H6 Joint Programme Report

Delivering health results for women, children and adolescents everywhere

2012 – 2019

UNAIDS UNFPA unicef UN WOMEN World Health Organization THE WORLD BANK IBRD • IDA | WORLD BANK GROUP

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
BEmONC	basic emergency obstetric and newborn care
CEmONC	comprehensive emergency obstetric and newborn care
CHW	community health worker
CoIA	Commission on Information and Accountability
DFID	United Kingdom Department for International Development Assistance
EID	early infant diagnosis
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
ESA	East and Southern Africa
EU	European Union
EWEC	Every Woman Every Child
Gavi	Gavi, the Vaccine Alliance
GBV	gender-based violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
HDF	Health Development Fund
HIV	human immunodeficiency virus
HMIS	health management information systems
HSTP	health system transition plan
ICM	International Confederation of Midwives
IMCI/IMNCI	integrated management of (newborn and) childhood illnesses
M&E	monitoring and evaluation
MDG	Millennium Development Goal
MDSR	maternal death surveillance and response
MNCAH	maternal, newborn, child and adolescent health
MNCH	maternal, newborn and child health
MNDSR	maternal and neonatal death surveillance and response

MNH	maternal and newborn health
MPDSR	maternal and perinatal death surveillance and response
NGO	non-governmental organization
PMNCH	Partnership for Maternal, Neonatal and Child Health
PMTCT	prevention of mother-to-child transmission (of HIV)
QED	quality, equity, dignity
RHR	reproductive health and rights
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCH	reproductive, maternal, newborn and child health
RMNH	reproductive, maternal and newborn health
SDG	Sustainable Development Goal
SHR	sexual health and rights
Sida	Swedish International Development Cooperation Agency
SMAG	Safe Motherhood Action Group
SRHR	sexual and reproductive health and rights
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
SRMNCAH-N	sexual, reproductive, maternal, newborn, child and adolescent health and nutrition
SRMNCH	sexual, reproductive, maternal, newborn and child health
STI	sexually transmitted infection
UHC	universal health coverage
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WAG	Women's Action Group
WCA	West and Central Africa
WHO	World Health Organization

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The H6 Partnership, representing the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the World Health Organization (WHO) and the World Bank, wishes to express deep gratitude to Sweden for its generous support to the H6 Joint Programme that concluded in June 2019.[1] The support received from the Swedish International Development Cooperation Agency (Sida) represents an important contribution and accelerates the implementation of the commitments made to the United Nations Secretary-General's Global Strategy as part of the Every Woman Every Child movement.

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

In the Sustainable Development Goals (SDGs) era, H6 is transforming and building on existing strengths to remain relevant and to coordinate United Nations (UN) action on the health of women, children and adolescents and to deliver on health-related targets of the SDGs. Through strong stewardship by H6 principals, drawing on the best of each member, the H6 Joint Programme can become the gold standard for translating UN reform into results for people as a transformative and country-focused mechanism that represents the start of a new era for UN delivery in countries.

1 The Sida collaboration started in 2012. Only a few global-level preparatory activities were initiated in 2012. The actual implementation of planned activities at country and global levels started in 2013. Therefore, narrative progress is reported in the entire report from January 2013 to 30 June 2019.


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EXECUTIVE SUMMARY

The SDG agenda and the Global Strategy for Women's, Children's and Adolescents' Health call upon UN Member States and their partners to deliver on ambitious outcomes by 2030. This includes the unfinished Survive agenda as well as the Thrive and Transform agenda. Every Woman Every Child (EWEC) is an unprecedented global movement that mobilizes and intensifies both international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women, children and adolescents around the world.

Since 2008, UNICEF, UNFPA, the World Bank and WHO have joined forces under the H4 Joint Programme, and later, in 2016, together with UNAIDS and UN Women, formed the H6 Partnership with the main goals of improving health outcomes for women, children and adolescents – as the technical support arm of the EWEC movement. The purpose of the H6 Partnership is to leverage the collective strengths, comparative advantages and capacities of each of its six member organizations, in order to support countries with high burdens of maternal, neonatal, child and adolescent mortality and morbidity, in their efforts to improve the survival, health and well-being of every woman, newborn, child and adolescent.

To deliver on its purpose and in support of the implementation of the 2016–2030 Global Strategy for Women's, Children's and Adolescents' Health, the H6 Partnership assists countries by (a) coordinating and providing technical support, (b) convening policymakers, service providers and partners to discuss and agree on priorities and a joint response, and (c) advocating for the strengthening of health systems to improve equitable access to and use of quality sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH-N) information, care and services in all settings.

The SDG agenda and the Global Strategy for Women's, Children's and Adolescents' Health call upon H6 to strengthen its support to countries to accelerate progress in health outcomes. To this end, the H6 Joint Programme, in collaboration with countries and partners, has identified six SRMNCAH priority areas that are required to implement the unfinished SRMNCAH Survive agenda, as well as to improve health systems response and deliver on the new goals of Thrive and Transform.

In this dynamic context, countries are developing and updating national health strategies and plans that reflect their ambitions to reach the SDGs, including the universal health coverage (UHC) goals and related health outcomes.

SRMNCAH-N continues to feature prominently in national health priorities. In response, the SRMNCAH community is identifying innovative ways to address epidemiological shifts and changing health needs by leveraging financial mechanisms, aiming to leave no one behind, and building partnerships that go well beyond the health sector, to ensure that every woman, child and adolescent has access to care and enjoys a healthy life. Part of this response is reflected in the development of investment cases for SRMNCAH-N by the Global Financing Facility (GFF) and other new strategies and partnerships within and across countries.

The H6 Joint Programme has received support from Canada and Sida amounting to $99.76 million. The aim is to provide catalytic and strategic support to national health systems to address the root causes of poor maternal and child health outcomes in 10 countries – Burkina Faso, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Guinea-Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe – as well as carrying out global-level activities. Collaboration with Canada started in 2012 and ended in 2016, whereas collaboration with Sida ran from 2013 to June 2019. This is the final report on the H6 Sida collaboration, completed on 30 June 2019. Therefore, this report reviews the progress of the H6 Sida collaboration only.

H6 JOINT PROGRAMME COUNTRY-LEVEL PROGRESS (2013–2019)

During the reporting period, H6 Joint Programme countries completed planned activities. Four countries (Cameroon, Ethiopia, Guinea-Bissau and Liberia) received no-cost extensions for 2017 to complete planned activities, whereas Côte d'Ivoire and Zimbabwe completed activities that were in the pipeline at the end of 2016. The programme design followed a health system building block approach. In 2018/19, activities at the country level were confined to developing and implementing transition plans to sustain programme gains. At the same time, the H6 Partnership witnessed a transformative transition from a joint programme to joint programming.

Looking at Sida's support from 2013 to 2019, the vast majority of expenditures were made at the country level (86 per cent), with 10 per cent at the global level (10 per cent); some 4 per cent was spent on programme management, monitoring and evaluation. Four outputs account for 81 per cent of country-level expenditure: health technologies and commodities, human resources for health, information systems, and service delivery. The output receiving the lowest level of investment was health financing, with just 1 per cent of all expenditure.

THE PARTNERSHIP'S GLOBAL-LEVEL PROGRESS

The H6 Partnership contributed to the implementation of several new global efforts. These included global strategies such as the Global Strategy for Women's, Children's and Adolescents' Health; the GFF; the Every Newborn Action Plan (ENAP); and Ending Preventable Maternal Mortality (EPMM). H6 also received a five-year extension of collaborative funding from the French Muskoka Initiative for countries in West and Central Africa (WCA). Ten million euros were allocated for 2018, with budgets for the following years to be decided on an annual basis.

In 2018–2019, the H6 Partnership continued to mobilize political support for the EWEC movement and for the health targets of the SDGs. Advocacy continued among national governments across the H6 Partnership in 43 countries. The final evaluation findings were effectively disseminated, reaching a variety of stakeholders, including development partners and the donor community at the global level, as well as national-level partners in ministries of health, academia, non-governmental organizations (NGOs) and implementing partners. Resource mobilization efforts and discussions were initiated with potential donors for future collaboration.

The focus in 2018–2019 was to galvanize partnership, building upon existing platforms at global, regional and local levels. The emphasis was on rejuvenating H6 regional teams for stewardship and leadership to drive H6 Partnership at the country level. In WCA, eight countries were reached through the Muskoka Initiative to develop joint work plans for SRMNCAH. An exclusive meeting of 17 countries from East and Southern Africa (ESA) was organized under the leadership of officials from the ministries of health to develop joint work plans for 2019–2020 in alignment with six focus areas, individual country contexts and priorities, and regional drivers in May 2019.

LOOKING BACK AND MOVING FORWARD

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

The H6 Partnership's strategic interventions for the coming years are underpinned by principles of human rights and gender equality and are aligned with the milestones and strategic interventions of the H6 Results 2020 framework. This aims to harmonize actions across the EWEC

ecosystem, which includes the H6 Partnership, the GFF and the Partnership for Maternal, Neonatal and Child Health (PMNCH). This will work across sectors and partners engaged in implementing the EWEC Global Strategy, helping to maintain country focus, implement joint programming and ensure complementarity with existing efforts to magnify results.

In 2018, the H6 Partnership successfully conducted a survey of 43 countries that have H6 country platforms. Key achievements were identified through this survey, including an increased number of trained health-care workers, support for SRMNCAH-related health plans and/or legal frameworks and updated standards of care across the SRMNCAH continuum. The results and achievements indicated in the 2018 country survey will inform future planning and support in relation to the core functions of the H6 Partnership's strategic vision.

The H6 Partnership has identified six focus areas for the future: early childhood development; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights; empowerment of women, girls and communities; and humanitarian and fragile settings. Together, these focus areas are based on the partnership's comparative advantage and are built into a strategic implementation plan for results at the country, regional and global levels. The H6 Partnership is implementing this within the context of UN reforms at the country level.

The H6 Joint Programme has a responsive, flexible structure that relies extensively on virtual teams and networks to strengthen the capacity of countries to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. The H6 Joint Programme is ripe to become a convening hub for actors across and beyond the UN, taking a multi-stakeholder and multisectoral approach to health and social justice. Strengthening the role of the H6 Joint Programme as a resource and entry point for funding partners at the field level will be key.

The H6 Results 2020 framework builds on the achievements of the H6 Joint Programme to date and reinforces existing mechanisms, while focusing the partnership on selected results and priorities and leveraging the UN reform agenda. By strengthening ways of working, the H6 Joint Programme aims to position itself as countries' main and preferred source of technical advice and support for SRMNCAH policies, strategies and best practices, as well as for data and convening stakeholders.

The ambitious SDG health goals, changing health needs and growing public expectations are raising the bar for national health systems' delivery of improved health outcomes and greater social value.

The H6 Joint Programme is poised to become a conduit of evidence-informed technical assistance, convening and coordinating a platform for actors across

and beyond the UN, and taking a multi-stakeholder and multisectoral approach to health and social justice. Strengthening the role of the H6 Joint Programme as a resource will be pivotal to facilitating processes for supporting countries to realize health-related SDGs.

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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 and Sweden, subsequently renamed the H6 Joint Programme. The H6 collaboration with Canada and Sweden mobilized a combined grant of $99.76 million to accelerate progress towards Millennium Development Goal (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 MDGs related to reproductive, maternal, newborn, child and adolescent health.[2]

In 2016, the H6 collaboration with Canada concluded as planned. The H6 collaboration with Sida received a no-cost extension up to June 2019 to complete the approved activities pertaining to actions on the management responses to the end line evaluation. The programme interventions were divided into two categories: global and country-level activities.

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

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

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

- development and dissemination of global knowledge products, including lessons learned
- capacity development initiatives of country teams and key stakeholders from 75 high-burden countries in order to strengthen national capacity around the design, implementation and monitoring of reproductive, maternal, newborn, child and adolescent health (RMNCAH) strategies
- advocacy initiatives for greater action and investment for RMNCAH.

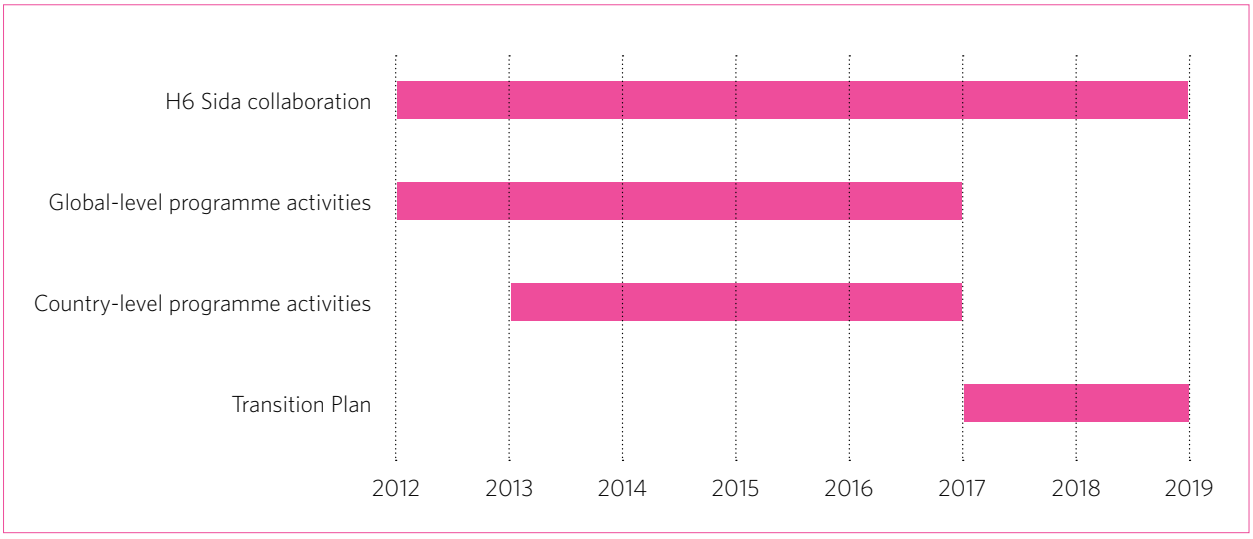
2 SRMNCAH is used for post-2016 new H6 efforts. The H6 Joint Programme interventions were confined to RMNCAH.

The joint results framework[3] is the basis for joint coordinated implementation. It has four thematic areas: policy planning and costing, quality, equality and accountability. Each thematic area is further divided into eight action areas. In the eight action areas, which correspond to four thematic areas, deliverables are associated with the 17 outputs to be achieved by the programme.

The six countries covered by the H6 Joint Programme (Sida) are low- and lower middle-income countries and are ranked among the lowest in the United Nations Development Programme (UNDP) Human Development Report, with high maternal, infant and child mortality rates. Although 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.

This is the final report on the H6 Sida collaboration, covering the reporting period up to 30 June 2019. The Sida collaboration started in 2012, with only a few global-level preparatory activities initiated in 2012. The actual implementation of planned activities at country and global levels started in 2013. Hence narrative progress is presented in the report from January 2013 to 30 June 2019, as depicted in **Figure 1.**

Figure 1: H6 Joint Programme timeline of activities



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

H6 JOINT PROGRAMME AT THE COUNTRY LEVEL (2012–2019)

The programme is designed to provide catalytic and strategic technical support for RMNCAH, to strengthen national health systems in line with national health plans through the close collaboration of H6 regional teams. The programme design at the country level follows an expanded "health system building block" approach that includes leadership and governance, financing, technologies and commodities, human resources, health information and service delivery, community ownership and demand generation, as well as advocacy for mobilizing commitments and resources. Where possible, existing national platforms for coordination received support to facilitate implementation and provide oversight at the national, provincial and subnational levels.

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

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

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

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. For the H6 Joint Programme design, the local context was prioritized and interventions were rolled out in a holistic manner. Each country team, under the leadership of their respective Ministry of Health and in consultation with local key stakeholders, identified needs and priority interventions in alignment with the agreed monitoring and evaluation framework. The proposed policy and programme interventions were based on global evidence and evidence from other countries that had demonstrated success in improving health outcomes for women and children. Community participation and demand generation interventions were integrated with supply-side interventions. During 2018

and 2019, the focus was to develop and implement transition plans to sustain programme gains. In 2018, an extensive survey was conducted to provide an up-to-date overview of the H6 work, coordination and outputs. Forty-three countries responded to the H6 survey, and the analysis of the responses provided guidance for the improved positioning of the H6 Partnership in the SDG era.

CHALLENGES FACED IN THE IMPLEMENTATION PHASE

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

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

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

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

In Cameroon, the intervention districts in the Northern Province were affected by the activities of Boko Haram, leading to insecurity and a high number of vacancies among skilled providers. The H6 country coordinator was located in the province to enhance coordination with the authorities and to improve interventions for skills enhancement and community participation, which covered the entire range of facilities from health posts (grass roots) to secondary-level health facilities. Programmatic support to the communities helped health-care providers to overcome the perception of threat.

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

A volatile political climate in Guinea-Bissau saw the introduction of four

successive governments from 2015 onwards. The political turnover slowed programme implementation. The H6 support focused on building national capacity with skilled human resources and obtaining a cadre of RMNCAH service providers.

PROGRESS AT THE COUNTRY LEVEL DURING THE PERIOD 2013–2017[4]

OUTPUT 1: LEADERSHIP AND GOVERNANCE - POLICY-LEVEL SUPPORT TO STRENGTHEN LEADERSHIP AND GOVERNANCE OF NATIONAL HEALTH SYSTEMS

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

- advocacy and facilitation to enhance domestic resource allocation for RMNCAH
- capacity-building and promoting the implementation of evidence-based protocols and standards to improve the quality of RMNCAH services
- supporting the development of strategy and policy documents for RMNCAH and the removal of financial barriers to access RMNCAH care services
- strengthening and monitoring processes to improve effectiveness and accountability, including maternal death surveillance and response (MDSR);
- supporting ministries of health, programme managers and health workers to integrate gender-responsive measures in policy, programming and service delivery for RMNCAH.

Between 2013 and 2017, key results at the policy level included the following:

- Cameroon finalized and disseminated a national policy on community health, the national strategic reproductive, maternal, newborn and child health (RMNCH) plan and developed the human resources strategy and the plan for deployment and retention of health staff. Updated standards and protocols for integrated management of childhood illnesses (IMCI) and RMNCH/human immunodeficiency virus (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 the provision of integrated RMNCAH services. The national policy on community health and the referral guide were also developed.

4 The country-specific interventions for eight outputs had ended by 2017.

- Ethiopia's accomplishments included the development of a national strategy to eliminate mother-to-child transmission of HIV, national guidelines on the prevention of mother-to-child transmission of HIV (PMTCT) and congenital syphilis, a national roadmap for maternal, newborn and child health (MNCH) quality of care and a plan of action to eliminate preventable obstetric haemorrhage deaths.

- In Guinea-Bissau, the national plan of action for prevention and eradication of gender-based violence (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 two global initiatives: A Promise Renewed and the Every Newborn Action Plan. The Health Sector Coordination Committee at the national level and regional level also received support to function effectively; the committees are under the leadership of senior political representatives (governors and regional secretaries).

- In Liberia, H6 supported the revision of the national maternal, newborn, child and adolescent health (MNCAH), maternal and neonatal death surveillance and response (MNDSR), and adolescent sexual and reproductive health protocols in 2013. National PMTCT guidelines were revised and the national elimination of mother-to-child transmission of HIV (EMTCT) plans were developed. H6 provided technical support for national RMNCAH policy development. In 2016, the GFF investment case development was supported, and a maternal and perinatal death surveillance and response (MPDSR) training manual was developed along with a national RMNCAH annual operational plan integrating H6 programme interventions.

- In Zimbabwe, H6 supported the development of guidelines 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 paediatric antiretroviral therapy (ART) and integrated management of newborn and childhood illnesses (IMNCI) training materials. Support was also provided for the development of the adolescent reproductive health strategy (2010–2015), the national PMTCT strategy (2011–2015), the option B+ strategy for PMTCT, the new 2013 HIV guidelines and a national nutrition and food policy. In 2016, the emergency obstetric and newborn care (EmONC) improvement plan was finalized, the child survival strategy was revised and the RMNCAH score card was reviewed and adapted for district use.

CASE STUDY

ZAMBIA
SAFE MOTHERHOOD ACTION GROUP

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, spoke about the impact of their work.

A male group member that helped a couple living with HIV achieve better health said "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."

A female SMAG member addressed reproductive health issues, saying "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".

Guidance from both a male and a female SMAG member encouraged an adolescent to seek health care. The male group member said that "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."

OUTPUT 2: HEALTH FINANCING - ADDRESSING FINANCIAL BARRIERS TO RMNCAH

The H6 Joint Programme interventions to address financial barriers were catalytic, need-based and complementary to the ongoing support in the RMNCAH sector at the country level. The interventions aimed to remove financing barriers for target populations, primarily to reduce the direct costs of RMNCAH services for users. A significant achievement reported by Guinea-Bissau was the development of a national "free of charge" policy and the facilitation of its implementation in the H6 Joint Programme intervention area. H6 supported the development of a national "free of charge" policy in Guinea-Bissau. The policy aimed to eliminate user fees for pregnant women, children under 5 and adults over 60. A feasibility study of the free care mechanisms was conducted in 2013. The financing needed to replace user fees initially came from the H6 Joint Programme in 2014 and an European Union (EU)-funded RMNCAH programme.

OUTPUT 3: HEALTH TECHNOLOGIES AND COMMODITIES - SUPPORT FOR IMPROVED SERVICE ENVIRONMENT (EQUIPMENT, INFRASTRUCTURE AND SUPPLIES)

Support under this output aimed to improve the service environment, particularly by reducing stock-out rates for the essential drugs and medicines required for maternal and child health, and by the provision of essential equipment and supplies for RMNCAH services at intervention facilities. Referral linkages in all countries were strengthened by improved communication at all levels of initiating and receiving referrals; in addition, the provision of ambulances enhanced the connectivity between communities and primary and secondary health facilities. Progress on an improved service environment included the following:

- In Côte d'Ivoire, blood transfusion bags (10,000) were purchased for use in 30 districts and included support for the collection of donor blood and quality assurance. Eight district health centres and 46 health facilities were provided with equipment and medicine for essential childcare, and 27 facilities received need-based equipment for EmONC.
- In Cameroon, with the support of H6, equipment and materials for basic emergency obstetric and newborn care (BEmONC) services were provided to 91 health facilities, and need-based surgical equipment was provided to five comprehensive emergency obstetric and newborn care (CEmONC) centres at district hospitals.
- Autoclaves were installed and made operational, to ensure the quality of maternal and newborn services in 19 maternity health facilities in Ethiopia.

- Guinea-Bissau reported the procurement and distribution of essential drugs, instruments and medical consumables to 75 health facilities in seven intervention health regions, for the provision of quality mother and child health services.
- Efforts to revive maternal and newborn care in six counties of Liberia continued, where the installation of medical equipment was finalized in 18 intervention health facilities and a need-based running water supply facility was established at seven intervention health facilities. In six intervention counties, 25 health facilities were made functional for the provision of RMNCAH services, contributing to the Ebola recovery phase of the national health system.
- All six intervention districts of Zimbabwe received EmONC drugs and medicine for 19 identified 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 bundles for early infant diagnosis (EID) were procured and distributed; each bundle provides 960 tests, giving a total of 211,200 tests.

OUTPUT 4: SKILLED HUMAN RESOURCES FOR HEALTH

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

From 2013 to 2017, key results in human resources for health included that about 23,464 health functionaries received training in a wide range of skills in the areas of EmONC, IMNCI, family planning, PMTCT, newborn care, community awareness and pre-service training. This included enhancing the quality and capacities of the training institutions and trainers.

Table 2: Human resources for health – skills enhancement and competencies in RMNCAH (2013–2017)

Country	Maternal health[a]	Newborn and infant care	HIV prevention and treatment	Family planning	Youth-friendly health care	Health-care management	Health-care technologies – community health workers	Total
Cameroon	970	398	30	210	–	–	229	1,837
Côte d'Ivoire	924	398	63	187	457	143	1,463	3,635
Ethiopia	3,443	3,197	256	–	–	743	447	8,086
Guinea-Bissau	848	–	–	483	140	150	2,221	3,842
Liberia	941[b]	448[b]	377[b]	527	159	302	487	3,241
Zimbabwe	565	1,567	964	–	247	88	425	3,856
Total	7,691	6,008	1,690	1,407	1,003	1,426	5,272	24,497

Note: Total trained: 7,131 (30 per cent) in 2014; 5,937 (25 per cent) in 2015; 9,169 (39 per cent) in 2016; 2,260 (5 per cent) in 2017 =24,497 individuals trained.

[a] EmONC/BEmONC/CEmONC, midwifery, maternal and child health aids, sexual, reproductive, maternal, newborn and child health (SRMNCH), maternal death review and working with individuals, families and communities approach.

[b] Joint training for RMNCH.

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

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

OUTPUT 5: INFORMATION SYSTEMS, MONITORING AND EVALUATION – STRENGTHENING PROGRAMME MONITORING AND INTEGRATING ACCOUNTABILITY THROUGH MDSR

The major support under this output was strengthening 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 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 the capacity of monitoring officers and programme managers for improved data management. The second major area of investment was to establish and institutionalize the MDSR mechanism towards integration of accountability mechanisms in the public health systems of all programme countries during the period 2013–2017.

Under this output, two indicators were tracked. The first relates to the proportion of districts that submit a 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.

In Cameroon, the H6 Joint 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 drew up 2016 micro plans.

In 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 and Niakara) implemented their biannual monitoring of the minimum activities package and essential family practices to identify bottlenecks and their causes while analysing the different paths taken and favouring local solutions.

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 the six countries of the H6 Joint Programme. Two major achievements were reported by all countries: (1) enhancement of access to quality EmONC services and (2) integration of PMTCT with the RMNCAH service package at health facilities. The positive contribution made by H6 to the health system capacity to deliver

services in RMNCAH, especially in districts, underserved counties and health zones, 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 reduction in the levels of trust attained by the significant contribution from the programme. Conscious efforts were undertaken during 2018 and 2019 by H6 country teams to develop and execute transition plans to sustain programmatic gains.

Five of the six H6 Joint Programme countries, with the exception of Ethiopia, followed a strategy of targeting a subset of health districts with poor outcomes in RMNCAH, which are usually underserved and hard-to-reach districts.

Table 3: Geographical targeting of H6 Joint Programme countries in the planning stage (2013)

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

Findings from the end line evaluation of the H6 Joint Programme endorsed that:

- The H6 Joint Programme contributed to health system strengthening for RMNCAH at national and subnational levels across all of the WHO's

elements of health system building blocks. It contributed to improved capacity and quality of service in RMNCAH, most notably in EmONC and in MDSR. It provided a positive contribution to the quality of care, especially at the subnational level. Interventions were almost always complementary and sometimes catalytic and aligned with national priorities.

- The H6 Joint Programme contributed to expanding the access to services in RMNCAH by consistently targeting the service provision to underserved and hard-to-reach areas and poor populations. The H6 Joint Programme supported the integration of services in RMNCAH, especially for HIV and acquired immunodeficiency syndrome (AIDS) and including PMTCT, and it aimed to overcome barriers by increasing the capabilities of health workers, improving infrastructure and strengthening the referral and outreach processes.

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. Reaching end users among vulnerable, marginalized, underserved or neglected groups was a challenging process requiring multiple levels of engagement. Community engagement was given varying levels of support in H6 countries. The end line evaluation found the need to balance demand-side interventions with supply-side interventions, to best optimize results by addressing gender inequality and unequal gender norms. Other challenges and limitations included the lack of uniform effort in establishing exit strategies and the varying level of optimum inputs used to inform policy.

In 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 Liberia, demand and community participation were 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 RMNCAH initiatives. These efforts have led to an increase in community leader involvement, reporting of gender-based violence and men accompanying their partners to health facilities.

CHWs were the main drivers of demand creation in Guinea-Bissau throughout the programme period, improving quality of care, providing free delivery of services and sensitizing communities. In 2016, UN Women also organized five training sessions for CHWs and NGO– staff members on SRMNCAH, HIV

and gender-based violence. The first National Youth Forum for Peer Educators in Reproductive Health was held in August 2016, bringing together 140 peer educators for training in topics such as sexually transmitted infections (STIs), HIV and AIDS, gender-based violence, family planning, and reproductive rights.

Côte d'Ivoire focused on the creation of several different types of community groups. Husbands' schools were created to promote sexual and reproductive health. Seven women's groups benefited from support to establish profit-making activities to reduce financial barriers, and 43 committees were created to address sociocultural barriers to RMNCAH services and improve access.

In Cameroon, through existing networks of associations and traditional leaders, H6 worked to sensitize groups and individuals on issues of women's rights and RMNCAH 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.

OUTPUT 8: COMMUNICATION AND ADVOCACY – GLOBAL AND COUNTRY LEVELS

Communication and advocacy played a vital role in mobilizing the EWEC Global Strategy by ensuring a unified vision and message of H6 members in tackling the root causes of maternal, newborn, child and adolescent mortality and morbidity, including gender inequalities, and sociocultural 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 community, including by decision makers, the media, donors, development partners and civil society.

The H6 Partnership increased its engagement with a number of advocacy communications arms of UN agencies, bilateral organizations, civil society organizations and other multi-stakeholder bodies to collaborate on the promotion of UN international days, such as World Prematurity Day, and international meetings such as the Global Maternal Newborn Health Conference in Mexico City and the Women Deliver conference. In addition to these international meetings, this collaboration promoted groundbreaking reports such as The Lancet's series on ending preventable stillbirths. The H6 global technical team shared this knowledge with countries and developed social media materials to further align visions and voices.

Communication and advocacy have focused on support for the plans and activities of the EWEC 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).

At the country level, H6 countries increased their engagement and generated targeted and forward-looking communication interventions, offering many innovative and effective strategies that support the H6 messages about RMNCAH.

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

The H6 Joint Programme supported useful innovations in each programme country, based on a practical definition of innovative practice. Innovations were supported for scale-up at the national level in a number of countries. The scale-up efforts and innovations were limited due to a lack of evidence-based documentation on tested innovations that could adequately support policymakers. Finally, the H6 Joint Programme demonstrated a capacity to adjust and respond to changing needs and priorities at the country level. For example, there was an effective response to changing conditions, such as the Ebola virus. Joint programming of dedicated funds for RMNCAH contributed to the strengthened collaboration and changed nature of the partnership. However, in some countries, national leadership became effective late in the programme or was not sustained throughout the programme, which delayed or reduced the overall level of effectiveness and impact. The strengthened level of collaboration and stronger partnerships at the country level, however, did not include the World Bank.

CASE STUDY

ETHIOPIA
LEVERAGING RESOURCES CREATES SYNERGY

Despite registering noticeable downward trends in maternal mortality during the MDG era, the development of an obstetric fistula still remains one of the main complications of childbirth in Ethiopia. It is estimated that up to 3,500 women develop a fistula every year and some 37,000 cases remain untreated.

As part of Ethiopia's new health sector transformation plan, a strategy to eliminate obstetric fistulas from the country between 2015 and 2020 was set in motion. To make this possible, the Ministry of Health took the innovative step of "piggybacking" on the national polio campaign, conducted in February 2015 in response to a polio outbreak in Ethiopia, and the global polio eradication initiative. The polio campaign team checked for obstetric fistula cases at each household they visited as part of the polio campaign. Simple tools, translated into local languages, were used to orient health functionaries at different levels. This was followed with house-to-house surveys on fistula cases, covering 99.7 per cent of households. Through this campaign, 2,497 suspected fistula cases were identified and mapped. All of the suspected patients were linked to fistula treatment centres for screening, and the confirmed cases were treated. An additional 375 uterine prolapse cases identified in Amhara Region were referred to health facilities for treatment.

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

H6 JOINT PROGRAMME AT THE GLOBAL LEVEL

One of the main activities at the global level in 2018 and 2019 was the facilitation and follow-up actions on the management responses of the independent end line evaluation findings. A detailed plan was developed to disseminate findings among key stakeholders at global, regional and country levels. First, the methodology and outcomes were shared with evaluation professionals, as shown in Table 4. At the global level, stakeholders were informed of results through the side events organized at the PMNCH board meeting and during the UN General Assembly. The management response of the H6 partners to the evaluation's findings and their key recommendations were presented to the UNFPA Executive Board in an informal briefing session. At the country level, stakeholders were encouraged to use the results of the evaluation in their respective countries' planning processes and to integrate its recommendations for action into their future programming.

Table 4: Dissemination of evaluation results (2017–2019)

Stakeholders	Time period	Description
Evaluation professionals	March and May 2017	African Evaluation Association meeting in Kampala, Uganda; and UN Evaluation Group meeting in Vienna, Austria
Global level: donors, academia, private sector, international NGOs and UN Member States	May 2017 to January 2018	PMNCH board meeting in Ottawa, Canada; UN General Assembly side event in New York; and meetings of UNFPA Executive Board
Country level: ministries of health and gender and women's empowerment officials, donors, H6 regional and country partners, academia, NGOs and other key stakeholders	May 2017 to December 2017	Burkina Faso, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea-Bissau, Liberia, Zambia, Zimbabwe
UNFPA Executive Board	January 2018	Informal presentation by H6 team on the H6 evaluation, in partnership with the evaluation offices of UNFPA and UNICEF
Regional and country levels: ministries of health and H6 regional and country partners	November 2018	Meeting of 29 countries from entire Africa region at Johannesburg, South Africa
Regional and country levels: ministries of health and H6 regional and country partners	May 2019	17 countries from the ESA region met in Addis Ababa, Ethiopia

In November 2018, an MPDSR workshop was organized by UNFPA, WHO and the UNICEF ESA Regional Office for 29 countries (18 in the ESA region and 11 in the WCA region). The workshop provided an opportunity to discuss the H6 Partnership with H6 regional teams and country teams, to enlist next steps for moving towards joint programming in the region.

In May 2019, a three-day H6 meeting was held, convening 17 countries from the ESA region, held at Addis Ababa, Ethiopia. The objective of the meeting was to galvanize actions in priority high-burden countries in the ESA region and to identify technical support to improve SRMNCAH in 17 countries for the period 2019–2020. The first day was dedicated to internal consultation of H6 countries, and there was an opportunity for the regional and global teams to discuss the H6 vision and results 2020 framework. Ministry of Health officials joined for the following two days, which were devoted to the exchange of knowledge, new developments and experiences pertaining to SRMNCAH.

Complementing each other and building on each other's strengths, the H6 Partnership helps countries to respond to SRMNCAH needs by taking a strategic vision and a holistic health systems approach to SRMNCAH, by providing strong intergovernmental and multi-partner relationships and by offering excellence in SRMNCAH technical assistance. Based on the values of human rights and gender equality, the H6 Joint Programme engages with countries by following the principles of (1) country focus – joint technical support for strengthening national capacities to operationalize the EWEC Global Strategy; (2) additionality – interventions that are complementary to existing agencies' programmes; and (3) joint programming – planning and delivering together by leveraging joint expertise from the H6 Partnership.

SUPPORT FOR IMPLEMENTATION OF THE RMNCAH INVESTMENT CASE FOR THE GFF

Out of 17 participating countries, nine countries[5] have experience with the GFF platform at the country level for the RMNCAH investment case. Most of the country teams expressed that H6 is suboptimally engaged in the implementation phase of the RMNCAH investment case, although H6 remained the technical arm for the implementation of RMNCAH strategy in most countries. The GFF representative explained how the GFF works through various levels of architecture (investors groups, the GFF secretariat and the role of the World Bank, country GFF platforms).

The GFF has not only brought a source of funding for RMNCAH but also is a platform from which to engage governments in increasing domestic resource

5 The Democratic Republic of the Congo, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Tanzania and Uganda.

investment in priority areas, and it combines wider external support and innovative sources for resource mobilization. For example, in Mozambique and Ethiopia a sector-wide basket funding mechanism was developed where other donors also contributed to the basket funding. The GFF platform is also promoting the engagement of private sectors. Most countries expressed their concern that there is a gap in communication from the GFF and many are not clear about the engagement of H6 in the GFF country platform. The GFF secretariat acknowledged the gap and promised to give feedback to the GFF liaison officer in order to improve engagement with H6 teams at the country level.

H6 needs to be more proactive and engage better with the GFF investment by promoting inclusive and strong country-led planning, implementation, tracking of resources and accountability.

A renewed commitment to the H6 principals in the form of a joint statement, engagement of regional directors and ownership of head of agencies at the country level is fundamental to rejuvenate the H6 Partnership. The meeting concluded with the commitment of H6 country teams to galvanize the partnership and support multi-stakeholders' country platforms to further SRMNCAH under the leadership of their ministries of health and following national plans. The ESA regional team would come up with a mutually agreed mechanism for a collective drive to support countries in a more cohesive and collaborative manner. The global team would facilitate the process of engaging senior management at the regional level and would work in close collaboration with the H6 regional team to mobilize the needed technical assistance and knowledge management to enable country teams to effectively support national plans to strengthen national health systems for SRMNCAH.

In 2018, the emphasis was on developing the H6 vision and the Results 2020 framework while initiating a few catalytic interventions.

The H6 Results 2020 framework builds on the achievements of the H6 Joint Programme to date and reinforces existing mechanisms while focusing the partnership on selected results and priorities and leveraging the UN reform agenda.

The overarching goals in the results framework are as follows:

1. All young children's environments are healthy, safe, nurturing and responsive.
2. All adolescents are supported and enabled by their environment (policy, social and other) to develop the knowledge, skills and agency to protect their mental and physical health and well-being.
3. Quality, equity and dignity are integral parts of the SRMNCAH services.

4. All people, especially women and adolescents, have access to comprehensive sexual and reproductive health information, services and rights protection that are fully integrated into strong health and community systems.

5. All women, children and adolescents can exercise their right to quality care in health services without discrimination, even in humanitarian and fragile settings.

6. All women, girls, adolescents and communities are empowered to engage meaningfully with and influence all levels of health decision-making.

The H6 Partnership is undergoing a transition in its approach at the country level, moving from a joint programme to joint programming. This entails not only planning together but also delivering together by complementing financial and human resources for the six focus areas of the H6 Results 2020 framework.

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SECTION 2. FINANCIAL MANAGEMENT AND COORDINATION OF THE H6 JOINT PROGRAMME

SPENDING BY LEVEL AND OUTPUT AREA

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

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

Table 5: Expenditures by partner and programme levels, H6 Joint Programme, January 2013 to 30 June 2019 (USD $)

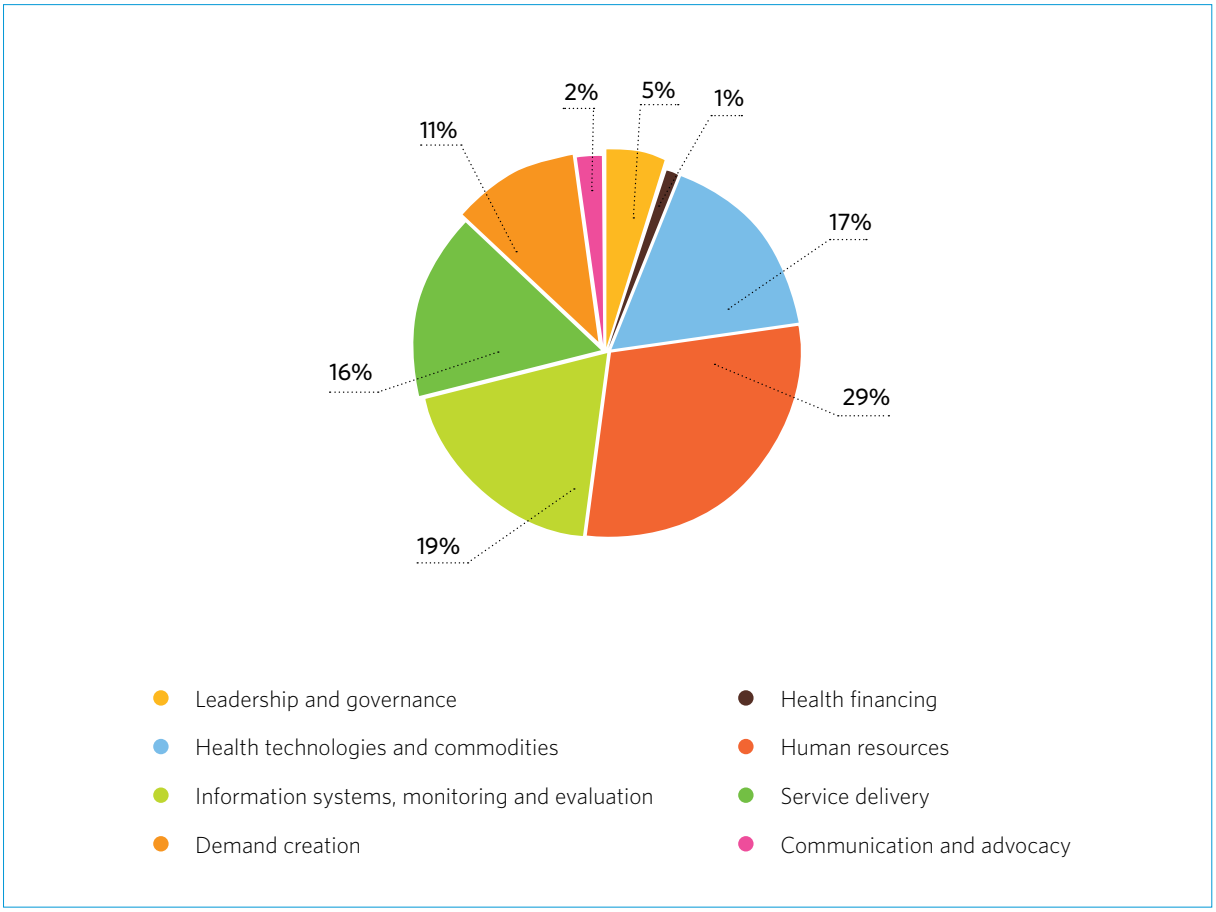
Partner	Country level	Global level	Programme management	Total	Percentage of total
UNFPA	19,035,488	1,119,412		20,154,900	36%
UNICEF	10,488,062	1,408,465		11,896,527	23%
WHO	9,713,980	1,486,457		11,200,437	22%
UN Women	3,656,483	405,073		4,061,556	8%
UNAIDS	2,176,966	914,626		3,091,592	6%
Programme management, M&E			1,633,865	1,633,865	4%
Administrative agent charges			525,841	525,841	1%
Total	45,070,978	5,334,033	2,159,706	52,564,717	
Percentage of total	86%	10%	4%		100%

Source: H6 Sida, final expenditures for 2013 to 2018 and provisional expenditure up to 30 June 2019.

A total expenditure of $52,564,717 was incurred during the H6 Sida collaboration (2012–2019). Over 86 per cent of all expenditures ($45,070,978) were incurred at the country level compared with 10 per cent at the global level ($5,334,033) and 4 per cent on programme management and administrative agent charges ($2,159,706). Programme management includes intercountry meetings, joint missions, annual reporting, joint steering committee meetings, mid-term evaluations and end line evaluations. Administrative agent charges pertain to payments to UNFPA to administer the grant.

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

Figure 2: Country-level expenditures by output area, H6 joint programme (2013–2017)



Note: country-level activities ended in 2017.

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

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

AT THE GLOBAL LEVEL

PROGRAMME MANAGEMENT

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

The H6 coordination unit is responsible for organizing joint steering committee meetings and reporting compliance with decisions made. Since the inception of the Sida collaboration, eight steering committee meetings have been held. The meetings were jointly organized for the Canada and Sida grants until 2016. These meetings addressed the appropriation and utilization of funds, reviewed progress and made decisions to enhance the effectiveness of the programme.

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

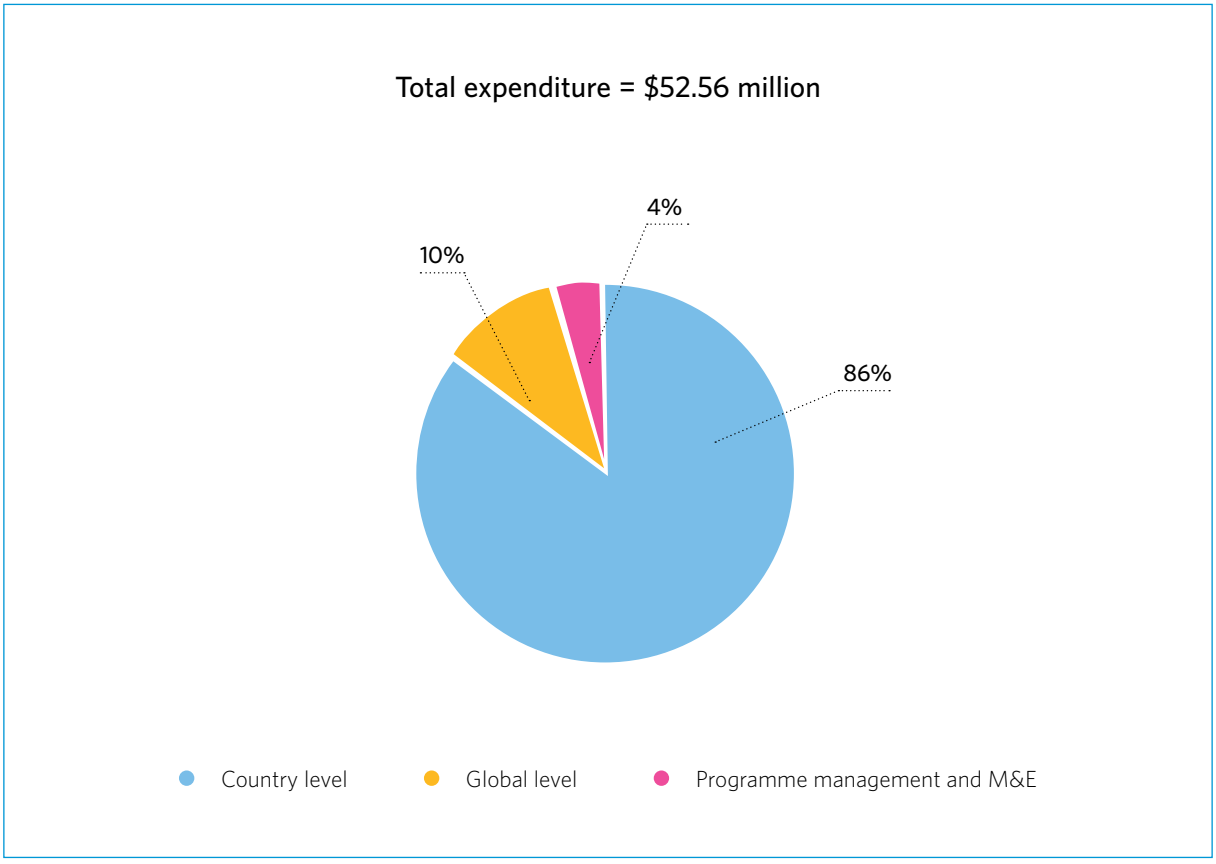
In 2019, a three-day H6 meeting of 17 countries from the ESA region was held at Addis Ababa, Ethiopia, from 14 to 16 May. The H6 meeting was organized with the objective of galvanizing actions in priority high-burden countries in the ESA region to identify technical support to improve SRMNCAH in 17 countries for the period 2019–2020, including support for implementing national SRMNCAH-N plans and strengthening H6 country coordination platforms.

FINANCIAL MANAGEMENT

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

For the Sida collaboration, of the total $52.58 million received as of June 2019[6] by the H6 Joint Programme, after deducting administrative agent charges, some $52.06 million remained for programming. Of this, $45.07 million was spent at the country level and $5.33 million at the global level. By the end of June 2019, the total provisional expenditure was $52.56 million. Country-level programming was prioritized and, as such, the originally agreed ratio was spent at the country level.

Figure 3: Percentage of total funds spent at country and global levels, 2013 to 30 June 2019



6 The provisional expenditure figures of 2019 were used in the computation.

CASE STUDY

LIBERIA
AN INNOVATIVE APPROACH TO IMPROVING THE SERVICE ENVIRONMENT

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 mobile phone flashlights when providing health services in these poorly electrified facilities. In 2016, the H6 Joint Programme, through the Ministry of Health and county/district health teams, installed solar suitcases as a backup source of electricity at the maternity wards in 26 health facilities and in 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. In addition, 115 health workers at the 25 health facilities (county health technicians and clinic officers, midwives, security staff and others) received training to maintain and operate the solar suitcases and to manage the backup electricity device.

H6 STAKEHOLDER COORDINATION AND CONVENING ROLE

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

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 2013–2019, more than 140 teleconferences were organized for the global technical teams represented by all H6 partners and representatives of EWEC, resulting in improved coordination, more efficient exchange of information and harmonized responses to key issues and opportunities. Decisions made during the weekly calls are well documented for follow-up.

During the period 2015–2017, H6 global and regional team members participated in joint missions to all programme countries. These joint missions promoted interaction among H6 country teams and enabled them to assess programme progress on intervention implementation, coordination mechanisms and innovation, and to identify needs and mobilize technical assistance. The missions also organized visits at the subnational level (in areas of intervention) to observe progress and draw lessons for experience sharing. In addition, engagement with key stakeholders, including government representatives, district managers and H6 partners, facilitated efforts to analyse barriers to and enablers of progress. An assessment of country strengths and opportunities was conducted to define evidence-based corrective actions to address challenges. The role of the H6 Joint Programme in coordinating and convening stakeholders helps countries to sustain their development gains.

AT THE COUNTRY LEVEL

PROGRAMME MANAGEMENT

In each of the six countries in the H6 Joint Programme, one of the H6 agencies has been appointed as the lead agency (Table 6). It acts as the H6 focal point, or country coordinator, overseeing and

coordinating implementation at the country level. At the country level, the programme is led by the collective efforts of country teams, in close collaboration with their ministries of health.

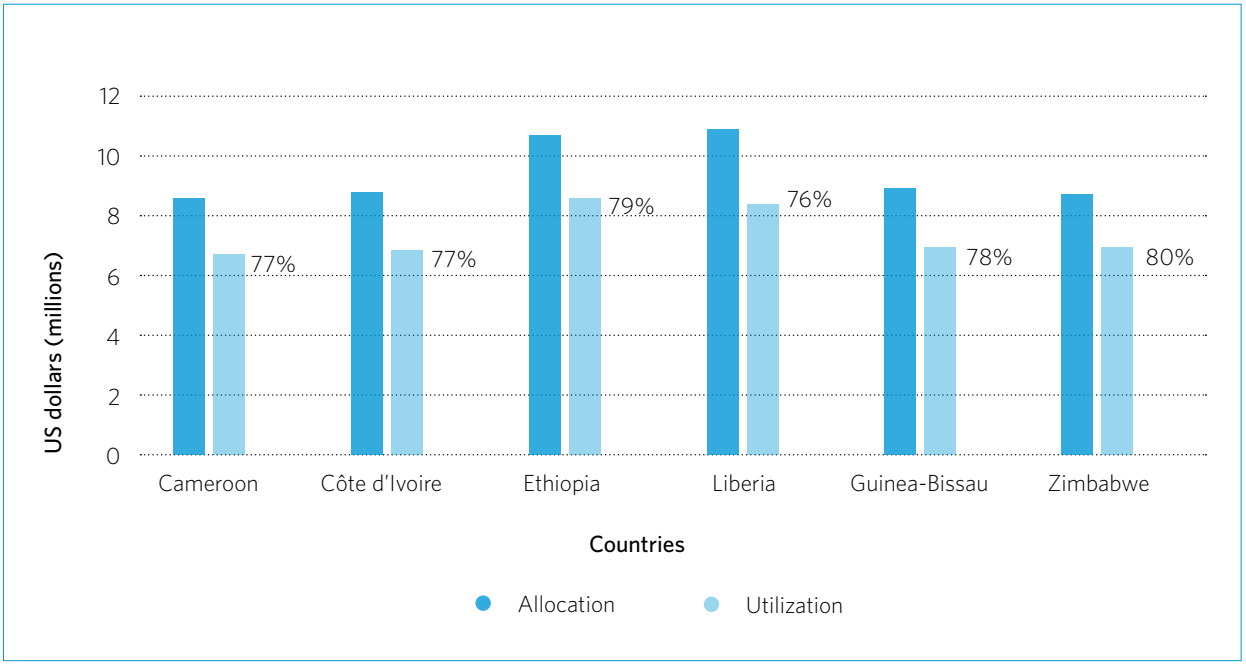
Table 6: Lead agencies in H6 Joint Programme countries

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

FINANCIAL MANAGEMENT

The present trends indicate the full utilization of grants received from Sida. The degree to which the allocated budget was utilized, however, varied by country. Figure 4 illustrates the state of finances under Sida's collaboration. An analysis of the total cumulative expenditure incurred against the allocation for 2013–2019 reveals that the average fund utilization rate for all six countries was about 76 per cent. In absolute terms, the highest allocation was for Liberia at $10.8 million, followed by Ethiopia at $10.7 million, Guinea-Bissau at $8.9 million, Côte d'Ivoire at $8.8 million, Zimbabwe at $8.7 million and Cameroon at $8.6 million.

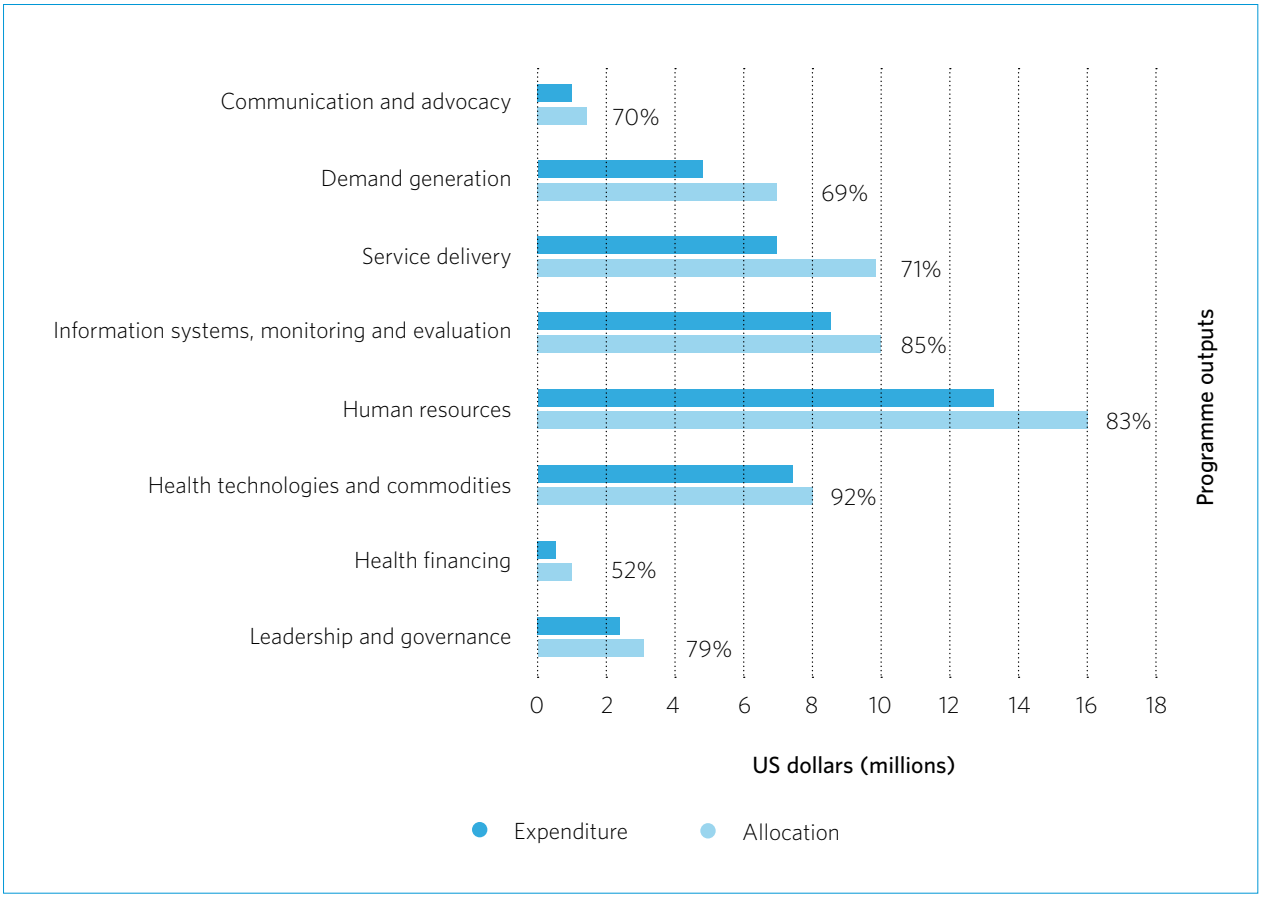
Figure 4: Fund utilization rate in Sida collaboration countries (2013–2017)



Note: The country-level activities through funds transfer to H6 country teams ended in 2017.

An analysis of the total expenditure and allocation for all six programme countries of the H6 Joint Programme outputs is illustrated in Figure 5.

Figure 5: Budget allocation and expenditure of outputs for six countries, with percentage utilization rate (2013–2017)



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

In the beginning, the pace of activity implementation and fund utilization was slow, but as the programme went on and protocols were established, the rate of implementation increased. Monitoring activities focused on strengthening the national HMIS. MDSR systems were established in all programme countries. The other two areas in which fund utilization was high compared with allocations were leadership and governance, and service delivery. For the service delivery output, different countries faced context-specific challenges to making facilities operational. Early on, implementation was slow for the service delivery output in 2013, but implementation gained momentum from 2014 onwards, once

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

CASE STUDY

ZIMBABWE
PAVING THE WAY FOR IMPROVED HEALTH

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 a 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 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. Gladys said: "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". After receiving the calendar, Gladys's husband changed and he also started attending WAG meetings. In March 2015, they went for HIV testing together and were both found to be HIV-negative, which also helped her husband change his attitude towards extramarital affairs. Gladys safely delivered her third child at the clinic in September 2015. She said: "there were so many dangers associated with home deliveries but I had no option as I had to respect my husband". 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.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SECTION 3. LOOKING BACK AND MOVING FORWARD

H6 JOINT PROGRAMME CONTRIBUTION (2013–2019)

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

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

There were variations in the focus and approach in countries, as national contexts vary from country to country. Although programme support was always complementary to efforts by larger programmes in support of RMNCAH, examples of catalytic interventions were significant in each country. The programme made important contributions to significantly increased capacities in EmONC and, at the same time, promoted an integrated

package of RMNCAH services at the subnational level. The catalytic impact is evident in the experience of Côte d'Ivoire, where annual district planning for integrated RMNCAH services is now spreading into non-intervention districts. All countries reported the integration of PMTCT with MNCH care in health facilities. In Liberia, programming was reorganized to supplement and complement national efforts to combat Ebola virus disease and effectively manage the recovery phase for the health sector. The experience of Cameroon is also unique due to its environment of insecurity. A systematic approach was used in Cameroon to enhance access to and utilization of RMNCAH services through community ownership and community support to service providers, to ensure their security while working in health facilities located in Boko Haram-affected areas.

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

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

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

Box 1: Leveraging resources towards the collective drive of H6 countries to integrate MPDSR into national health systems in Africa

Monitoring of the MPDSR system is necessary to ensure that the major steps in the system are functioning adequately and improving with time. Institutionalizing MPDSR is one of the priorities of the African Union Commission action plan towards ending preventable maternal, newborn and child mortality in Africa. MDSR is also one of the key areas for the implementation of the Commission on Information and Accountability (CoIA) framework for the UN Secretary-General's Global Strategy for Women's and Children's Health. The CoIA aims to encourage countries to be more accountable for women's and children's health. Therefore, real-time monitoring is needed if accountability at the country level is to be achieved and maternal deaths reduced.

In 2014 and 2016, the ESA Regional Office initiated a process to track the integration of MDSR in national health systems from identified countries. Following that initiative, in November 2018 an MPDSR workshop was organized by UNFPA, WHO and the UNICEF ESA Regional Office for 30 countries (18 countries in the ESA region and 12 countries in the WCA region). A typical country delegation is composed of a representative each from the Ministry of Health, WHO, UNICEF, the UNFPA Country Office and all H6 regions.

Progress in the past four years shows that critical components of the MPDSR system are in place in all ESA countries except for South Sudan. However, despite this progress, the functionality and effectiveness of the MPDSR systems vary between countries. A status report indicates that maternal death is a notifiable event in all surveyed countries with the exception of South Sudan, although seven countries[7] have yet to make perinatal death a notifiable event. Reviews of perinatal death are lacking – only seven countries[8] have established perinatal death review committees. Coordination structures, at both a national and a subnational level, are in place in all countries with the exception of South Sudan. Furthermore, a functional MPDSR committee should issue a national annual report, yet seven countries have yet to produce an MPSDR report although they have an MPDSR committee. WHO recommends that all maternal deaths be reviewed – yet this assessment indicates that only 38 per cent of countries review all cases of notified maternal deaths.

Despite the real MPDSR progress made by these countries, gaps remain. The policies for maternal and perinatal death notification and review may be in place, but they face several challenges: low coverage of maternal death notification, inadequate review and reporting, lack of involvement from civil society and communities, and competing priorities in an already overtaxed health-care system, among others. The targets are demanding but not impossible to achieve to ensure universal access to SRMNCAH care for women, children and adolescents during the era of the SDGs.

By leveraging the opportunity of a regional drive, the workshop provided an opportunity to discuss the H6 Partnership with H6 regional teams and country teams and to enlist the next steps for moving towards joint programming in the region.

7 Angola, Burundi, the Democratic Republic of the Congo, Madagascar, South Sudan, Tanzania, Zanzibar.

8 Ethiopia, Kenya, Mozambique, South Africa, Tanzania, Uganda, Zimbabwe.

CASE STUDY

MOZAMBIQUE
COLLECTIVE DRIVE OF H6 PARTNERS

For Mozambique, H6 is coordinating different joint programmes covering the key intervention, including a three-year joint programme funded by the United Kingdom Department for International Development Assistance (DFID) (2017–2020), implemented by UNFPA, UNICEF and WHO and aiming to improve the demand, use and quality of RMNACH information and services in Mozambique. Coordination within agencies for programme implementation, monitoring and reporting to donors has been successful, and this paves the way for building inter-agency coordination mechanisms.

Additionally, Mozambique is one of the countries where the EU-UN Spotlight Initiative is to be implemented, and a lot of coordination within UNFPA, UNICEF and UN Women has been required to set up the programme. The multisectoral approach for the programme is posing several challenges, which are being addressed by the H6 team.

With regard to the GFF, and specifically to the investment case, UN agencies have worked together to support the Ministry of Health and the World Bank in the construction of detailed plans and in tracking the implementation. However, there is still a need for better coordination of all agencies with the World Bank because agencies usually work individually with the World Bank on mission-specific issues. However, better coordination and a more open position from the World Bank is required to plan and deliver together.

SUSTAINING HEALTH SYSTEMS, STRENGTHENING GAINS AND TRANSITION PLANS

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

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

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

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

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

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

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

LESSONS LEARNED

The H6 Partnership has been successful at both the global and country levels in strengthening health systems and RMNCAH services. The end line evaluation found that H6 partners arrived at an effective division of labour in programme countries to optimize individual advantage and collective strength. The partners were successful in avoiding duplication and overlap and were able to achieve a greater level of collaboration at both country and global levels. The evaluation also found that more effective advocacy and "one voice" were used at the country level and that the partners were able to develop useful, high-quality global knowledge products. Value added in support of the EWEC Global Strategy has been most evident in contributions to improved quality of service and access to RMNCAH at the country level and increased coherence in policy engagement and advocacy at both country and global levels. A flexible approach to the development and implementation of support was positively received by national authorities. There was more broad participation in the global agenda-setting process for the EWEC Global Strategy, especially in 2015.

In terms of challenges and limitations, the evaluation found that the results of work on global knowledge products were not systematically communicated in order to be used by H6 country teams. Moreover, there was a missed opportunity for the collective engagement of H6 country teams on the broader issues of the enabling environment for RMNCAH at the country level.

In these stated successes and challenges, many lessons have been learned since the formation of the H6 Partnership in 2008.

Lesson 1: Coordination among technical teams is time-consuming but pays off with rich synergies that yield results

The UN system is vast but, by design, delivers as one, which can be difficult when working across different mandates and levels. However, the grants provided by Canada and Sweden created an unprecedented opportunity for the technical teams of the H6 organizations to align mandates and work across levels towards a common purpose. Harmonizing connections resulted in better service delivery and a stronger coalition, and a stronger voice at the policy level. This, however, takes notable time for the H6 partners: a sense of teamwork took approximately 4–10 months to develop. Yet, it is widely understood that this investment in time and communication, although often overlooked and underestimated, is worth it and yield results.[9,10]

Lesson 2: Strategic and catalytic support methods maximize resources

Aside from technical expertise, understanding the context of existing efforts goes a long way to improving the delivery of RMNCAH services and the quality of care. It is important to adjust to the country context when implementing evidence-informed interventions. H6 partners ensure an innovative environment by using support methods that are strategic, to avoid overlap and duplication, and are catalytic, to complement existing services. These strategic and catalytic support methods are best demonstrated by the success in targeting marginalized populations, such as geographically isolated populations, adolescents and youths, people with disabilities and people who are impoverished. For example, in Zambia, small structures were constructed to provide women with privacy for antenatal visits and maternal health services closer to home. Several studies have similarly noted that integrating services, taking services to the community – often by providing additional training to CHWs – and establishing financial incentives are strategies used to increased RMNCAH for these marginalized populations.[11]

9 T. Pang (2015). Women's health beyond 2015: challenges and opportunities for global health governance. *BJOG: An International Journal of Obstetrics and Gynaecology* vol. 122, No. 2 (January): pp. 149–151. Available at: https://doi.org/10.1111/1471-0528.13023.

10 Atul Gawande (2013). Slow ideas. *New Yorker*, 22 July. Available at: https://www.newyorker.com/magazine/2013/07/29/slow-ideas (accessed 8 July 2019).

11 Abbey Byrne, Andrew Hodge, Eliana Jimenez-Soto, and Alison Morgan (2014). What works? Strategies to increase reproductive, maternal and child health in difficult to access mountainous locations: a systematic literature review. *PloS One*, vol. 9, No. 2 (February), e87683. Available at: https://doi.org/10.1371/journal.pone.0087683.

Lesson 3: The creation of an interface can potentially enhance the interaction of country, regional and global teams

The H6 Partnership is unique in that it has created a two-way interface between partners at all levels – global, regional and national – that fostered communication and accountability and harmonized coordination. Communication is key; if all H6 partners can relay information to their regional and country offices with one voice, rather than to their respective teams separately, their ability to coordinate and respond as a unit is vastly improved and valuable for policy and advocacy efforts. This two-way interface is likely to improve the existing impact of H6 programming by enhancing coordination efforts and translating successes between health districts and counties. The coordination of diverse initiatives at varying levels is often noted as both an opportunity and a challenge in global health governance,[12] calling for strategic shifts in a post-MDG era. This collaboration proves to be easier at the global level, whereas it took time to define roles and responsibilities at the country and regional levels.

Lesson 4: Scaling up, as a strategy to connecting communities with the health system, requires more evidence

Scaling up continues to prove difficult in the context of RMNCAH, despite being a widely used term throughout global public health.[13] It is understood that programmes must be scaled up for maximum impact. For RMNCAH, the goal is to scale up to the national level – anything else limits progress. However, scaling up is not an isolated process,[14] and needs to be embedded in programme design, through documentation, evaluation and analysis.[15] Again, as outlined in lesson 2, strategies for scale-up are context and situation dependent; there are different ways to scale up different programmes and interventions. Many publications maintain that scale-up must be accounted for and thought through in the planning phase – not solely as an afterthought or after success. Although it is perhaps idealistic to plan for scale-up in the pre-implementation phase, it is a good place to start. More evidence and case documentation need to be studied to better understand the progress of programmes; thus it helps if there is some kind of standardization in the

12 T. Pang (2015). Women's health beyond 2015: challenges and opportunities for global health governance. *BJOG: An International Journal of Obstetrics and Gynaecology* vol. 122, No. 2 (January): pp. 149–151. Available at: https://doi.org/10.1111/1471-0528.13023

13 Gavin Yamey (2012). What are the barriers to scaling up health interventions in low and middle income countries? A qualitative study of academic leaders in implementation science. *Globalization and Health*, vol. 8 (May), p. 11. Available at: https://doi.org/10.1186/1744-8603-8-11.

14 *Ibid.*

15 Neil Spicer, Dipankar Bhattacharya, Ritgak Dimka, Feleke Fanta, Lindsay Mangham-Jefferies, Joanna Schellenberg, Addis Tamire-Woldemariam, Gill Walt, and Deepthi Wickremasinghe (2014). 'Scaling-up is a craft not a science': catalysing scale-up of health innovations in Ethiopia, India and Nigeria. *Social Science & Medicine*, vol. 121 (November), pp. 30–38. Available at: https://doi.org/10.1016/j.socscimed.2014.09.046.

planning process. That said, many H6 initiatives were scaled up. In Liberia, solar suitcases are providing health facilities with the power and light required to assist in obstetric emergencies – most of which occur at night and have historically proven to be problematic to treat in the absence of a reliable supply of electricity. In the Democratic Republic of the Congo, the Family Health Kit, a kit that includes a voucher to access RMNCAH at a subsidized cost, was implemented at the national level, after success in five provinces and with the partnership of UNICEF, GFATM, the EU and Gavi, the Vaccine Alliance.

Lesson 5: Influencing system-wide change through intervention-area learning is challenging and requires persistent effort

These efforts are ongoing and require persistent work and coordination among several players. In the case of the H6 Joint Programme, it was critical for the partnership's efforts to be shared at the policy level of programme countries. This created a sustainable way for the H6 Partnership to maintain relationships with key stakeholders, including government and national health system officials. This, in turn, fostered a sense of collaboration over competition and created a space for continuous monitoring, evaluation, assessment and, ultimately, institutionalization. Beyond the widely accepted understanding that substantial and persistent time, effort and determination are needed, the literature agrees that "early and ongoing advocacy" is critical to achieving sustainable results.[16]

Among the successes and lessons learned from the H6 Partnership is an understanding that the work is far from over. There is continuous demand for collaboration over competition, a joint focus, monitoring and a shared vision in order to improve SRMNCAH systems and services in the countries that need it most.

16 UNFPA (2017). *End line evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011-2016.*


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CASE STUDY

MALAWI
INCLUSIVE SUPPORT FOR THE GFF

Malawi has been included in the GFF recipient countries with a focus on RMNCAH, and nutrition plans are under way to prepare for the development of an investment case. The GFF has been designed using a flexible approach that supports countries in three ways: (1) strengthening dialogue among key stakeholders under the leadership of the government and supporting the identification of a clear set of priority results that all partners commit their resources to achieving; (2) getting more results from existing resources and increasing the total volume of financing from four sources: domestic government resources, financing from the International Development Association and the International Bank of Reconstruction and Development, aligned external financing and private sector resources; and (3) strengthening systems to track progress, learn and correct course.

The Malawi investment case known as Every Woman, Every Child will have four priority areas: RMNCAH, early learning, nutrition, and civil registration and vital statistics.

The H6 country team is an active member of the national GFF task force. The government has engaged different stakeholders, including the H6 Partnership, NGOs, civil society organizations, faith-based organizations and Ministry of Health and Population departments, to work on different components of the investment case.

H6 actively supported the development of the investment case. By providing technical support, H6 is represented in the RMNCAH, nutrition, and civil registration and vital statistics subgroups. H6 in collaboration with other stakeholders was involved in teams that drafted and validated the situation, and that analysed the financial gaps and bottlenecks for the investment case, including the costing of the identified activities to address the bottlenecks.

MALAWI INVESTMENT CASE ROADMAP

Proposed revised GFF Investment Case roadmap, 12 April 2019

Current situation: 12 April 2019	**15 April – 29 May 2019**	**30 May 2019**	**31 May – 7 July 2019**
Situation analysis: - Writing teams submitted draft situation analysis sections in October 2018 - Draft consolidated situation analysis submitted to the Department for Planning and Policy Development in January 2019	Situation analysis: - Cleared by Department for Planning and Policy Development by 6 May	GFF task force meeting: - To review bottleneck analysis workshop outcomes - To launch investment case writing team - To agree on investment case priorities - To agree on reorganized investment case outline	- Platform meeting on 31 May - Investment case writing workshops (3–7, 24–26 June) - Circulation of draft 1 investment case by 14 June - Comments received no later than 21 June - Revised investment case draft circulated by 1 July - GFF task force meeting to endorse the investment case on 4 July - Platform meeting on 5 July - Submission of the final investment case to SH on 7 July
Financial gap analysis: - Analysis being undertaken	Financial gap analysis: - Cleared financial gap analysis		
Bottleneck analysis: - Subset of the essential health package being used for the analysis	Bottleneck analysis: - Analysis completed by 6 May - Bottleneck workshop conducted (15–17 May) - Circulation of draft revised outline of investment case - Circulation of terms of reference and recruitment of investment case writing team		


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SECTION 4. WORKING TOGETHER ON THE SRMNCAH AGENDA: CONTRIBUTIONS OF THE H6 PARTNERSHIP

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

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

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

The countries of the Arab States region have received technical assistance from the H6 team to strengthen RMNCAH services in humanitarian settings, to assess RMNCAH targets and indicators in line with the SDGs and to

strengthen the adoption of surveillance tools at national and subnational levels, in line with WHO standards and guidelines for improving the measurement of maternal, newborn and child deaths.

The quality, equity, dignity (QED) effort unites and builds on the technical and advocacy work of the ENAP and EPMM groups and engages PMNCH partners. It was initially led by nine countries already spearheading efforts. Launched in 2017, QED aims to strengthen national efforts to end preventable deaths by 2030, as envisaged in the EWEC Global Strategy. The interventions include strengthening the capacity of health professionals to plan and manage quality improvement; improving data collection; and increasing access to medicines, supplies, equipment and clean water. Currently, the network includes 11 pathfinder countries, namely Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, Tanzania and Uganda.

As of March 2019, additional countries have joined the network, namely Botswana, Cameroon, Chad, the Democratic Republic of the Congo, Liberia, Mozambique, Namibia, Niger, Senegal, South Sudan, Sudan, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka and Timor-Leste.

By the end of 2017, 43 countries and territories with a high burden of newborn mortality and stillbirth had finalized national newborn plans or strengthened the relevant components within national health strategies. An additional 24 countries adopted the ENAP tracking tool in 2017, bringing the total to 75 countries. The tracker helps countries identify gaps and establish neonatal mortality and stillbirth reduction targets, which are essential SDG and EWEC Global Strategy indicators. By the end of 2018, 90 countries were covered by ENAP, out of which 87 per cent had completed a newborn action plan or updated the maternal and newborn health (MNH) component of the RMNCAH plan.

H6 COUNTRY SURVEY: 2018

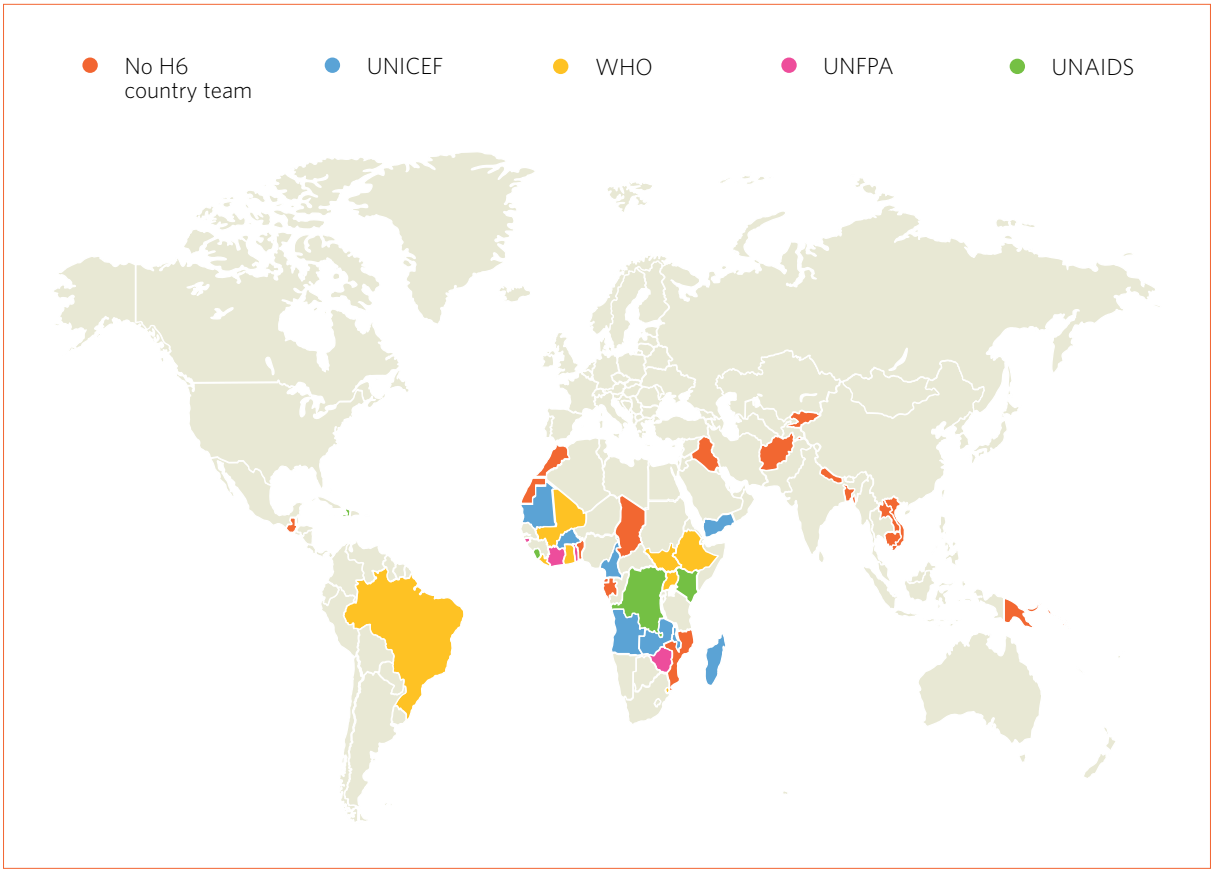
In 2018, the H6 Joint Programme conducted a survey in 43 countries with a high burden of new mortality, to provide a comprehensive, up-to-date overview of the H6 Partnership. The survey looked at the structure, coordination, functionality and activities of countries towards supporting the adoption and implementation of the EWEC Global Strategy and achievement of high-quality SRMNCAH. Results from this survey will serve as a baseline for subsequent analyses of progress.

Further objectives of the H6 country survey include:

- providing an up-to-date analysis of the H6 work on progress, gaps and challenges towards its mandate, in line with national plans and strategies
- informing the development of country-specific H6 technical support plans and assessing their respective resource needs for 2018–2020, by documenting suggestions from H6 country teams and sharing lessons learned from the H6 country-level work on inter-agency collaboration and joint planning, programming and projects
- assessing the progress of H6 efforts towards supporting country implementation of the EWEC Global Strategy, the H6 vision and the H6 Results Framework 2018–2020, endorsed recently by the H6 principals
- raising the profile and efficiency of the joint UN systems' support, particularly in high-burden countries, in making an impact on SRMNCAH and reaching the EWEC Global Strategy goals.

The survey was distributed to country directors from the six agencies in August 2018, with data collection continuing until October 2018. Responses reflect the collective work of the H6 Partnership, the work achieved in collaboration and not by individual agencies. The survey consisted of 85 questions, all relating to the survey objectives. The survey had a response rate of 74 per cent.

Figure 6: H6 organizations representing the country teams in the survey



The 43 countries that responded to the survey are categorized in specific regions: Asia and Pacific (7 respondents),[17] East and Southern Africa (12 respondents),[18] Eastern Europe and Central Asia (1 respondent),[19] Latin America and the Caribbean (3 respondents),[20] North Africa and the Middle East (3 respondents)[21] and West and Central Africa (17 respondents).[22]

Of the 43 country teams that responded to the survey, 27 have a functional H6 country team.[23] A preliminary comparison of the 2018 survey responses with the responses from the last H6 survey, conducted in 2015, indicates a substantial decrease in functional H6 country platforms. In the Asia and Pacific region, there was a severe loss of functional team presence, dropping from seven functional teams in 2015 to no functional teams in 2018. There was no significant change in two regions: East and Southern Africa reported 11 functional teams in 2015 and 2018, and West and Central Africa reported 14 functional teams in 2015 and 13 functional teams in 2018. In one region, the single country with a functional team in 2015 changed to a different one in 2018. Both the Latin America and Caribbean, and the North Africa and Middle East regions experienced a gain in the number of functional country teams. The Latin America and Caribbean region increased from one functional team in 2015 to two teams in 2018. The North Africa and Middle East region increased by one team as well, reporting no functional teams in 2015 and one in 2018.

Twenty-three respondent teams have a humanitarian or post-conflict situation in their countries. Among countries with a functioning H6 country team, 44 per cent indicated that they currently or in the past have pooled funds with other H6 agencies, while 48 per cent have not. The most common thematic groups focused on neonatal health, maternal health, reproductive health and rights (RHR), adolescent health and well-being, data management, monitoring and evaluation, sexual health and rights (SHR), family planning, childcare and quality of care. Ten respondent teams reported the presence of a technical wing in addition to the head of agencies groups. These technical wings reportedly serve several valuable functions, including providing technical reviews, planning and the coordination of interventions (Zambia); playing an

17 Asia and Pacific: Afghanistan, Bangladesh, Cambodia, the Lao People's Democratic Republic, Nepal, Papua New Guinea, Vietnam.

18 East and Southern Africa: Angola, Comoros, Eswatini, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, South Sudan, Uganda, Zambia, Zimbabwe.

19 Eastern Europe and Central Asia: Kyrgyzstan.

20 Latin America and the Caribbean: Brazil, Guatemala, Haiti.

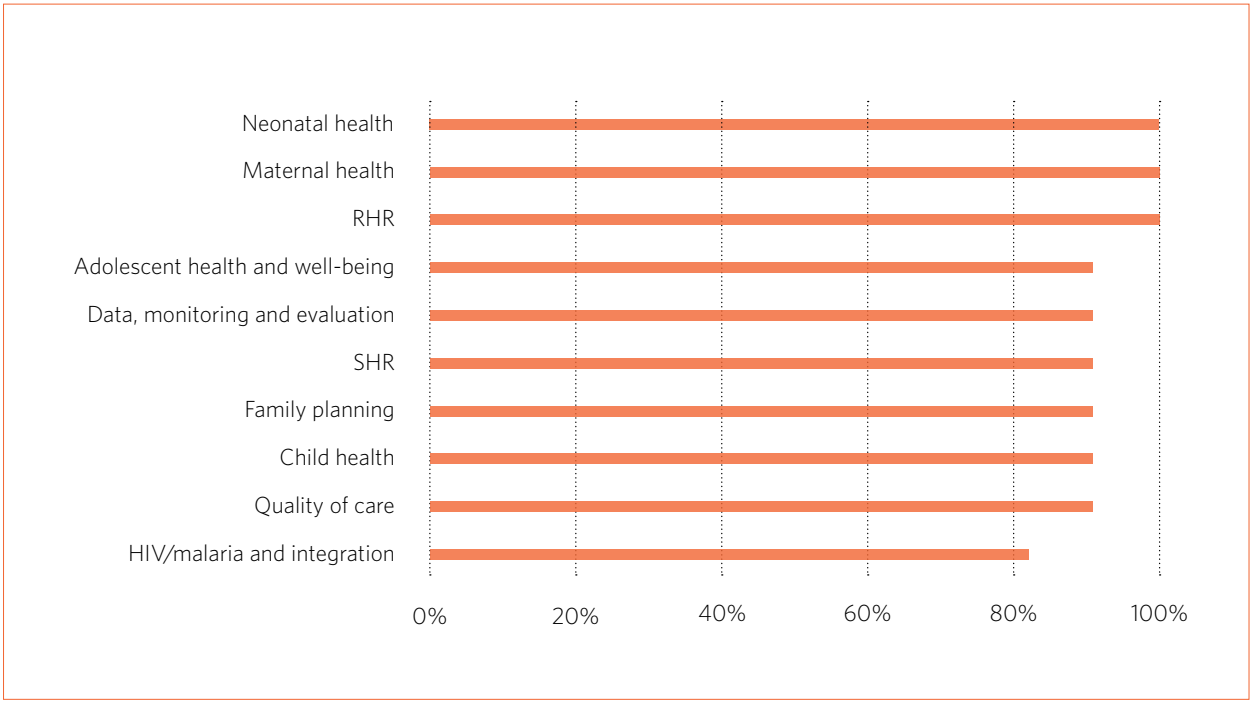
21 North Africa and the Middle East: Iraq, Morocco, Yemen.

22 West and Central Africa: Benin, Burkina Faso, Burundi, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea-Bissau, Liberia, Mali, Mauritania, Sierra Leone, Togo.

23 The 27 countries with a functional H6 country team are Angola, Brazil, Burkina Faso, Burundi, Cameroon, Comoros, Côte d'Ivoire, the Democratic Republic of the Congo, Eswatini, Ethiopia, Gambia, Ghana, Guinea-Bissau, Haiti, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Sierra Leone, South Sudan, Togo, Uganda, Yemen, Zambia and Zimbabwe.

advisory role, process intervention and implementation recommendations (Sierra Leone); and facilitating technical discussions and the development of documents (Malawi).

Figure 7: Top 10 areas of assistance provided by H6



Key achievements and findings identified through the survey in 2018 include the following:

- Twenty-two H6 teams assisted with training and increasing the number of health-care workers.
- Twenty-one H6 teams supported SRMNCAH-related health plans and/or legal frameworks.
- Twenty-one H6 teams helped to update the standards of care across the SRMNCAH continuum.

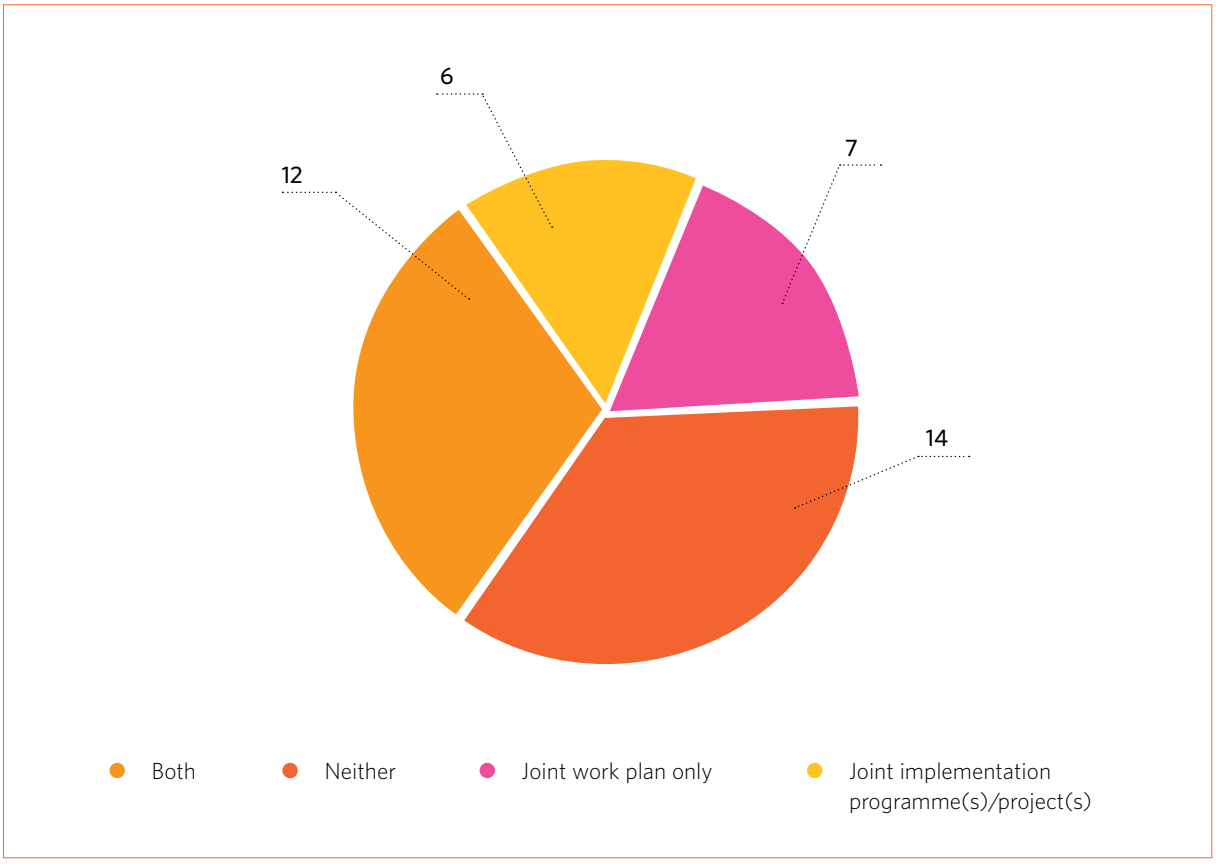
SRMNCAH-RELATED ACTIVITIES, RESOURCE MOBILIZATION AND TECHNICAL SUPPORT PROVISION

Although the majority of respondent teams have a joint work plan or joint implementation programme(s), joint project(s) or both, 14 reported that they had none. All of those that had at least one joint plan, programme or project reported that those activities are aligned with, are in support of and are integrated with national SRMNCAH strategies. Twenty-three teams reported that their H6 team meetings and work plan, joint programme or joint project

review meetings are open for other SRMNCAH partners' participation and contribution, but 15 teams' meetings are not. Of those teams that allow partner participation, 19 said that national partners were engaged in the drafting of the work plan, but only one team reported that no national partners were similarly engaged.

Funding of these activities remains an issue for many H6 teams. Twenty-one of 25 respondents said that all or some of their joint H6 programmes or projects are funded, but 14 said that none are. Those whose projects are funded receive funds globally from the H6 Joint Programme, bilaterally at the country level or from other sources.

Figure 8: Joint work plans, implementation programmes and projects (*n* = 39)



All 43 countries reported that the current UN Development Assistance Framework (UNDAF) includes a specific thematic area on SRMNCAH, but only 53 per cent reported that H6 implementation plans, joint activities, programmes and/or projects are included in the UNDAF. H6 country teams are involved in several initiatives, including the GFF, "Start Free, Stay Free, AIDS Free", the PMNCH, the EWEC Global Strategy 2016-2020, "Family Planning 20/20" and the ENAP.

Respondents most commonly thought that the key areas on which SRMNCAH

partnerships should focus from 2018 to 2020 were maternal health and mortality, neonatal health and mortality, adolescent health, child health and mortality, and SRHR. From 2020 to 2030, these top five categories remained the same, with the exception of quality of care replacing sexual and reproductive health and rights (SRHR). Respondents also specified the most common areas on which the H6 Joint Programme should focus in the next two to three years. These included maternal health and mortality, neonatal health and mortality, quality of care, adolescent health, and child health and mortality.

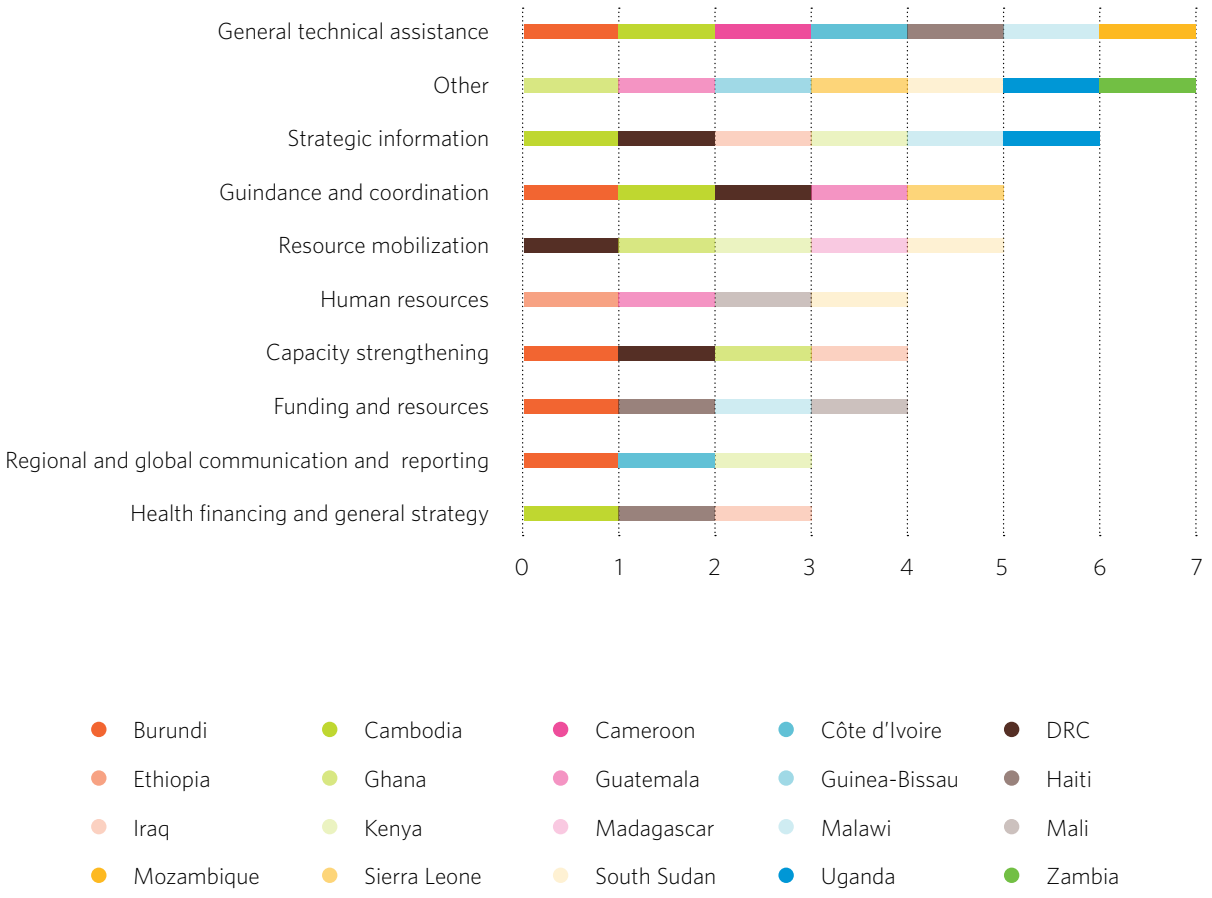
NATIONAL STRATEGIES, PARTNERSHIPS AND MECHANISMS

Of countries belonging to a multi-stakeholder platform/forum/partnership/coordination structure, key technical needs included general assistance, other country-specific needs, strategic information, guidance and coordination, and resource mobilization.

Fifteen respondents indicated active PMNCH partnerships in their country, but 16 said that there were no PMNCH partnerships currently in existence. Five countries (Brazil, Ethiopia, Gambia, Malawi and Zimbabwe) specified some sort of collaboration between H6 and the PMNCH. Some key challenges included the lack of technical and financial support (multiple countries); weak integration and coordination, lack of community participation and a shortage of qualified human resources (Iraq), and a shortage of MNCAH professionals (Brazil).

Among the four respondents for which H6 has been supporting GFF-funded activities, key challenges and areas for future support included coordination, capacity, challenging environments, resources and general technical support.

Figure 9: Technical assistance needs for countries in multi-stakeholder partnerships (*n* = 20)



CHALLENGES AND OPPORTUNITIES FOR H6 TEAMS

Most notably, of the 43 respondent teams, 27 have a functioning H6 country team,[24] and in 10 of those teams, the H6 Partnership chair has been the same agency for five to nine years, which poses the greatest weakness and the greatest challenge.

Moreover, there is some coordination missing between H6 and the GFF: of the 43 countries, 19 are implementing the GFF, while only four countries have reported H6 active collaboration with GFF planning and implementation. Other challenges identified through the H6 country survey can be divided into four broad categories: (1) political challenges, issues related to SRMNCAH and

24 The 27 countries with a functional H6 country team are Angola, Brazil, Burkina Faso, Burundi, Cameroon, Comoros, Côte d'Ivoire, the Democratic Republic of the Congo, Eswatini, Ethiopia, Gambia, Ghana, Guinea-Bissau, Haiti, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Sierra Leone, South Sudan, Togo, Uganda, Yemen, Zambia and Zimbabwe.

the implementation of the EWEC Global Strategy, (2) cultural and otherwise complex problems, (3) programme implementation challenges and (4) other country-specific challenges.

Under the category of political challenges, issues related to SRMNCAH and the implementation of the EWEC Global Strategy, the key challenges included financing and lack of government leadership for creating multi-stakeholder coordination platforms. Several respondents suggested that advocacy from the H6 Partnership could play a key role in addressing these issues. This could help in terms of supporting the government to mobilize internal and external resources (Zimbabwe), enhancing the dissemination of national plans and guidelines (Guatemala) and ensuring continuous joint programming (Haiti). To establish the areas to advocate, respondents from Mozambique suggested first prioritizing an agenda of common interest and later working with governments to implement their own priorities.

Cultural issues and otherwise complex problems remain an issue in many countries. Respondents cited child marriage, early sexual debut, female genital mutilation, violence, including sexual and gender-based violence, and ethnicity-related barriers as key issues. Often the problem is not just the phenomena themselves, but the lack of data that countries possess to describe them (Burundi). Countries cited that these issues are largely driven by sociocultural norms (Eswatini and Haiti), lack of understanding of the causality chain (Guinea-Bissau) and religious and patriarchal beliefs (Burundi and Eswatini). Future H6 strategies to address these complex issues should include the engagement of the male population (Burundi and Eswatini), investing in proven and family-centred behaviour change models and interventions (Eswatini) and providing technical support to remote and underserved regions of the country (Ethiopia).

Programme implementation challenges focus heavily on the lack of financial resources, limited human resources and fragmentation among programmes and implementers. For some countries, dependency on donors and their specific focuses prevent countries from working on their own priority areas. To combat this problem, some countries expressed a desire for heightened country involvement. Respondent teams suggested that stakeholders must be involved in an inclusive manner of participation – being part of the solution allows them to take ownership of all stages, from development to implementation (Guinea-Bissau).

Several countries struggle with limited finances and resources (Ethiopia, Guatemala, Haiti, the Lao People's Democratic Republic and Uganda), a lack of or inequitable distribution of human resources (Cambodia, Guatemala and Zambia) and ineffective coordination (the Lao People's Democratic Republic and Zambia). More specific examples include epidemic outbreaks (Uganda) and natural

disasters (Haiti), which can take a toll on multiple facets of the health system. The H6 Joint Programme has been addressing country-specific issues using advocacy in several instances (Burundi, Malawi and Zimbabwe). In Zimbabwe, this has been done by prioritizing young people, especially adolescent girls, and by supporting the new government in identifying its priorities.

THE H6 PARTNERSHIP VISION: A TRANSFORMATIVE AGENDA

Globally, the health of women, children and adolescents is improving faster than at any point in history. Since 1990, the world's maternal death rate has fallen by 44 per cent, while death rates of children under the age of 5 declined by 53 per cent. But evidence and advocacy efforts are revealing major gaps in countries' health responses. The Global Burden of Disease Study projects that just 5 out of the 24 health-related SDG targets currently measured will be met by 2030. In 2016 alone, more than 7 million maternal, child and adolescent deaths occurred. Some 3,000 adolescents die each day from mostly preventable causes, with stark differences in the leading causes for regions, younger and older adolescents and gender.

We know that healthy and empowered women transform societies, and therefore H6 puts women, children and adolescents at the centre of a shared response. The UN health space can become a central construct and a living laboratory for UN reform – to deliver on 28 health targets across 11 health-related SDGs – focused on better results for people. The H6 Partnership leverages the full strengths of UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank to mobilize political commitment and resources, to accelerate results and to provide countries with a one-stop shop for:

- data and strategic information to reveal gaps, show returns on investment and prioritize responses
- technical support and capacity strengthening
- support to countries to leverage investments
- reporting results on a global level
- convening a hub within the health space.

The EWEC movement aims to transform societies so that women, children and adolescents everywhere can realize their rights to the highest attainable standards of health and well-being, ensuring that every woman, child and adolescent can survive, thrive and contribute to more peaceful and prosperous societies.

CASE STUDY

KENYA
SUPPORT OF H6 PARTNERS IN THE DEVELOPMENT AND IMPLEMENTATION OF THE GFF INVESTMENT PLAN

Kenya is a front-runner country for the GFF, where implementation of the RMNCAH investment framework has been ongoing since 2016. The H6 partners contributed to the development of the RMNCAH investment case through the identification of priority investments to achieve RMNCAH outcomes and by identifying priority health-financing reforms in support of the roadmap for UHC. This was spearheaded by UNFPA and the World Bank. H6 played a critical role by convening the various stakeholders at different levels, in consultation with the Ministry of Health.

The H6 partners have provided specific technical support to the Ministry of Health in defining the essential benefit package for UHC, which is under consideration. The national investment case has adopted an equity lens and is focusing on women and children as the key populations that are not adequately covered. This investment framework has been used for reference for implementing many RMNCAH programmes and interventions, not only those implemented by the World Bank under the GFF platform but also those implemented by other NGOs as well.

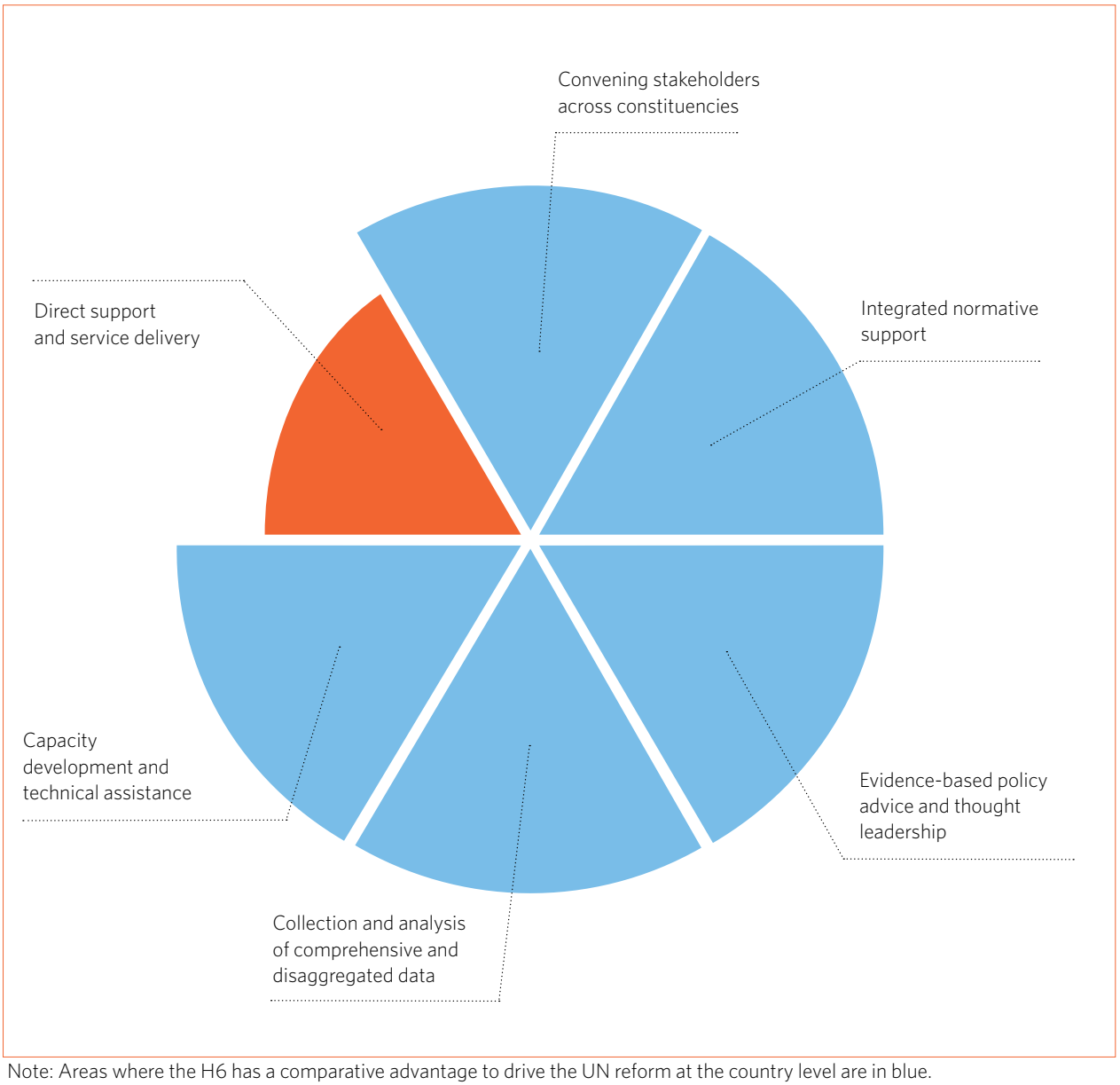
Additionally, the H6 partners are implementing a programme on RMNCAH, targeting the six counties, Isiolo, Lamu, Mandera, Marsabit, Migori and Wajir, that account for 50 per cent of the burden of maternal mortality. The initial phase of this programme was funded by the RMNCH Trust Fund ($15 million) for about two years and was subsequently funded by the Danish International Development Agency. The H6-funded RMNCAH programmes complement the GFF-funded programmes in the six counties, as well as in 16 other counties. The improved EmONC coverage increased access to skilled birth attendants (from 24 per cent to 42 per cent in some counties) and reduced facility-based maternal deaths, and enhanced child survival is reported in the intervention area.

The H6 Joint Programme also advocated for the inclusion and funding of the civil registration and vital statistics component in the GFF. To this end, the GFF funded advocacy and capacity-building interventions in two counties. Other related interventions include MPDSR.

The H6 partners are supporting the country in the development of health-financing strategies for the entire health sector and the implementation of key health-financing reforms, including reforms of the National Hospital Insurance Fund to move towards a system of social health insurance and consolidate multiple existing risk pool schemes. Advocacy efforts have been put in place by the H6 Joint Programme to support domestic resource mobilization for the overall health sector and for RMNCAH.

In general, the H6 collaboration in the GFF platform is leveraging technical support, advocacy and partnership.

Figure 10: Six core UN system functions needed to effectively implement the SDGs outlined by the UN Secretary-General.



Note: Areas where the H6 has a comparative advantage to drive the UN reform at the country level are in blue.

The H6 Partnership already provides a mechanism to coordinate UN action on health and is an entry point to deliver on SDG 3 and health-related targets of the SDGs. Through strong stewardship by H6 principals and drawing on the best of each member, the H6 Joint Programme can become the gold standard for translating UN reform into results for people, by being a transformative and country-focused mechanism that represents the start of a new era for UN delivery in countries.

The 2030 Agenda for Sustainable Development has given major impetus to global health, and momentum is building. Robust investments in leading

global health funds – namely Gavi, GFATM and the GFF – demonstrate that the global community is confident that the sector can deliver significant returns. The UN plays a critical role in making this money work for women's, children's and adolescents' health and well-being. It brings unique and added value through political leadership, expertise, capacity strengthening and its physical presence around the world.

Without country presence, major health funders rely heavily on the UN – specifically the H6 Joint Programme – to deliver on the EWEC Global Strategy. The H6 Joint Programme has proven to be indispensable in linking global funding, policy and advocacy with country priorities and results for people. It provides a unique and valued country platform for improving coordination and coherence within the EWEC ecosystem. By leveraging the comparative advantages of its six partners, the H6 Joint Programme can drive unparalleled multisectoral action to deliver despite complex health, development and social justice challenges. Renewed dynamism in global health, coupled with the Secretary-General's UN reform agenda, offers a singular opportunity to elevate the H6 Joint Programme. Many of the priorities of UN reform – joint working, reducing fragmentation and duplication, generating strategic information, delivering integrated policy advice and strengthening accountability – are at the heart of the H6 model, making it well placed to serve as an incubator of reform.

The H6 Joint Programme has a responsive, flexible structure that relies extensively on virtual teams and networks to strengthen country's capacities to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. Taking the H6 Joint Programme to the next level will require building on best practices and raising our ambition. Through a transformative agenda, we can unlock the full potential of H6 structures, functions and ways of working.

Accelerating the results and serving as a platform for UN reform will require the strengthening of the partnership as an instrument to deliver better at the country level. It will demand the crystallization of H6 strategic areas of focus and core functions and the alignment of efforts around these and then the identification of key countries in which we commit to implement the reform agenda. The H6 Joint Programme is ripe to become a convening hub for actors across and beyond the UN, taking a multi-stakeholder and multisectoral approach to health and social justice. Strengthening the role of the H6 Joint Programme as a resource and entry point for funding partners at the field level will be key.

Four key functions to deliver results for people and drive UN reform are the following.

1. **Being a one-stop shop for UN technical assistance for health by providing:**

- country-owned roadmaps, linked to investment cases, to align partners to country priorities, to reduce duplication, mobilize additional resources and accelerate results
- a single technical support platform to enable countries to know where o find quality expertise to enable implementation, facilitate pooling resources and skills, and facilitate South–South cooperation
- a single, high-level H6 results framework, building on synergetic interventions of partners to address persistent, cross-cutting challenges
- a differentiated H6 leadership in individual results areas and building cross-country networks (among and beyond the H6 Partnership) on particularly challenging issues.

2. **Supporting countries to leverage health investments by providing:**

- support to prepare grant proposals and develop investment cases, including for the GFF, using data across sectors to inform country priority setting.

3. **Acting as a data hub for gathering strategic information to identify gaps, show returns on investment, prioritize response and drive accountability by providing:**

- a one-stop shop for data, with strengthened capacity and expanded to encompass the monitoring of policy and systems enablers that will be key to accelerating progress on women's, children's and adolescents' health
- real-time data visualization of local health situations as a live complement to the "Countdown to 2030" country dashboards
- increased capacity for data collection and reporting in countries.

4. **Acting as convener and broker across the health space and beyond by:**

- leveraging the UN's convening power to build innovative partnerships with business, humanitarian actors, NGOs and communities, to identify targeted investment opportunities, address cross-cutting issues and unblock hurdles
- bringing change agents into national planning.

Great transparency and accountability for collective results will be shown in the following ways:

- Reporting: the H6 Joint Programme, with the involvement of implementing partners, will report on country results to the chief executives/boards and the high-level steering group.

- Accountability: to support this transformative agenda, the H6 Joint Programme will need innovative and inclusive oversight mechanisms to discuss political and strategic priorities and review progress. Beyond the H6 principals' leadership, an H6 board, involving the H6 Partnership, EWEC, the PMNCH, the GFF and the Secretary-General/ Deputy Secretary-General, would provide such a governance platform. Furthermore, a group of friends of H6, gathering development partners and implementing countries, will enable H6 to demonstrate and discuss results, align priorities and coordinate efforts.

- Evaluation: a joint H6 evaluation plan will be developed, including an independent review, to assess and demonstrate the added value of joint working and the contribution to the UN reform.

The ambitious SDG health goals, changing health needs and growing public expectations are raising the bar for national health systems to deliver improved health outcomes and greater social value. The H6 Joint Programme is poised to become a conduit of evidence-informed technical assistance, convening and coordinating a platform for actors across and beyond the UN and taking a multi-stakeholder and multisectoral approach to health and social justice. Strengthening the role of the H6 Joint Programme as a resource will be pivotal to facilitating processes to support countries in realizing SDG targets.

SECTION 5. CONCLUSION

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

The SDG goals are ambitious, although financial resources are limited. Domestic resources will drive the 2030 Agenda forward. It remains critical to leverage resources through all possible channels, bilateral and multilateral, public and private, to target high-impact investments. Similarly, the assessment of challenges and opportunities to forge partnerships among key stakeholders and to support multi-stakeholder platforms, to further collaboration, is critical for transformative results.

Financial support was received through several different mechanisms to support the mission and work of the ever-evolving H6. Between 2013 and 2017, the RMNCH Trust Fund – with support from DFID and Norway – existed to provide catalytic funding, of about $240 million, to support 19 countries to accelerate progress towards MDGs 4 and 5. Concurrently, funding was also provided to global teams of experts to address global commodity-related bottlenecks and support the implementation of the RMNCH Trust Fund programmes at the country level. Two major grants were received from Canada and Sweden, Can$50 million and US$52 million respectively, to work in collaboration and accelerate MDG progress in 10 high-burden countries in the partnership's major initiative at the time, the H4+ Joint Programme, from 2012 to 2019. The Muskoka Initiative supported eight countries in WCA during the period 2012–2018 with €95 million of funding.

Throughout the period 2008–2019, we experienced a drastic change in the external environment and approach to programming when the SDGs replaced the MDGs. The SDGs presented a cohesive, well-coordinated approach, with a multisectoral approach to strengthening national health and with SRMNCAH as an integral component.

In order to remain relevant and contribute in a meaningful manner, the H6 Partnership itself is undergoing a transition. The major transition, from a joint programme to joint programming, will entail planning and delivering together at the global, regional and country levels, using the available resources of each partner.

The SDG era will follow the principles of the progressive realization of UHC, where SRMNCAH is a central pillar. Unleashing the potential of half of our population, represented by women, creating equal opportunities for youth and providing social protection for those left behind, is crucial to realizing inclusive development. This will require the creation of a chain of coordinated efforts and further strategic partnerships for the meaningful participation of women, youth and those left behind in the participatory processes of development.

Digital inclusion can be a powerful engine of change. Capitalizing on the transformative potential of technology demands more investment in people, especially women and children. This will require the collective drive and coordinated efforts of development partners, academic institutions, professional bodies, NGOs, community-based organizations, other organizations and Member States.

Finally, political stewardship, knowledge management, innovations, capacity-building and partnerships are going to be key drivers of change. The collective drive of organizations from all political, economic and social spheres is critical to addressing complex development challenges.

The success of H6 endeavours needs leadership of H6 teams at all levels. At the same time, the engagement and support of the GFF, collaborating with global funds and other funding streams, are equally important. The active contribution of H6 to UN reforms that are under way to strengthen the Resident Coordinator system, ranging from planning together to delivering together, should be appreciated fully, as H6 has provided vital contributions to path-breaking strategic reforms to the UN system.

Through a transformative agenda, we can unlock the full potential of H6 structures, functions and ways of working. H6 is poised and well positioned to become the gold standard for coordinating UN action on health, translating UN reform into real results for women, children and adolescents as a transformative and country-focused mechanism that represents the start of a new era for UN delivery in countries.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PHARMACEUTIQUES
INTRANTS GRATUITS

APPENDIX 1: H6 GLOBAL-LEVEL ACTIVITIES (2012–2019)[25]

THEMATIC AREA 1: POLICY, PLANNING AND COSTING				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
Topic 1: Provide support to countries to identify and address systems constraints to improve RMNCH, which are MDG-driven 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 disseminated	Capacity-building	UNICEF	H4+ activities disseminated during the 2013 Global Newborn Health Conference in Johannesburg, South Africa
	ENAP bottleneck analysis tool used during country consultations on newborn care	Capacity-building	UNICEF	Bottleneck analysis tool for ENAP disseminated through website and during country (at least five 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)

25 The Sida collaboration started in 2012. Only a few global-level preparatory activities were initiated in 2012. The actual implementation of planned activities at country and global levels started in 2013. Therefore, narrative progress is reported in the report from January 2013 to 30 June 2019.

THEMATIC AREA 1: POLICY, PLANNING AND COSTING

YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	Revision of Lives Saved Tool for updating the OneHealth and Lives Saved Tool instruments	Global knowledge product	WHO	Lives Saved Tool http://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 Global Strategy.2.0 and the GFF	Capacity-building	WHO	Report with no link
	Developed pre-qualified pool of 26 senior experts on country investment planning processes for EWEC Global Strategy 2.0	Capacity-building	WHO	Report with no link
	Development of an RMNCAH toolkit	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/
2019	Development of a programme guide	Global knowledge product	UN Women	Programme Guide: Promoting Gender Equality in Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health http://www.unwomen.org/en/digital-library/publications/2019/06/promoting-gender-equality-in-srmncah

THEMATIC AREA 1: POLICY, PLANNING AND COSTING

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 national RMNCH plans is strengthened				
2012	Toolkit for RMNCH strategic planning, implementation, monitoring and reviews	Global knowledge product	WHO	Costing Tool 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	Global knowledge product	UN Women	Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era 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

THEMATIC AREA 1: POLICY, PLANNING AND COSTING

YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	(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 Lives Saved Tool instruments	Global knowledge product	WHO	Lives Saved Tool http://www.livessavedtool.org/
	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 technical assistance agenda around RMNCAH investment plans and technical assistance 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

THEMATIC AREA 1: POLICY, PLANNING AND COSTING				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	The following policy briefs and guidance documents were published: (1) Core Competencies in Adolescent Health and Development for Primary Care Providers (2015) (2) A tool to assess the adolescent health and development component in pre-service education (3) A Standards-driven Approach to Improve the Quality of Health-care Services for Adolescents (2015) (4) Building an Adolescent-competent Workforce (2015) (5) WHO Recommedations on Interventions to Improve Preterm Birth Outcomes (6) WHO Recommendations for Prevention and Treatment of Maternal Peripartum Infections (2015) (7) Guidelines on Basic Newborn Resuscitation (2012) (8) Breastfeeding of Low-birth-weight infants (2015)	Global knowledge product	WHO	(1) and (2) http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf (3) http://apps.who.int/iris/bitstream/10665/184035/1/WHO_FWC_MCA_15.06_eng.pdf (4) http://apps.who.int/iris/bitstream/10665/183151/1/WHO_FWC_MCA_15.05_eng.pdf (5) http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf?ua=1 (6) http://apps.who.int/iris/bitstream/10665/186171/1/9789241549363_eng.pdf (7) http://apps.who.int/iris/bitstream/10665/75157/1/9789241503693_eng.pdf?ua=1 (8) http://www.who.int/elena/titles/supplementary_feeding/en/

THEMATIC AREA 1: POLICY, PLANNING AND COSTING

YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	(9) Improving Paediatric Quality of Care at First-level Referral Hospitals (2015) (10) Revised WHO Classification and Treatment of Childhood Pneumonia at Health Facilities (2014) (11) Caring for the Sick Child in the Community: Adaptation for High HIV or TB Settings – CHW Manual (2014) (12) Ending Preventable Maternal and Newborn Mortality and Stillbirths: Effective Interventions and Strategies (2015)	Global knowledge product	WHO	(9) http://www.who.int/maternal_child_adolescent/documents/paediatric-hospital-care-quality/en/ (10) http://apps.who.int/iris/bitstream/10665/137319/1/9789241507813_eng.pdf (11) http://www.who.int/maternal_child_adolescent/documents/9789241548045.pdf (12) http://www.everywomaneverychild.org/images/07__Ending_Preventable_Maternal_andNewborn_Mortality_and_Stillbirths.pdf
2018	H6 Vision and H6 Results Framework 2018–2020	Policy document	UNAIDS	The H6 Partnership Vision: a catalyst for transformation in the United Nations to deliver health results for women, children and adolescents in support of the Sustainable Development Goals https://www.unaids.org/en/resources/documents/2018/h6-partnership-vision The H6 Results Framework: developed to accelerate change while setting ambitious goals and committing to deliver on concrete results for 2020 https://www.unaids.org/en/resources/presscentre/featurestories/2018/may/heads-of-h6-agencies-embrace-new-results-framework
2019	Inter-country meeting of 17 countries from ESA to develop joint planning to support and focus areas of EWEC	Capacity-building	UNFPA, WHO	Report with no link

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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 up 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 for MNH/Family planning; draft report with recommendations is available	Documentation	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 MNH compiled	Global knowledge product	UNICEF	H+ inter-agency list http://www.who.int/medicines/areas/policy/12-IPC_InteragencylistMandMD.pdf
	Diagnose, Intervene, Verify, Adjust (DIVA) procurement and supply tool (final version) available	Global knowledge product	UNICEF	UNICEF's systematic and outcome-based DIVA approach

THEMATIC AREA 2: QUALITY

YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2014	(1) Core set of indicators of quality of MNCH care in facilities published (2) Quality of care panel published in Countdown 2014 report (3) BJOG supplement on quality of care in MNH to be published in August (WHO staff co-editor and WHO staff contributors) (4) Meta review on quality of care assessments in MNCH published (5) Quality of care core indicators pilot tested in Uganda and Tanzania. Quality of care field testing manual/operations drafted (6) Technical support provided to the Democratic Republic of the Congo (strategy development), Zambia (GAPPD and home-based newborn care), Zimbabwe (quality of care) and Burkina Faso (community services and GFATM proposal) (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 help mHealth implementers and countries to successfully and sustainably scale up their innovations	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 (7) mHealth MAPS toolkit http://who.int/life-course/publications/mhealth-toolkit/en

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2014	(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) Quality of care workshop to develop a pool of quality-of-care experts organized for 15 countries	Capacity building	WHO	(1) Workshop reports, with no link (2) Mission reports, with no link. Participating countries: Bangladesh, the Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Malawi, *Nigeria, Pakistan, Sierra Leone (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

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	(1) Feasibility of WHO indicators of quality of care for MNCH care in facilities tested in the Democratic Republic of the Congo, Chad, Tanzania, Zambia and Zimbabwe (2) Qualitative study to understand challenges in monitoring quality of care conducted in the Democratic Republic of the Congo and Tanzania (3) National capacity-building for quality of care assessment and improvement in the Democratic Republic of the Congo, Malawi, the Republic of the Congo, Swaziland and Tanzania (4) Integrated management of pregnancy and childbirth guidelines updated with latest WHO recommendations (5) Maternal mortality ratio estimates published in 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

THEMATIC AREA 2: QUALITY				
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 seven modules of the Essential Childbirth Care 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

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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/
2016	Agenda for Zero Discrimination in Health-care Settings	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 CHW's, 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 a 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
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

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	(1) Midwifery Service Framework developed, printed and disseminated (2) Development of CHW's reproductive, maternal and newborn health (RMNH) training guidance (3) The final report of the assessments initiated of Midwifery Workforce (MWA) in Mozambique and the Tanzania, is still with the government for final approval. No other workforce assessment is planned at this stage (4) Development and release of the State of the World's Midwifery report in June 2014 (5) The State of the World's Midwifery 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) International Confederation of Midwives (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) Finalization of report in progress (4) and (5) State of the World's Midwifery report http://www.unfpa.org/sowmy

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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 CHW's				
Output 5a: Innovations in RMNCH and 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 and Pacific region), Dakar (WCA) and Cairo (Arab states). (2) Three regional gap analysis workshops organized: first in Senegal for Chad, Guinea-Bissau, Mauritania, Mauritius and Senegal, second in Togo for Benin, Burkina Faso, Côte d'Ivoire, Kenya, Mali and Niger. (3) Midwifery Service Framework field tested at Lesotho and Bangladesh (4) Quality of care during childbirth: evidence-based statements, inputs, outputs and outcomes developed on experience of care (respect and dignity, communications, emotional support) to ensure updated tools align with quality of care 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
2013	Strategic communications and advocacy platforms in place	Advocacy	UNFPA	https://docs.google.com/file/d/1hjoGHMzIDtbFBeujX9OiRC9sTi3hjzazOTmZI_sJzTgmV1Kq5GMyBIkkTiw6/edit http://integrare.es/?p=1363

THEMATIC AREA 2: QUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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 factsheets published and disseminated for Burkina Faso, Cameroon, Sierra 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				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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 that 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 MNH. The modules describe the roles and responsibilities of programme manager, supervisor and facilitator (CHW) and will be included in the existing WHO/UNICEF manual 'Caring for Newborns and Children in the Community' (2015) (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 MNH to women's groups in rural settings. Ongoing participatory review with women networks in Ethiopia, Bangladesh, Côte d'Ivoire and priority Global Plan countries (4) Developed and finalized the planning handbook for caring for newborns and children in the community	Global knowledge product	WHO	(1) http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/ (2) Gender and RMNCAH: A Framework for Action (2015) http://genderandaids.org/rmncah/wp-content/uploads/2016/05/Gender-and-RMNCAH-Framework.pdf (3) Caring for Newborns and Children in the Community (2015) http://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/ (4) Positive Health, Dignity and Prevention for Women and their Babies http://www.gnpplus.net/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/

THEMATIC AREA 3: EQUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	Literacy and advocacy kit for specific country contexts and to support pregnant and breastfeeding women and 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 compiled 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

THEMATIC AREA 3: EQUALITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	People Living with HIV: E-analysis tool for the stigma index methodology developed to empower networks of People Living with HIV to analyse and clean up data and generate further analyses through the 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
	Draft Gender Equality Conceptual Framework for RMNCAH developed and global/regional consultation held. Drafting of programming guidance in progress	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				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
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: MPDSR 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, 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 MDSR 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 increasing the demand for MNH during regional C4D workshops in West, Central and Southern Africa	Capacity building	UNICEF	Workshop report with no link
	MDSR subregional workshop held in Libreville, Gabon, on 24-27 June for eight countries: Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Gabon, the Republic of the Congo and Sao Tome and Principe	Global knowledge product	WHO	These are meetings with private reports. No links available.

THEMATIC AREA 4: ACCOUNTABILITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2014	MDSR implementation monitoring tool drafted	Global knowledge product	WHO	Technical assistance 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 in Côte d'Ivoire for francophone countries and in Zambia for anglophone countries		UNFPA	Training report with no link
	(1) BMC Supplement published to highlight bottlenecks and recommendations for nine high-impact maternal–newborn interventions (2) Support was provided to bottleneck analysis and situation assessments in Iraq, Malawi and Nepal. Based on this work, Malawi and Nepal have developed their national plans for newborn care and Iraq's is in progress (3) ENAP progress report developed (4) The mHealth interventions and Rapid-Pro for community reporting were documented and disseminated included on pregnancy and newborn care and on Ebola at different events including the Mexico Global Maternal Newborn Health Conference	Global knowledge product	UNICEF	(1) BMC Supplement https://www.everynewborn.org/wp-content/uploads/2015/09/Overview-of-Series.pdf (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

THEMATIC AREA 4: ACCOUNTABILITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	(1) In-depth evaluation of MDSR implementation conducted in Guinea-Bissau 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, Canada, in October 2015	Capacity building and global knowledge product	WHO	(1) Have not received final report for Guinea-Bissau but have requested it from subregional 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 Maternal, Newborn, Child and Adolescent Health Progress Report 2014-15 (2015) http://apps.who.int/iris/bitstream/10665/205631/1/9789241510356_eng.pdf
2018	MDSR African Region Workshop	Capacity building	UNFPA	Report with no link.
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 that have made commitments to the Global Strategy, to assess progress, gaps and country needs as well as explore the role of H4+ partners in supporting the 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

THEMATIC AREA 4: ACCOUNTABILITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2012	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
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

THEMATIC AREA 4: ACCOUNTABILITY				
YEAR	DESCRIPTION	CATEGORY	LEAD AGENCY	LINK
2015	Survey of H4+ support to countries in 2014, responded to by 62 countries, and an overview of H4+ coordination, functionality and activities in 2014. The survey looked across 2013 and 2014 to examine the trajectory of H4+ work over time and offered insight into the post-2015 development agenda initiatives by documenting H4+ lessons learned on inter-agency 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
2017	End line evaluation findings and discussion/ dissemination at country, regional and global levels	Advocacy	UNFPA	Report with no link
2018	End line evaluation presentation to UNFPA and UNICEF Executive Board	Accountability	UNFPA	Report with no link
2019	Implementation of management response and end line evaluation dissemination in Africa and Arab states	Capacity building	UNFPA	Report with no link

APPENDIX 2: PROGRESS ON INDICATORS IN THE H6 JOINT PROGRAMME M&E FRAMEWORK (2013–2017)

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 district or facility, based on the country-specific practices of data collection. In 2017, Cameroon, Ethiopia, Guinea-Bissau and Liberia received a no-cost extension and completed activities by June 2017. In line with activities carried out in 2017, only relevant output values are changed. "N/A"signifies not "not applicable" because there was no intervention and "nd" signifies "no data" because information is not available.

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

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

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

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

*Reported data of 100% show that national guidelines were finalized and made available to the districts. The extent of use or compliance of the guidelines depends on improved supervision and monitoring.

**When a region is implementing 60% of national standards, it is considered as achieving the indicator.

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

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

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

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

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

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

*There is no unique costed RMNCH plan, but there are sectorial costed plans such as ENAP 2017–2021, the strategic plan Integrated Communication and Community Mobilization 2016–2020, the national nutrition plan 2016–2020 and the strategic national plan to fight malaria 2013–2017.

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

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: No	Baseline: 0%	Baseline: N/A	Baseline: N/A	Baseline: N/A	Baseline: N/A
Target: Yes	Target: 100% (8/8)	Target: 100% (11/11)	Target: N/A	Target: N/A	Target: N/A
2017: Yes	2016: 100% (8/8)	2017: 100% (11/11)	2017: N/A	2017: 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 three months (this includes information on preventing stock-outs of contraception and HIV tests)

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

*The sources of information are mainly provincial or subnational estimates that are based on surveys or assessments conducted by the Ministry of Health. Therefore, the above data do 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 three months*

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

*The sources of information are mainly provincial or subnational estimates that are based on surveys or assessments conducted by the Ministry of Health. Therefore, the above data do not reflect the exact situation of the health facilities covered by H6 interventions.

Output 4: Skilled 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 that are trained in programme areas and have adequate skills and knowledge according to national norms to provide EmONC services in the targeted districts (training of providers and managers in other RMNCAH areas is also included)

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

*A large number of skills enhancement training sessions are taking place in each country. Many countries monitored and reported progress on the number of health professionals.

**Including integrated emergency surgical officers.

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

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: 30 Target: 300 2016: 327	Baseline: nd Target: 1,417 2016: 1,417	Baseline: 893 Target: 2,881 2017: 2,571	Baseline: nd Target: 514 2016: 447	Baseline: 84 Target: 275 2017: 300	Baseline: 410 Target: 1,049 2016: 1,049

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

Output 5: Health information systems, monitoring and 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 three months

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

*Liberia reported for 26 intervention facilities

Common indicator 5.2: Proportion of targeted districts with established and functioning MDSR mechanisms, including maternal death reviews

*Cameroon reported on primary and secondary level health facilities from intervention districts and Liberia reported on intervention facilities

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

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

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

*Community engagement processes that require quarterly meetings with community leaders exist but the extent to which they are effectively reviewing progress for evidence-based planning cannot be established from the data.

**Liberia reported on the intervention area health facilities only.

Output 6: Health service delivery

Common indicator 6.1: Numbers of health-care facilities in areas supported by the H6 Joint Programme that provided EmONC services in 2013–2016/17

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

*Cameroon includes health post, primary and secondary facilities for a range of RMNCH services.

**In Guinea-Bissau, 96% of health facilities provided basic and/or comprehensive EmONC services in 2013 but none met EmONC norms and standards.

***For Ethiopia, reported data are from a national EmONC needs assessment study 2017

Common indicator 6.2: Proportion of antenatal care and delivery services in targeted districts that provided PMTCT services according to the national guidelines.

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

*Liberia reported on the intervention facilities.

Output 7: Demand creation, including community ownership and participation

Common indicator 7.1: Number of active community groups (safe motherhood groups, volunteers, etc.) or rural committees established in targeted districts

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: 0 Target: 1,151 2016: 1,151	Baseline: N/A Target: N/A 2016: N/A	Baseline: 95 Target: nd 2017: 2,132	Baseline: N/A Target: N/A 2017: N/A	Baseline: 84 Target: 300 2017: 300	Baseline: 21 Target: 263 2016: 263

Output 8: Communication (including communication for development) and advocacy

Common indicator 8.1: Proportion of targeted districts with demonstrable social mobilization programmes that include at least two of the following communication themes: prevention of early pregnancy, expanding knowledge of key family practices, HIV prevention, importance of breastfeeding and recognition of danger signs during postnatal care for mothers and newborns

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: 28% Target: 100% 2016: 100%	Baseline: N/A Target: N/A 2016: N/A	Baseline: nd Target: 100% 2017: 100%	Baseline: N/A Target: N/A 2017: N/A	Baseline: N/A Target: N/A 2017: N/A	Baseline: nd Target: 100% 2016: 100%

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

Cameroon	Côte d'Ivoire	Guinea-Bissau	Ethiopia	Liberia	Zimbabwe
Baseline: nd Target: nd 2016: 5	Baseline: nd Target: nd 2016: 18	Baseline: nd Target: 168 2016: 144	Baseline: nd Target: 18 2016: 18	Baseline: N/A Target: N/A 2017: N/A	Baseline: 0 Target: nd 2016: 11

APPENDIX 3: KEY INTERVENTIONS IMPLEMENTED AT THE COUNTRY LEVEL

KEY INTERVENTIONS	CAMEROON	CÔTE D'IVOIRE	GUINEA -BISSAU	ETHIOPIA	LIBERIA	ZIMBABWE
(1) Leadership and governance						
Support to national task force and policy environment for RMNCAH (including EmONC)	X	X	X	X	X	X
Supporting adaptation of international guidelines on quality of care in RMNCAH	X	X	X	X	X	X
Midwifery policy and advocacy, support to midwife training and to quality assurance for training	X	X	X	X	X	
(2) Health financing						
Introduction/support to results-based financing			X			
Supporting pricing incentives and subsidies for RMNCAH services and community health funds		X				
(3) Health technologies and commodities, including improved service environment						
Procurement of training aids for midwives and for EmONC capacity-building at the facility level	X	X	X	X	X	X
Provision of equipment, medicines and commodities	X	X	X	X	X	X
Construction and support of maternity waiting shelters and annexes			X		X	X
Support for running water and/or solar power for facilities; water, sanitation and hygiene	X	X	X	X	X	X
(4) Skilled human resources for health						
Strengthening EmONC training and post-training supervision and family planning	X	X	X	X	X	X

KEY INTERVENTIONS	CAMEROON	CÔTE D'IVOIRE	GUINEA -BISSAU	ETHIOPIA	LIBERIA	ZIMBABWE
Support for pre-service training of midwives	X	X	X	X	X	
Support for in-service training (EmONC, IMNCI, family planning, PMTCT, task shifting)	X	X	X	X	X	X
(5) Health information systems, monitoring and evaluation						
Strengthening monitoring and evaluation	X	X	X	X	X	X
Support for the establishment and operation (national, provincial, district) of MDSR systems	X	X	X	X	X	X
Technical advice and support for information management and HMIS	X	X	X	X	X	X
(6) Health service delivery						
Support for national obstetric fistula programme				X		X
Support for PMTCT and paediatric HIV treatment including training and quality assurance	X	X	X	X	X	X
Support for transportation (motorbikes, bicycles) at the community level	X		X		X	X
Supporting youth-friendly services for adolescent health and sexuality education	X	X	X		X	X
Support for IMNCI (including family kits)	X	X	X	X	X	X
Support for national PMTCT and HIV and AIDS plans and programmes	X	X	X	X	X	X
(7) Demand creation including community ownership and participation						
Support for training of community-based health workers and volunteers	X	X	X	X	X	X

KEY INTERVENTIONS	CAMEROON	CÔTE D'IVOIRE	GUINEA -BISSAU	ETHIOPIA	LIBERIA	ZIMBABWE
Educational materials for community involvement	X	X	X	X	X	X
Partnerships with religious leaders			X			X
Engaging men and boys around RMNCAH, gender-based violence and gender equality activities		X		X	X	X
Engaging traditional leaders in RMNCAH	X				X	
Supporting training of community group leaders including community-based advocates	X	X	X	X	X	X
(8) Communication and advocacy						
Studies of community structures that influence reproductive and maternal health of girls and women	X		X	X		X
Mass media campaigns on PMTCT	X	X			X	
Reducing violence against girls and women programme	X	X	X	X	X	

APPENDIX 4: KEY PROGRAMME ACTIVITY HIGHLIGHTS BY COUNTRY (2013–2017)

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

Cameroon	Over the course of the H6 Joint Programme, the national strategic RMNCH plan (2014–2020) was finalized and disseminated, and the human resources strategy and plan for deployment and retention of health staff were developed. Updated standards and protocols for IMCI and RMNH/HIV were disseminated in 2014. The operational plan for newborn health was developed in 2014 and revised in 2016. National MDSR guidelines and tools were developed in 2015. In 2016, support was extended to the Ministry of Health to scale up the provision of integrated RMNCAH services. The national policy on community health and the referral guide were also developed. In 2017, the national policy on community health was disseminated nationwide.
Côte d'Ivoire	Technical support was provided for the development of national health accounts, nutrition guidelines and the institutionalization of MDSR. Family planning and HIV/AIDS strategic documents were produced and disseminated at regional and district levels. 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 by 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 system transition plan (HSTP-V) 2016–2020; the national strategic plan for EMTCT; and guidelines for MNH care, obstetric protocols, MDSR and gender mainstreaming. In 2016, a national adolescent and youth health strategy (2016–2020) was finalized. During 2017, the national strategy to eliminate mother-to-child transmission of HIV and national PMTCT and congenital syphilis guidelines were developed.
Guinea-Bissau	The national plan of action for prevention and eradication of GBV was validated in 2014 along with the national gender policy. H6 supported the development of a policy on free access to health services for RMNCH, HIV and gender-based violence for health facilities at the community level. The H6 team played a critical role in mobilizing the commitment of Guinea-Bissau to the global initiatives "A Promise Renewed" and ENAP. In 2017, the national ENAP plan was developed and validated. Client satisfaction surveys were introduced into hospitals to establish an accountability mechanism.
Liberia	H6 supported the revision of the national MNCAH, MNDSR and adolescent sexual and reproductive health protocols in 2013. National PMTCT guidelines were revised and the national EMTCT plans were developed. H6 provided technical support for national RMNCAH policy development. In 2016, the GFF investment case development was supported and an MNDSR training manual was developed along with a national RMNCAH annual operational plan integrating H6 programme interventions. During 2017, the national RMNCAH 2017–2018 plan was developed and national HMIS data collection tools were updated.
Zimbabwe	H6 supported the development of guidelines 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 paediatric ART and IMNCI training materials. Support was also provided for the development of the adolescent reproductive health strategy (2010–2015), the national PMTCT strategy (2011–2015), the Option B+ strategy for PMTCT, the new 2013 HIV guidelines and a national nutrition and food policy. In 2016, the EmONC improvement plan was finalized, the child survival strategy was revised, and the RMNCAH scorecard was reviewed and adapted for district use.

Output 2: Health financing – addressing financial barriers to RMNCAH

Côte d'Ivoire	Under a national scheme, the H6 Joint Programme supported social franchise schemes by imparting management training and basic supplies to establish for-profit activities to reduce financial barriers to accessing RMNCH services for seven women's groups composed of 850 members.
Guinea-Bissau	H6 supported development of a national "free of charge" policy. The policy aimed to eliminate user fees for pregnant women, children under 5 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 from an EU-funded RMNCAH programme.

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

Cameroon	With the support of H6, equipment and materials for BEmONC services were provided to 91 health facilities and need-based surgical equipment was provided to five CEmONC centres at district hospitals. Twelve motorcycle ambulances and one normal ambulance were also purchased alongside 95 motorcycles for outreach and supervision activities for the health districts. During the programme period, all 91 supported health facilities (health post, primary and secondary level facilities) received essential drugs and supplies to treat severe malnutrition, as well as kits to treat neonatal infections. All 91 intervention health facilities received drugs and supplies during 2017.
Côte d'Ivoire	Eight district health centres and 46 health facilities were provided with equipment and medicine for essential childcare and 27 facilities received need-based equipment for EmONC. In 2017, 10,000 blood bags were procured and distributed for transfusion in 30 districts, including support for the collection of donor blood and for the quality assurance needed to strengthen CEmONC services.
Ethiopia	During 2016, equipment for Gondar and Jimma fistula repair centres was procured. Equipment was also procured for midwifery, anaesthesia and nursing training programmes, which has been distributed to training institutions for the three training programmes. This included four operating tables, 600 blood pressure machines and stethoscopes, six light sources for operations, 10 oxygen concentrators, 50 speculums, 50 resuscitators and 25 vacuum extractors. In addition, 564 anaesthesia and 900 neonatal nursing books were procured and distributed.
Guinea-Bissau	By the end of 2015, six intervention regions had received motorcycle 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 that 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, delivered to programme counties; and 25 "helping mothers survive" kits and simulation materials, 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 provide youth-friendly services. In 2016, a total of 220 dried blood spots bundles for EID were procured and distributed; each bundle provides 960 tests, giving a total of 211,200 tests.

Output 4: Skilled human resources for health – support for expanding the skilled human resource base

Cameroon	An expert coordinator for training midwives was recruited at the outset of the programme. H6 developed e-learning modules that are being used by midwifery schools in Douala, which will then be implemented nationwide. The programme supported training of service providers; as a result, 81 per cent of health facilities have skilled human resources, with 282 CHWs having been trained and equipped (bicycle, essential drugs and FP kit).
Côte d'Ivoire	Training and supervision helped revitalize the practice of the 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 professionals were trained to make 54 intervention facilities fully functional for essential maternal and newborn care. In total 1,417 CHWs received training for awareness generation and enhancing community participation in RMNCAH.
Ethiopia	The focus of the H6 Joint Programme was on expanding the human resource base of skilled birth attendants. In total, 261 identified health facilities across the country were made functional for maternity care by providing 464 midwives with a three-week competency-based BEmONC training course, out of a target of 560. Since the H6 Joint Programme began, 319 integrated emergency surgical officers were trained in offering life-saving maternity care. It is reported that integrated emergency surgical officers are doing 90 per cent of the emergency procedures and that 62 per cent of these are caesarean sections in the facilities where they are deployed. The programme also supported the training of 367 anaesthetists and 288 mid-level health workers in fistula identification. In 2017, about 404 health professionals received skills enhancement in-service training.
Guinea-Bissau	In order to strengthen the national health system, H6 recruited eight international experts (three obstetrician-gynaecologists, four paediatricians and one anaesthetist) to deliver CEmONC services and train national providers in two regional hospitals. Similarly, one international midwifery expert supported the national midwifery school in the adoption of the ICM curriculum and training of tutors to impart quality training in pre-service midwifery schools. During the programme period, 42 midwifery tutors received intensive "training of trainers" (for six months), seven general practitioners received training on CEmONC (for two months); and 34 nurse anaesthetists were trained in hospital attachments (for three months).
Liberia	In 2013, the H6 Joint Programme supported 15 BEmONC and three CEmONC facilities of three counties of the south-eastern region. In the post-Ebola recovery phase, the Liberia country team received additional support to revive MNH care in nine facilities in three additional counties: Gbarpolu, Grand Cape Mount and Rivercess. With additional funding received in 2015, the revised RMNCAH training target became 536 health professionals. By the end of 2016, 736 health professionals h ad completed the training (including 200 staff from non- intervention health facilities and counties who also benefited from the training). Similarly, 300 CHWs benefited from training on preventive and health promotive aspects of RMNCAH.
Zimbabwe	Zimbabwe is the only country that has opted for in-service training of health-care providers. In 2013, when EmONC training was initiated in the country, a curriculum comprised seven days of orientation. 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 suboptimal. Realizing this, H6 designed a clinical mentorship programme that proved successful, prompting the development of national clinical mentorship guidelines for MNH. During 2017, support was provided for programme management training in the six districts (20 district managers trained) and the first national training on the IMNCI computerized adaptation and training tool for improved pre-service training (the participants were paediatricians and nurse tutors in training schools) was organized successfully.

Output 5: Health information systems, monitoring and evaluation – strengthening programme monitoring and integrating accountability through MDSR

Cameroon	The H6 Joint Programme continued to support 30 regional districts using integrated tools for monitoring and evaluation, including routine maternal and neonatal deaths surveillance. Seven districts and 64 health areas evaluated their 2016 micro plans and created 2017 micro plans.
Côte d'Ivoire	Quality assurance assessment tools were adapted to ensure their utilization to offer quality maternal and child health care. Three districts (Katiola, Dabakala and Niakara) implemented the biannual monitoring of the minimum activities package and the essential family practices to identify bottlenecks and their causes while analysing the different paths taken and favouring local solutions.
Guinea-Bissau	The national health information system was harmonized at the outset of the H6 Joint Programme, incorporating indicators of SRMNCH (sexual and reproductive health/HIV/GBV), disaggregated by sex and age. An MDSR system was established.
Ethiopia	HMIS and data management training was conducted in 2016 along with the quality-of-care assessments in 29 identified hospitals. A national antenatal care/PMTCT surveillance system assessment was conducted and the findings were used for surveillance roadmap development. The H6 Joint Programme initiated processes in a partnership with Ethiopian public health institutions. The Ethiopian Public Health Institute analysed 200 maternal deaths to inform HSTP-V to strengthen post-partum care as a key maternal health strategy.
Liberia	The programme supported the revision of existing national HMIS tools and programme indicators that are integrated into national HMIS tools. Health facilities submitted timely and complete reports that were in accordance with national guidelines and schedules. The number of programmes reported as being completed in a timely manner increased from 47 per cent in 2013 to 96 per cent in 2017. The programme invested in establishing and technically supporting the MNDSR process at the national level. It also helped to revitalize the national commitment to MNDSR following the end of the Ebola virus disease outbreak. An official MDSR system was set up in 2013 and community-level HMIS indicators were developed and integrated into national reporting systems in 2014. These systems are being scaled up to other facilities in the country with support from the county health teams, WHO, UNICEF and UNFPA.
Zimbabwe	The Ministry of Health and Childcare and health authorities in H6 Joint Programme provinces and districts conducted supportive supervision and monitoring visits from 2014 onwards. National coordination meetings on point of care/EID, PMTCT and HIV care were supported at the national and provincial levels. The drafting and printing of a national 2015 HIV/AIDS report and the Option B+ interim review report were supported.

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

Cameroon	The referral linkages were strengthened from community-level to secondary-level facilities. In order to enhance service delivery at the community level, 365 trained CHWs referred cases to the health facility in 2016 for malaria (3,103 cases), acute respiratory tract infection/pneumonia (1,743 cases), diarrhoea (1,271 cases) and malnutrition (4,968 cases). In addition, 727 pregnant women were referred to health centres for obstetric complications and indications. Some 91 health facilities, including health posts and primary-level and secondary-level health facilities, were targeted to be made functional. The number of fully functional health facilities increased from 6 in 2013 to 74 by the end of 2017. The proportion of antenatal care and delivery services in targeted districts that provide PMTCT services as per national norms increased to 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 were new users). Some 36 per cent of clients opted for injectables; 15 per cent opted for implants and 48 per cent opted for oral contraceptive methods. In addition, 499 women underwent screening for cancer of the cervix by visual inspection with acetic acid, 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 7 to 48 between 2012 and the end of 2016, and the number of fully functional CEmONC facilities doubled from three to six, achieving targets set for the programme. Similarly, intervention facilities offering PMTCT as an integral part of RMNCH services increased from 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 midwife was engaged to develop a pre-service curriculum based on ICM standards and to facilitate the initiation of midwifery training in two midwifery training schools. The tutors had intensive training (six months) at a national hospital. On the other side, international specialists for obstetrics, paediatrics and anaesthesiology were engaged to provide services in regional and national hospitals and simultaneously train a range of providers, from general practitioners to nurse anaesthetists, in the provision of EmONC services. In seven intervention regions, the target was to operationalize 120 BEmONC and 10 CEmONC facilities by the end of the H6 Joint Programme, and about 66 per cent of the target was achieved by the end of 2017. In 2017, the maternity wings of five health facilities were refurbished and infection prevention and control equipment was provided in six intervention facilities.
Liberia	In 2013, 18 facilities in three counties of the south-eastern region were identified to be made operational for the provision of EmONC services. However, the country witnessed a collapse of services in mid-2014 with the Ebola outbreak. In 2015, it was decided that extra funds would be provided to cover three more counties, focusing on making eight health facilities operational for the provision of EmONC services, as an effort to support the national health system and to revive MNH care in the post-Ebola recovery phase. The provision of integrated RMNCAH services was made in all 26 intervention facilities. During 2017, the refurbishment of six maternity waiting homes and improved water, sanitation and hygiene facilities in seven health facilities received support under the H6 Joint Programme.
Zimbabwe	In the six intervention districts, the strategy was to operationalize at least one CEmONC facility and make 14 BEmONC facilities fully functional by offering all seven signal functions. In 2013, out of 19 intervention facilities, only two facilities were offering all signal functions for EmONC. By the end of 2016, 84 per cent of the target facilities had been made fully functional. In 2016 alone, some 929 households were reached by parent-to-child communication on sexual and reproductive health, with a total of 7,253 "parent person exposures" achieved and 9,965 adolescents reached.

Output 7: Demand creation – building demand and enhancing community participation

Cameroon	Through existing networks of associations and traditional leaders, H6 worked to sensitize groups and individuals on issues of women's rights and RMNCH issues in communities. Some 343 committee members and 264 community leaders received training and 73 associations and two youth centres received materials to support these activities. Communication materials were also disseminated through five advocacy campaigns to increase demand. In 2016, simplified tools were made available to continue to promote MNCH activities.
Côte d'Ivoire	Côte d'Ivoire focused on the creation of several different types of community groups. Husbands' schools were created to promote sexual and reproductive health; seven women's groups benefited from support to establish profit-making activities to reduce financial barriers; and 43 committees were created to address sociocultural barriers to RMNCH services and to improve access. In 2016, partners organized the national week of maternal health, reaching 30,664 pregnant women with information on PMTCT, antenatal care, 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, providing free delivery of services and sensitizing communities. In 2016, UN Women also organized five training sessions for CHWs and NGO staff members on SRMNCH, HIV and gender-based violence. The First National Youth Forum for Peer Educators in Reproductive Health was held in August 2016, bringing together 140 peer educators for training on topics such as STIs, HIV and AIDS, gender-based violence, family planning and reproductive rights.
Liberia	Demand for services and community participation was enhanced through the involvement of community groups, community leaders and 26 adolescent peer groups. Awareness was further raised through radio programmes, and parliamentarians were engaged to support RMNCH initiatives. In 2016, 48 community groups participated in training on sexual and reproductive health and reproductive rights, MNH, gender-based violence and masculinity. Through these groups, 27 campaigns and 161 outreach activities were conducted. Overall, these projects aimed at breaking gender barriers and improving community roles and norms as they related to MNH. These efforts have led to an increase in community leader involvement, reporting of gender-based violence and men accompanying their partners to health facilities.
Zimbabwe	Community work through youth and community leaders helped to raise awareness, participation and service uptake focusing on RMNCH issues. Forty men were trained to increase awareness and mobilize communities on HIV testing, PMTCT and other areas of MNCH. Thirty-three safe spaces for young women were created and three festivals were organized around RMNCH issues. Additional techniques such as road shows, peer groups and peer-to-peer counselling were also implemented to raise awareness and increase participation in H6 programming.

Output 8: Communication and advocacy, including communication for development

Cameroon	Communication for development 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 spread the message 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 was held that focused on RMNCH. It was led by the maternal and child health directorate of the Ministry of Health, and it included a rally, a new hospital visit and a consultative meeting of RMNCHS stakeholders. In other activities, a best practice event on midwife exchange and midwife mentoring from St Paul Hospital and its catchment health centres in Addis Ababa was disseminated in the national RMNCAH and nutritionr eview meeting in August 2016. In the 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 translated into Portuguese in order to reach more people at the national level, including the regions targeted by the H6 Joint Programme.
Liberia	In Liberia, high-level advocacy meetings were held with parliamentarians at the national, county and district levels and radio talk shows raised awareness. In 2016, H6 produced an online documentary about the 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, benefited from essential information on prevention and treatment. Some 12,125 people were voluntarily tested for HIV.
Zimbabwe	A storybook and video documentary was developed around the work being done in Zimbabwe. Community mobilization was also conducted in all six target districts, engaging traditional leaders to raise awareness and utilization of services. H6 also supported a media tour to Chiredzi district that resulted in a number of newspaper articles and radio stories. Materials were produced including stickers (4,000), soldier games (4,000), red roses and ribbons (4,000), T-shirts and leaflets.

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