Interagency List *http://www.who.int/medicines/areas/policy/12-IPC_InteragencylistMandMD.pdf*
	DIVA Procurement and Supply tool (final version) available.	Global Knowledge Product	UNICEF	*http://ccmcentral.com/wp-content/uploads/2014/04/DIVA-Guidebook-Strengthening-district-mgmt-for-results-with-equity-_UNICEF-MSH_2012.pdf* UNICEF's systematic and outcome-based DIVA (Diagnose, Intervene, Verify, Adjust) approach
2014	1) Core set of indicators of quality of MNCH care in facilities published. 2) QoC panel published in Countdown 2014 Report. 3) BJOG supplement on QoC in MNH to be published in August (WHO staff co-editor and WHO staff contributors). 4) Meta review on QoC assessments in MNCH published. 5) QoC core indicators pilot tested in Uganda and Tanzania. QoC field testing manual/operations drafted. 6) Technical support provided to DRC (strategy development), Zambia (GAPPD and home-based newborn care), Zimbabwe (Quality of care) and Burkina Faso (community services and GFATM proposal).	Global Knowledge Product	WHO	1) Consultation on improving measurement of the quality of maternal, newborn and child care in health facilities (2014) *http://apps.who.int/iris/bitstream/10665/128206/1/9789241507417_eng.pdf* 2) Fulfilling the Health Agenda for Women and Children: The 2014 Report (2014) *http://www.countdown2015mnch.org/documents/2014Report/The2014report/Countdown_The_2014_Report_final.pdf* 3) Quality of care during labour and birth *https://www.dropbox.com/s/rdoeu9rfyk29zuk/QOC%20During%20Labor%20and%20Birth.pdf?dl=0* 4) Confidential report 5) Global Monitoring of Implementation of Maternal Death Surveillance and Response (MDSR) (2015) *http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/global-monitoring/en/* 6) The H4+ partnership: Joint support to improve women's and children's health *http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf*

Year	Description	Category	Lead Agency	Link
2014	7) Contributed, with H4+ agencies and country partners, to development of guide providing for safe delivery and newborn care in the context of an Ebola outbreak. 8) The mHealth Assessment and Planning for Scale tool was developed and launched, to provide mHealth implementers and countries successfully and sustainable scale their innovations.	Global Knowledge Product	WHO	7) mHealth MAPS toolkit *http://who.int/life-course/publications/mhealth-toolkit/en/*
	1) Support provided to strengthen H4+ coordination activities. 2) Maintain strong partnership with the Every Newborn Group (WHO, UNFPA) to advocate for strengthening of MNH activities.	Advocacy	UNFPA	Report with no link
	ENAP developed and disseminated.	Global Knowledge Product	UNICEF	*https://www.unicef.org/media/media_81931.html*
	1) Organization of two regional workshops (Dakar, Arusha) on C4D and MNH to strengthen country planning and implementation. 2) Support provided to countries, in collaboration with the global Chlorhexidine Working group (Commodity Working Group), to strengthen procurement, supply management and use of chlorhexidine. 3) QoC workshop to develop pool of QOC experts organized for 15 countries.	Capacity Building	WHO	1) Workshop reports, with no link. 2) Mission reports, with no link. Participating countries: Pakistan, Sierra Leone, Ethiopia, Liberia, DRC, Malawi, Bangladesh, Kenya, *Nigeria 3) Workshop report, with no link. Participating countries: Benin, Botswana, Burkina Faso, Côte d'Ivoire, Ethiopia, Malawi, Mali, Mozambique, Niger, South Africa, South Sudan, Togo, Uganda, Zambia and Zimbabwe
2015	1) Feasibility of WHO indicators of QOC for MNCH care in facilities tested in DRC, Chad, Tanzania, Zambia and Zimbabwe. 2) Qualitative study to understand challenges in monitoring QOC conducted in DRC and Tanzania. 3) National capacity building for quality of care assessment and improvement in Congo, Malawi, Swaziland, Tanzania and DRC. 4) IMPAC guidelines updated with latest WHO recommendations. 5) MMR Estimates published November 2015 following extensive country consultations and follow up with H4+ countries, an implementation of a refined methodology that favoured closer following and better use of country-level data.	Capacity Building and Global Knowledge Product	WHO	1) In-Depth Feasibility Analysis of 19 Quality of Care Indicators for Maternal, Newborn and Child Care in Faith Based Health Care Facilities in Two Sub-Saharan African Countries *https://www.dropbox.com/s/2merq2gxd4iox2h/WHO%20QOC%20Indicators%20Final.pdf?dl=0* 2) Qualitative study to understand challenges in monitoring QOC *https://www.dropbox.com/s/aekm22ilkiwz3c4/WHO%20Report%20QOC%20Field%20Report%20Final.PDF?dl=0* 4) Updated version available soon. *http://www.who.int/maternal_child_adolescent/documents/impac/en/* 5) A conversation with the special rapporteurs (2016) *http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1*

Year	Description	Category	Lead Agency	Link
2015	1) ENAP partnership maintained and strengthened. 2) ENAP Progress Report published and launched at WHA in May 2015. Two side events organized to update on progress. 3) Technical support provided to countries to develop newborn strategies and scale up plans. 4) H4+ and other countries supported to submit abstracts and participate in the Global Maternal Newborn Conference in Mexico. 5) List of essential MNCH medicines printed and disseminated. 6) Specific technical inputs provided to revise patient guidelines and country recommendations in response to reports of CHX drops being used by mothers for newborns eyes in Nigeria. 7) "Global Standards for Quality Health Care Services for Adolescents" published 8) Final draft of all 7 modules of the Essential Childbirth Care (ECBC) course completed.	Global Knowledge Product	UNICEF	1) ENAP Progress Report (2015) *http://www.who.int/life-course/news/enap-press-release/en/* 4) Global Maternal Newborn Conference website *https://www.globalmnh2015.org/* 5) Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health (2014) *http://www.who.int/medical_devices/md_maternal_v12_web.pdf* 6) Global standards for quality health care services for adolescents *http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/* 7) Essential Newborn Care Training course *http://apps.who.int/iris/bitstream/10665/70540/3/WHO_MPS_10.1_Training_file_eng.pdf*
2016	Newborn Guide for humanitarian settings printed and disseminated.	Global Knowledge Product	UNICEF	*http://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide-interim-version/*
	Agenda for Zero Discrimination in Health Care.	Global Knowledge Product	UNAIDS	*http://www.unaids.org/sites/default/files/media_asset/2017ZeroDiscriminationHealthCare.pdf*
	A treatment literacy guide for pregnant women and mothers living with HIV	Global Knowledge Product	UNAIDS	*http://www.gnpplus.net/resources/positive-health-dignity-and-prevention-for-women-and-their-babies/*
	"Ending the AIDS epidemic, for adolescents, with adolescents": a practical guide to meaningfully engage adolescents in the AIDS response.	Global Knowledge Product	UNAIDS	*http://www.unaids.org/sites/default/files/media_asset/ending-AIDS-epidemic-adolescents_en.pdf*
Topic 4: Address the urgent need for skilled health workers, particularly midwives and other related cadre of personnel, including community health workers, and related modalities for maximizing delivery, such as task-shifting.				
Output 4a: Increased number and quality of trained midwives and CHWs in priority countries (baseline figures 2011) Output 4b: Priority countries have costed HRH plans with RMNCH module linked to or integrating related HIV/STIs, GBV, etc. costs				
2012	"Global Standards for Quality Health Care Services for Adolescents"	Global Knowledge Product	WHO	*http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/*
	Midwifery Services Framework (draft).	Global Knowledge Product	UNFPA	*http://internationalmidwives.org/projects-programmes/midwifery-service-framework.html*

Year	Description	Category	Lead Agency	Link
2014	High Burden Countries Initiative (HBCI) – Technical Guidance and ongoing country Midwifery workforce assessments.	Global Knowledge Product	UNFPA	*http://www.icsintegrare.org/wp-content/uploads/2016/02/SRMNAH-Handbook.pdf*
2015	1) Midwifery Service framework developed, printed and disseminated. 2) Development of the CHW's RMNH training guidance. 3) Assessments initiated of Midwifery Workforce (MWA) in Mozambique and the Tanzania report, final, is still with the government for final approval. No other workforce assessment is planned at this stage. 4) Development and release of SoWMY report in June 2014. 5) The SoWMY report disseminated in 26 countries for advocacy to mobilize political and administrative support for education, regulations and associations of midwives.	Global Knowledge Product	UNFPA	1) ICM Midwifery Service Framework *http://www.internationalmidwives.org/assets/uploads/documents/Manuals%20and%20Guidelines/MSF%20for%20field-testing,%2017Mar15.pdf* 2) Developed with WHO as indicated by WHO 3) Report in progress of finalization 4 & 5) SoWMY Report *www.unfpa.org/sowmy*
Topic 5: Support countries to address demand-side barriers to access to services, especially for the marginalized and most vulnerable, particularly through community engagement, and community health workers.				
Output 5a: Innovations in RMNCH, community engagement, including partner participation, implemented and documented in priority countries. Output 5b: Guidance provided to priority countries for the scaling up of innovations that address barriers (particularly demand-side) to access to services.				
2012	1) Three regional workshops for dissemination of MWA organized at Bangkok (Asia & Pacific region), Dakar (West and Central Africa) and Cairo (Arab states). 2) Three regional gap analysis workshop-first at Senegal for Senegal, Chad, Mauritania, Mauritius and Guinea Conakry, second at TOGO for Mali, Niger, Ivory Coast, Benin, Burkina Faso and Togo and Kenya organized. 3) Midwifery service framework field tested at Lesotho and Bangladesh 4) Quality of care during childbirth: evidenced based statements, inputs, outputs and outcomes developed on experience of care (respect and dignity, communications, emotional support) to ensure updated tools align to QoC midwifery.	Capacity Building	UNFPA	1) Workshop reports with no link 2) Regional workshop report with no link 3) Midwifery Service Framework Field Test Framework with no link 4) Link yet to be developed
	Project briefs developed and disseminated.	Advocacy	UNFPA	*http://www.slideshare.net/EveryWomanEveryChild/h4-activities-and-plans*

Year	Description	Category	Lead Agency	Link
2013	Strategic communications and advocacy platforms in place.	Advocacy	UNFPA	*https://docs.google.com/file/d/1hjoGHMzIDtbFBeujX9OiRC9sTi3hjzazOTmZI_sJzTgmV1Kq5GMyBIkkTiw6/edit*
2014	RMNH training guidelines for CHWs developed.	Global Knowledge Product	UNFPA	Strengthening the capacity of community health workers to deliver care for Sexual Reproductive Maternal Newborn Child and Adolescent Health: *http://apps.who.int/iris/bitstream/10665/174112/1/WHO_FWC_MCA_15.04_eng.pdf* Developing Capacities of Community Health Workers in Sexual and Reproductive, Maternal, Newborn, Child, and Adolescent Health: A Mapping and Review of Training Resources *http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0094948*
2015	The mapping of tools to assess and address HIV-related stigma and discrimination in health care.	Global Knowledge Product	UNAIDS	*https://www.dropbox.com/s/9tfrutxuiqzxm2c/UNAIDS%20-%20Human%20Rights%20Mapping%20Tools%20S%26D%20in%20healthcare%20settings%20-%20draft.pdf?dl=0*
	The Legal Barriers/Age of Consent Advocacy Pack The Age of Consent Reform Advocacy Pack for Legal Barriers to Access Health Services, including HIV testing and treatment.	Global Knowledge Product	UNAIDS and UNICEF	Semi-public link. Request access through *http://dev.ecp-geo.nam.org.uk/*
	Country case study fact sheets published and disseminated for Burkina Faso, Cameroon, Serra Leone, Zambia and Zimbabwe. Liberia under development. (20) An integrated C4D guide on MNCH prepared and rolled out in multiple countries.	Documentation	UNICEF	*http://www.who.int/maternal_child_adolescent/documents/imci_community_care/en/*
2016	Eliminating discrimination in health care. Stepping stone towards ending the AIDS epidemic.	Global Knowledge Product	UNAIDS	*http://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-in-health-care_en.pdf*
2017	E-repository and Tool-finder, tools to assess and address HIV-related discrimination in health care.	Global Knowledge Product	UNAIDS	*www.ZeroHIVdiscrimination.com*
Thematic Area 3: Equality				
Topic 6: Tackle the root causes of maternal, newborn and child mortality and morbidity, and HIV including gender inequality, low access to education (especially for girls), child marriage and adolescent pregnancy.				
Output 6a: Priority countries have comprehensive sex-education component, including skills development, included in their curricula for high schools and other places adolescents gather. Output 6b The root causes of maternal mortality and morbidity explored and key actions to address them are highlighted in priority countries, including the development and/or dissemination of evidence-based guidelines on these root causes. Output 6c: Demand-creation around services and resources addressing root causes of maternal, newborn, and child mortality and morbidity are increased through community engagement and strengthened advocacy and leadership capacity.				
2015	1) Three modules (first draft) have been developed to help RMNCH teams to support community groups, using participatory learning with women's groups, to improve maternal and newborn health. The modules describe the roles and responsibilities of programme manager, supervisor	Global Knowledge Product	WHO	1) Caring for newborns and children in the community (2015) *http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/* 2) Gender and RMNCAH: A framework for action (2015) *http://genderandaids.org/rmncah/wp-content/uploads/2016/05/Gender-and-RMNCAH-Framework.pdf*

Year	Description	Category	Lead Agency	Link
2015	and facilitator (community health worker) and will be included in the existing WHO/UNICEF manual 'Caring for Newborns and Children in the Community'. 2) Draft Gender Equality Framework for RMNCAH developed and under review through key stakeholders. 3) Set of modules developed in partnership with WHO, Women and Children First and UNICEF for Improving quality of maternal and newborn health to women's groups in rural settings. Ongoing participatory review with women networks in Ethiopia, Bangladesh, Cote d'Ivoire and priority Global Plan countries. 4) Developed and finalized of the 'Planning handbook for caring for NB and children in the community.	Global Knowledge Product	WHO	3) Caring for newborns and children in the community (2015) *http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/* 4) 'Positive health, dignity and prevention for women and their babies *http://www.gnpplus.net/assets/wbb_file_updown/5671/Facilitators%20Manual%20English%20Treatment%20literacy%20PMTCT.pdf* 5) Caring for the newborn at home Caring for newborns and children in the community *http://www.who.int/maternal_child_adolescent/documents/caring-for-the-newborn-at-home/en/*
	Literacy and advocacy kit to specific country contexts and to support pregnant and breastfeeding women groups and networks of women living with HIV, in communities with limited levels of literacy. Tool 1 and 2.	Advocacy	UNAIDS	Tool 1 (under review) and Tool 2 *https://www.gnpplus.net/resources/positive-health-dignity-and-prevention-for-women-and-their-babies/* *http://www.gnpplus.net/assets/wbb_file_updown/5325/Facilitators%20Manual%20English%20Treatment%20literacy%20PMTCT.pdf* *http://www.gnpplus.net/assets/wbb_file_updown/5325/FlipChart%20English%20Treatment%20literacy%20PMTCT.pdf* *http://www.gnpplus.net/assets/wbb_file_updown/5325/Poster%20English%20Treatment%20literacy%20PMTCT.pdf* *http://www.gnpplus.net/assets/wbb_file_updown/5325/Guide%20Animatrice%20Francais%20Treatment%20literacy%20PMTCT.pdf* *http://www.gnpplus.net/assets/wbb_file_updown/5325/FlipChart%20Francais%20Treatment%20literacy%20PMTCT.pdf* *http://www.gnpplus.net/assets/wbb_file_updown/5325/Poster%20Francais%20Treatment%20literacy%20PMTCT.pdf*
	Annotated bibliography of community-based delivery service costing methodologies complied and to be published in 2016.	Global Knowledge Product	UNAIDS	*https://www.dropbox.com/s/venqy077vadm2c9/UNAIDS%20Annonated%20Bibliography%20of%20Community%20Based%20Costing%20Methodologies.docx?dl=0*
	Two Community Engagement Indicators developed by CEWG.	Global Knowledge Product	UNAIDS	*https://www.dropbox.com/s/7dhsqyrtcvtyyz6/UNAIDS%20-%20CE%20Indicators%20for%20pilot%20test%2013.10.2015%20Cote%20d%27Ivoire%20NCPI%20EMTCT%20validation.doc?dl=0*
	People Living with HIV E-analysis tool for the Stigma Index methodology developed to empower networks of PLHIV to analyse and clean up data and generate further analysis through RMNCAH lens.	Global Knowledge Product	UNAIDS	Semi-public link. Request access through *http://dev.ecp-geo.nam.org.uk/*
	Global Consultation with Adolescent and Youth Leaders in Harare, Zimbabwe. Goal: a roadmap that helps take the All In response process forward in the 25 focus countries.	Advocacy	UNAIDS	*https://www.dropbox.com/s/s1m8xohxg1c1crl/UNAIDS%20-%20Brief%20All%20In%20Report%20-%20Harare.docx.pdf?dl=0*

Year	Description	Category	Lead Agency	Link
2015	Draft Gender Equality Conceptual Framework for RMNCAH developed and global/regional consultation held. Drafting of programming guidance under process.	Global Knowledge Product	UN Women	*http://genderandaids.org/rmncah/*
2016	Frontier Dialogue among UN Agencies: Addressing Discrimination in Health Care	Global Knowledge Product	UNAIDS	*https://docs.google.com/document/d/1U9bKC2LxpcxwXPE5qiehle5_f8vhjUxjBg3hw53wSsE/edit?usp=sharing*
Thematic Area 4: Accountability				
Topic 7: Strengthen monitoring and evaluation systems to ensure availability of credible data in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health				
Output 7a: Support is provided to priority countries to produce and report internationally agreed RMNCH indicators routinely. Output 7b: Maternal and perinatal death surveillance and response reviews strengthened/established.				
2011	A tool for rapid assessment of national (and district) RMNCH plans has been drafted based on how to conduct a Joint Assessment of a National health Strategy (JANS), drawing from country experience.	Global Knowledge Product	UNICEF	Link yet to be developed
2012	Capacity of national programme managers in three Sida supported countries.	Capacity Building	UNICEF	Workshop report with no link
2013	Technical guidelines for Maternal Death Surveillance and Response produced. WHO recommendations on maternal, newborn, child and adolescent health compiled.	Global Knowledge Product	WHO	Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death (2013) *http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/*
2014	Technical support provided to countries to assess barriers and challenges to increase demand for MNH during regional C4D workshops at West, Central and Southern Africa.	Capacity Building	UNICEF	Workshop report with no link
	MDSR sub-regional workshop held in Libreville on 24-27 June for eight countries: Angola, Burundi, Cameroon, Chad, Congo, Gabon, DRC, SaoTome & Principe (AFRO/CA).	Global Knowledge Product	WHO	These are meetings with private reports. No links available.
	MDSR implementation monitoring tool drafted.	Global Knowledge Product	WHO	TA provided, mission reports available if needed.
2015	Di-Monitoring tool modified and face to face training of all 10 country teams organized in May 2015 at Côte d'Ivoire for francophone countries and in Zambia for anglophone countries.	Capacity Building	UNFPA	Training report with no link
	1) BMC Supplement published to highlight bottlenecks and recommendations for nine high- impact maternal-newborn interventions.	Global Knowledge Product	UNICEF	1) BMC Supplement *https://www.everynewborn.org/wp-content/uploads/2015/09/Overview-of-Series.pdf*

Year	Description	Category	Lead Agency	Link
2015	2) Support was provided to Bottle Neck Analysis and situation assessments in Iraq, Nepal and Malawi. Based on this work, Nepal and Malawi have developed their National Plans for newborn care and Iraq is in progress. 3) ENAP progress report developed. 4) The m-health interventions and Rapid-Pro for community reporting were documented and disseminated included on pregnancy and newborn care and on Ebola at different fora including Mexico GMNH Conference.	Global Knowledge Product	UNICEF	2) ENAP plans Iraq ENAP plan: *https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNJQN1OxF45ju6nta?dl=0* Nepal ENAP plan: *http://www.healthynewbornnetwork.org/hnn-content/uploads/NENAP-final-low-resolution.pdf* Malawi ENAP plan: *http://www.who.int/pmnch/media/events/2015/malawi_enap.pdf?ua=1* 3) ENAP Progress Report *http://www.healthynewbornnetwork.org/resource/every-newborn-action-plan-country-progress-tracking-report/* 4) Link yet to be developed
	1) In-depth evaluation of MDSR implementation conducted in Guinea and Burkina Faso. 2) First global report on MDSR implementation published. 3) Case studies documenting successes and challenges in MDSR implementation published. 4) Global workshop on MDSR convened in Vancouver in Oct 2015.	Capacity Building and Global Knowledge Product	WHO	1) Have not received final report for Guinea but have requested it from sub-regional office in West Africa. Same project was never carried out in Burkina Faso so there is no report. 2) Maternal Death Surveillance and Response website *http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/* 3) Full List of MDSR case studies *http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance_implementation/en/* 4) Department of MCA Progress Report 2014-15 (2015) *http://apps.who.int/iris/bitstream/10665/205631/1/9789241510356_eng.pdf*
Topic 8: Documentation, evaluation, and sharing of best practices of the H4+ mechanism and country efforts				
Output 8a: Planned regular assessments of the added outputs and impact of the H4+ coordination mechanism. Output 8b: Best practices in implementation, innovation, leadership, and/or advocacy in RMNCH are documented and shared.				
2011	H4+ undertook a survey of 57 countries who have made commitments to the Global Strategy, to assess progress, gaps, country needs as well as explore the role of H4+ partners in supporting implementation of the commitments.	Documentation	WHO	*http://www.who.int/reproductivehealth/global_strategy_women_children/en/index.html*
2012	Mapping of progress and needs in implementation of country commitments: Survey of 53 countries committed to the Global Strategy.	Documentation	WHO	*http://www.who.int/reproductivehealth/global_strategy_women_children/WHO_H4-report_tables.pdf*
	Country profiles including baseline information in areas according to H4+ scope of work.	Documentation	WHO	*https://docs.google.com/file/d/1hjoGHMzIDtbFBeujX9OiRC9sTi3hjzazOTmZI_sJzTgmV1Kq5GMyBIkkTiw6/edit*
	A matrix for data analysis reflecting the H4+ scope of work.	Documentation	WHO	*http://apps.who.int/iris/bitstream/10665/134746/1/WHO_RHR_14.27_eng.pdf*

Year	Description	Category	Lead Agency	Link
2013	Factsheets with MNH coverage indicators developed for all H4+ Canada countries (as well as over 20 high-burden countries) and posted on EN website.	Documentation	UNICEF	*https://www.dropbox.com/sh/2kdnkorpxsyslvw/AAAxNW5ncn_Fq3-h6U36J8oPa?dl=0*
	H4+ 2013 Annual Report published.	Documentation	UNICEF	H4+/EWEC high-level stakeholders meeting convened in May 2013 *www.everywomaneverychild.org*
	H4+ progress report 2013 developed, acknowledged by member states and partners and by the independent expert group on Women's and Children's health.	Documentation	WHO and UNFPA	H4+ Partnership *http://www.unfpa.org/sites/default/files/pub-pdf/h4report_2014_final.pdf*
2014	1) Survey of H4+ support to countries updated to reflect Global H4+ Results Framework finalized in 2014, including a section on value added of H4+ mechanism, as well as achievements and challenges. 2) Survey disseminated to 58 countries, 44 of which completed the survey including all Canada-funded countries. 3) Data to form the base of H4+ 2014 Progress Report and serve as a baseline for future monitoring of H4+ support.	Documentation	WHO and UNFPA	The H4+ partnership Joint support to improve women's and children's health Progress report (June 2014) *http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf*
2015	Survey of H4+ support to countries in 2014, responded to by 62 countries, and provided an overview of H4+ coordination, functionality and activities in 2014. The survey looked across 2013 and 2014 to examine the trajectory of H4+ work overtime and offered insight into the post-2015 development agenda initiatives by documenting H4+ lessons learned on interagency collaboration and joint implementation.	Documentation	WHO and UNFPA	The H4+ Partnership Joint support to improve women's and children's health: Progress Report (June 2014) *http://apps.who.int/iris/bitstream/10665/189285/1/9789241508889_eng.pdf*
2016	Case studies were developed to document multi-sectoral adolescent health programming experience in Bangladesh and Mongolia.	Global Knowledge Product	UNICEF	Bangladesh case study *https://www.dropbox.com/sh/7gjt7ylklhztid5/AAAw5h8evwGXBGf0Ab5ZxBhpa?dl=0* Mongolia case study *https://www.dropbox.com/sh/sto0r6ytm0le6sj/AABYkCvq5W79cb_ACR7u7IPda?dl=0*

Appendix 2: Country level progress: H6 Joint Programme results framework (2011-2016)[23]

[23] In all H6 Canada collaboration countries, actual programme implementation initiated in mid-2012. Thus, baseline for these countries is 2012 data. For H6 Sida collaboration, the baseline data is from the year 2013 which was the first year of implementation of programme interventions

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. N/A signifies not "not applicable" because there was no intervention, "nd" signifies "no data," information is not available.

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.*

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **100%** Target: **100%** 2016: **100%**	Baseline: **100%** Target: **100%** 2016: **100%**	Baseline: **100%** Target: **100%** 2015: **100%**	Baseline: **85%** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **80%** 2016: **100%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau****	**Ethiopia**	**Liberia**
Baseline: **0%** Target: **100%** 2016: **95%**	Baseline: **0** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **100%** Target: **100%** 2016: **100%**	Baseline: **33%** Target: **100%** 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 depend 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.*

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **Yes** 2016: **Yes**	Baseline: **Yes** Target: **Yes** 2016: **Yes**	Baseline: **nd** Target: **Yes** 2015: **Yes**	Baseline: **Yes** Target: **Yes** 2016: **Yes**	Baseline: **0** Target: **Yes** 2016: **Yes**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **Yes** Target: **Yes** 2016: **Yes**	Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **Yes** Target: **Yes** 2016: **Yes**	Baseline: **Yes** 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 SRMNCAH.

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

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **Yes** Target: **Yes** 2015: **Yes**	Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **N/A** Target: **N/A** 2016: **N/A**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau***	**Ethiopia**	**Liberia**
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **nd** Target: **Yes** 2016: **Yes**	Baseline: **No** Target: **Yes** 2016: **Yes**

*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.)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **55% (5/9**) Target: **78% (7/9)** 2016: **100% (9/9)**	Baseline: **33% (3/9)** Target: **100% (9/9)** 2016: **56% (5/9)**	Baseline: **nd** Target: **100%(14/14)** 2015: **100%(14/14)**	Baseline: **nd** Target: **nd** 2016: **nd**	Baseline: **N/A** Target: **N/A** 2016: **N/A**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **No** Target: **Yes** 2016: **Yes**	Baseline: **0%** Target: **100% (8/8)** 2016: **100% (8/8)**	Baseline: **N/A** Target: **100% (11/11)** 2016: **100% (11/11)**	Baseline: **N/A** Target: **N/A** 2016: **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)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **11%** Target: **95%** 2016: **85%**	Baseline: **13%** Target: **100%** 2016: **36.2%**	Baseline: **41%** Target: **100%** 2015: **68%**	Baseline: **30%** Target: **100%** 2016: **60%**	Baseline: **77%** Target: **90%** 2016: **90%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **nd** Target: **90%** 2016: **86%**	Baseline: **9%** Target: **100%** 2016: **88%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **47%** Target: **90%** 2016: **81%**

*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*

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **35%** Target: **90%** 2016: **67%**	Baseline: **15%** Target: **100%** 2016: **nd**	Baseline: **nd** Target: **100%** 2015: **68%**	Baseline: **30%** Target: **100%** 2016: **50%**	Baseline: **30%** Target: **70%** 2016: **nd**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **0%** Target: **90%** 2016: **79%**	Baseline: **9%** Target: **100%** 2016: **79%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **47%** Target: **90%** 2016: **96%**

*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)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **(178/266) 67%** Target: **266) 100%** 2016: **(437/266) 164%**	Baseline: **(55/500) 11%** Target: **(500) 100%** 2016: **(839/500) 168%**	Baseline: **(81/300) 27%** Target: **(300) 100%** 2015: **(203/300) 68%**	Baseline: **(5/50) 10%** Target: **(25/50) 50%** 2016: **(91/50) 182%**	Baseline: **(75/252) 30%** Target: **(252) 100%** 2016: **(252) 100%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia ****	**Liberia**
Baseline: **(14/200) 7%** Target: **(100/200) 50%** 2016: **(52/200) 26%**	Baseline: **0%** Target: **(268) 100%** 2016: **(268) 100%**	Baseline: **0%** Target: **(92) 100%** 2016: **(59/92) 64%**	Baseline: **nd** Target: **(283) 100%** 2016: **(319/283) 112%**	Baseline: **(75/236) 30%** Target: **(75/236) 30%** 2016: **(736/536) 137%**

* 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

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

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **3,000** 2016: **2,182**	Baseline: **136** Target: **500** 2016: **471**	Baseline: **nd** Target: **2100** 2015: **2100**	Baseline: **500** Target: **960** 2016: **900**	Baseline: **410** Target: **1049** 2016: **1049**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **30** Target: **261** 2016: **282**	Baseline: **nd** Target: **1417** 2016: **1417**	Baseline: **893** Target: **2881** 2016: **2512**	Baseline: **nd** Target: **514** 2016: **447**	Baseline: **84** Target: **275** 2016: **300**

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 (* Zambia reported for 30 intervention facilities and Liberia reported for 26 intervention facilities)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **30%** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2015: **100%**	Baseline: **60%** Target: **100%** 2016: **100%**	Baseline: **50%** Target: **100%** 2016: **100%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **57%** Target: **100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2016: **72%**	Baseline: **47%** Target: **100%** 2016: **94%**

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)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2015: **100%**	Baseline: **75%** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2016: **100%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **0%** Target: **100%** 2016: **100%**	Baseline: **62%** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2016: **72%**	Baseline: **17%** Target: **(26) 100%** 2016: **94%**

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*

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **100%** 2016: **90%**	Baseline: **100%** Target: **100%** 2016: **100%**	Baseline: **100%** Target: **100%** 2015: **100%**	Baseline: **50%** Target: **(30) 100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia ****
Baseline: **0%** Target: **100%** 2016: **(7/7) 100%**	Baseline: **0%** Target: **100%** 2016: **100%**	Baseline: **0%** Target: **100%** 2016: **80%**	Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **50%** Target: **(26) 100%** 2016: **100%**

* Community engagement processes that requires 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.

** Zambia and Liberia reported for the intervention health facilities.

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 (* Cameroon include health post, primary and secondary facilities. ** 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, the mean availability of BEmONC signal function is 46% as per SARA 2017).

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **0** Target: **7** 2016: **7**	Baseline: **2** Target: **18** 2016: **9**	Baseline: **65 facilities** Target: **78 facilities** 2015: **75 facilities**	Baseline: **15** Target: **25** 2016: **30**	Baseline: **2** Target: **19** 2016: **16**
Cameroon *	**Côte d'Ivoire**	**Guinea-Bissau ****	**Ethiopia *****	**Liberia**
Baseline: **6** Target: **91** 2016: **74**	Baseline: **10** Target: **54** 2016: **54**	Baseline: **nd** Target: **130** 2016: **86**	Baseline: **33** Target: **300** 2016: **165**	Baseline: **13** Target: **26** 2016: **25**

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

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **33%** Target: **100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2015: **N/A**	Baseline: **80%** Target: **100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **50%** Target: **100%** 2016: **99%**	Baseline: **49%** Target: **100%** 2016: **100%**	Baseline: **90%** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2016: **77%**	Baseline: **89%** Target: **100%** 2016: **100%**

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.

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **9** Target: **24** 2016: **21**	Baseline: **85** Target: **338** 2015: **543**	Baseline: **50** Target: **100** 2016: **100**	Baseline: **21** Target: **263** 2016: **263**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **0** Target: **1151** 2016: **1151**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **95** Target: **nd** 2016: **772**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **84** Target: **300** 2016: **276**

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, recognition of danger signs during postnatal care for mothers and newborns.

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **23%** Target: **100%** 2015: **100%**	Baseline: **100%** Target: **100%** 2016: **100%**	Baseline: **nd** Target: **100%** 2016: **100%**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia**
Baseline: **28%** Target: **100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **nd** Target: **100%** 2016: **100%**	Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **N/A** Target: **N/A** 2016: **N/A**

Common indicator 8.2: Number of media and advocacy initiatives executed (include information about any resulting commitments or contributions from governments or partners)

Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe
Baseline: **N/A** Target: **N/A** 2016: **N/A**	Baseline: **nd** Target: **48** 2016: **42**	Baseline: **2** Target: **4** 2015: **4**	Baseline: **5** Target: **25** 2016: **50**	Baseline: **0** Target: **nd** 2016: **11**
Cameroon	**Côte d'Ivoire**	**Guinea-Bissau**	**Ethiopia**	**Liberia ****
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** 2016: **N/A**

Appendix 3: Human resources for health: skills enhancement 2016

Country	Maternal health*	Newborn and infant care	HIV prevention and treatment	Family Planning	Youth-friendly health care	Health care management	Health care-CHW's**	2016 TOTAL
Burkina Faso	130	146		751	22		535	1,584
Cameroon	173	211	30	75			229	718
Côte d'Ivoire	24	134			397	124	1,254	1,933
DRC								
Ethiopia	604	922				288		1,814
Guinea-Bissau	83			140	140		2,221	2,584
Liberia	518	218	219	318	87	243	200	1,265
Sierra Leone	125	50	250	100	60		740	1,325
Zambia	68	20	430	51	40	0	0	609
Zimbabwe	129	465	235			26		846
Grand total	1,854	2,166	1,164	1,435	746	681	5,179	13,225

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

** Joint training for RMNCH

In 2016, a total of 13,225 individuals received training to enhance skills. This brings the total over four years to 43,009 individuals trained, including 6,398 in 2013; 9,810 in 2014; 13,576 in 2015 and 13,225 in 2016.

Appendix 4: Key findings of the end line evaluation

- The End Line Evaluation (ELE) of H6 Joint Programme representing Canada and Sida grants of $99.78 million started in January 2016. The evaluation criterion includes: (1) Strengthening health systems for RMNCAH; (2) Expanded access to integrated care; (3) Responding to national and local needs; (4) Supporting innovations; (5) Division of labour to optimize individual advantage and collective strength; (6) Value added by H6 to Every Woman Every Child.

- The ELE process covered all 10 countries (Burkina Faso, Cameroon, Côte d'Ivoire, DRC, Ethiopia, Guinea-Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe). Six countries were covered through desk reviews and four countries (DRC, Liberia, Zambia and Zimbabwe) were covered through country case studies including a three-week field visit in each country.

- Several countries with functional H6 teams beyond the H6 Joint Programme were also covered for comparative assessment by administrating a questionnaire to the country teams.

Conclusions of the evaluation

1. H6 Joint Programme contributed to health system strengthening for RMNCAH at national and subnational level across all WHO's elements of health system building blocks. Contributed to improved capacity and quality of service in RMNCAH notably in EmONC and in MDSR. Positive contribution to quality of care, especially at subnational level. Interventions were almost always complementary and sometimes catalytic and aligned with national priorities.

   Challenges/limitations: Uniform efforts for exit strategy missing. Balance between supply side and demand side interventions. Varying level of optimum inputs to inform policy.

2. H6 Joint Programme contributed to expanding access to services in RMNCAH by consistently targeting service provision to underserved and hard-to-reach areas and poor populations. Supported integration of services in RMNCAH especially HIV and AIDS (including PMTCT) and aimed to overcome barriers by increasing capability of health workers, improving infrastructure, strengthening referral and outreach.

   Challenges/limitations: Overall weakness in meeting the needs of adolescents and youth, especially young girls.

3. H6 Joint Programme demonstrated a capacity to adjust and respond to changing needs and priorities at country level. Effective responses to changing conditions (e.g. Ebola Virus Disease). Joint programming of dedicated funds for RMNCAH contributed to strengthened collaboration and changed the nature of the partnership.

   Challenges/limitations: In some countries, national leadership became effective late in the programme or was not sustained throughout, which delayed or reduced the overall level of effectiveness. Strengthened level of collaboration and stronger partnership at county level did not include the World Bank.

4. H6 Joint Programme supported useful innovations in each programme country based on a practical definition of innovative practice. Innovations were being supported for scale up at national level in a number of countries.

   Challenges/limitations: Lack of evidence-based documentation on tested innovations that could adequately support policy makers.

5. H6 partners arrived at an effective division of labour in programme countries to optimize individual advantage and collective strength. Largely avoided duplication and overlap. Achieved a greater level of collaboration at both country and global level. More effective advocacy and "one voice" at country level. Developed useful, high-quality global knowledge products.

   Challenges/limitations: Results of work on global knowledge products not systematically communicated to be used by H6 country teams.

6. Value added in support of Global Strategy has been most evident in contribution to improved quality of service and access to RMNCAH at country level and increased coherence in policy engagement and advocacy at both country and global level. Strongest contribution in targeted districts and provinces in programme countries. Flexible approach to development and implementation of support met positive response from national authorities. Widened participation in the global agenda setting process for Every Woman Every Child and Global Strategy, especially in 2015.

Challenges/limitations: Missed opportunity for collective engagement by H6 country teams in broader issues of the enabling environment for RMNCAH at country level.

Appendix 5A: Interventions implemented at country level

10 countries of the H6 Joint Programme

Key Interventions	Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe	Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia
1. Leadership and governance										
• Support to national task force and policy environment for RMNCAH (including EmONC)	X	X	X	X	X	X	X	X	X	X
• Supporting adaptation of international guidelines on Quality of Care in RMNCAH	X	X	X	X	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	X	X	X	X
2. Health financing										
• Support to national health accounts		X		X						
• Introduction/support to results-based financing	X							X		
• Supporting pricing incentives and subsidies for RMNCAH services and community health funds	X	X	X				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	X	X	X	X
• Provision of equipment, medicines, commodities	X	X	X	X	X	X	X	X	X	X
• Construction and support of maternity waiting shelters and annexes		X	X	X	X			X		X
• Support to running water and/or solar power for facilities; Water, sanitation and hygiene	X	X	X	X	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	X	X	X	X
• Support for pre-service training of midwives	X	X	X	X		X	X	X	X	X
• Support for in-service training (EmONC, IMNCI, FP, PMTCT, task shifting)	X	X	X	X	X	X	X	X	X	X
5. Health information systems, monitoring & evaluation										
• Strengthening monitoring and evaluation	X	X	X	X	X	X	X	X	X	X
• Support to establishment and operation (national, provincial, district) of MDSR systems	X	X	X	X	X	X	X	X	X	X
• Technical advice and support to information management and HMIS	X	X	X	X	X	X	X	X	X	X

Key Interventions	Burkina Faso	DRC	Sierra Leone	Zambia	Zimbabwe	Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia
6. Health service delivery										
• Support to national obstetric fistula programme		X			X				X	
• Support PMTCT and pediatric HIV treatment including training and quality assurance	X	X	X	X	X	X	X	X	X	X
• Support to transportation (motorbikes, bicycles) for community level	X	X	X	X	X	X		X		X
• Supporting youth friendly services adolescent health and sexuality education			X	X	X	X	X	X		X
• Support to IMNCI (including family kits)	X	X	X	X	X	X	X	X	X	X
• Support national PMTCT and HIV and AIDS plans and programmes		X		X	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	X	X	X	X
• Educational materials for community involvement	X	X	X	X	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		X		X	X
• Engage traditional leaders in RMNCAH		X		X		X				X
• Supporting training of community group leaders including community-based advocates	X	X	X	X	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	X	X		X	X	
• Mass media campaigns on PMTCT		X	X	X	X	X	X			X
• Reducing violence against girls and women programme		X	X			X	X	X	X	X

Appendix 5B: Programme activity highlights by country

Output 1: Leadership and governance: Policy-level support to strengthen leadership and governance of national health systems	
Burkina Faso	Provided technical support to the review of the Human Resource Development Plan 2016-2018, institutionalization of modular EmONC, family planning and IMCI training at the national school of public health and four associated provincial schools. Additionally, in 2014 supported the development of regional and district operational plans and in 2013 facilitated development of a number of guides adapting WHO guidelines for PMTCT, IMCI, BEmONC, adolescent and youth-friendly services, home-based newborn care, and emergency triage assessment and treatment.
DRC	Starting in 2012, efforts were made to sensitize parliamentarians on the need for additional resources for maternal health. Since that time, advocacy efforts have succeeded in mobilizing resources and creating additional policies and guidelines to improve RMNCAH. Efforts were made to promote rights-based programming through advocacy for the approval of the Reproductive Health Law. The bill received opposition from a strong segment of religious leaders and still remains under consideration for approval. In 2014, a strategic plan on family planning and a roadmap were also developed and, in April 2015, the standards and guidelines for MNCH were updated. In 2016, the DRC finalized the National Plan for Health Development 2016–2020.
Sierra Leone	The RMNCAH strategy (2012–2017), MDSR, EmONC services, adolescent and youth-friendly services, post-abortion guidelines were developed over the course of H6 programme support. The health system recovery and resilience strategy to guide post-Ebola reconstruction efforts in the health sector was developed and divided into three phases: (1) The Early Recovery Phase from July 2015 to March 2016; (2) The Recovery Phase from April 2016 to December 2017); and (3) Resilient Health System from 2018 to 2020.
Zambia	H6 supported the development of the National Health Strategic Plan (2011–2015), the midterm evaluation of the National AIDS Strategic Framework 2011–2015, and the national planning process of the MNCH Road Map. In 2016, MDSR guidelines and data collection tools were finalized, PNC and management of pediatric HIV guidelines were updated. Consolidated guidelines for Prevention and Treatment of HIV were adapted based on the most recent WHO guidance and 90-90-90 targets.
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 was developed. Updated standards and protocols for IMCI and RMNH/HIV were disseminated in 2014. The Operational Plan on 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 provision of integrated RMNCAH services. The National Policy on Community Health and the referral guide were also developed.
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.

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."
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, a RMNDSR training manual was developed along with a National RMNCAH Annual Operational Plan integrating H6 programme interventions.
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 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 score card was reviewed and adapted for district use.
Output 2: Health financing: Addressing financial barriers to RMNCAH	
Burkina Faso	H6 supported the development of the national 'free of charge' policy in Burkina Faso. The National Strategy to subsidize deliveries in Burkina Faso allows for providing EmONC services without prepayment and at a subsidized cost of 80 per cent for C-section, thereby removing the bottlenecks linked to direct payment of health care services. In four out of five Intervention CEmONC facilities, 80 per cent cost-sharing resulted into coverage of 78 per cent of cases requiring C-section delivery in the catchment area of respective health facilities.
DRC	The vouchers were distributed through Family Kits, enabling women to access basic RMNCAH services at subsidized cost. The H6 Joint Programme activities focused on supporting voluntary community health insurance schemes ('mutuelles de santé') in some of the intervention districts by strengthening their management capacities reaching 3,654 beneficiaries, including 1,240 women and 1,458 children. Support for the development of national health accounts was provided to enhance accountability of governance for health.
Sierra Leone	A voucher scheme for providing in-kind services to teenage girls, pregnant women, mothers and newborns was tested in two districts for in-kind health support.
Zambia	During 2011–2012, technical and financial support was provided to the Ministry of Health and the Ministry of Community Development, Mother and Child Health to develop a national strategy for healthcare financing and design a social health insurance policy by tracking resources for women's and children's health through National Health Accounts.
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)	
Burkina Faso	Rapid tests were introduced for early HIV/AIDS detection. H6 also supplied three ambulances and 15 motorcycle ambulances, EmONC instruments for 62 centres and nine hospitals, PMTCT equipment according to need, and instruments for newborn resuscitation. Managers in logistics and supply management were trained in CHANNEL software for computerized logistics management information systems (LMIS) in 50 health districts and eight regional hospitals of 11 health regions.
DRC	The H6 Joint Programme supported distribution of contraceptives received from other sources to cover 110 health zones; 120 midwifery, surgical and obstetric kits were distributed for ten health zones; 12 motorcycles and three ambulances were provided in the H6 intervention facilities; and 45 health facilities in nine districts were supplied with equipment and materials for childbirth and EmONC.
Sierra Leone	H6 provided technical assistance to the Free Health Care initiative, which is the main mechanism for the monitoring, support and logistics and distribution of medical commodities. Over the period of programme implementation, the availability of ambulances in Sierra Leone tripled. This may be assigned to the support received from several donors in the post-Ebola recovery phase of the nation.
Zambia	H6 provided strategic guidance to national forecasting and quantification, and helped to strengthen and decentralize supply chain management for essential supplies. Additionally, capacity building was conducted for logistics management, commodity security and supply chain management. Finally, in 2016, essential supplies and equipment were provided across districts including 370 midwifery kits, 100 beds for the maternity waiting shelters, 300 blankets, 40 delivery beds, 120 baby cots and 10 incubators.
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 centers 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.
Côte d'Ivoire	Eight district health centers and 46 health facilities were provided with equipment and medicine for essential child care, and 27 facilities received need based equipment for EmONC.
Ethiopia	During 2016 procurement was done for equipment for Gondar and Jimma Fistula repair centres. Equipment were also procured for midwifery, anesthesia 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 anesthesia 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	
Burkina Faso	The three year National Human Resources for Health Development plan was developed under the aegis of H6 Joint Programme. The national school of public health and four provincial schools adapted modular training for EmONC, family planning and IMCI. In five health districts of the two intervention regions, 159 community health workers received in-service EmONC training whereas only 73 per cent of the target of 3000 CHWs training could be achieved in the programme period.
DRC	DRC standardized in-service training of EmONC training and the curriculum on ICM standards for midwifery schools. The KOICA adapted EmONC training process and module to replicate trainings in other health zones. About 471 CHWs received RMNCAH training in nine intervention zones; within that target of 500 individuals trained, 94 per cent of the target was achieved within the programme timeframe. In addition to providers trained in targeted areas, the pools of trainers put in place by the H6 were also trained with funds from other donors (KATKORIA, MSH, MEMISSA), including 611 claimants in other areas of health beyond the nine areas of the H6 Joint Programme.
Sierra Leone	Since 2013, 122 midwives have completed pre-service training which has contributed to the 2016 target of 66 per cent. The pre-service trainings were disrupted in 2014 due to the Ebola outbreak. Three General Practitioners received support to undergo post-graduate courses in obstetrics and gynecology in Nigeria to build in-house capacity for CEmONC services. About 2,100 CHWs trained in intervention districts in the post-Ebola period to revive RMNCAH services by rebuilding the confidence of communities to seek care in health facilities and awareness generation around preventive and promotive aspects of health.
Zambia	To revive EmONC services in 30 intervention health facilities, the target was set to enhance the skills of 50 Health professionals. About 107 per cent (75/70) of targeted nurses trained as midwives in pre-service institutions and deployed. In 2012, 33 retired midwives were deployed to meet SBA requirement to make intervention facilities functional. They were gradually replaced by updating skills of nurses as qualified midwife.
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 per cent of health facilities have skilled human resources with 282 CHWs trained and equipped (bicycle, essential drugs and EFP kit).
Côte d'Ivoire	In 2016, a total 1,933 individuals were trained. 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 per cent 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 2013–2016 to make 54 intervention facilities fully functional for essential maternal and newborn care. About 1,417 CHWs received trainings 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 by committing 60 per cent of project expenditure on this output. Some 300 identified health facilities across the country for maternity care were made functional by providing 464 midwives a three-week competency-based BEmONC training, against a target of 560. Since the H6 programme began, 319 Integrated Emergency Surgical Officers were trained, exceeding the target of 283, and placed in 101 designated primary health facilities offering life-saving maternity care. It is reported that IESO's are doing 90 per cent of emergency procedures and 62 per cent are C-sections in the 101 facilities where they are deployed. The programme also supported the training for 367 anesthetists and 288 mid-level health workers in fistula identification. About 1,200 pre-service midwifery students received support during 2013–2016.
Guinea-Bissau	In order to strengthen the national health system, H6 recruited eight international experts (three OBGYNs, four pediatricians and one anesthetist) to deliver CEmONC services and train national providers in two regional hospitals. 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 (2013–2016), 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). UN Women also led the activity of integrating Gender/HIV and Human Rights dimensions to EmONC procedures. The H6 Joint Programme trained 66 per cent of health care providers against a target of 191 for enhancing functional aspects of 80 BEmONC and six CEmONC facilities of seven regions covering 50 per cent of the national population.
Liberia	In 2013, the H6 Joint Programme supported 15 BEmONC and three CEmONC facilities of three counties of south-eastern region. In 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. During and in the recovery phase of the Ebola epidemic post-2015, institutional deliveries increased from 33 per cent in 2014 to 50 per cent in 2015 in the intervention facilities of south-eastern counties. 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 locations other than intervention health facilities and counties, who also benefited from the trainings). Similarly, 200 community health workers from the south-eastern counties and 100 from new counties benefitted with orientation on preventive and promotive aspect of RMNCAH.
Zimbabwe	Zimbabwe is only country that has opted for in-service training of health care providers. In 2013, when EmONC trainings were 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. In six intervention districts, the H6 Joint Programme successfully imparted training to 252 HFs, meeting the target set for 2016. Similarly, the target set for training of CHWs was fully achieved by the end of 2016.
Output 5: Health information systems, monitoring & evaluation: Strengthen programme monitoring and integrating accountability through MDSR	
Burkina Faso	In Burkina Faso, data collection tools and processes for monitoring health information at the health centre level were introduced; providers were also trained on conducting MNCH audits. In 2016, quality of care data from health facilities was analyzed, revealing shortcomings of the data which contributed to the development of a guide for routine quality of care data. Studies were also conducted in 2016 tracking health indicators for reproductive, maternal, neonatal and infant health. Efforts were initiated from 2012 to institutionalize MDSR. The H6 country team has succeeded in integrating the surveillance of maternal deaths within the existing system in the country, and for the surveillance of the diseases of potential epidemic, especially in the Telegramme Lettre Officiel Hebdomadaire (TLOH), which has not created supplementary costs outside of the engagement of the actors.

DRC	The H6 country team has supported the development of a monitoring framework and evaluation of the national plan for health development by ensuring that the RMNCAH indicators are taken into account. At the end of 2016, 324 of 516 areas of health reported cases of maternal deaths. H6 helped the country set up the MAA (improve Monitoring for Action), which is a monitoring and evaluation tool that aims to determine the coverage of high-impact interventions for maternal, newborn and child health in the 26 provincial health divisions to establish the dashboard and baseline. H6 supported the harmonization of a number of different data collection forms, management tools and reporting templates. H6 also supplied tools for data collection to aid this process; these tools were also used outside of the nine target health zones. Training in data collection, analysis and management was conducted in 151 provincial and district cadres as well as for 350 district teams. The H6 Joint Programme supported the establishment of the national MDSR system, including MDSR committees at health zone, provincial and central level and the training of health zone teams in 39 health zones. Maternal deaths are now included in the list of notifiable diseases in the national disease surveillance system.
Sierra Leone	Initially in 2012 in Sierra Leone, it was planned to support m-health intervention nationwide. But, in early 2013, all officials of the national HMIS cell were placed under suspension as a result of administrative enquiry. This delayed support to strengthen national HMIS system. HMIS at national and district levels was strengthened by regular supportive supervisions, training of data entry clerks, provision of improved and printed data collection tools and data collection, analysis, and management skills of health providers in all districts. MDSR guidelines were developed. Capacity building and logistics support was provided through provision of a data management facility for all 14 District Health Management Teams (DHMT) for the implementation of the MDSR strategy. Supervision and data management will need to be strengthened from national to district and from district to Peripheral Health Unit (PHU) to ensure quality implementation of MDSR.
Zambia	Monitoring capacity in intervention districts was strengthened during quarterly joint monitoring visits and visits of the monitoring institution INESOR (Institute of Economic and Social Research). INESOR was engaged to build capacity of intervention districts and facility team for data management. All five supported districts conducted HMIS data review meetings with community leaders and health providers. The government also received support to develop tools to strengthen the national civil registration and vital statistics systems. The investment was made for technically supporting the development and implementation of the MDSR system while supporting the application of MDSR reviews in the H6 focus districts and provinces. The capacity building of programme managers to facility in-charge was undertaken to roll-out MNDSR processes. Over the period of programmatic support, 10 MDSR review meetings were convened including community meetings. H6 provided technical support to the government in order to develop national road maps for MDSR and training of trainers to implement 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 2014–2015 micro plans and elaborated 2016 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. In 2014, a MDSR system was established.
Ethiopia	HMIS and data management training were conducted in 2016 along with quality of care assessments in 29 identified hospitals. A national ANC/PMTCT surveillance system assessment was conducted and the findings were used for surveillance road map development. The H6 Joint Programme initiated processes in partnership of Ethiopian Public Health Institutions. The EPHI analyzed information of 200 maternal deaths and that informed HSTP-V to strengthen post-partum care as a key strategy to reduce maternal mortality and morbidity in the country.
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 94 per cent in 2016. The programme invested in establishing and technically supporting the MNDSR process at national level whilst also supporting the application of MNDSR reviews in the H6 focus counties to ensure the process was maintained. It also helped to revitalize national commitment to MNDSR following the end of the Ebola Virus Disease (EVD) outbreak. (For example, interviews with the ERG and the H4+ country team focused on the H4+ supported revitalization of the process after the EVD outbreak including the integration of maternal deaths into routine reporting.) 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	
Burkina Faso	The programme covered services additional health facilities to make the provision of EmONC services in two regions functional. The focus of the H6 programme was to enhance the availability of SBA, improve ANC (four visits) and enhance the contraceptive prevalence rate.
DRC	The target of H6 Joint Programme was to make 18 facilitates fully functional for EmONC services in nine Health Zones of Bandaudu, Bas Congo and Kinshasa provinces. But by end of 2016 only 9 of these facilities were offering all signal functions of EmONC. The target of imparting EmONC training to 500 health workers during the programme period was exceeded, with impressive results of training 839 HWs achieved. The integration of PMTCT with ANC services improved from a baseline of 30 per cent to 90 per cent coverage by the end of 2016.
Sierra Leone	In 2012, all 65 community health centres were given training on the provision of integrated RMNCH services with focus on quality EmONC care. In 2014, two districts were targeted to demonstrate change. However, in early 2014, the Ebola outbreak set the programme back. The H6 Joint Programme responded by capacity building of service providers in all 65 facilities of the country with provision of supplies for infection prevention and control.

Zambia	To strengthen access to EmONC care, five CEmONC and 25 BEmONC facilities were identified in five intervention districts. In 2012, only one CEmONC and two BEmONC were partially functional in each district. A sequential strategy engaged retired midwives and supported nurses working in maternity wards to undergo a one-year training course to become a qualified midwife; this strategy worked well. The programme supported integration of PMTCT services, expanding provision of information and services for family planning, IMCI, ANC and ART. In order to learn from each other, districts have been conducting exchange visits to see and learn what other districts and health facilities have been doing in order to improve service provision. The district staff from the District Health Office have also used the visits as opportunities for mentoring staff, especially those at rural health centres.
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 per cent 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.
Cameroon	The referral linkages were strengthened from community level to secondary level facilities. In order to enhance service delivery at 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), diarrhea (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 2016, which was 81 per cent of the target. 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 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 other side, international specialists for obstetrics, pediatrics 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 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 target was achieved by end of 2016.
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, in 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.

Output 7: Demand creation: Building demand and enhancing community participation	
Burkina Faso	Husband's Schools were established in Burkina Faso with the goal of raising awareness about family planning and gender-based violence among men. Posters were also produced with information about danger signs during pregnancy, childbirth and the postpartum period. An ASRH social marketing campaign was carried out in 2014 that used mass media, theater, discussions and activities to promote reproductive health. In 2015, media was also used for a broader public using film, theatre, radio and television with the aim of changing behaviour.
DRC	Demand creation and community participation in DRC was promoted through several routes. Communication tools including handouts and images were distributed through youth networks and other vulnerable groups around themes such as family planning, HIV and the dangers of early marriage. Also, 72 men and boys clubs were established with the goal of promoting women's empowerment and reproductive rights. One hundred traditional and community leaders received training on maternal and child health, sexual and gender-based violence, and HIV and AIDS. Networks of women's associations and women's cooperatives were established to increase financial empowerment and reduce financial barriers. Additionally, four multimedia campaigns helped create demand for family planning.
Sierra Leone	Three functional Peer Educators Network Centres were established at the community level that served as resource centrs. Men's networks and Husband's Schools were also created through by peer educators to increase male involvement and sensitize men on sexual and reproductive health issues. In the context of the Ebola outbreak, CHWs and community networks participated in training on the revised guidelines for providing community health.
Zambia	H6 supported the creation 400 community-based volunteers (CBVs), most organized as Safe Motherhood Action Groups (SMAGs) and Community Based Distributors, who were trained to promote family planning, sexual and reproductive health and MNCAH. These CBVs were also provided with materials and transportation to facilitate their work in the communities. Traditional leaders and CHWs were trained in issues such as adolescent health, gender issues and HIV. In 2016, 80 SMAGs were trained and 45 community leaders were oriented on RHNCAH issues.
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 committee 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 trainings 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 reproducdtive 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 counseling were also implemented to raise awareness and increase participation in H6 programming.
Output 8: Communication and advocacy, including communication for development	
Burkina Faso	A radio serial and a soap opera covering themes including maternal health, family planning, gender, fistula, FGM and immunization were disseminated to raise awareness about these issues. A regional advocacy plan was also run around issues of family planning. Specific advocacy efforts were made at the national, regional and community levels among decision-makers, government authorities, administrators and traditional, religious and community leaders. In 2016, a short documentary film was used to show the impact of the maternal and infant health programme.
DRC	At the community level, awareness was raised about the causes of maternal death and 41 community radio hosts were trained in MNCH issues to promote awareness about issues like EmONC, family planning, gender-based violence and fistula. In 2016, women parliamentarians, ministers and leaders were oriented to rally support for approval of RH law.
Sierra Leone	In collaboration with the District Health Management Teams, H6 supported 36 community drama performances in hard-to-reach communities on maternal health issues with a focus on ANC services, skilled birth attendance and family planning. Print, electronic and radio media was also used, working on trainings for journalists and the dissemination of programmes. Parliamentarians were engaged around issues of sexual and reproductive helath including family planning, gender-based violence, institutional delivery and adolescents. In 2015, 28 journalists from different media houses were oriented on the response of the H6 Joint Programme to the reduction of maternal and child deaths in the country resulting in impressive visibility of RMNCAH issues in print and electronic media.

Zambia	Community campaigns were run on television and radio and print materials were produced around issues of PMTCT and pediatric HIV care, support and treatment in Zambia. In 2016, the Western Province Medical Office received support to host the 2016 National Safe Motherhood Week launch and commemoration in Mwandi District. This included training and sensitizing traditional leaders in order to advocate for their support for contributing to reducing maternal mortality due to preventable causes. H6 supported drama performances about the harmful consequences of early marriage and the benefits of contraception, targeting adolescents and women of child-bearing age in communities and schools in the Chama and Chadiza districts. Through this innovative programming, an increased number of women were able to access long-acting reversible contraceptive methods (LARCs).
Zimbabwe	A story book and video documentary were 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.
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 actitivities, 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 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.

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