H4+ Canada Initiative

*Accelerating Progress In Maternal And Newborn Health*

Reporting period: 1 January 2013-31 December 2013
June 2014
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Cover photo: Abbie Trayler-Smith/H4+
ACKNOWLEDGEMENTS

The H4+ partners – six United Nations agencies - UNAIDS, UNICEF, UNFPA, UN Women, WHO and the World Bank – are working together to improve Women’s and Children’s Health. The H4+ wishes to express its deep gratitude to the Department of Foreign Affairs, Trade and Development (DFATD), Government of Canada, for its support towards improving sexual, reproductive, maternal, newborn and child health and contributing to accelerating the implementation of the commitments made to the United Nations Secretary General’s Global Strategy for Women’s and Children’s Health, particularly in five countries supported by the H4+ Canada programme: Burkina Faso, Democratic Republic of Congo, Sierra Leone, Zambia and Zimbabwe.

We wish to acknowledge our partnership with national governments represented by Ministries of Health, as well as with implementing partners for their collaboration, support and commitment in championing sexual, reproductive, maternal, newborn and children’s health issues. The active participation of health care providers and civil society organizations in making this partnership viable and productive also deserves special thanks.

Finally, we would like to extend our sincere appreciation to the H4+ Canada country teams for their efforts to realize the objectives of the H4+ Canada collaboration by addressing various challenges in order to strengthen health systems, and to Julie McCormack and Geoff Black, representatives of DFATD Canada, who have helped to develop an excellent spirit of collaboration.

We look forward to continuing this productive collaboration to improve the lives of women and children.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ADB</td>
<td>African Development Bank</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ASRH</td>
<td>Adolescent sexual reproductive health</td>
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<tr>
<td>BEmONC</td>
<td>Basic emergency obstetric and neonatal care</td>
</tr>
<tr>
<td>BNA</td>
<td>Bottleneck analysis</td>
</tr>
<tr>
<td>BPEHS</td>
<td>Basic package of essential health services</td>
</tr>
<tr>
<td>BTS</td>
<td>Born too soon</td>
</tr>
<tr>
<td>CAG</td>
<td>Community advocacy group</td>
</tr>
<tr>
<td>CARMMA</td>
<td>Campaign for the Accelerated Reduction of Maternal Mortality in Africa</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for development</td>
</tr>
<tr>
<td>CCORE</td>
<td>Centre for Collaborative Operational Research and Evaluation (Zimbabwe)</td>
</tr>
<tr>
<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CMA</td>
<td>Central Medical Emergency Unit (offering surgery) (Burkina Faso)</td>
</tr>
<tr>
<td>COIA</td>
<td>Commission on Information and Accountability for Women and Children’s Health</td>
</tr>
<tr>
<td>CSPro</td>
<td>Census and Survey Processing System</td>
</tr>
<tr>
<td>CSPS</td>
<td>Social Promotion Health Centres (Burkina Faso)</td>
</tr>
<tr>
<td>CUAMM</td>
<td>Collegio Universitario Aspiranti Medici Missionari (Doctors with Africa), Italy</td>
</tr>
<tr>
<td>DBS</td>
<td>Dried blood spots (for use in identifying HIV/AIDS)</td>
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<tr>
<td>DEP</td>
<td>Direction d’Etude et Planification (Research and Planning Directorate), DRC</td>
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<tr>
<td>DFID</td>
<td>Department for International Development Assistance (UK)</td>
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<td>DFATD</td>
<td>Department of Foreign Affairs, Trade and Development Canada</td>
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<tr>
<td>DHMT</td>
<td>District Health Management Team (Sierra Leone)</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DHT</td>
<td>District Health Team (Zimbabwe)</td>
</tr>
<tr>
<td>DIVA</td>
<td>Diagnose-Intervene-Verify-Adjust</td>
</tr>
<tr>
<td>DPPI</td>
<td>Directorate of Policy, Planning and Information (MoHS Sierra Leone)</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>DSME</td>
<td>Directorate for the Health of Mothers and Children (Burkina Faso)</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
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<tr>
<td>EMTCT</td>
<td>Elimination of Mother-to-Child Transmission</td>
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<tr>
<td>EN</td>
<td>Every Newborn</td>
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<td>ENAP</td>
<td>Every Newborn Action Plan</td>
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<tr>
<td>ENSP</td>
<td>Ecole Nationale de Santé Publique (National School of Public Health, Burkina Faso)</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme of Immunization</td>
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<tr>
<td>EPMM</td>
<td>End Preventable Maternal Mortality</td>
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<tr>
<td>ETAT</td>
<td>Emergency Triage Assessment and Treatment</td>
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<td>EU</td>
<td>European Union</td>
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<td>EWEC</td>
<td>Every Woman Every Child</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>FGM/C</td>
<td>Female Genital Mutilation and Cutting</td>
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<tr>
<td>FIGO</td>
<td>International Federation of Gynecology and Obstetrics</td>
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<tr>
<td>FINE-SL</td>
<td>Fambul Initiative Network for Equality (Sierra Leone)</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<tr>
<td>GNHC</td>
<td>Global Newborn Health Conference</td>
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<tr>
<td>GPRHCS</td>
<td>Global Programme to Enhance Reproductive Health Commodity Security (UNFPA)</td>
</tr>
<tr>
<td>GRC</td>
<td>Guidelines and Research Committee (WHO)</td>
</tr>
<tr>
<td>HBCI</td>
<td>High Burden Countries Initiative</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>HTC</td>
<td>HIV testing and counselling</td>
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<tr>
<td>HTF</td>
<td>Health Transition Fund (Zimbabwe)</td>
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<tr>
<td>HW</td>
<td>Health Worker</td>
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<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
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<tr>
<td>ICS</td>
<td>Institute of Social Cooperation (Barcelona, Spain)</td>
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<tr>
<td>iERG</td>
<td>Independent Expert Review Group</td>
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<tr>
<td>IFC</td>
<td>Working with Individuals, Families and Communities approach</td>
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<tr>
<td>IMCI/IMNCI</td>
<td>Integrated Management (of Newborn) and Childhood Illnesses</td>
</tr>
<tr>
<td>INESOR</td>
<td>University of Zambia Institute of Economic and Social Research</td>
</tr>
<tr>
<td>IPACT</td>
<td>Evaluation and training service arm of Immpact, (Initiative for Maternal Mortality Programme Assessment), University of Aberdeen, UK</td>
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<tr>
<td>IRMNH</td>
<td>Improving Reproductive, Maternal and Newborn Health (Sierra Leone)</td>
</tr>
<tr>
<td>IRSS</td>
<td>Institut de Recherche en Sciences de la Santé</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and young child feeding</td>
</tr>
<tr>
<td>JANS</td>
<td>Joint Assessment of National Health Strategies and Plans</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Johns Hopkins international non-profit health organization</td>
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<tr>
<td>KS</td>
<td>Knowledge sharing</td>
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<tr>
<td>LSS</td>
<td>Life-saving skills</td>
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<tr>
<td>LSTM</td>
<td>Liverpool School of Tropical Medicine</td>
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<tr>
<td>M-Health</td>
<td>Mobile Health; the practice of medicine and public health supported by mobile devices</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MAE</td>
<td>Ministère des Affaires Étrangères (French Ministry of Foreign Affairs)</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MCHA</td>
<td>Maternal and Child Health Aides (Sierra Leone)</td>
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<td>MCHIP</td>
<td>Maternal and Child Health Integrated Program</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MDR</td>
<td>Maternal Death Review</td>
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<td>MDSR</td>
<td>Maternal Deaths Surveillance and Response</td>
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<td>MH</td>
<td>Maternal Health</td>
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<tr>
<td>MHTF</td>
<td>Maternal Health Trust Fund</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHS</td>
<td>Ministry of Health and Sanitation (Sierra Leone)</td>
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<tr>
<td>m-health</td>
<td>Mobile Health Technology</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Rates</td>
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<tr>
<td>MNH</td>
<td>Maternal and Newborn Health</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MNCAH</td>
<td>Maternal, Newborn, Child and Adolescent Health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoHCW</td>
<td>Ministry of Health and Child Welfare (Zimbabwe)</td>
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<td>MOHS</td>
<td>Ministry of Health and Sanitation (Sierra Leone)</td>
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<tr>
<td>MSF</td>
<td>Midwifery Services Framework</td>
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<td>MWA</td>
<td>Midwifery Workforce Assessments</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council (Zimbabwe)</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<tr>
<td>OJT</td>
<td>On-the-job Training</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration salts</td>
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<tr>
<td>PBF</td>
<td>Performance-based financing for funding</td>
</tr>
<tr>
<td>PE</td>
<td>Peer Educator</td>
</tr>
<tr>
<td>PHU</td>
<td>Peripheral Health Unit (Sierra Leone)</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMNCH</td>
<td>Partnership for Maternal, Newborn and Child Health</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission (of HIV/AIDS)</td>
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<tr>
<td>PNC</td>
<td>Post-natal care</td>
</tr>
<tr>
<td>POC</td>
<td>Portable Oxygen Concentrator</td>
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<tr>
<td>PoC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>PSM</td>
<td>Procurement and Supply Management</td>
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<tr>
<td>QoC</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>RAIC</td>
<td>Rapid Assessment of RMNCH Life-Saving Interventions and Commodities</td>
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<tr>
<td>RBM</td>
<td>Results-based management</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RI</td>
<td>Routine immunization (Zimbabwe)</td>
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<tr>
<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
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<td>RMNCH</td>
<td>Reproductive, Maternal, Newborn and Child Health</td>
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<tr>
<td>SARA</td>
<td>Service Availability and Readiness Survey</td>
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<td>SC</td>
<td>Steering Committee</td>
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<td>SDPs</td>
<td>Service Delivery Points (Sierra Leone)</td>
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<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
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<tr>
<td>SMAG</td>
<td>Safe Motherhood Action Group</td>
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<tr>
<td>SNIS</td>
<td>Système National d’Information Sanitaire (Burkina Faso)</td>
</tr>
<tr>
<td>SPHC</td>
<td>Social Promotion Health Centre (Burkina Faso)</td>
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<tr>
<td>SRMNCH</td>
<td>Sexual, Reproductive, Maternal, Newborn, and Child Health</td>
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<tr>
<td>SRH</td>
<td>Sexual Reproductive Health</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SWAPs</td>
<td>Sector-wide Approach (Zambia)</td>
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<tr>
<td>SoWMy</td>
<td>State of the World’s Midwifery report (UNFPA)</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UN Women</td>
<td>United Nations Entity for Gender Equality and the Empowerment of Women</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNF</td>
<td>United Nations Foundation</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VMAHS</td>
<td>Vital Medicines Availability and Health Services Survey (Zimbabwe)</td>
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<tr>
<td>VSO</td>
<td>Development agency working through volunteers (UK)</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YFHS</td>
<td>Youth-friendly health services</td>
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<td>ZNFPC</td>
<td>Zimbabwe National Family Planning Council</td>
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EXECUTIVE SUMMARY

In 2010, the United Nations Secretary General spearheaded a global movement known as Every Woman, Every Child (EWEC) – a strategy to mobilize and intensify global action to improve the health of women and children around the world. In March 2011, four UN agencies (UNAIDS, UNICEF, UNFPA and WHO, plus the World Bank\(^1\)) with financial support from the government of Canada, developed the H4+ Canada programme. The goal of the H4+ is to accelerate global progress in Sexual Reproductive, Maternal, Newborn and Child Health (SRMNCH). UN Women joined the H4+ in 2012 and is now a full participant in this joint UN collaboration, which operates at both the global and country levels. Five African countries were selected for country-level implementation: Burkina Faso, the Democratic Republic of Congo (DRC), Sierra Leone, Zambia and Zimbabwe. All of these countries rank among the world’s lowest in Human Development;\(^2\) each records a Maternal Mortality Rate of more than 300 per 100,000 live births.\(^3\) UNICEF, UNFPA and WHO are the recipients of the Canadian funds and implementing agencies of the grant, with UNFPA acting as administrative agent and UNAIDS and UN Women as collaborating agencies.

The reporting period (2013) witnessed an increase in the pace of programme implementation in all five countries. The implementation rate increased against allocation from the level of 56% (against $20 million) in 2012 to 76% (against $30 million) in 2013. Similarly, global-level activities also gained momentum by expanding the knowledge base for the provision of quality SRMNCH services. The H4+ Canada collaboration provided a unique opportunity to the H4+ agencies to collectively, collaboratively and simultaneously undertake knowledge-management and “upstream” work at the global level, while working in tandem at the country level to demonstrate and support “downstream” initiatives implemented to strengthen health systems to promote positive health outcomes for women and children.

GLOBAL LEVEL

The main purpose of the H4+ Canada grant programme at the global level is to make available the tools, guidelines and other essential materials that will support creating an enabling environment and capacity building for SRMNCH. During the current reporting period, UNICEF, UNFPA and WHO provided leadership and oversight for eight global areas of activity. The accomplishments under the eight areas are helping to establish a stronger evidence base for programme planning and implementation at the country level, as well as helping to bring SRMNCH closer to the forefront of the global agenda.

In all, the programme supported the development of some 20 distinct knowledge products in 2013, including reports, results frameworks, policy compendiums, tools, technical guidelines, recommendations, handbooks, analyses, action plans, fact sheets, communication guides, best practices, lessons learned, key messages, brochures, web pages, talking points, photo reportage, use of social media and lists of medical devices. Key achievements per area include:

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\(^1\) The World Bank joined the H4+ in order to increase its collaboration in the SRH/MNCH field and support EWEC.


Area 1: H4+ produced a 2013 progress report as part of the first Independent Expert Review Group (iERG) report on Every Woman, Every Child, published by WHO. The programme also developed an H4+ results framework to harmonize programmatic response through different funding sources at the global and country levels.

Area 2: An RMNCH Policy Compendium was developed and strategic planning with specific focus on RMNCH continued with the use of the OneHealth tool for planning and costing. Technical guidelines for Maternal Death Surveillance and Response (MDSR) were developed and published. An H4+ programme implementation and monitoring tool, aimed at improving the programme’s implementation in order to achieve better results, has been developed and launched for use at country level.

Area 3: The final version of a tool for the Rapid Assessment of RMNCH Interventions and Commodities (RAIC) was disseminated. The Every Newborn Bottleneck Analysis (BNA) tool was used during country consultations on newborn care. A draft of the Every Newborn Action Plan (ENAP) was submitted to the WHO Executive Board in January 2014 before being discussed at the World Health Assembly in May 2014.

Area 4: A compendium of case studies on innovative approaches in Maternal and Newborn Health Care (MNHC) was published to promote knowledge sharing among developing countries and guidelines for documenting innovative approaches to support knowledge sharing.

Area 5: H4+ Communications activities ramped up during 2013, with the development of key H4+ messages and the launch of the H4+ webpage on the Every Woman Every Child website. New reports and news were added during the year and regular communication took place among global and country partners. Most of the communication activities at country level were planned for demand generation, which were implemented in 2013. The communication for advocacy and providing visibility to H4+ needs systematic planning and will be addressed through communication workshop planned in 2014.

Area 6: The H4+ agencies worked together to finalize joint H4+ lists of essential medicines, devices and commodities. A DIVA module for procurement and supply management was developed.

Area 7: The High Burden Country Initiative (HBCI), launched to assist countries in conducting comprehensive midwifery workforce assessments, continues to work in Bangladesh, Ethiopia, Tanzania, Afghanistan and Mozambique. The Bangladesh report has been endorsed by the government of that country and is now being used to stimulate policy dialogue on midwifery care. The workforce assessment methodology was revised based on country experiences and new projection methods were included. The development of the second State of the World’s Midwifery report, to be launch at the ICM Congress in June 2014, has begun with data collection and national workshops in 73 countries.
Area 8: The annual planning meeting for developing the 2014 country-level work plan was held in November 2013 in Sierra Leone. The meeting provided opportunity to the representatives of Sida supported countries to learn from H4+ Canada Programme and share experience. The first draft of 2014 annual country plans were developed and countries received feedback from the Global technical team to focus interventions, strengthen M&E and enhance communication interventions for improved visibility of H4+ programme and RMNCH issues.

COUNTRY LEVEL

Work plans for each of the five H4+ Canada countries are developed annually and discussed each year during an inter-country meeting, the last one having been held in Sierra Leone in November 2013. Work at country level has both a national dimension (addressing policies, strategies, standards, etc.) and a local dimension as it supports the implementation and M&E of national and sub-national SRH/MNCH programmes/plans of action. On average, all countries exceeded initiation of two third of planned activities. Burkina Faso and Zambia reported more than 85% of planned activities in progress whereas about 30% of the activities in DRC could not start as planned. The Mid Term Review of H4+ Canada program is expected to provide details analysis of program progress. Highlights of country-level activities include:

Output 1. Leadership and Governance:
In Burkina Faso, a national-level Human Resources for Health Development Plan was adopted and adolescent- and youth-friendly health care standards were developed. In the Democratic Republic of the Congo, a framework for accelerating the reduction of maternal and infant mortality was developed and launched. This framework is aligned to the National Health Development Plan 2011-2015. H4+ advocacy resulted in government commitments of US $300,000 for contraceptives and US $66 million for medical equipment beyond programme funds. The Ministry of Higher Education established a three-year, direct-entry Midwives Education programme. In Zambia, H4+ Canada advocated for increased investments in MNCH through its participation in National Health SWAPs and policy dialogues. In Zimbabwe, H4+ supported the development and launch of no fewer than 12 strategic documents and policy guidelines on the various aspects of SRMNCH.

Output 2. Health financing:
All the identified intervention facilities from the five countries reported progress in this Output Area, particularly in terms of the development and implementation of innovative approaches to financing, subsidization, voucher schemes, in-kind packages, and mutual healthcare insurance. National costed RMNCH plans (including human resources) were developed in two countries (Burkina Faso and Zambia) based on a comprehensive situation analysis that highlights priorities and gaps.

Output 3. Health technologies and commodities:
All H4+ Canada countries took important steps to improve supplies of essential materials, medicines and equipment for RMNH, including strengthening supply chains. Among the equipment provided in 2013 were vehicles for emergency transport of patients to health centres and trucks for delivering supplies; BEmONC materials, diagnostic supplies, contraceptives, manikins for maternal and newborn care, partographs, ANC cards, HMIS tools, delivery kits, beds, solar panels, job aids for youth-friendly service
delivery and machines for measuring HIV. Stock-outs of medicines for mothers and newborns are being monitored and steps are being taken to prevent them. For example in Zambia, H4+ Canada provided strategic guidance to the national forecasting, quantification and decentralized supply chain management processes for all essential medicines in order to ensure the availability of commodities at all levels.

Output 4. Human workforce:
In 2013 in the five countries supported by H4+ Canada, a total of 6,629 health care providers were trained in quality maternal, neonatal, infant care and emergency obstetric and neonatal care; thus bringing life-saving essential and emergency health services nearer to the more than 20 million people living in the countries’ target regions, including many in remote areas.

Most of the individuals trained were already health care providers whose skills in EmONC were expanded and upgraded; but nearly 1,700 were members of local communities with little or no previous medical experience. These individuals are now able to increase awareness among women and communities of the need for routine and emergency care for women and to provide health education, advice and support on FP issues. H4+ Canada is also focused on policies of human resources for health (in DRC) and is strengthening training institutions through the training of trainers at the national level – thus laying a foundation for expanding quality maternal and newborn care beyond the targeted regions. Didactic materials and equipment, including computers and diagnostic devices, were also provided and Ministries of Health received support in developing user-friendly training modules and rolling out on-the-job programmes.

Output 5. Health Information systems, monitoring and evaluation:
Each of the five H4+ Canada countries made progress in the area of health communication, monitoring and evaluation in 2013, including through the provision of tools both at the global and regional levels, thus laying a foundation for expanding and improving M&E at the national level. On average, 84 per cent of targeted districts submitted timely and complete reports, according to national guidelines and schedules, during the last three months of the reporting period, as per reports of MoH. Burkina Faso, DRC and Zambia produced maternal death surveillance reports in 2013, while Sierra Leone’s MDSR is being finalized and Zimbabwe’s new guidelines for conducting MDSRs are being printed.

Output 6. Health service delivery:
In every programme country, the provision of SRMNCH services was strengthened in 2013, and in many cases made more accessible in hard-to-reach areas. People were made aware of the availability of these services and the capacities of service-providers were strengthened. On average among the five countries, 78 per cent of target districts provided PMTCT services according the national guidelines. In the two target regions of Burkina Faso, 71 health care facilities received support for EmONC. In DRC, 542 facilities in the three target regions now provide pre-natal consultations, PMTCT and PNC. In Sierra Leone, 65 health facilities were upgraded to BEmONC centres. In Zambia, significant improvements in service delivery were recorded for antenatal, postnatal and skilled birth attendance in all five-target districts. In comparison with the 2012 figures, there was an improvement in utilization of ANC, PNC and SBA ranging between 9 and 20% by the end of 2013 in intervention districts. In Zimbabwe, where the emphasis is on preventing, treating and de-stigmatizing HIV/AIDS, the number of males tested for HIV
increased from 2,928 (14% of pregnant women) in 2011 to 7,202 (36% of pregnant women) in 2013,, as did the number of men supporting their wives in accessing ANC and PNC services. Health Centre Committees were revived to support MNCH and PMTCT services in rural areas. In two of the target districts, monthly outreach services were launched in hard-to-reach areas.

**Output 7. Demand, including community ownership and participation:**
A number of innovative strategies enabled community members in the five countries to actively engage in, and take ownership for, strategies and activities that promote SRMNCH. Demand for MNH services was created through community mobilization, public awareness and sensitization campaigns, advocacy and the establishment of community groups and local committees. The deployment of community volunteers and the engagement of community leaders were also effective.

In **Burkina Faso**, where all 257 health centres in the programme areas have management committees made up of local community members, H4+ Canada supported the launch of two new strategies: The School for Husbands (to encourage men’s involvement in MCH) and social marketing of ASRH. In **DRC**, a social mobilization campaign was carried out to increase demand for FP services and for delivery in a health facility. The plan to promote men’s involvement was carried out with the help of 300 trained traditional and religious leaders. In **Sierra Leone**, a community outreach sensitization programme on GBV and sexual and reproductive health and rights, carried out in four communities by paralegals, reached 300 women, men and adolescents. They also supported two health facilities by providing free medical care for 500 GBV victims. Trained community advocacy groups and male peer educator networks continue to promote SRH and the prevention of GBV and refer cases for SRH, institutional deliveries, family planning and STIs. In **Zambia**, community ownership, engagement and participation in maternal health programmes increased. Twenty self-help outreach shelters for MNCH services were constructed and 106 community volunteers were trained as part of Safe Motherhood Action Groups. In **Zimbabwe**, road shows were performed and dialogues were held with community and church leaders, parents and young people to increase demand for ASRH. Community leaders established local ASRH committees – support groups for young people living with HIV that meet regularly in the communities.

**Output 8. Communication (including communication for development) and advocacy:**
A wide variety of innovative communication activities were carried out in nearly all programme countries, a number of which reached the national level.

In **Burkina Faso**, TV spots in local languages on the prevention of unwanted pregnancies in young women between the ages of 15 and 24 were broadcast on three networks a total of 351 times. The spots were also adapted for radio and aired 800 times on four stations; the programme distributed 4,884 posters to health centres. In **DRC**, as a result of H4+ advocacy, the government allocated funds for contraceptives, medical equipment, materials and the refurbishment and/or construction of 198 hospitals and 1,320 health centres. A media campaign on PMTCT was launched on radio, television and in print. In **Sierra Leone**, 630 individuals were trained to advocate for key SRMNCH issues, including FP, institutional deliveries and the prevention of GBV/FGM/C and 60 religious leaders received orientation on HIV/AIDS. In **Zambia**, district-specific campaigns to promote HIV testing were developed, including the production of appropriate IEC materials, radio broadcasts and dramas for MNCH community sensitization. In **Zimbabwe**, community mobilization for ASRH was conducted in all six district target
areas. Community meetings brought together traditional leaders, including chiefs and religious leaders. One community helped build a “youth corner” at their health facility.

H4+ activities are designed to be catalytic; that is, to lay the groundwork for establishing quality SRMNCH as a global norm, as well as throughout the programme countries – all of which saw evidence of this at the national level in 2013. H4+ activities are also designed to promote gender equality, and each country is implementing innovative projects to achieve this goal. Examples include Burkina Faso’s School for Husbands; work with religious and community leaders as change agents for social norm and practices pro to gender equality in DRC and Zimbabwe; community sensitization and legal support for GBV and the promotion of male involvement in RMNCH/GBV in Sierra Leone; and the promotion of male involvement in RMNCH in Zambia.

Efforts to achieve sustainability are intrinsic to H4+ activities. Examples include institutional capacity-building of training institutions; legislation to promote quality RMNCH in DRC and Burkina Faso; developing buy-in at national and district levels through ownership and leadership of MoH and regular conduct of national level coordination meeting under MoH; integrating/coordinating H4+ efforts with those of other national initiatives; and strengthening service delivery sub-systems, like improved planning and supportive supervision at sub-national and district level.

Although the pace of implementation of the H4+ Canada programme increased markedly in 2013, the programme was also affected by external environments. Challenges include the need to maintain standards of quality in health services and the low skill levels of health care providers; inadequate or dilapidated health care infrastructure; destabilizing changes in the national environment; the need to adopt effective training methods; the need for reliable HMIS and data at all levels; the need to mobilize more resources and commitments. The need for improving coordination, monitoring, communication and documentation of planned intervention has also been identified. Effective ways to meet these challenges are being actively pursued in all countries and at the global level. The engagement and communication with the countries have been increased in a systematic manner through teleconferences and face to face meetings. It is planned to organize joint country mission based on half-yearly progress review for on-site supportive supervision. Furthermore, for each country, the H4+ lead agency at Global level maintains regular communication with country team on the programme progress and provide required guidance and support. The country teams have been advised to pay high attention and emphasis to inform national system based on work done at sub-national level.

Overall, the year 2013 was very productive for the H4+ Canada programme. This programme is ambitious, complex and challenging and requires the dedication of many partners around the world and at all levels. Yet it has the potential to make a huge difference in the lives of mothers, newborns and young children everywhere, significantly reducing preventable maternal mortality in the near future.
The H4+ is also receiving funding from Sweden (the H4+ Sida grant), active at the global level and in six African countries, including Zimbabwe. France (through the Muskoka grant) is targeting nine Francophone African countries and Haiti with a programme organized more at the regional level (through UNFPA, UNICEF, WHO and UN Women). Harmonization of the planning, monitoring and evaluation processes and tools of these grants with H4+ Canada is an ongoing effort, as is the search for synergies. For example, the H4+ Sida country teams were invited in the annual Canada planning meeting to learn the planning process. Similarly, there are plans for 2014 to organize common communication workshops to harmonize response for communication and advocacy activities. In addition, the same M&E framework is used for both H4+ Canada and H4+ Sida programmes.

1. PROGRAMME RATIONALE AND BACKGROUND

Purpose, principles and expectations: The H4+ partnership, comprised of UNFPA, UNICEF, WHO, UNAIDS, UN Women and the World Bank, seeks to improve sexual, reproductive, maternal, newborn and child health (SRMNCH), particularly through accelerating progress toward achieving the Health Millennium Development Goals (MDGs) 4, to reduce child mortality, 5, to improve maternal health and 6 to prevent and treat HIV, malaria and TB. The programme’s strengths are collective leadership, collaborative efforts and synergy. It is aimed to enhance the capacities of the structures, systems and processes of global and national health systems to deliver equitable services for SRMNCH. To do this, the H4+ uses catalytic initiatives to fill existing gaps in these structures and processes.

The H4+ received a five-year\(^4\) grant of US $50 million from the Department of Foreign Affairs, Trade and Development, government of Canada, to support global work and country-level programmes in five African countries: Burkina Faso, the Democratic Republic of Congo (DRC), Sierra Leone, Zambia and Zimbabwe. The main objective of this grant is to support country-level efforts to fulfill commitments made under the UN Secretary General’s 2010 Global Strategy for Women’s and Children’s Health (the Global Strategy hereinafter), as well as a number of global- and regional-level initiatives. The programme has three specific objectives:

1. To provide joint support for the national scale-up of integrated SRMNCH interventions with a focus on equity, through maximizing co-ordination and synergies among agencies;
2. To support the strengthening of national health systems, in partnership with others and guided by national plans;
3. To collect and analyze data to identify, document and support innovative approaches and evidence of what works, for adaptation and roll-out in other high-burden countries.\(^5\)

The five countries supported by the H4+ Canada grant were identified following objective criteria: They all have low Human Development Indicators (HDI); Maternal Mortality Ratios (MMR) of more than 300 per 100,000 live births and high infant mortality rates. Zambia and Zimbabwe both have HIV prevalence\(^4\) March 2011 - March 2016.\(^5\) The H4+ High Burden Countries Initiative is led by the United Nations “health” agencies and works directly with Ministries of Health, health care professional associations and other key government and development partners in countries with high levels of maternal and newborn mortality and morbidity that have a clear need for additional support.
rates of more than 12 per cent in general population. All five countries are having deficiency of skilled human resources for SRMNH and face strong financial constraints. On the other hand, these are countries in which the H4+ agencies are well established and where the grant can be aligned with existing processes and complement existing funds and programmes, allowing for more coherent progress and results under government leadership.

At the country level, programme support follows a “health system building-blocks” approach, which includes governance, financing, technologies and commodities, human resources, health information, service delivery, community ownership and communications. Global-level interventions follow eight identified activity areas to cover policy, quality, equality, and accountability dimensions of SRMNCH information and services.

The principles guiding the H4+ Canada programme are based on an understanding of national and local needs. They aim to complement existing efforts by filling critical gaps, thereby creating a continuum of SRMNCH care from households to health facilities, in order to solve local problems in the provision of SRMNCH services in the local context, through innovative approaches.

The grant is also expected to be catalytic, as the work of H4+ is aligned with: (1) the global Every Woman Every Child (EWEC) Strategy, thus leveraging high-level political attention to ensure success and results; (2) the pursuit of the MDGs and the measuring of success in accordance with MDG indicators; and (3) leadership and coordination mechanisms for SRMNCH at the global and country levels, thereby providing platforms for identifying and acting on opportunities for complementary and synergistic efforts.

Programme Implementation: The H4+ Canada collaboration began in 2011 and actual programme implementation started during 2012 at the country and global levels. At the global level, the thrust of activities was on building and using a knowledge base for SRMNCH care with a focus on countries with high burdens of maternal and neonatal mortality. Programmatic interventions at the country level included “upstream” (national level) and “downstream” (local level) activities, with an emphasis on strengthening the capacity of health systems to deliver quality SRMNCH services. The approach was designed to complement the existing efforts of health systems by addressing gaps through catalytic interventions.

Programme management and coordination:
- The H4+ Canada steering committee met once face-to-face and once via teleconference during the year 2013. All recommendations of the steering committee were followed by timely action and compliance.
- Members of the H4+ Global technical team interact through weekly phone calls. This provides a forum to discuss progress and make decisions on a variety of collaborative work currently underway, including the H4+ Canada programme. There are challenges for coordination at country level, three key challenges at country level being addressed are: 1) Non availability of all focal persons on a fixed day meeting due to responsibility for field visits for other programmes; 2) lack of joint field visits and 3) irregular meetings at national levels to review programmes. This is being addressed through
regular meetings, including participation by call, with documentation of discussions and planned joint field visits.

- An M&E global reference group was established to oversee and support all M&E aspects of the programme. The group, led by UNICEF, developed a global M&E framework, oriented country teams to track progress through common indicators and provided support in the development of country M&E plans. The reference group is managing the mid-term review process during 2013. This exercise is conducted by an independent agency, Ipact, and is aimed to inform programmes at national and global levels.

- The collaborative leadership of H4+ agencies is a driving force of the programme. The work in each global-level activity area is led by one of the UN participating organizations – UNICEF, UNFPA and WHO – (i.e., the H4+ Canada agencies, recipients of funds) as described in the next section. These participating organizations work closely with the other UN agencies, or H4+ collaborating organizations that are not recipients of funds, UNAIDS, and UN Women.

- In each of the five programme countries, one H4+ agency has been appointed as lead for the H4+ programme and a representative from that agency acts as the H4+ focal point that oversees and coordinates implementation at the country level. In Burkina Faso, the lead agency is WHO; in DRC, Sierra Leone and Zimbabwe, the lead is UNFPA; and in Zambia it is UNICEF. The collective efforts of country teams, in close collaboration with health ministries, lead the programme at country level.

- In 2013, the annual H4+ Canada meeting took place in Sierra Leone between November 19 and 21. The meeting brought together teams from the five H4+ Canada countries and from Sida-supported countries, as well as regional and global H4+ focal points and representative of the Canadian government. Reviews of progress made since the beginning of the year, lessons learned and priorities for the period 2014 were the focus of discussions and work during this three-day meeting and draft work plans for 2014 were prepared.

2. GLOBAL LEVEL PROGRESS AND ACCOMPLISHMENTS

2.1. Analysis of Progress and Moving Forward

This section of the report provides information and analysis of progress and key accomplishments achieved as a result of global-level activities in the high-priority project areas, followed by information on challenges faced and remedies applied during this reporting period, as well as priorities for 2014.

During the current reporting period UNICEF, UNFPA and WHO provided leadership and oversight of seven Global Areas of Activity (see Table 1). Key accomplishments under the seven areas will help establish a strong evidence-base for programme planning and implementation at the country-level, even beyond intervention countries.

Products and knowledge sharing: The table below summarizes the products produced under Areas 1-8 along with information on dissemination and plans for knowledge sharing and capacity building to ensure that the products are useful to, and used by, the respective countries.
<table>
<thead>
<tr>
<th>Global Area</th>
<th>Lead Agency</th>
<th>Key Accomplishments</th>
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| **Area 1:** Mapping/monitoring of global and country activities within the broad H4+ scope of work and implementation of the Global SRMNCH Strategy 2012-13. | WHO | A. H4+ progress report 2013 developed, acknowledged by member states and partners and by the independent expert group on Women’s and Children’s health.  
B. Common H4+ results framework developed. |
| **Area 2:** Developing tools and building capacity for strategic planning, programme management, implementation and M&E for SRMNCH. | WHO | A. RMNCH Policy Compendium developed.  
B. Strategic planning with specific focus on RMNCH continued through the One Health tool for planning and costing.  
D. WHO recommendations on maternal, newborn, child and adolescent health compiled.  
E. Handbook developed to support countries in introducing and scaling up community-based interventions for newborn and child health. |
| **AREA 3:** Dissemination of H4+ products for accelerated action in countries | UNICEF | A. H4+ 2013 Annual Report published.  
B. Final version of tool for Rapid Assessment of RMNCH Interventions and Commodities (RAIC) disseminated.  
C. Every Newborn bottleneck analysis (BNA) tool used during country consultations on newborn care.  
D. Draft of Every Newborn Action plan (ENAP) submitted to WHO Executive Board.  
E. Factsheets with MNH coverage indicators developed for all H4+ Canada countries (as well as over 20 high-burden countries) and posted on EN website.  
F. MNH communication for development (C4D) guide drafted. |
| **AREA 4:** Documentation of good practices and sharing of knowledge among the H4+ countries through South-South collaboration | UNICEF | A. Inception report on the mid-term review of the H4+ Canada initiative reviewed and submitted.  
B. Fact sheets on five H4+ Canada countries available.  
C. Compendium of case studies on innovative approaches in maternal/newborn care (final version) prepared.  
D. Guidance for documenting innovative approaches to MNH available.  
E. Best practices in scaling up maternal/newborn care, and lessons learned, shared among H4+ Canada countries. |
| **AREA 5:** Outline of increased H4+ communication efforts to support the implementation of the Global Strategy in priority countries | UNFPA | A. Regular, ongoing communication among H4+ communication focal points initiated.  
B. Country Communications focal points identified; country-based stories and articles requested.  
C. H4+ key messages, boilerplate and online H4+ descriptions for partners’ websites produced.  
D. H4+ brochures (English and French) created.  
E. H4+ webpage created and housed on EWEC website.  
F. H4+ speakers and talking points for sessions at international meetings identified; articles summarizing sessions shared and posted on some partners’ websites.  
G. Increased partnership activities carried out with EWEC |
### AREA 6: Strengthening support to national procurement plans for essential medicines and medical devices

**UNICEF**

- A. Final list of essential medical devices for Maternal and Newborn Health compiled.
- B. DIVA Procurement and Supply tool (final version) available.

### AREA 7: Strengthening support to countries to improve the numbers and quality of human resources for RMNH (in particular skilled birth attendants)

**UNFPA**

- A. Midwifery Services Framework (known as the Guiding Tool for Developing RMNH Services by Midwives) endorsed by the International Confederation of Midwives (ICM) board. To be launched at the ICM Congress, June 2014, in Prague.
- B. Active partnerships established to support the development and implementation of national policies and plans on midwifery workforces.
- C. High Burden Country Initiative: Support was provided to policy dialogue and national midwifery policy and plans developed were developed in four countries (Afghanistan, Bangladesh, Ethiopia and Tanzania). Bangladesh’s MNCH Workforce Assessment endorsed by the government.
- D. RMNH training guidelines for CHWs developed. A mapping of existing training tools for CHWs in SRH/MNH will be available on the WHO website.

### AREA 8. H4+ Canada Collaboration Programme Co-ordination Mechanism

**UNFPA**

- A. The annual face-to-face and teleconference meetings of the SC were held.
- B. The annual planning meeting for developing the 2014 work plan was held in November 2013.
- C. Regular follow-up for the compliance of the SC recommendations.

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**ACTIVITY AREA 1. Mapping/monitoring of global and country activities within the broad H4+ scope of work and implementation of the Global Strategy SRMNCH 2011-12 (WHO)**

A. **H4+ progress report 2013 published**, acknowledged by member states and partners and by the Independent Expert Group on Women’s and Children’s Health. The report includes an assessment of the support that the H4+ partnership has provided to help countries reach their SRMNCH goals. The objectives of the report were:

- To review H4+ work in progress and remaining gaps towards its mandate of supporting the achievement of MDGs 4 and 5 in high-burden countries, in line with the countries’ national plans and strategies.
- To bring together information on H4+ efforts to accelerate the implementation of the UNSG’s Global Strategy for Women’s and Children’s Health.
In addition to providing the results of the survey of 53 countries (46 responded) that have made commitments to improve SRMNCH policies and services in the context of the UNSG’s Global Strategy, the report documented progress in specific programmes, including the support to five countries in the context of Canada grant.

The report concluded that H4+ has already demonstrated the many benefits and added value that this kind of partnership can leverage.

The report’s key messages include:
• In certain areas, coordination can be improved by engaging more actively with other UN partners in health, including with the World Bank.
• Various initiatives can be streamlined to address specific needs, including the need for greater clarity on the division of labour among the partners.
• H4+ needs sufficient funds for more technical assistance, improved M&E systems and stronger advocacy.
• Improve coordination is needed, not only with initiatives focused on HIV and malaria, but also to better address the social determinants of health; systematic efforts should be made to optimize the integration of SRMNCH with HIV and malaria prevention and treatment.

B. Common H4+ results framework developed.
The six lead UN agencies share a common information platform and are thus able to galvanize support, both externally and within countries, for the RMNCH cause. This support ranges from political support and advocacy to leveraging additional financial resources. The partnership ensures standardization of methodologies, information and data, which enhances international compatibility. The partnership facilitates consistency in training materials to ensure standardized, high-quality human capacity. In 2013 this included building institutional capacity at universities in many countries. The partnership is becoming a “one-stop shop” for countries to access technical and financial support for the entire spectrum of RMNCH issues. The coordination mechanism has been simplified and streamlined, enabling countries to approach a single H4+ coordinating team to access support.

Additionally, efforts were initiated to streamline the M&E frameworks of various programmes that support H4+ in line with the COIA framework and a draft H4+ results framework was developed.

Moving forward in Area 1, priorities for 2014 include:
• Strengthening information to support the development of strategies to End Preventable Maternal Mortality (EPMM),
• Conducting in-depth analysis of cause-specific maternal mortality data for selected countries,
• Identifying three countries and supporting their capacity to develop country-specific EPMM milestones and strategies.
ACTIVITY AREA 2: Develop tools and build capacity for strategic planning, programme management, implementation and M&E for RMNCH (WHO)

Building on the achievements of 2012, the work on developing and harmonizing tools and approaches for building and strengthening the capacities of country teams for strategic planning, management and review made important progress during the reporting period. Some highlights include:

A. RMNCH Policy Compendium

An SRMNCH Policy Compendium was developed and posted on the WHO website. Bringing together relevant evidence, policy recommendations and guidance for RMNCH interventions, it is the result of work led by WHO and the Partnership for Maternal, Newborn and Child Health (PMNCH), in collaboration with the H4+ partners, academia and professional associations. The compendium is designed for policy-makers and managers who are responsible for developing, implementing and evaluating RMNCH strategies, plans and programmes, as well as those from other sectors that influence health-service delivery and RMNCH outcomes. It can be used either as an overall checklist for the RMNCH continuum of care, or to examine single, selected policy topics (such as human resources) or technical areas (such as emergency obstetric care).

http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf

B. Strategic planning with focus on SRMNCH continued through OneHealth

Building on the achievements of 2012, the work to develop and harmonize tools and approaches – in order to build and strengthen the capacities of country teams for strategic planning, management and review – made important progress during the reporting period in 2013. For example, capacity-building for strategic planning with specific focus on SRMNCH continued through OneHealth workshops at regional levels (Africa as well as other regions such as the Eastern Mediterranean) and the tool was increasingly used at country levels.

http://www.internationalhealthpartnership.net/en/tools/one-health-tool/

C. Technical guidelines for Maternal Death Surveillance and Response (MDSR)

Technical guidelines on MDSR have been developed and published. Carefully-targeted interventions are most effective in improving the quality of care and ensuring maternal survival, and identifying these targeted interventions requires accurate information on maternal deaths: who died, when, where and why. MDSR provides this information through the identification and timely notification of maternal deaths, followed by a review and analysis of the particular circumstances. MDSR also underpins better information on the magnitude of maternal mortality, better civil registration and vital statistics, and information on the quality of maternal and perinatal care. In 2013 WHO led the international working group on MDSR, which includes partner agencies, academic and research institutions, professional organizations and advocacy groups. The working group has introduced the concept of MDSR through regional and national workshops covering all 75 high-burden countries, which account for 95 per cent of maternal and child deaths.


D. WHO recommendations on maternal, newborn, child and adolescent health, produced by all related departments, were compiled by WHO and the compilations were approved by WHO’s Guidelines Review Committee (GRC). This series of recommendations responds to the “what”
questions, i.e., What health interventions should a pregnant woman, mother, newborn, child or adolescent receive and when should s/he receive them? What health behaviours should s/he practise (or not practise)? [http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/](http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/)

E. Training packages for community health workers (CHWs)
Countries are increasingly seeking to ensure universal coverage of essential SRMNCH interventions by training CHWs. In preparation for providing support, the H4+ partnership of multilateral health agencies mapped existing training materials for CHWs in various components of SRMNCH. This joint exercise by WHO and UNFPA aimed to shed light on gaps and opportunities for harmonizing approaches to developing CHW capacity. Thirty-one relevant training packages were identified, classified by health themes and analysed according to agreed parameters. A subsequent technical consultation was organized by WHO and UNFPA to agree on next steps, including broad dissemination of the mapping. A technical brief on strengthening the capacity of CHWs to deliver care in SRMNCH was developed and is currently under review by the H4+ partners. Finally, the various WHO publications that outline evidence-based tasks for CHWs, and a list of core and additional interventions that CHWs can provide according to their level of training, is being consolidated and will be published in 2014.

A handbook to support countries in introducing and scaling up community-based interventions for newborn and child health was developed in collaboration with partners. It promotes planning for the implementation of three WHO-UNICEF training packages contained in the package, Caring for Newborns and Children in the Community: (1) Caring for the newborn at home, (2) Caring for the child’s healthy growth and development, and (3) Caring for the sick child in the community (to be published).

Products and knowledge-sharing: The table below summarizes the products produced under Areas 1 and 2, along with information on dissemination and plans for knowledge-sharing (KS) and capacity-building to ensure that the products are used by, and useful to, respective countries.

Table 2: Products, Dissemination and Plans to Ensure the Products are Useful to and Used by Countries

<table>
<thead>
<tr>
<th>Products</th>
<th>Dissemination</th>
<th>Knowledge-sharing and Capacity-building Plans</th>
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<tr>
<td><strong>Area 1</strong></td>
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<td><strong>Area 2</strong></td>
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<tr>
<td>RMNCH Policy Compendium</td>
<td><a href="http://www.who.int/pmnch/knowledgel/policies/policy_compendium.pdf">http://www.who.int/pmnch/knowledgel/policies/policy_compendium.pdf</a></td>
<td>To be used in strategic planning.</td>
</tr>
<tr>
<td>Strategic planning with specific focus on RMNCH continued through OneHealth</td>
<td><a href="http://www.internationalhealthpartnership.net/en/tools/one-health-tool/">http://www.internationalhealthpartnership.net/en/tools/one-health-tool/</a></td>
<td>Training workshops.</td>
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<tr>
<td>H4+ mapping of training packages for community health workers</td>
<td>To be published</td>
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<td>A handbook to support countries in introducing and scaling up community-based interventions for newborn and child health</td>
<td>To be published</td>
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Catalytic nature of Key Accomplishments under Areas 1 and 2:

All activities implemented under Activity Areas 1 and 2 are aimed to enhance processes for accelerating progress to achieve MDGs 4 and 5 and to strengthen the commitment of the countries to the global strategy of Every Women Every Child. The catalytic effect has gone beyond the Canada intervention countries.

- The H4+ progress report brings together information on H4+ efforts to accelerate the implementation of the UNSG’s Global Strategy to Support Women’s and Children’s Health.
- The RMNCH policy compendium is a compilation of evidence, policy recommendations and guidance for RMNCH interventions to help countries in planning effective RMNCH strategies and implementing programmes.
- Technical guidance on MDSR will help countries initiate and establish MDSR as a mechanism to enhance the accountability of health systems and promote evidence-based responses and mid-course correction in programming to avert maternal deaths and disability.
- The training package on CHWs will enable several developing countries to invest resources in the capacity-building of CHWs in order to enhance access to, and utilization of, RMNCH information and services.

Moving forward in Area 2, priorities include:

An article on training packages for community health workers will be published in early 2014. The various WHO publications that outline evidence-based tasks for CHWs, as well as a list of core and additional interventions that CHWs can provide, according to their level of training, will also be published in 2014.

Also in 2014, an assessment of the quality of care (QoC) in MNCH in the five H4+ countries will be carried out. This will include assessments of the implementation of MDSR and a monitoring of QoC indicators in health care facilities, including reporting on QoC indicators.
Guidance on rolling out EmONC interventions after needs assessment will be developed and disseminated to facilitate needs assessment and planning and improve the functioning of facilities in providing the entire range of EmONC services (Lead: UNFPA). This process will include engaging an implementing partner from another agency (not a member of the H4+ team) to coordinate the entire process in close collaboration with H4+ partners; forming a working group; taking stock of available tools and developing EmONC guidelines, as well as a consultation for finalizing the guidance.

**ACTIVITY AREA 3. Continued work to disseminate H4+ products for accelerated action in countries (UNICEF)**

A wide variety of capacity-building products on topics ranging from commodities procurement to care for mothers and newborns was produced and disseminated at the global level by H4+ Canada in 2013. Highlights include:

A. **H4+ 2013 Annual Report** - As the coordinating agency, UNICEF provided technical support for the development of the 2013 H4+ annual report.

B. **Rapid Assessment of RMNCH Interventions and Commodities (RAIC) tool** - A final version of the RAIC tool was disseminated.

C. **Every Newborn bottleneck analysis (BNA)** - This tool was used during country consultations on newborn care.

D. **Every Newborn Action Plan (ENAP)** - A draft of the ENAP was submitted to the WHO Executive Board.

E. **Factsheets showing MNH coverage indicators** were developed for all Canada-supported countries (as well as over 20 high-burden countries) and posted on the Every Newborn (EN) website [http://www.everynewborn.org/](http://www.everynewborn.org/).

F. **MNH communication for development (C4D) guide:** UNICEF is coordinating the development of a global C4D MNH guide. The guide will be designed to assist programme managers and planners in determining the social and communication context for C4D MNCH programmes and following strategic programme planning steps to develop evidence-based, equity-focused, multi-level, culturally- and population-appropriate programmes and coordinated communication activities. Canada as well as Sida H4+ countries will be engaged in the Africa workshops to pilot the guide.

G. **Every Woman Every Child consultation** - Under UNICEF’s leadership, H4+ convened the third EWEC informal stakeholder consultation on May 1st 2013. Almost 50 stakeholders participated via teleconference, videoconference or in person in New York. There were also representatives from various constituencies, including the private sector, academia, NGOs, governments, donors, and the United Nations. The aim of the meeting was to draw lessons learned from various initiatives focused on meeting the global commitments made to EWEC. This forum provided an opportunity to share updates and on-going initiatives and discuss ways to accelerate efforts to support the implementation of the Global Strategy.

**ACTIVITY AREA 4. Documentation of good practices and sharing of knowledge among the H4+ through South-South collaboration (UNICEF)**

All of the components of Area 4 are aimed at improving the quality of MNH care, including access to reliable country data, support to innovations, guidelines for documentation and scaling up of best practices. UNICEF provided technical assistance to strengthen national/sub-national capacities to
conduct bottleneck analysis and evidence-based planning in several countries. Capacity-building workshops on evidence-based planning were conducted in March 2013 in Zambia and Cameroon to sharpen the RMNCH roadmap/plan. Highlights of the year include:

A. **Midterm review of H4+ Canada:**
   The aim of the midterm review of the H4+ Canada Initiative was to assess (1) the relevance, effectiveness, efficiency and sustainability of the country programmes; (2) innovative interventions (at least one per country) arising from country implementation; and (3) the added value of the H4+ inter-agency coordination. Under UNICEF’s coordination, the mid-term review was conducted in the programme countries by the Independent Evaluation Team (Ipact and its partners) between September 2013 and January 2014. In preparation for the review, preliminary country visits were organized by Ipact in the five H4+ countries in February and March 2013. An inception report was written by Ipact and shared with all countries in order to: describe the methodological approach, including the evaluation framework; provide a list of evaluation questions with judgment criteria; present the implementation plan for the mid-term evaluation; and outline a schedule for the final evaluation. Once approved, the findings of the review will be applied to improve implementation of interventions during the remaining two years of the grant.

B. **Country fact sheets:**
   Ten H4+ country fact sheets (funded by Canada and Sweden) were developed and shared with countries and with Canada to provide brief updates on programme implementation and progress.

C. **Compendium of innovative approaches to MNH**
   A compendium of case studies on innovative approaches to MNH was finalized and published in print and electronically. Copies were also provided to all H4+ countries at the annual Canada H4+ meeting. The ultimate purpose of the compendium is to inform countries about existing innovative approaches to MNH and highlight some key considerations for bringing MNH innovations to scale. In addition, a guidance note for documenting innovative approaches to MNH was developed and shared with H4+ countries to enhance active documentation of best practices.

D. **Guidelines for documenting innovative approaches to MNH** were made available.

E. **Best practices in scaling up MNH**
   The H4+ Canada programme provided a number of opportunities for countries to share best practices in scaling up maternal/newborn care and lessons learned:
   - H4+ organized three panel sessions at the 2013 Global Maternal Health Conference in Arusha, Tanzania in January 2013. One of the panels was on innovative approaches to maternal/newborn health care. The session highlighted the compendium of innovative MNH approaches that was being developed, presented a global review to identify definitions and criteria for classifying MNH innovations and shared country case studies on innovative approaches from India, Nepal, Philippines and Sierra Leone. The session was also an opportunity to generate feedback and suggestions related to the planning, practice and policy of MNH innovations to improve demand, supply and/or quality of care; create new links and dialogue among MNH experts with regard to MNH innovations; and promote the exchange of best practices and lessons learned from the field.
During the 2013 Global Newborn Health Conference in Johannesburg in April, a workshop was organized for delegates from 14 countries (Bangladesh, Ethiopia, India, Indonesia, Liberia, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Senegal, Tanzania, Uganda and Zambia) to identify key actions to be taken at the country level – based on what the delegates had been exposed to over the first four days of the conference – with regard to overall newborn (and maternal) programme efforts and high-priority interventions. Country capacities were also built at an M&E skills-building session at the conference.

Table 3: Products, Dissemination and Plans to Ensure the Products are Used by and Useful to Countries

<table>
<thead>
<tr>
<th>Key Products</th>
<th>Dissemination</th>
<th>Knowledge-sharing and Capacity-building Plans</th>
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</thead>
<tbody>
<tr>
<td><strong>Activity Area 3</strong></td>
<td></td>
<td></td>
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<tr>
<td>• H4+ 2013 Annual Report</td>
<td>H4+ work disseminated to stakeholders through various channels, including website, conferences, webinars, etc.</td>
<td>Information regularly provided on H4+ during international and regional meetings;</td>
</tr>
<tr>
<td>• Rapid Assessment of SRMNCH Interventions and Commodities (RAIC) tool (final version)</td>
<td>• H4+/EWEC high-level stakeholders meeting convened in May 2013 <a href="http://www.everywomaneverychild.org/">http://www.everywomaneverychild.org/</a></td>
<td>• M&amp;E skill-building and knowledge session on the RAIC process and decentralized monitoring organized at the 2013 GNHC (side event);</td>
</tr>
<tr>
<td>• Every Newborn bottleneck analysis (BNA) tool to inform the development of the Every Newborn Action Plan (ENAP)</td>
<td>• UNICEF H4+ global activities presented during the H4+ Canada annual planning workshop (Meeting report)</td>
<td>• Capacity-building webinar organized in February 2013 on RAIC tool and process to strengthen SRMNCH landscape analysis in H4+ countries;</td>
</tr>
<tr>
<td>• MNH country profiles of high-burden countries (fact sheets including H4+ CANADA countries)</td>
<td>• H4+ activities disseminated during the 2013 Global Newborn Health Conference (GNHC) in Johannesburg, SA <a href="http://newborn2013.com/">http://newborn2013.com/</a></td>
<td>• Every Newborn information and tools shared during global, regional and country workshops; advocacy and technical consultation on newborn care.</td>
</tr>
<tr>
<td>• Country and regional bottleneck analysis workshops on newborn care</td>
<td>• Bottleneck analysis tool for ENAP disseminated through website and during country (at least 5 countries) and regional (Asia, Africa) newborn consultations <a href="http://www.everynewborn.org">www.everynewborn.org</a></td>
<td></td>
</tr>
<tr>
<td>• ENAP draft document submitted to WHO Executive Board</td>
<td>• UNICEF Technical update in June 2013 on ENAP development process</td>
<td></td>
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<tr>
<td><strong>Area 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• National/sub-national capacities strengthened to conduct bottleneck analysis and evidence-based planning.</td>
<td>• RAIC process and Tanahashi model presented/disseminated at a side event during the 2013 GNHC: <a href="http://newborn2013.com/">http://newborn2013.com/</a></td>
<td>• M&amp;E skills-building session at the 2013 GNHC.</td>
</tr>
<tr>
<td>• Compendium of case studies</td>
<td>• Documents and tools available and disseminated during country</td>
<td>• Sub-national bottleneck analysis workshops to scale up newborn care conducted in Pakistan (6 provinces)</td>
</tr>
</tbody>
</table>

NB: All products listed above (tools, reports, PowerPoint presentations, draft documents, fact sheets) are available for consultation.
Table 3: Products, Dissemination and Plans to Ensure the Products are Used by and Useful to Countries

<table>
<thead>
<tr>
<th>Key Products</th>
<th>Dissemination</th>
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<tbody>
<tr>
<td>- on innovative approaches in Maternal/Newborn care (final version).&lt;br&gt;- Guidance for documenting innovative approaches to MNH (final version).&lt;br&gt;- Best practices in scaling-up maternal/newborn care and lessons learned shared between countries.&lt;br&gt;- Fact sheets of 5 H4+ Canada countries.&lt;br&gt;- Inception report for the midterm review of H4+ Canada Initiative (developed by Ipact under UNICEF coordination)&lt;br&gt;- Midterm review of H4+/Canada Initiative.&lt;br&gt;- Global M&amp;E Framework.</td>
<td>- workshops.&lt;br&gt;- Documentation on innovative approaches in MNH shared at the 2013 Global Maternal Health Conference during the H4+ panel on innovation: <a href="http://vimeo.com/59982645">http://vimeo.com/59982645</a>&lt;br&gt;- Documents on innovative approaches shared through routine channels, including website, conferences: <a href="http://www.unicef.org/health/files/Innovative_Approaches_MNH_CaseStudies-2013.pdf">http://www.unicef.org/health/files/Innovative_Approaches_MNH_CaseStudies-2013.pdf</a>&lt;br&gt;- Guidance document disseminated at the H4+ annual planning meeting and through the H4+ agencies’ country/regional offices&lt;br&gt;- Innovative approaches in MNH, best practices and lessons learned shared at the 2013 GNHC (plenary sessions, panel on innovation, workshops, etc.)&lt;br&gt;- H4+ products shared with Canada and disseminated to countries through emails, the H4+ agencies’ country/regional offices and during the annual H4+ planning meeting.&lt;br&gt;- Information on the mid-term review shared with countries during the annual planning meeting.</td>
<td>- Capacity-building workshops on evidence-based planning in H4+ countries (Zambia, Cameroun) for the sharpening of the SRMNCNCH roadmap/plan in March 2013.&lt;br&gt;- Documentation on innovative approaches in MNH shared through the H4+ agency network to strengthen implementation and build capacity.&lt;br&gt;- Country fact sheets developed to share brief updates on progress.&lt;br&gt;- Inception report sent to 5 H4+ countries to share information on the midterm review process and facilitate the organization of in-country visits.&lt;br&gt;- M&amp; E framework shared with new H4+ staff (M&amp; E and program) to build capacity and improve monitoring.</td>
</tr>
</tbody>
</table>

NB: Conference reports, draft documents, fact sheets are available for consultation

Catalytic nature of Key Accomplishments under Areas 3 and 4: Canadian funding for global-level initiatives has enabled activities in Areas 3 and 4 to link with, and support, other global activities (such as Every Woman, Every Child, the Child Survival Call to Action and the Every Newborn Action Plan) rather than initiating stand-alone activities. The Global Maternal Health Conference in January 2013 and the Global Newborn Health Conference in April 2013 brought together a number of countries to exchange best practices and lessons learned in scaling up maternal and newborn health care.

Moving forward in Areas 3 and 4, priorities include:
- Continuous dissemination of H4+ products through webinars and conferences,
- Finalization of the Every Newborn Action Plan for scaling up newborn care,
- Development of a global Communication for Development (C4D) guidance document for MNH,
- Cross-regional and country exchange visits organized to share best practices in scaling up maternal newborn care,
- Documentation of innovative approaches to MNH,
- Supporting monitoring and evaluation activities,
• Drawing lessons learned and using recommendations of the midterm review to support countries for midcourse correction.

**ACTIVITY AREA 5. Outline of increased H4+ communication efforts to support the implementation of the Global Strategy in priority countries (UNFPA)**

Communications activities grew and spread rapidly during 2013. Many basic items and actions were developed to build awareness of H4+ as a credible joint effort, working to accelerate action on MDGs 4 and 5, among members of the international development community, including decision-makers, media, donors, development partners and the public.

A. **Regular, ongoing communication** took place among H4+ Communications focal points in order to ensure consensus on all H4+ Communications activities.

B. **H4+ key messages**, boilerplate and online descriptions of H4+ for partners’ websites were produced; H4+ brochures were produced in English and French and the H4+ webpage was created and housed on the EWEC website.

C. **H4+ Communications promoted** the H4+ presence at a number of international meetings. At the Global Maternal Health Conference in January, social media activities were conducted with EWEC and the Maternal Health Thematic Fund (MHTF). At the World Health Assembly and Women Deliver, talking points were developed and H4+ worked closely with advocacy partners on communications plans, issuing media advisories (where appropriate) and drafting summary articles that were posted on partner websites.

D. **H4+ Communications worked with EWEC** to identify an H4+ speaker and develop talking points for the EWEC Briefing to the Missions in September. We also partnered closely with EWEC on UNGA activities by ensuring the inclusion of H4+ speakers at the UNF/EWEC luncheon, the UNF private sector lunch, the EWEC/UNF Networking Reception and the Women’s And Children’s Health: The Unfinished Agenda of the MDGs in Support of EWEC, sponsored by Tanzania and Canada in September 2013.

E. **To expand the H4+ media presence**, photojournalists sent reports from DRC and Sierra Leone, which were featured in The Guardian and Huffington Post. The Guardian photo essay received high praise from many organizations and was tweeted many times during UNGA. The photos were then shared with, and used by, numerous agencies and organizations.

F. **H4+ Communications expanded its social media presence** by developing template tweets and sharing them with partners and EWEC for posting during major events.

**Catalytic nature of Key Accomplishments under Areas 5:** Communication interventions are aimed to enhance the visibility of H4+ within the international development community (including decision-makers, media, donors and development partners) as a credible joint effort of six UN agencies. The accomplishments achieved under Area 5 have set the stage for the programme countries and global team to begin working together to raise awareness about H4+ and the important work being conducted (including relationship-building with Ministries of Health, the establishment and strengthening of training schools for midwives and health workers, the availability Family Planning kits, etc.) to help improve and save the lives of women, adolescents and children in the countries supported by H4+. 
Moving forward in Area 5, priorities include:

- A review and modifications to the Dropbox system for use as a mechanism for knowledge sharing.
- In order to maintain global visibility for H4+, major revisions of the H4+ microsite will be carried out in collaboration with the EWEC website company, as will the microsite’s maintenance on the EWEC website. Content, including reports, press clips, feature stories, images and other multimedia products to be produced with H4+ funds will be regularly uploaded.
- Production of evidence-based stories and communication materials (website updates, brochures, feature articles, etc.) for the enhanced visibility of the H4+ initiative with due recognition of the donor.
- A capacity-building workshop for Communications focal points from all H4+ Canada and Sida grant countries to plan and implement Communications interventions in an effective manner.

ACTIVITY AREA 6: Strengthening support to national procurement plans for essential medicines and medical devices (UNICEF)

A. The H4+ list of essential medical devices for Maternal and Newborn Health has been finalized. It includes the essential medicines, supplies and medical devices related to essential interventions performed for family planning, during pregnancy until the maternal quarantine, and during the first 28 days of life of the newborn. The list was developed following a global review of the latest WHO treatment guidelines, packages of interventions, and clinical and programmatic guidance, as well as in response to challenges and successes in Procurement and Supply Management (PSM). Following this review, several inter-agency meetings were held in Copenhagen and Geneva. The list has been agreed upon by all H4+ agencies and its dissemination is nearly completed.

B. A final version of the DIVA (diagnose-intervene-verify-adjust) procurement and supply tool is now available. The tool was developed to support the identification of procurement and supply management problems that occur at the peripheral level, as well as to help overcome bottlenecks. The main outputs of the PSM module are: identification of key PSM bottlenecks and their root causes; development of a national master reference list of medicines, supplies and equipment; and the identification of priority interventions to be developed and implemented. The development of the tool is almost complete.

Table 4: Products, Dissemination and Plans to Ensure that the Products are Used by, and Useful to Countries

<table>
<thead>
<tr>
<th>Key Products</th>
<th>Dissemination</th>
<th>Knowledge-sharing and Capacity-building Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final List of Essential Medical Devices for Maternal and Newborn Health</td>
<td>Involvement of key H4+ agencies in developing the list. Finalized list will be published and disseminated to all H4+ agencies, regions and countries.</td>
<td>Will be disseminated through H4+ web-portal and by all countries for efficient procurement and supply management.</td>
</tr>
<tr>
<td>DIVA Procurement and Supply tool (final version)</td>
<td>Finalized tool will be published and disseminated to all H4+ agencies, regions and countries.</td>
<td></td>
</tr>
</tbody>
</table>
**Catalytic nature of Key Accomplishments under Area 6:**
The essential list of medical devices of MNH care will help countries to ensure that they assign priority to the procurement of essential medical devices necessary to deliver quality MNH care. DIVA will support strengthened procurement and supply system management for the improved effectiveness of health systems.

**Moving forward in Area 6:**
- Publish and disseminate the essential list of medicines in regions and countries,
- Pilot and field-test the PSM Bottleneck Assessment Module in one country,
- Work with SRMNCH and the UN Commodity Commission working groups to support the availability of the 13 lifesaving commodities.

**ACTIVITY AREA 7: Strengthening support to countries to improve human resources for MNCH (in particular skilled birth attendants) in number and quality (UNFPA)**

A. The Midwifery Services Framework (MSF) now called “Guiding tool for developing RMNH services by midwives” was drafted and endorsed by the board of the International Confederation of Midwives (ICM). An expert meeting held at ICM HQ in The Hague in December 2013 allowed for a review of the final draft, which will be field-tested in two countries (to be chosen) and finalized in 2014. Active partnerships were established to support the development and implementation of national policies and plans on building a midwifery workforce.

B. In 2013, H4+ engaged Integrare (ICS),6 to coordinate the review and revision of the Workforce Assessment Methodology and add a chapter on projections, a critical issue in planning for human resources. This methodology is expected to be endorsed and published as an H4+ document in 2014. In addition, there is a plan to develop a methodology for a “quick” workforce assessment – that a very user-friendly assessment tool for conducting less-costly surveys.

C. The main achievement of 2013, however, was the endorsement by the government of Bangladesh of that country’s RMNH Workforce Assessment report. The report is now being used in

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6 A research institute based in Barcelona, Spain.
Bangladesh’s national dialogue on human resources at a critical time, as the country is investing in its first three-year, direct-entry midwifery training programme. The countries still in the process of doing Midwives Workforce Assessments are Tanzania, Afghanistan, Ethiopia, DRC and Mozambique.

D. Guidelines for training community health workers in RMNH are being developed.
An experts meeting on training CHWs in SRH/MNH was held for H4+ countries and partners in February 2013 to analyse the desk review/mapping conducted in October-December 2012; the mapping of existing training tools for CHWs in SRH/MNH will soon be available on the WHO website.

Catalytic nature of key accomplishments under Areas 7:

- The critical shortage of skilled human resources in many developing countries is one of the main barriers to achieving MDGs 4 and 5. The Midwifery Service Framework is expected to be widely used, as no other guidelines exist to assist countries in implementing a midwifery programme.
- The Midwifery Assessment tools will provide strategic support to countries as they seek to improve planning to address the shortage of skilled birth attendants.
- Long-awaited information to standardize the training of CHWs for SRH/MNH will be available to enable countries to judiciously use scarce resources for capacity-building initiatives.

Moving forward in Area 7, priorities include:

1. **Midwifery Services**
The HBCI has led to comprehensive Midwifery Workforce Assessments (MWAs) in countries with high MMR and large populations. This revised methodology of MWA is expected to be endorsed and published as an H4+ document in 2014. The Midwifery Services Framework (MSF, now called “Guiding Tool for Developing RMNH Services by Midwives”) will be field-tested in two countries, followed by finalization, endorsement and dissemination.

   H4+ guidelines on country-level MWA will be finalized and two regional and country-level capacity-development workshops on MWA will be organized (one in Africa, one in Asia).

2. **Second State of the World’s Midwifery report (SoWMy report 2014):** SoWMy 2014, including 73 country briefs and analyses, will be launched at the ICM Triennial Congress in Prague in June 2014 and subsequently in 10 countries.

3. **Community Health Workers (CHWs):** A literature review on CHW issues is being carried out in collaboration with WHO/MNCHA. It includes a paper on the contexts and conditions of each intervention that CHWs can implement and will serve as a supplement to an ongoing, systematic review.

4. **Financing mechanisms:** A paper will be developed on the subject, “What demand-side financing mechanisms, including conditional cash transfers, vouchers, user-fee exemptions and subsidies, and are effective in improving MNH outcomes?”

5. **Supporting and analyzing community-level MDSR programmes in selected countries:** Country MSDR programmes will be assessed and lessons learned/recommendations for MSDR implementation at the community level will be developed.

6. **Supporting and analyzing the role of CHWs in Ending Preventable Maternal Mortality (EPMM).**

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7 The report is entitled, “Training resource packages for community health workers in sexual, reproductive, maternal, newborn, child, and adolescent health: taking stock and moving forward.”

ACTIVITY AREA 8. H4+ Canada Collaboration – Programme Coordination Mechanism

Area 8 refers to the institutional coordination mechanism, which was built into the structure of H4+ Canada on its establishment in 2011. This mechanism is designed to ensure the optimum use of resources through synergy among the H4+ partners and donors, as well as their well-coordinated collaboration.

Face-to-face Steering Committee (SC) meetings are held during the first quarter of each year in order to approve the annual work plan and review progress of the past year. A teleconference SC meeting was held during the last quarter. In addition, from 19-21 November 2013 an inter-country planning meeting was organized in Sierra Leone to discuss progress and plan country-level activities for 2014. The weekly H4+ teleconferences provided ongoing opportunities to review progress and make suggestions to the Canada grant countries, as required, and to develop the global activity plan for 2014.

Since the inception of the H4+ Canada collaboration, the following SC meetings have been held:

Table 5: H4+ Steering Committee Meetings

<table>
<thead>
<tr>
<th>H4+ CANADA Steering Committee Meetings</th>
<th>SC Meeting*</th>
<th>Second SC Meeting</th>
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<tbody>
<tr>
<td>2011</td>
<td>7-8 July</td>
<td>17 August</td>
</tr>
<tr>
<td>2012</td>
<td>28-29 February</td>
<td>5 September</td>
</tr>
<tr>
<td>2013</td>
<td>12-13 February</td>
<td>28 October</td>
</tr>
<tr>
<td>2014</td>
<td>12 March</td>
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</tbody>
</table>

*In 2013 and 2014, joined Steering Committee meetings held for H4+ Canada and Sida collaborations

2.2 Challenges and Remedies

This section summarizes challenges and remedies that affected the overall H4+ Canada plan of work. Challenges and remedies relevant only to specific countries are mentioned in the country sections.

- Improving the implementation and results of programmes and priority interventions is the major challenge governments and partners are facing. A new H4+ implementation monitoring tool will be introduced in every country to improve the effective management of the programmes’ implementation.
- The role of the H4+ is to support governments at the policy and programme levels. This includes supporting the implementation of proven, effective sub-national activities and helping to identify the most appropriate mechanisms for improving national policies and strategies, implementation and M&E, these are primarily the responsibility of governments H4+ is facilitating required processes.
- A major challenge faced at the country level in 2013 stemmed from fluctuations and uncertainties associated with the governance of the health sector. For example, the planning...
division of the Ministry of Health in Sierra Leone experienced a complete restructuring. This resulted in considerable delays in m-health, a major intervention planned for 2013. Since all country plans are aligned with national plans, challenges arise when health systems experience any turbulence. Steps are being taken to plan interventions under the leadership of Ministries of Health with due consideration of the programme environment prevailing in each country.

- Country-level interventions are often designed to cover only a part of the entire geographic territory of each nation. In addition, data-generation and collection often depend on existing HMIS, which are sometimes incomplete or out-of-date. This poses many challenges to the collection of desired information on all common indicators in the project intervention area. In order to overcome this challenge, country-level consultations are planned during 2014. All key stakeholders will be engaged to discuss and resolve issues of reporting on the agreed M&E framework. The potential roles of local institutions in facilitating data collection and analysis will also be discussed.

- More financial resources are required to enhance the technical assistance provided by H4+ in building the capacities of countries to achieve MDGs 4 and 5. It is also critical to enhance the visibility of H4+ activities, the collective strengths of the partners and the contribution of the donor. During 2014, structured, carefully-designed efforts in communication and advocacy will be intensified to this end.

- Continued efforts during 2013 to improve communications and coordination at the global and country levels have borne fruit in programme improvements and progress. However, more efforts to engage potential donors are required to mobilize the resources that will be needed to realize the goals of Every Women and Every Child.

2.3 Engaging Other Donors

The H4+ team of UN partner agencies, building on the technical competencies and comparative advantage of each agency, was successful in engaging other donors in 2013.

A. H4+ Sida collaborative programme was launched in 2013 to support the implementation of the global H4+ strategy in Cameroon, Cote d’Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe. The Sida programme focuses on accelerating progress towards MDGs 4 and 5 by supporting the implementation of national SRMNCH plans. Under the H4+ Sida collaboration, all H4+ partner agencies – UNICEF, UN Women, UNAIDS, UNFPA and WHO – are recipients of funds for global- and country level- activities.

B. H4+ is also implementing other multi-country initiatives similar to the H4+ Canada and Sida joint programmes. These include:

- The French Muskoka initiative, a collaboration with MAE, France. Two of the twelve countries covered through the MAE grant (Burkina Faso and DRC) are also supported by the Canada grant. This has increased opportunities to work in a complementary manner at country the level.

- Australia has pledged support to H4+ for three years to support RMNCH interventions to accelerate progress toward achieving MDGs 4 and 5 in three Pacific Island Countries.

- The EU will provide €1 million to Guinea-Bissau to scale up the implementation of the free MNCH care model that is already being implemented in some regions of the country.

- The EU also recently awarded a grant of €24 million in Sierra Leone (to be coordinated by UNICEF) to H4+ for the two-year duration.
The H4+ is actively participating in country-level processes to identify existing financial gaps in SRMNCH. This will pave the way for the country and global teams to undertake advocacy to mobilize more resources and commitments for the SRMNCH sector. Through its coordinated technical support and harmonized response to SRMNCH issues, H4+ will continue to strengthen the knowledge management and health systems of the five programme countries, thus enabling them to implement and scale up interventions through continued collaboration with development partners.

3. COUNTRY-LEVEL PROGRESS AND ACCOMPLISHMENTS

As of 2013, the H4+ Canada programme was active in five African countries in selected areas. These programme areas have a total, combined population of more than 21 million.

**Burkina Faso:**

The H4+ Canada programme operated in two of 13 regions: North Region has four provinces and Central North has three provinces. The total population of the H4+ areas is 2,964,424, or 16 per cent of the national population. These two regions have among the highest rates of maternal and newborn mortality and morbidity in the country. The national MMR in Burkina Faso is 300.8

*Figure 1: Implementation of the H4+ programme in Burkina Faso*

**Democratic Republic of the Congo:**

The H4+ Canada programme operated in three of 11 regions. These three regions – Bas Congo, Kinshasa and Bandundu, have a population of 15,400,000, or 23 per cent of the total population of the country. The national MMR in DRC is 540 per 100,000 live births.10

*Figure 2: Implementation of H4+ in the Democratic Republic of the Congo*

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8 Maternal Mortality Rate per 100,000 live births. The World Bank, 2012 (http://data.worldbank.org/indicator/SP.UWT.TFRT)
10 Ibid.
Sierra Leone:

The programme originally operated country-wide in all 13 districts (total national population, 5,743,725). In 2013, it was decided to focus on two districts (Port Loko, pop. 500,992, and Pujehun, pop. 292,543), in order to better identify the impact of the H4+ Canada grant. The population of these two districts is approximately 14 per cent of the total. The national MMR in Sierra Leone is 890, the highest among the H4+ Canada countries.

Figure 3: Implementation of the H4+ programme in Sierra Leone:

Zambia:

The programme operated in five districts (Lukulu, Kalabo, Serenje, Chama and Chadiza) which are located in four provinces: Western, Central, Muchinga and Eastern (in orange). The total population of these five districts is 643,000 (or 5 per cent of the national population). The MMR in Zambia is 440.11

Figure 4: Implementation of the H4+ programme in Zambia

11 Ibid.
**Zimbabwe:**

The programme is in six provinces: Manicaland, Matabeleland North, Midlands, Masvingo, Mashonaland West and Mashonaland Centra and in one district of each Province. The total population of the H4+ target areas is 1,367,267, or 10 per cent of the national population. The MMR in Zimbabwe is 570.\(^\text{12}\)

*Figure 4: Implementation of the H4+ programme in Zimbabwe*

In the reporting period (2013), activities and key accomplishments of the H4+ Canada programme at the country level focused on implementing programmatic activities and providing technical assistance related to the eight main Output Areas.

Key accomplishments included both upstream and downstream work:

(A) **Policy level**

In all five countries, the H4+ Canada programme is aligned with national plans and support, creating an enabling policy environment to strengthen national health systems, through:

1. Advocacy and facilitation processes to enhance resource allocation for the SRMNCH sector;
2. Capacity-building and promoting the use of evidence-based protocols and standards to improve the quality of SRMNCH care;
3. Support to the development of strategic and policy documents (such as Human Resources for Health plans and MNCH road maps) and to the removal of financial barriers;
4. Strengthening systems and processes to improve the effectiveness and accountability of health systems, including the rollout of MDSR.

(B) **Programme Level**

In the geographical areas identified in each country, the H4+ Canada programme focused on downstream efforts to strengthen quality SRMNCH care and enhance community engagement to demand and use services.

\(^{12}\) Ibid.
This included:

1. Strengthening institutional capacities to build the capacities of health care providers and managers through skills-enhancement and training for the provision of SRMNCH care;
2. Expanding and improving the quality of SRMNCH and HIV services in health facilities;
3. Improving the service environment of health facilities through the provision of essential equipment, medicines and supplies for quality SRMNCH services;
4. Infrastructure, including ambulances, motorcycles, electricity and the rehabilitation of delivery rooms and maternity shelters;
5. Strengthening the provision of community-based maternity, newborn and child health services and family planning, including working with male peer educators;
6. Programme follow-up, monitoring and documentation, including MDSR.

3.1 Progress Made in the Eight Output Areas

The next section presents information on the key accomplishments in each of the H4+ country-level Output Areas. Each sub-section begins with a brief description of the Output Area, followed by brief comments regarding how many countries reported progress and/or results in the Output Area and what the main themes were across countries. Lastly, tables organized by H4+ common indicators for each Output Area provide highlights on progress and accomplishments in each country during the reporting period. The Global M&E Framework includes specific information by indicator in baselines, targets and values for 2013.

OUTPUT 1: Leadership and governance

This area refers to the definition of a vision and direction that address governance for health and health equity; exerting influence through regulation and advocacy; collecting and using information; and accountability for equitable health outcomes.

In 2013 in each programme country, a wide variety of accomplishments in the area of leadership and governance had impact both in programme areas and at the policy level. This is largely because national-level partners, including every country’s Ministry of Health, were involved in programme planning and implementation.

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13 Governance and Leadership; Health Financing; Health Technologies; Human Workforce; Health Information Systems, Monitoring and Evaluation; Health Service Delivery; Demand including Community Ownership; and Communication.
The result was capacity-building for each apex national institutions. The inherent flexibility of the H4+ Canada programme meant that each country was able to focus on those areas of SRMNCH that were most needed in the local context. In addition to producing reports using updated RMNCH/HIV standards and guidelines, in 2013 all five countries produced and disseminated key norms, standards, guidelines, policies and plans that establish an essential foundation for effective national SRMNCH programmes. While the distribution of these materials took place within the provinces and districts covered by the H4+ Canada programme, they are now available to support SRMNCH programs at the national level.

The plans, strategies and policies developed in 2013 cover human resources, joint funding management, a national AIDS strategic framework and plans to accelerate the reduction of maternal mortality, scale up the treatment of diarrhea and regulate blood transfusions. Standards and guidelines established include those for strengthening governance and management, health services, public health policies, IMCI, HR information systems, adolescent and youth-friendly standards, two MNCH road maps and WHO guidelines for the treatment and prevention of HIV and for growth monitoring and assessment. Training manuals, modules and capacity-building were made available in the areas of home-based newborn care, BEmONC and management of HIV. Resource allocation was strengthened in four of the five countries and experiences were shared among all five countries. Funding for Family Planning and SRMNCH was increased at the national level in three countries. Finally, fruitful collaboration also took place between H4+ Canada and key government agencies.

Table 7 Output 1: Progress and Key Accomplishments

<table>
<thead>
<tr>
<th>Output 1. Leadership and Governance: Governance and management of health sectors and financing systems are strengthened to that ensure SRMNCH services respond to the needs of women and children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common indicator 1.1:</strong> Proportion of targeted districts that used updated RMNH/HIV national standards and guidelines as well as MCH Aide curriculum and modules based on recent recommendations in MNH.*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: N/A 2013: 100%</td>
<td>Baseline: 100% 2013: 100%</td>
<td>Baseline: N/A 2013: 100%</td>
<td>Baseline: 85% 2013: 100%</td>
<td>Baseline: 100% 2013: 100%</td>
</tr>
<tr>
<td>• IMCNI; Basic Newborn Care in Health Centres; PMTCT; EmONC; ETAT</td>
<td>• Guidelines for Integrated Intervention in MNCH</td>
<td>• RMNH/HIV National Standards and Guidelines</td>
<td>• MNCH Road Map</td>
<td>• Revised PNC guidelines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MCH Aide curriculum and modules, based on recent recommendations in MNH</td>
<td>• National AIDS Strategic Framework 2011-2015</td>
<td>• An Option B+ strategy for PMTCT launched in November 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Zambia Consolidated Guidelines for the Treatment and Prevention of HIV Infection (2013)</td>
<td>• New 2013 HIV guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Launching of Option B+ strategy for eMTCT</td>
<td>• IMNCI guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• EmONC guidelines</td>
</tr>
</tbody>
</table>

*Above reported data of 100% shows that national guidelines were finalized and made available to the districts. The extend of use or compliance of above guidelines depend upon improved supervision and monitoring.*
Additional Achievements:

**Burkina Faso:**
- Training manuals, incorporating latest WHO recommendations, developed for PMTCT service providers.
- Human Resources for Health Development Plan adopted to inform the national three-year plan.
- A plan to scale up the treatment of diarrhea with ORS and zinc launched in all health districts in the target areas.
- National blood transfusion policy implemented.
- Modules adapted and tools developed for community-based service providers of home-based neonatal care and to guide public health policies in PMTCT, IMCI, BEmONC and ETAT.
- Training manuals and tools for home-based newborn care in the country context, produced by WHO
- Adolescent- and youth-friendly health care standards disseminated in the two programme regions.
- Capacity-building during 2012 in IT and computer peripherals enabled National School of Public Health and Department of Family Health to improve training quality and follow-up in 2013.

**Democratic Republic of the Congo:**
- A component to reduce maternal and infant mortality was included in the National Health Development Plan 2011-2015.
- H4+ Canada advocacy resulting in government commitments of US $300,000 for contraceptives and US $66 million for medical equipment beyond programme areas to strengthen the health system.
- New training modules for BEmONC developed, approved and in use.
- Support to development and coordination of Operational Plans of Action in the nine Health Zones.
- Training modules in the management of HIV developed for the Health Zones.

**Sierra Leone:**
- Contributed to MoHS in the design of, and on-the-job training (OJT) for, MNH Continuum of Care.14
- As a result of H4+ Canada advocacy, civil society lobbied the government to increase financial support to SRMNCH, especially procurement of contraceptives and maternal death reporting. Between 2011 and 2014, government budget allocations for the Directorate of SRMNCH increased more than doubled, from US $2,689,956 to US $5,757,605.
- Following the signed Country Compact and Joint Programme of Work and Funding for 2012-2014, the government began developing a joint funding arrangement (JFA) as part of fiduciary joint management to mitigate identified systemic risks.

**Zambia:**
- Provided technical and financial support to the mid-term evaluation of the National AIDS Strategic Framework 2011-2015 and the national planning process.
- Provided technical and financial support for the finalization and launch of an MNCH road map and the adaptation of the 2013 WHO consolidated Guidelines for Treatment and Prevention of HIV.

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14 Adolescent health, FP, ANC, delivery, postnatal care, neonatal and childcare.
• Advocated for increased investments in MNCH through participation in National Health SWAPs and policy dialogue. H4+ Canada’s participation in bi-annual Health Sector Advisory meetings helped ensure government commitment to maternal and newborn survival.

• H4+ is part of regular MNCH coordination mechanism and technical working groups in Ministry of Community Development, Mother and Child Health. This collaboration is a positive indicator for sustainability and ownership of the programme.

**Zimbabwe:**

• In the Democratic Republic of the Congo in 2012, H4+ Canada advocacy led to parliamentary debates on the allocation of resources for MNCH in programme provinces and commitments of provincial governments to increase resources for MNCH through a budget line. Inspired by reports of these activities, parliamentary debates in Zimbabwe led to discussions with MoH on the use of tools for resource allocation based on needs and priorities at the national level.

• Strategic documents and policy guidelines launched with the support of H4+ partners included: Adolescent Reproductive Health Strategy (2010-15); National PMTCT Strategy 2011-15; Option B+ strategy for PMTCT; New 2013 HIV guidelines; a National Nutrition and Food Policy.

• Documents and policies revised: RH Policy; Immunisation Schedule; Child Health card; Midterm review of ASRH National Strategy.

• Guidelines developed: IMNCI, EmONC, PNC and Programme Management.

• UNFPA helped develop BEmONC training manual and UNICEF designed, printed and distributed 20,000 DBS (dried blood spots analysis for identifying HIV/AIDS) job aides and 20,000 Early Infant Diagnosis posters.

• WHO growth monitoring and assessment standards adopted by health department.

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

<table>
<thead>
<tr>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: yes</td>
<td>Baseline: yes</td>
<td>Baseline: N/A</td>
<td>Baseline: yes</td>
<td>Baseline: yes</td>
</tr>
<tr>
<td>2013: yes</td>
<td>2013: yes</td>
<td>2013: yes</td>
<td>2013: yes</td>
<td>2013: yes</td>
</tr>
<tr>
<td>• Monthly between partners and MoH, IRSS.</td>
<td>• Quarterly MNCH Task force</td>
<td>• Monthly Health partners meeting by the Chief Medical Officer (NGOs, development partners)</td>
<td>• Monthly Health sector steering committee</td>
<td>• Quarterly national planning and review meetings</td>
</tr>
<tr>
<td></td>
<td>• Quarterly FP Task force</td>
<td>• Monthly health development partners meeting chaired by DFID</td>
<td></td>
<td>• Monthly inter-agency coordination meeting</td>
</tr>
<tr>
<td></td>
<td>• Monthly meeting of the Inter-Donor Group.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
OUTPUT 2: Health financing

This area refers to the collection of funds from various sources in order to make them available to ensure rational selection and purchase of cost-effective interventions; support the provision of appropriate financial incentives to health care providers, and take steps to help ensure that all individuals have access to effective health services.

All five countries reported progress and/or results in this Output Area, particularly in terms of the development and implementation of innovative approaches to financing, including Result-based Financing (RBF), subsidization, voucher schemes, in-kind packages, and mutual healthcare insurance. These are ambitious, often innovative strategies and they all have implications for national solutions to the challenge of funding health care. They also require considerable expertise, organization and transparency. For the most part, the five countries are at the initial stages of establishing reliable sources for affective health services, but they are taking important steps to lay the foundations for these services.

Table 8 Output 2: Progress and Key Accomplishments

<table>
<thead>
<tr>
<th>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</th>
<th>Common indicator 2.1: National costed SRMNCH plans (including human resources) are developed and based on a comprehensive situation analysis that highlights priorities and gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>DRC</td>
</tr>
<tr>
<td>Baseline: Yes 2013: Yes</td>
<td>Baseline: No 2013: Yes, focused on MDGs 4 &amp; 5</td>
</tr>
</tbody>
</table>
Additional achievements:

**Burkina Faso:**
- Costed road map developed to accelerate the reduction of maternal and newborn mortality.
- H4+ Canada advocacy resulted in maintaining the line item in the national budget (approx. US $1 million) for the purchase of contraceptives. In addition, as a result of advocacy, the user charges of contraceptives were halved, effective in 2014.

**Zambia:**
- Provided technical and financial support to the Ministry of Health and the Ministry of Community Development, Mother and Child Health to develop a national strategy for healthcare financing and design a social health insurance policy by tracking resources for women’s and children’s health through National Health Accounts for 2011-2012. The capacities of 16 healthcare providers in RBF were strengthened.
- Supported development and launch of a national eight-year plan for family planning in response to the July 2011 London summit.

**Zimbabwe:**
- No direct financing of health interventions through H4+ in 2013 as financial barriers for healthcare are being addressed through World Bank programme of RBF and multi-donor Health Transition fund.

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

<table>
<thead>
<tr>
<th></th>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td>1/9 districts</td>
<td>3/9 districts</td>
<td>N/A</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>2013:</td>
<td>78% (7/9 districts)</td>
<td>5 of the 9 health zones, compared to 4 in 2012.</td>
<td>2013: process details developed for implementation of the voucher system and in-kind packages for vulnerable, pregnant girls and women in remote areas will commence in 2014 in two pilot districts, Port Loko and Pujehun.</td>
<td>As primary health care free of charge in Zambia</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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**Additional accomplishments:**

**Burkina Faso:**
- The H4+ Canada grant contributed to the implementation of a national strategy to subsidize the cost of childbirth and EmONC. Tools for managing this strategy were developed and made available to providers at all levels in 2012, and were in use during 2013. A preliminary evaluation and consensus-building workshops were organized in two districts to prepare for cost-sharing in order to reduce financial barriers to care. Costs of childbirth and EmONC are shared among the patient, the local health service committee and the MoH, which covers 80 per cent of costs. By the end of 2013, seven districts out of nine were using this system and the process should be finalized in 2014 in the remaining two districts.
Democratic Republic of the Congo:

- An awareness-raising campaign resulted in a large number of households taking out social health insurance in Bandundu. The authorities pledged support to the provincial branch of The Mutual Health Care Fund of Bandundu, launched with 1,012 beneficiaries. In Kenge, the Mutual Health Care Fund was improved and now has 3,654 beneficiaries compared to 2,800 in 2012. In Mosango the fund, focused on pregnant women, has 7,852 beneficiaries.

- A Result-Based Financing (RBF) study led to the development of a plan to implement RBF in each health zone (i.e., financial support based on each health facility meeting agreed-upon indicator targets). The implementers (60 regulators, 72 service providers and 175 community members) were trained and the implementation of RBF is planned for 2014.

Sierra Leone:

- Amendments to the original RBF operational manual were made in October 2013 to reflect lessons learned, and a RBF programme supported by the World Bank is now operating in all 13 districts. Additional funding was received from a World Bank project to extend the cash-to-facilities RBF scheme to private clinics and district hospitals in 2014. Despite major challenges in terms of regular payments and availability of data, in 2013 more than Le 10 billion (US $2,317,497) was paid to Peripheral Health Units (PHUs), while hospitals received more than Le 3.6 billion (US $834,299).\(^\text{15}\)

- Consultants were recruited to provide technical assistance to establish a voucher system and develop in-kind packages for pregnant, vulnerable girls and women in hard-to-reach areas. The documents were developed and are awaiting validation and dissemination. Implementation of both systems is expected in 2014.

OUTPUT 3: Health technologies

Health technologies includes the application of organized technologies and skills in the form of devices, medicines, vaccines, biological equipment, procedures and systems developed to solve health problems and improve quality of life. It includes medicines, technologies, and commodities, but not infrastructure.

All H4+ Canada countries took important steps to improve supplies of essential materials, medicines and equipment for RMNCH, including strengthening supply chains, developing standard operating procedures, monitoring to maintain transparency, strategic guidance to national forecasting and quantification and the formation of provincial hubs to expedite the distribution of supplies. While some countries provided more information than others, all reported experiencing some stock-outs of essential medicines for mothers and newborns, with Zimbabwe having the best results and Burkina Faso encountering the most problems. Nevertheless, because of capacity-building at national-level institutions, progress made in the H4+ districts has the potential to have nation-wide impact in all of the countries.

Among the supplies provided through the programme in 2013 were vehicles for the emergency transport of patients to health centres and trucks to deliver supplies, BEmONC materials, diagnostic

\(^{15}\) Using UN rate of using UN rate of US $1 = Le 4,315)
supplies, contraceptives, manikins for newborn care, partographs, ANC cards, HMIS tools, delivery kits, beds, solar panels, job aids for youth-friendly service delivery and machines for measuring HIV. Many catalytic effects were seen as a result. In Zimbabwe, for example, the effectiveness of the 20 PoC PIMA machines provided by H4+ Canada to measure CD4 cell counts generated great interest with the MoHCC and other partners, who purchased additional machines to support CD4 count services. To date, the country has over 300 PIMA machines and the MoHCC is preparing guidelines to standardize their use and maintenance.

Table 9 Output Area 3: Progress and Key Accomplishments

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

| Common indicator 3.1: Proportion of health facilities reporting no stock-out of selected essential medicines for mothers (oxytocin, misoprostol, contraceptives, HIV tests, magnesium sulphate) during the last 3 months (this includes information on preventing stock-outs of contraception and HIV tests). |
|---|---|---|---|---|
| Burkina Faso | DRC | Sierra Leone | Zambia | Zimbabwe |
| Baseline: N/A 2013: | Baseline: N/A 2013: | Baseline: N/A 2013: | Baseline: 30% 2013: | Baseline: 77% Oxytocin, 40% for Magnesium Sulphate (national indicators) 2013: |
| • 11.7% of health facilities reported no stock-outs of Oxytocin | • 11.6% of health facilities reported no stock-outs in 2013, compared to 13% in 2012. | • 52.3% OF SDPs reported no stock-outs of contraceptives in 6 months. | • 50% (2013 District HMIS Reports) | • 68.7% reported no stock-outs of Oxytocin; |
| • 11.1% reported on stock-outs of Magnesium Sulphate | | • 86.6% of SDPs reported no stock-outs of Magnesium Sulphate | | • 67% reported no stock-outs of Magnesium Sulphate (VMAHS report July 2013) |
| • 5.2% reported no stock-outs of Diazepan | | • 35% of SDPs reported no stock-outs of Misoprostol | | |
| • 14.3% reported no stock-outs of HIV test | | • 81.4% of SDPs reported no stock-outs of Oxytocin | | |
| • 97.4% reported no stock-outs of Misoprostol | | (Annual Survey of Commodities, 2013) | | |

*The source of information is mainly provincial or sub-national estimates based on survey or assessments conducted by the MoH. Therefore above data is not reflecting exact situation of the health facilities covered by H4+ interventions.

Additional accomplishments:

Democratic Republic of the Congo:
• Fifteen general referral hospitals and 141 maternity clinics in the programme areas received
equipment and materials.

**Sierra Leone:**
- It was intended that in 2013, UNFPA, with the support of the MoHS, would implement an m-health project to monitor stock-outs and maternal deaths. The project was supposed to be undertaken in collaboration with the Department of Planning, Directorate of Information and the Disease Surveillance and RH/FP units of the Ministry. However, there were delays due to the suspension and prosecution of key MoHS officials in early 2013, severely affecting the implementation of the m-health project. Replacements were appointed only later in the year.
- With the revised focus of H4+ Canada support, the m-health project will be implemented only in two districts in 2014.

**Zambia:**
- H4+ Canada provided strategic guidance to the national forecasting, quantification and decentralized supply chain management processes for all essential medicines in order to ensure the availability of commodities at all levels.
- Medical equipment and supplies procured, included neonatal training manikins, partographs, ANC cards, HMIS tools, delivery kits, beds and solar panels.

**Zimbabwe:**
- The six districts received EmONC commodities (233,500 vials of oxytocin; 226,000 vials of ergometrine; 153,000 vials of magnesium sulphate) and 36 sets of EmONC training models.
- Provision of equipment and job aides for 12 Peer Educators and 12 Youth-friendly Health Service providers, allowing six district hospitals can now provide youth-friendly services.
- Twenty Point of Care PIMA machines to measure CD 4 counts in HIV diagnosis procured and distributed to high-volume sites in the six districts, greatly increasing access to ART by pregnant and lactating women.

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

<table>
<thead>
<tr>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region:</td>
<td>11.6% of health centres, compared to 15% in 2012.</td>
<td>89% reported no stock-out of essential medicines for newborns during the last 3 months; updated figure will be reported in SARA/EmONC assessment in 2014.</td>
<td>20% (2013 District HMIS Reports)</td>
<td>30% (VMAHS report July 2013)</td>
</tr>
<tr>
<td>North Central Region:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.9% reported no stock-outs of bags and masks for neonatal resuscitation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53.6% reported no stock-outs of vacuum aspirators.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.4% reported no stock-outs of bags and masks for neonatal resuscitation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.3% reported no stock-outs of manual vacuum aspirators.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Enquete complementaire IRSS 2013)

*The source of information is mainly provincial or sub-national estimates based on survey or assessments conducted by the MoH. Therefore above data is not reflecting exact situation of the health facilities covered by H4+ interventions.*
OUTPUT 4: Human workforce

This area refers to all strategies/activities ensuring that the health workforce (i.e., persons primarily engaged in actions intended to enhance health) is available and functional – planned for, managed and utilized – to deliver effective health services. It includes strengthening capacity, training, management, staff motivation and retention.

In 2013 in the five countries supported by H4+ Canada, a total of 6,536 health care providers were trained in quality maternal, neonatal, infant care and emergency obstetric care, thus bringing life-saving essential and emergency care nearer to the more than 21 million people living in the five target regions, including many in remote areas. (See Table 10 below for a breakdown of the numbers of SRMNCH providers trained in each H4+ country in 2013; see Annex II for the total numbers of SRMNCH providers trained in all H4+ countries in 2013.)

Most of the individuals trained were already health care providers before the H4+ training. However, nearly 1,700 were members of local communities who are now able to provide information and services to their neighbours after undergoing training. And while most of the training took place within the programme regions, H4+ Canada also supported the training of institution-based trainers at the national level, thus laying a foundation for expanding the impact of the programme beyond the targeted regions. Didactic materials and equipment, including computers, diagnostic devices and vehicles were also provided and Ministries of Health received support in developing user-friendly training modules and rolling out OJT programmes. Health care providers were trained in family planning methods and youth-friendly services and retired midwives received incentives to cover facilities experiencing shortages of skilled providers. Emphasis was placed on competency-based learning, record-keeping of maternal and neonatal deaths and the “individuals, families and communities approach.”

Table 10. Total numbers of health care providers trained in 2013 in all five H4+ Canada countries*

<table>
<thead>
<tr>
<th>Maternal health</th>
<th>Newborn and infant care</th>
<th>HIV prevention and treatment</th>
<th>FP</th>
<th>Youth-friendly health care</th>
<th>Health Care Management</th>
<th>Health Care Technologies</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,738</td>
<td>1,412</td>
<td>429</td>
<td>1,338</td>
<td>202</td>
<td>382</td>
<td>35</td>
<td>6,536</td>
</tr>
</tbody>
</table>

* EmONC/ BEmONC/ CEmONC, Midwifery, MCH Aides, SRMNCH, MDR, IFC approach
Table 11 Output Area 4: Progress and Key Accomplishments

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

**Common indicator 4.1:** Proportion of health care providers trained in programme areas with adequate skills and knowledge according to national norms to provide EmONC services in the targeted districts during the last two years (Training of providers and managers in other SRMNCH areas is also included)

<table>
<thead>
<tr>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>73% (195/266)</td>
<td>40%, compared to 11% in 2012.</td>
<td>NA</td>
<td>60% (78/130)</td>
<td>30%</td>
</tr>
<tr>
<td>MNCH + PMTCT: 58%</td>
<td>(A total of 673 BEmONC workers were trained in 2012-2013)</td>
<td></td>
<td>2012: 38</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2013: 40</td>
<td></td>
</tr>
</tbody>
</table>

*A large number of skills enhancement trainings are going on in each country. During 2014, emphasize will be on establishing improving quality of trainings through appropriate assessments and supportive supervision.

Additional achievements:

**Burkina Faso:**
- Nearly half of all the training organized in 2013 was in Burkina Faso, where a total of 3,321 individuals were trained. A major focus was to support trainers and supervise trained CHWs in managing home-based newborn care.
- Training of instructors and coaches was carried out using modules for EmONC and PMTCT. This can form the basis of broader advocacy in favour of modular teaching in future.
- Twenty generalist physicians were trained in basic surgery, thus bringing emergency care nearer to communities that formerly lacked access.
- 125 health agents were trained to audit Maternal Deaths.
- A coach and supervisor were trained in the “School for Husbands” strategy that supports the involvement of men in the management of RH problems.
- 262 service providers trained in the “Individual, Family and Community” approach to health care.
- 140 health agents were trained in community monitoring.

**Democratic Republic of the Congo:**
- Seven health care training institutions received support from H4+ Canada.
- At the national level, 21 EmONC instructors were trained.
- Eighty service providers were trained in EmONC.
- Fifty service providers were trained in Family Planning.
- Fifty patient peer educators were trained.
- Sixty trainers and coaches in midwifery received instruction in the new competency-based methodology.

**Sierra Leone:**
- A total of 802 health care providers were trained, including BEmONC workers, midwives, MCH Aides, MCH Aides’ tutors and coordinators, school district health care focal points, CHC providers in BEmONC facilities and physicians trained in SRMNCH.
- Despite political uncertainties, all key staff positions have been filled, a Strategic Plan for HR/Health Policy was launched and a Draft HR Training Plan developed.

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16 An approach to teaching and learning focused on the acquisition of concrete skills.
• The NGO CUAMM is providing continuous medical education to health care providers in all 74 PHUs in Pujehun District.
• H4+ Canada funds were used to augment the payment allowances of 686 MCH Aide trainees and 168 tutors and coordinators.
• Two midwifery schools have been supported: 247 midwives out of a target group of 300 have been trained using funds from H4+ and DFID. The support went towards tuition and allowances for both students and tutors. Computer laboratories with Internet access to enhance knowledge and update students and tutors on current developments in midwifery were established in both schools. In-service training for 300 practicing midwives, State Enrolled Community Health Nurses (SECHN) and Medical Officers was provided between 2012 and 2013.
• Institutional support provided to School and Adolescent Health programme, including capacity-building and logistics (vehicles).
• Fifty health service providers (MCH-Aides, Midwives, Nurses, etc.) from northern and southern districts were trained on integration of HIV/FP
• Regional dissemination workshops on youth-friendly health care targeted district health management teams and line ministries: Local Government, Education, Gender, Women and Children Affairs.

Zambia:
• Twenty healthcare providers were equipped with emergency obstetric and newborn care skills.
• Thirty-one nurses received scholarships in midwifery, of whom 16 completed the course in 2013 and 15 are still being trained; hence the initiative has reached 44 per cent of its target.
• Ten healthcare providers received training in long-acting family planning methods.

Zimbabwe:
• An EmONC Training of Trainers workshop was conducted for participants from all six programme districts.
• All six districts also received support in providing training for Youth friendly service provision, IMNCI, WHO growth standards and assessment, revised child health cards and revised RI schedule, pediatric ART, comprehensive HIV care and treatment using peer educator HIV patients, community-based IMNCI.
• Forty facilitators for IMCI case management were trained. Subsequently, 112 health workers have been trained in IMCI case management from the six districts.
• 211 health workers in the six districts were trained to promote breastfeeding through the Baby-friendly Hospital Initiative (BFHI).

In addition to providing classroom instruction and hands-on training, every country produced a number of training materials, thus promoting the sustainability of the capacity-building process and providing a means to expand it more widely in each country.

Training materials produced in 2013 include:

**Burkina Faso:**
• Teaching materials, computer materials and anatomical models provided.
• Modules and tools for community-based health care providers were developed to promote home-based infant care. Training of providers will take place in 2014.
**Democratic Republic of the Congo:**
- Training modules for HIV management.
- Midwife training institutions received manikins.

**Sierra Leone:**
- Part of the H4 + Canada funds were used to support the development of a standard, comprehensive training curriculum and the first set of training modules were reviewed and updated.
- The MoHS was supported in the design and rollout of 10 modules on the MNH Continuum of Care and master trainers from districts and national programmes were trained to support the rollout. Seven of the 10 modules were made more user-friendly. The programme focuses on ToT and supportive supervision of cascade trainings to ensure quality.
- Three training modules for MCH Aides (introduction, basic nursing and anatomy) were upgraded as per the 2012 gap analysis and revised curriculum. They are being printed for distribution to MCH Aide schools in all 13 districts. In addition, six more modules have been updated and validated.
- The in-service design framework developed with H4+ support is being implemented by MoHS.
- Nine hundred copies of Adolescent and Youth Friendly Standards were disseminated to key implementing and support partners in all regions, laying the foundation for establishing youth-friendly facilities in 2014.
- Institutional support was provided to the School and Adolescent Health programme, including capacity-building and logistics (vehicles). All regional dissemination workshops have been conducted targeting all health facilities with a supply of the youth-friendly standards. Participants were district health management teams and line ministries, including Local Government, Education, Gender, Women, and Children Affairs.

**Zimbabwe:**
- Prior to the distribution of the 20 PoC PIMA CD4 count machines (which measure levels of HIV), 35 health workers were trained in how to use and maintain the machines. The knowledge and skills gained during training were reinforced through supportive and mentorship visits to the sites. As a result, there was a marked reduction in breakdowns of the machines.
- Two National PMTCT Focal Persons received laptops to ensure proper communications and timely generation and submission of PMTCT reports.

**Common indicator 4.2:** Number of active CHWs/village health workers trained in community-based SRMNCH services, including essential newborn care in the targeted districts during the last two years.

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

**Additional achievements:**

**Burkina Faso:**
- A total of 1,696 community-based health service providers received training in the two programme regions, including 1,200 community-based distributors of contraceptives; 754 community health workers were trained in the “Individual, Family and Community” approach to
health care. Community-based newborn and IMCI caregivers are now serving 90 per cent of the 257 Community Health Centres and 50 per cent of the 1,825 villages in the two programme regions.

**Democratic Republic of the Congo:**
- In 2013, 410 community health care providers were trained, compared to 136 in 2012, and 138 were training in Family Planning and Maternal and Newborn Health.

**Sierra Leone:**
- 100 Health Workers (Community Health Officers, Nurses, MCH Aides) were training in BEmONC.

**Zambia:**
- A total of 160 community volunteers (Safe Motherhood Action Groups and community-based distributors of contraceptives) have been trained in MNCH and family planning to increase community awareness. This represents 40 per cent of a total of 400 volunteers.

**Zimbabwe:**
- 288 community-based health workers received training in infant feeding and 122 community-based health workers were trained in IMNCI.

**OUTPUT 5: Health information systems, monitoring and evaluation**

This area refers to the production, analysis, dissemination and use of reliable and timely information on areas that include, but are not limited to, health determinants, health system performance, health status of the population and national health accounts.

Each of the five H4+ Canada countries made progress in the area of health communication, monitoring and evaluation in 2013. Tools for these activities were provided both in the target regions and at the national level, thus laying a foundation for scaling up these activities country-wide.

**Table 12. Output 5: Progress and key accomplishments**

<table>
<thead>
<tr>
<th>Common indicator 5.1: Proportion of targeted districts that have submitted timely and complete reports as per national guidelines and schedules during the last 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
</tr>
<tr>
<td>Baseline: N/A</td>
</tr>
<tr>
<td>2013: 100%</td>
</tr>
</tbody>
</table>

**Additional achievements:**

**Democratic Republic of the Congo:**
- All nine health zones supported by H4+ Canada received tools for data collection (PNC registers, childbirth registers, partographs and monthly reporting tools), which are also being used in other health zones outside the target area.

**Sierra Leone:**
- All districts submitted reports, but some were late because the Department of Policy, Planning and Information at the MoHS was closed for nine months.
Zambia:
- The government received support to develop tools to strengthen the national civil registration and vital statistics systems. H4+ Canada is one of several partners supporting the MoH in assessing the HR information system to create a national observatory for HR for health.

Zimbabwe:
- The M&E framework was revised to capture output indicators outlined by H4+, enabling it to demonstrate the impact of the programme at output level. It was also synchronized with the Sida log frame. A monthly data collection tool was developed and shared with all districts to facilitate the submission of monthly reports. Quarterly M&E visits to the six districts were conducted by H4+ Canada, in collaboration with MoHCC and ZNFPC, to assess the implementation of the ASRH programme, specifically the Youth-friendly Corners.
- H4+ participated in a National HMIS planning meeting. Advocacy continued on including disaggregated data on young people in the national MNCH HMIS – from data collection tools to reporting formats at every level.
- A baseline survey report produced by CCORE in 2012 was endorsed by MoHCC.
- Three assessments were conducted to understand the perception of communities on key MHCH / RH / HIV and ASRH issues: 1) on maternal health problems and barriers to accessing services, 2) on approaches to reaching adolescents and young people with information and services on ASRH, and 3) on the awareness of community leaders, health workers, parents, young people and church leaders on ASRH services and HIV through focus group discussions. These assessments identified several gaps in correct knowledge and in information about access, availability, and quality of services. Findings from these assessments have the potential to guide the project’s future programming.

### Common indicator 5.2: Proportion of targeted districts with established and Functioning Maternal Death Surveillance and Response mechanisms, including Maternal Deaths Reviews

<table>
<thead>
<tr>
<th>Baseline: N/A</th>
<th>Baseline: 0%</th>
<th>Baseline: 8%</th>
<th>Baseline: 75%</th>
<th>Baseline: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013: 100%</td>
<td>2013: 0%</td>
<td>2013: N/A</td>
<td>2013: 100%</td>
<td>2013: N/A</td>
</tr>
</tbody>
</table>

Additional achievements:

**Sierra Leone:**
- The MoHS received support in conducting a collation and analysis towards the development of the 2013 MDSR. The MoHS was also supported by an international specialist to assess the MDR process to help identify, analyse and fill gaps and develop a framework for community-level MDR.
- Awareness-raising and sensitization sessions on MDR were held in two districts (Bo and Kono) and the blood transfusion unit received support to carry out sensitization for blood donations.

**Zambia:**
- Technical support was provided to the government to develop national road maps for MDSR and training of trainers to promote the implementation of MDSRs.
**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.

<table>
<thead>
<tr>
<th></th>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proportion</strong></td>
<td>90% (of health facilities monitor facility and community activities annually.)</td>
<td>100% (No district performed a quarterly review of HMIS data in 2013, but plans are in place to review HMIS data at district level in all districts. This is currently ongoing.)</td>
<td>80%</td>
<td>(Districts perform quarterly reviews during District Health Team meetings; more support will be given in 2014.)</td>
<td></td>
</tr>
</tbody>
</table>

*Community engagement processes that requires quarterly meetings with community leaders exist but to what extend they are effectively reviewing progress for evidence based planning cannot be established through above data.

**OUTPUT 6: Health service delivery**

This area includes strategies/activities to improve people’s health by providing comprehensive, integrated, equitable, quality and responsive essential health services. It includes guidance and tools, infrastructure and supply chain, but not training.

In every programme country, the provision of SRMNC services was strengthened in 2013, and in many cases made more accessible in hard-to-reach areas. People were made aware of the availability of these services and the capacities of service-providers were strengthened. The numbers of health care facilities providing EmONC services in areas supported by H4+ Canada are shown in Table 13 below.

**Table 13 Output 6: Health service delivery**

<table>
<thead>
<tr>
<th>Populations of target areas</th>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2012</strong></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total population of H4+ target areas: 2,964,424 (16% of national population).</td>
<td>Total population of H4+ target areas: 15,400,000 (23% of national population).</td>
<td>Total national population (H4+ target areas in 2013): 5,743,725.</td>
<td>Total population of H4+ target areas: 643,000 (5% of national population).</td>
<td>Total pop. of H4+ target areas: 1,367,267 (10% of national population).</td>
</tr>
</tbody>
</table>

- 5 BEmONC
- 4 CEmONC
- 15 general referral hospitals
- 141 maternity clinics.

- 65 BEmONC facilities
- 13 CEmONC facilities (in line with government priorities).

- 30 health EmONC facilities (five CEmONC and 25 BEmONC) in the five H4+ districts

- 7 health facilities provide BEmONC services;
- 4 BEmONC;
- 2 CEmONC.

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17 BEmONC-1 refers to facilities that offer six of the seven signal functions of BEmONC.
| 2013 | 71 health care facilities in the 2 target regions received support from H4+ Canada for EmONC. This represents 27% of the 266 facilities in the 2 regions. Of the 71 supported facilities, 62 are CSPS, located in administrative centres and 9 are CMAs. | Unchanged since 2012. However, a total of 542 facilities in the 3 target regions do provide pre-natal consultations, PMTCT and PNC. | Sierra Leone has about 1,205 PHUs; most offer delivery services. Of these, 65 were upgraded to BEmONC centres (5 in each of the 13 districts). 13 hospitals provide CEmONC. | Unchanged since 2012. | Data to be updated after completion of EmONC assessment. |

**Additional achievements:**

**Burkina Faso:**
- Family Planning services are available in nine hospitals and 257 Social Promotion Health Centres, as well as in 1,568 villages with no SPHC.
- Health care providers were trained and supervised in BEmONC, IMCI, FP, PMTCT, IMCI-HIV and basic surgery in all districts of both regions. Equipment was provided for BEmONC and for newborn resuscitation and three ambulances and 15 motorcycle ambulances also were delivered. (The costs of petrol, maintenance and a driver are covered by government and district funds.) Monitoring, follow-up and evaluation were carried out and supply records for maternal mortality and reproductive health products were maintained in order to support decision-making.
- All of the 257 health centres in the two target regions offer at least three modern methods of contraception and 18.25 per cent of villages at a distance of more than 10 km from a health centre are covered by community-based distributors of contraception.
- To support this output, 11 activities were defined and ten (90 per cent, with the exception of essential newborn care at the community level) have been partially realized. The latter activities should be facilitated by the validation of training modules and the training of community health workers.

**Democratic Republic of the Congo:**
- Sixty per cent of health care facilities offer at least three modern methods of contraception.

**Sierra Leone:**
- Anecdotal evidence shows significant improvements in service delivery for antenatal, postnatal and skilled birth attendance. Data gathered at the main referral hospital in Freetown shows that obstetric admissions increased from 1,533 in 2009 to 7,309 in 2013 and hospital deliveries increased from 1,709 in 2009 to 3,717 in 2013.
- Adolescent-friendly standards are being disseminated to all key implementing partners in four provinces; the process has been completed in two provinces.
- H4+ funds enabled six districts to conduct integrated, community-based outreach to improve access to high-impact MNCH interventions among hard-to-reach populations. Two CEmONC facilities serving marginalized groups received generators for electricity and one Centre providing prevention, treatment and support for fistula patients also received an incinerator. H4+ Canada

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funds supported the installation of solar suitcases\textsuperscript{18} in 40 BEmONC facilities country-wide, as well as supporting the recommissioning of 27 rehabilitated health facilities in five districts, complementing an ADB/UNFPA district-strengthening project.

- In partnership with VSO and CUAMM, H4+ catalytic funds supported OJT in providing supervision, mentoring and coaching of community-based MNH workers in hard-to-reach areas in all 14 districts of the country.

**Zambia:**

- Significant improvements in service delivery were recorded for antenatal, postnatal and skilled birth attendance in all five districts. The referral system was strengthened through the provision of five ambulances, one for each district, and high frequency communication radios for 30 target facilities (50 per cent of the total). Five maternity units with maternity waiting shelters (33 per cent of the total) are being rehabilitated to improve quality and access to facility delivery for hard-to-reach populations.
- In order to improve infrastructure and referral systems for delivery and EmONC services, rehabilitation work on delivery rooms and maternity waiting shelters was initiated.
- Two districts provided baby layettes as incentives for facility delivery, as evidence indicates that this increases demand for institutional delivery.
- All districts received support to conduct integrated, community-based services to improve access to high-impact MNCH interventions in hard-to-reach areas.
- Twenty retired midwives were contracted and compensated to fill staff vacancies in health facilities, thus increasing access to skilled birth attendants in the five target districts. Furthermore, off-duty staffs are motivated to cover facilities experiencing skilled provider shortages through the provision of incentives provided with H4+ funds. This has resulted in an increase in skilled birth attendants.

**Zimbabwe:**

- Visits from the MoHCC and other partners to target districts reported a significant increase in the uptake of PMTCT services and an improvement in data-capturing and reporting.
- Mentorship of Health Workers in MNCH, including PMTCT and IYCF, has had remarkable impact on men: an increase in the number of males tested for HIV (4,257 males in two districts) and an increase in the number supporting their wives in ANC and PNC services. Health Centre Committees were revived to support MNCH + PMTCT services in rural areas. In two districts, monthly outreach services were started in hard-to-reach areas.
- With support from programme-trained nurses, adolescents living with HIV initiated support groups in their districts to educate and support one another on issues related to relationships, disclosure and treatment adherence.
- Twenty-four Peer Educators (including 12 PLHIV) started working in the six district hospitals and surrounding communities.
- C-section increased from 1.14 per cent of all deliveries in 2011 in 2.2 per cent in 2013 in five of the six districts.
- In one district (Hurungwe) the number of new young people under age 24 accessing FP services from Youth-friendly Health Facilities increased from 785 in 2012 to 2,212 in August 2013.

\textsuperscript{18} Portable, cost-effective Solar Suitcases power critical lighting, mobile communication and medical devices in low-resource areas.
**Common indicator 6.2**: Proportion of ANC and delivery services in targeted districts that provided PMTCT services according to national guidelines.

<table>
<thead>
<tr>
<th></th>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Baseline</td>
<td>100%</td>
<td>33%</td>
<td>58%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

That data source is HMIS and may be underestimated. Furthermore, the baselines in the three health intervention regions are in the range of 15-40% whereas for other countries baseline is 80%+.

**Additional Achievements:**
**Burkina Faso:**
- All of the 257 health centres in the two target regions offer at least three modern methods of contraception and all offer long-term, advanced-strategy methods.
- 18.25% of villages at a distance of more than 10 km are covered by community-based distributors of contraception.

**OUTPUT 7: Demand, including community ownership**

This area refers to a representative mechanism that allows communities to influence the policy, planning, operation, use and enjoyment of the benefits arising from health services delivery. It also refers to the community taking ownership of its health and taking actions and adopting behaviours that promote and preserve health.

A number of innovative strategies were carried out in the five countries, which enabled community members to actively engage in, and take ownership for, strategies and activities that promote SRMNCH. The results of this community involvement can be far-reaching, promoting behaviour change and helping communities plan and advocate for better health care. In 2013 demand was created through community mobilization, public awareness and sensitization campaigns, as well as marketing, advocacy and the establishment of community groups and local committees. The deployment of community volunteers and the engagement of community leaders were also effective in creating demand for SRMNCH services.

**Table 14 Output 7: Progress and Key Indicators**

| Common indicator 7.1: Number of active community groups (safe motherhood groups, volunteers, etc.) or rural committees established in targeted districts. |
|-------------------------------------------------|-------------------|----------------|--------|--------|--------|
| **Burkina Faso**                                | **DRC**           | **Sierra Leone** | **Zambia** | **Zimbabwe** |
| Baseline: N/A                                    | Baseline: 9       | Baseline: 85    | Baseline: N/A |
| 2013: N/A                                       | 2013: 9 community | 2013: 201      | 2013:    |
| All of the 257 health centres have management  | groups focused on | community groups | Baseline: N/A |
| committees.                                      | MNH were created  | were active in  | 2013:    |
|                                                 | in 2013.          | 13 districts,  | 66 communities |
|                                                 |                   | including 173 CAGs | sensitized on |
|                                                 |                   | and 28 Male Peer | MNCH to     |
|                                                 |                   |                 | enhance healthy |
|                                                 |                   |                 | 2013:      |
|                                                 |                   |                 | Baseline: 0 |
|                                                 |                   |                 | 2013:      |
|                                                 |                   |                 | 20 safe motherhood |
|                                                 |                   |                 | groups in the 6 |
|                                                 |                   |                 | districts.    |
### Educator groups in the two new target districts.

100 communities sensitized to enhance community ownership of SRMNCH.

1 community-level ASRH committee established.

### Additional achievements:

#### Burkina Faso:

- H4+ Canada enabled Burkina Faso to carry out two new strategies: The School for Husbands and social marketing of ASRH.
- Ten School for Husbands have been established. Local administrators and community and religious leaders were involved in sharing information about the strategy and content of the plan of action and identifying health centres and social promotion sites for establishing Schools for Husbands on the basis of maternal health indicators. An advocacy workshop was organized to recruit a coach and supervisors. Next on the agency will be training, equipment and a plan of action for deploying SFH in schools.
- For the social marketing of ASRH, a study was conducted on basic RH knowledge, aptitudes and practices among youth in Kaya and Ouahigouya districts to support the launch of the demand-creation phase in the two district regional health departments through theatre, discussions, a pre-tested mass media campaign promoting RH among adolescents and youth, supervision of ASRH/HIV activities and coordination of activities through field visits.

#### Democratic Republic of the Congo:

- A door-to-door social mobilization campaign covering markets, churches, women’s and youth centres was carried out to increase demand for Family Planning services and institutional delivery.
- A plan to promote men’s involvement in SRMNCH was carried out with the help of traditional and religious leaders, 300 of whom received training and created a network to reach out to churches and communities.
- 410 community agents were trained and are being supervised to promote the sustainable use of community-based SRMNCH services.

#### Sierra Leone:

- In all 13 districts, communities were sensitized about MNCH. Traditional birth attendants, now called Community Wellness Advocates, trained to promote MNCH, received support in conducting outreach activities to refer clients for institutional delivery, FP and GBV. H4+ Canada funds continued to support integrated community interventions in SRH/GBV through the training of CAGs.
- Male Peer Educator resource centres that mainstream men in SRH/GBV interventions and refer clients for SRH/GBV services are fully functional in two pilot districts. Twenty-eight Peer Educator coordinators were trained to coordinate all activities of PENs in the target communities. Outreach sensitization activities by CAGs were supported in all the districts, increasing access to MNCH services through referrals.
- To enhance gender equality and rights, a community outreach sensitization programme on legal
advice and social counseling was carried out in four communities, two of them disadvantaged. This programme reached 300 women, men and adolescents in 2013. The NGO LAWYERS supported two health facilities in providing free medical care for 500 GBV victims.

**Zambia:**
- Community ownership, engagement and participation in maternal health programmes increased. Twenty self-help outreach shelters for MNCH services were constructed (four in each H4+ district) and 106 community volunteers (40 per cent of the total) were trained as Safe Motherhood Action Groups (SMAGs). They promote Family Planning and hope to be trained as community-based promoters of FP methods.
- Traditional leaders were engaged as champions for adolescent health, reducing adolescent pregnancies and early marriages and maternal health.

**Zimbabwe:**
- With additional funding from other sources, community mobilization – road shows, dialogues with community and church leaders, parents and young people – was conducted in all six districts to increase demand for ASRH. Community leaders in Mbire established ward-level ASRH committees and support groups for young people living with HIV, which meet regularly in the communities. In Mbire, activities including sports and dialogues in schools have been initiated. Community leaders and schoolteachers in the targeted districts are now supporting ASRH and HIV interventions.

**OUTPUT 8: Communication and advocacy**

This area includes community mobilization activities, radio programmes/campaigns, messaging, etc.

Output 8 was one of the most successful output areas in 2013. A wide variety of innovative communication activities were carried out in nearly all programme countries, a number of which reached the national level. Activities included television and print media campaigns, the production of radio soap operas, community theatre, billboards, advocacy with regional authorities, conferences, messaging and the involvement of high-profile champions of SRMNCH. H4+ Canada supported government ministries at the national level in planning and executing communication campaigns and producing and distributing information and behaviour-change materials. It enlisted the collaboration of religious and community leaders in raising public awareness about HIV prevention, SRMNCH and Family Planning. Additional topics covered by these communication
campaigns in 2013 included fistula, harmful traditional practices, vaccination, PMTCT and key family practices.\textsuperscript{19}

### Table 15. Output 8: Progress and Key Achievements

| Common indicator 8.1: Proportion of targeted districts with demonstrable social mobilization programmes that include at least two of the following communication themes: prevention of early pregnancy, expanding knowledge of key family practices, HIV prevention, importance of breastfeeding, recognition of danger signs during postnatal care for mothers and newborns. |
|---|---|---|---|---|
| Burkina Faso | DRC | Sierra Leone | Zambia | Zimbabwe |
| Baseline: 0% 2013: 100% | Baseline: 0% 2013: 100% | Baseline: 21% 2013: 100% | Baseline: 100% 2013: 100% | Baseline: 0% 2013: 100% |

The reported progress indicates organization of social mobilization programmes by H4+ and other sources.

**Additional achievements:**

**Burkina Faso:**

- H4+ Canada provided support to a regional advocacy campaign on Family Planning using RAPID messaging. It also supported broadcasts of a radio soap opera covering issues such as maternal health, FP, gender, fistula, FGM/C, vaccination and key family practices.
- A major focus of advocacy was on creating a demand for Family Planning. TV spots in local languages on the prevention of unwanted pregnancies in youth between the ages of 15 and 24 were aired on three networks a total of 351 times. The spots were also adapted for radio and aired 800 times on four TV stations. The programme distributed 4,884 posters to health centres and other localities on subjects such as danger signs during pregnancy, childbirth and immediately after. Other radio spots on SRH and FP aired on 20 stations. Brochures, documentary films and newspaper articles were also published, aimed primarily at decision-makers. Other populations targeted included vulnerable and/or marginalized groups, students, street vendors, the disabled and sex workers. Advocacy was conducted at the national, regional and community levels among decision-makers, government authorities, administrators and traditional, religious and community leaders.
- The First Lady presided over the country’s second Family Planning Week in June 2013 to commemorate the campaign, Africa’s Fight against Maternal Mortality.
- A demand-creation social marketing campaign targeted ASRH in both programme regions, starting with a baseline study on knowledge, attitudes and practices in SRH.
- RAPID SMS was used to raise awareness and promote active engagement among decision-makers.

**Democratic Republic of the Congo:**

- Following H4+ advocacy, the government allocated funds for contraceptives, medical equipment, materials and the refurbishment and/or construction of 198 hospitals and 1,320 health centres.
- A media campaign on PMTCT was launched on radio, television and in print.

\textsuperscript{19} UNICEF developed a list of Key Family Practices to ensure the health and development of newborns and young children. [http://www.unicef.org/nutrition/23964_familypractices.html](http://www.unicef.org/nutrition/23964_familypractices.html)
• A national conference on AIDS, “A Generation without AIDS” was held for 300 participants under the auspices of the President of the Republic and the patronage of the Prime Minister and the Minister of Health.

• In partnership with Radio Okapi, which broadcasts to all of the country’s 11 provinces, H4+ Canada supported radio programmes on maternal and neonatal health.

**Sierra Leone:**

• Community mobilization activities included radio programmes, campaigns and messaging. Sixty religious leaders received orientation on HIV/AIDS and male condoms were distributed.

• Family Planning and PMTCT were integrated into Mother and Child Weeks, held annually in May and November.

• The office of the First Lady continues to engage traditional and religious leaders on SRH, with particular focus on FP and teenage pregnancy, as part of her CARMMA activities.

• Sixty PLHIV in two districts were sensitized about Family Planning and safer sex.

• A total of 630 individuals – 350 Community Advocacy Group members and 280 Male Peer Educators (surpassing a combined target of 500) – were trained to advocate for key SRMNCH issues, including FP, institutional deliveries and the prevention of GBV and FGM/C.

**Zambia:**

• Support was provided for the 2013 National Safe Motherhood and Child Health weeks in line with CARMMA. The visibility of these initiatives was enhanced through billboards and roll-up pop-ups. (District-specific banners on a retractable stand that can be rolled up to display desired messages.)

• Behavioural Change Communication materials (including baby wrappers) bearing key MNCH messages and stamped with the logos of the Zambian government, Canada and One UN in Zambia were procured.

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

<table>
<thead>
<tr>
<th></th>
<th>Burkina Faso</th>
<th>Democratic Republic of the Congo</th>
<th>Sierra Leone</th>
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Advocacy campaigns in **Burkina Faso** and the **Democratic Republic of the Congo** resulted in substantial financial commitments to SRMNCH on the part of these national governments.

**Additional achievements:**

**Burkina Faso:**

• Continuous advocacy with government and the National Assembly maintained a regular budget line of around US $1 million for the purchase of contraceptive products.

• An advocacy campaign resulted in a 50 per cent reduction in the cost of contraceptives, to take effect in 2014.

**Democratic Republic of the Congo:**

• After CARMMA was launched in Bandundu Province, a line item for MNHC was included in the 2014 provincial budget. The Bandundu government has pledged to increase the amount of this line item.
• Advocacy with the national government resulted in the allocation of funds for the purchase of contraceptives, equipment, materials and refurbishment of 198 hospitals and 1,320 health centres.
• An awareness-raising campaign resulted in many households taking out health insurance in Bandundu province. The Mutual Health Care Fund of Bandundu was launched with 1,012 beneficiaries. In Kenge province, the Health Care Fund was improved and now has 3,654 beneficiaries compared to 2,800 in 2012.

Sierra Leone:
• All Coalition, a civil society network, conducted community sensitization and a stakeholders’ meeting with government and other partners to raise awareness on MDR. This improved reporting at the community level.
• A civil society group adapted the documentary “Why Mrs. X died” in the local language. It is now being broadcast on National TV and on mobile screens in the communities as an advocacy tool for MDR. In addition, MDR awareness-raising workshops for service providers were held in two districts and a civil society network conducted community sensitization to raise awareness on MDR. This improved reporting at the community level.
• A voluntary blood transfusion drive helped sensitize the public on the need to provide blood in hospitals as a lifesaving intervention. The session produced 40 units of blood.
• An orientation on SRMNCH with special focus on teenage pregnancy, Family Planning and HIV/PMTCT was held for traditional and religious leaders by FINE/SL, a leading network that promotes gender equity.

Zambia:
• The H4+ programme continued to strengthen the capacity of healthcare providers to plan Communication for Development (C4D). This resulted in the development of district-specific C4D plans that include the production of appropriate IEC materials, radio broadcasts and dramas for MNCH community sensitization.
• H4+ Canada supported the national Family Planning campaign launched by the First Lady to raise awareness on the importance of FP and the reduction of maternal morbidity and mortality.

Zimbabwe:
• H4+ participated in the national HMIS planning meeting, advocating for including disaggregated data on young people in national MNCH HMIS – from data collection tools to reporting formats at every level. MDR has now been added to the MoH’s weekly surveillance system report, after advocacy during and after the MDSR regional meeting in South Africa in May. This development is a significant step in strengthening MDSR. H4+ supported the development of MDSR guidelines and tools for conducting Maternal and Perinatal Death Audits, which are being printed.
• H4+ participated in, and supported, the mid-term review of the ASRH strategy. Advocacy for the interventions to be evidence-based and to include innovations based on regional good practices was carried out. This resulted in an age-appropriate breakdown of interventions as well as the introduction of innovations using new technologies to reach out to larger numbers of young people.
• Community mobilization for the ASRH programme was conducted in all six target districts. The community meetings included traditional leaders, in some cases chiefs and religious leaders. Community support for ASRH is evident; for example, one community helped build a Youth Corner at their health facility.
3.2 Catalytic Nature of Activities and Accomplishments

In each of the five countries supported by H4+ Canada, specific activities and interventions catalyzed ongoing activities and accomplishments, often helping to move the impact of the H4+ programme beyond target regions to the national level. Other, complementary initiatives were led by in-country entities such as the MoH, NGOs and other bilateral agencies.

The main areas of catalytic effects that took place in 2013 included: (1) the strengthening of leadership; (2) complementarity of H4+ interventions with programmes supported by other partners, thus promoting national coverage; (3) enhancing skills for creating resource pool of trainers at the national and sub-national levels by deploying national-level health care training plans, standards and tools; (4) legislation relating to reproductive health; (5) interest from other donors in funding SRMNCH and (6) strengthened mechanisms and processes for capacity-building of institutions and individuals at all levels.

**Burkina Faso:**
- Support was provided to the drafting of a National Health Care Human Resources development plan and its three-year work plan, to the training of skilled health care providers, the dissemination of policies and the national-level implementation of interventions.
- The availability of health care products was strengthened, as were the health information system, health care service delivery and health financing (i.e., cost-sharing).
- H4+ is having a positive effect on other programmes and in other regions of the country. For example, the development of human resources for health care planning is benefitting the entire health system. Technical support for national ministries, the production and distribution of reference materials and capacity-building in schools and health facilities all have a positive impact on the national health system. In fact, the graduates of technical schools and physicians whose skills have been upgraded thanks to H4+ Canada are now deployed in hospitals beyond the two programme regions, thus contributing to the provision of quality health services throughout the country.

**Democratic Republic of the Congo:**
- In order to raise awareness about MNCH, Family Planning and PMTCT, meetings of partner organizations, parliamentarians and civil society focused on the state of SRMNCH in the country. Line items on SRMNCH have been included in the national and provincial budgets.
- In order to ensure that SRMNCH actors and interventions at the national and provincial levels are coordinated, reports on all H4+ activities are being made available, norms and directives have been developed and their content made accessible and tools are consistent throughout the nine Health Zones of the programme. Meetings of the MNCH Task Force are held at all levels and planning in the nine target health zones has been supported and strengthened.
- A total of seven health care training institutions are receiving support to upgrade the quality of the training they offer to providers who will be deployed throughout the country.
- HMIS registers and data collection tools have been reproduced and are being used in other health zones outside the nine target zones.
• Support for provincial health departments (such as quarterly reviews, training in monitoring and evaluation, support for follow-up and supervision, etc.), as well as advocacy with the provincial assembly and the launch of CARMMA – all these activities have had an impact beyond the nine Health Zones covered by the project.

• At the national level, beyond the programme target areas, the catalytic effects of H4+ Canada activities include the regulation of the profession of midwifery, the strengthening of the MNCH Task Force; advocacy in support of MNCH at the National Assembly; the launch of the MDG Acceleration Framework; the development of a new national EmONC training curriculum and the drafting of new law on reproductive health.

• In addition, H4+ Canada has attracted other donors to the support of MNCH. The Korean International Cooperation Agency (KOICA) identified gaps in MNCH in two programme provinces. These gaps will be covered by KOICA in a programme in 14 Health Zones in two provinces.

Sierra Leone:

• H4+ Canada continues to enhance and compliment efforts to improve maternal, newborn and child health by building on gains made by other efforts such as the Free Health Care Initiative, the IRMNH Programme funded by DFID, and community interventions in MNH funded by Canada. DFID and other funding sources.

• H4+ Canada support to EmONC training has resulted in a commitment to increase the number of facilities benefitting from this training from 78 to 130 over the next two years, complementing additional funding provided by the RMNCH programme supported by DFID.

• H4 continues to foster close collaboration between the Implementing agencies as well as the partnership between the UN and the ministry through a mechanism created for meeting on a regular basis.

• There are also possibilities of spill-over into other countries. Pujehun, one of the 2014 pilot districts, shares a border with Liberia and Port Loko district is less than an hour from the Guinean border. Health centres in these districts provide free treatment care and support for fistula patients, as well as EmONC services for vulnerable women, and girls and patients from Liberia and Guinea access these services.

Zambia:

• In 2013, H4+ Canada funds were catalytic in supplementing government funding for district plans. The government provided monthly operational grants to the districts for service delivery and capital expenditure, as well as paying salaries for staff, including those of the H4+ Canada initiative.

• Also in 2013, the government awarded tenders for the construction of 650 equipped health posts countrywide.

• A National Human Resources for Health Strategic Plan for 2011-2015 and a National Training Operational Plan are in place.
Zimbabwe:

- Draft mentorship tools, developed in 2013, will be pre-tested and piloted in the six districts supported by H4+ Canada. After the pilot, use of these tools is expected to be cascaded to all the districts with funds from other sources. Not only will this act as a catalyst for strengthening mentorship in MNCH at the national level, it will also help reduce the need for expensive capacity-building initiatives under the MNCH programme.

- The 20 (PoC) PIMA machines procured by H4+ to measure CD4 counts were turned over to MoHCW, which distributed them to high-volume sites in the six districts to increase access to ART among pregnant and lactating women. The introduction of these machines contributed to a significant increase in the number of pregnant and lactating women being tested and accessing ART in sites providing these services. For example, in Gokwe North district, the number of women tested for CD4 counts increased to 88 per cent by the end of December 2013 and the number HIV +ve women accessing ART based on their CD4 count more than doubled. The effectiveness of the PoC PIMA machines has generated so much interest within the MoHCW and among other partners that additional machines have been bought to support CD4 count services. To date, the country has over 300 machines. The MoHCW is working on guidelines to standardize the use and maintenance of the machines.

3.3 Achieving Gender Equality

Support for gender equality underlies all of the initiatives of H4+ Canada. Not only does the programme support women’s reproductive health and safe childbearing, in every country it closely involves government ministries that focus on women, thus supporting their efforts and providing valuable learning experiences and capacity-building. Innovative initiatives such as Burkina Faso’s awareness-raising radio soap opera on reproductive health and its School for Husbands project, for example, are important strategies to support behaviour change. These and other initiatives can have a catalytic effect by serving as models for other countries.

Burkina Faso:

- Gender awareness is a major goal of the radio soap opera on reproductive health, currently being broadcast, which highlights problems of men and women, gender issues and human rights and ways to involve communities in health care management.

- The “School of Husbands” strategy also helps strengthen the gender-based approach. It is based on the theory that if men constitute obstacles to improvements in health, they can also be an important part of the solution to these problems. The approach uses “model” husbands chosen on the basis of clearly defined criteria who have a positive influence on the behaviour of their peers in support of women’s reproductive health. This strategy was actively implemented in 2013 and has generated real enthusiasm, not only through the involvement of community leaders but also because of the husbands who participate. Personal stories told by members of Schools for Husbands and by traditional leaders at the 2013 annual meeting indicate that in future, men will become increasingly involved in solving reproductive health problems.
Democratic Republic of the Congo:

• The H4+ Canada programme ensures that data are disaggregated by age and gender. For example, Kenge’s Mutual Health Insurance plan currently services 1,240 women, 956 men and 1,458 children.
• Advocacy with parliamentarians resulted in the adoption of the Reproductive Health Law (which replaces a previous law prohibiting the promotion of Family Planning). The new law has been ratified by the President of the Republic.
• A plan to involve men has been put in place in the Health Zones with the participation of traditional and religious leaders.
• A workshop was held to establish the use of a Gender and HIV tool at the Ministry of Gender. The validated tools are currently used by the Ministry to collect data disaggregated by age and gender.
• A workshop was also held validating a study on sexual/gender barriers to PMTCT in the Kinshasa Province. The results of study are currently used in the implementation of the National eMTCT Plan.

Sierra Leone:

• In all 13 districts of the country, traditional birth attendants, in their new role as Maternal and Child Health Promoters (or Community Wellness Advocates) are trained and supported with outreach activities that enable them to refer clients for institutional deliveries, Family Planning and problems of gender-based violence.
• To enhance gender equality and rights, a community outreach sensitization programme including legal advice and social counseling by the NGO LAWYERS was carried out in four disadvantaged communities.
• The involvement of male peer educators in addressing SRH issues through referrals has increased the acceptance of Family Planning and raised awareness among men – including traditional and religious Leaders – on SRH and gender-based violence, including FGM/C.

Zambia:

• MNCH programming in Zambia provides equal opportunities for men and women community volunteers to provide information, sensitization and services for safe motherhood. This promotes male involvement and participation in MNCH programming. The five districts participating in this initiative were selected because they are rural and remote; support is being provided to improve performance in promoting social inclusion.

Zimbabwe:

• The recruiting of peer educators provides equal opportunities for boys and girls. Adolescent boys and girls are also recruited to ensure the meaningful involvement of young people living with HIV and help address issues of HIV treatment and adherence, as well as stigma and discrimination. At least four peer educations (two boys and two girls) facilitate ASRH activities in each targeted hospital. Recreational services that are provided take into account the different needs of boys and girls. Efforts are also being made to increase the participation of female youth in ASRH activities.
• In two of the target districts, influential community members are receiving support in mobilizing male partners for HTC and couple counseling and to strengthen PMTCT services. Community support groups for lactating mothers are being established to promote exclusive breastfeeding and positive infant-feeding practices.

3.4 Ensuring the Sustainability of Results Achieved

In 2013 country reports indicate that efforts to achieve sustainability are intrinsic to activities such as (1) capacity building of local institutions; (2) the development of laws and policies to ensure access to, and delivery of, quality RMNCH services; (3) sensitizing stakeholders and developing buy-in at central and district levels; (4) integrating/coordinating H4+ efforts with those of other national initiatives and (5) ensuring up-to-date technical quality of materials for training and strengthening service delivery systems. Burkina Faso was able to maintain a budget line item of US $1 million for contraceptives and in DRC, provincial governments pledged to increase resources for MNCH through a budget line, which has already been included in the 2014 Bandundu provincial budget.

Democratic Republic of the Congo:
• The Reproductive Health Law, including articles on Family Planning, will set the stage for improvements in FP programming as well as EmONC. This means that the government is once again responsible for ensuring access to quality health care for mothers and babies.
• The National Reproductive Health Programme includes modules that are being used to train EmONC providers, including in OJT.
• The availability of appropriate training modules and management tools as part of Mutual Health Insurance plans will ensure the standardization of this approach.
• The national RH and HIV programmes contain guides and training modules in HIV management that will improve the integration of HIV services in RH.
• The revision of the midwife training curriculum will produce sustainable improvements in the basic training of midwives and will be applicable to all basic training institutions.
• The maternity waiting facility that was repaired in Mosango provides improved access for all members of the community.
• The strengthening of national capacity as a result of H4+ evaluations is a benefit that will outlast the H4+ Canada programme.

Sierra Leone:
• Technical support to develop and apply appropriate tools to implement adolescent health and youth-friendly programmes (such as the national training kit modules, plans and standards) has enabled MoHS to provide leadership and capacity-building in fast-tracking the government’s commitment to reduce teenage pregnancy.
• The goal of increasing the number of skilled birth attendants is being fast-tracked by upgrading the competencies of MCH Aides and updating training modules based on the 2012 revised curriculum.
• The Maternal Death Review (MDR) process, initiated in 2010 with the aim of monitoring how many women die, where they die and why has been rolled out nation-wide with H4+ Canada support. A rapid assessment conducted in 2013 indicates that most objectives have been implemented but that the structures and processes for investigating maternal deaths need to be strengthened, including the improvement of death notification through vital registration. As recommended by the Commission on Information and Accountability, the MoHS will also make progress on MDSR by building on the already-established Notification and Investigations of Events (MDR) system and linking it to the existing public health surveillance system in order to ensure that the provision of information is followed by response.

• The DHMT reports that support front-line health workers by introducing/improving high-impact MNCH interventions that use specifically designed operational tools are beginning to show results in infection control, partograph use, appropriate EmONC technologies and supportive supervision mentoring and coaching of MNCH Aides.

• The involvement of male peer educators in addressing SRH issues through referrals has increased the acceptance of Family Planning, as well as awareness of SRH and gender-based violence (including FGM/C) among men, especially traditional and religious leaders.

Zambia:

• Good collaboration between the H4+ agencies and leadership by the relevant government ministries is a positive indicator of the sustainability and ownership of this programme.

• The H4+ Canada initiative is in line with the national decentralization process of strengthening the capacities of the district health sector. It has become an integral component of district-level planning, in accordance with the government’s national framework and priorities and its emphasis on accelerating high-impact interventions for MDGs 4 and 5.

• The programme’s capacity-building for human resources will ensure that the provision of high-quality MNCH services is sustained.

• As communities become “agents” of maternal, newborn and child survival, community ownership of, and participation in MNCH are strengthened. This in turn leads to better health outcomes and has a positive impact on sustainable development.

Zimbabwe:

• Thirty-seven Child Health Managers were trained in Programme Management in order to achieve universal coverage in child health interventions and improve knowledge and skills for planning and implementation.

• Capacity-building in BEmONC will continue. EmONC training centres will be supported by Sida after an EmONC needs assessment.

3.5 Challenges and Remedies – Is the Programme on Track?

The pace of implementation of the H4+ Canada programme increased in 2013. At the same time, the programme was affected by the external environment in which it operated, and over which country teams have no control. Nevertheless, the progress experienced in 2013, both at the policy and
programme levels, was remarkable; efforts to magnify performance will continue in 2014. Overall, therefore, progress at the country level is on track.

Challenges remain and remedies are being sought. These challenges include (1) the maintenance of standards of quality in health services; (2) low skill levels of health care providers; (3) inadequate or dilapidated health care infrastructure; (4) the maintenance of continuity and consistency despite destabilizing changes in the national environment and (5) the effective implementation of modular teaching and training methods. At all levels (6), decision-making suffered from a lack of reliable HMIS and data.

**Burkina Faso:**

**Main challenges faced:**

- Maintaining continuous roll-out of health care interventions amid constant changes at all levels
- Holding regular consultation meetings between different actors
- Accelerating the use of modular instruction in training institutions
- The coordination of RH interventions in light of the large number of actors.
- The timely availability of data
- Problems of financing
- Communication problems (lack of understanding of the H4+ programme)
- The need to supervise health care providers after training
- Problems related to the availability of equipment at health facilities.

**Solutions proposed for meeting these challenges include:**

- The designation of H4+ focal points at the regional level to monitor interventions. For example, the regional coordinator in place to combat disease and protect specific groups could take on this responsibility and report regularly on the implementation of the programme in his/her region.
- New staff members at all levels need to receive thorough orientation on the H4+ Canada project in order to ensure optimal ownership of the programme in light of the challenges mentioned above.
- Regular meetings should be held with the leadership of the National School of Public Health at the University in order to define practical modalities for introducing and implementing modular instruction.
- Dynamic communication channels should be established among all those involved in RH in order to clarify: *Who does what? How? With whom?* Consultation meetings should be held regularly according to a predetermined schedule.
- Uninterrupted functioning of the ENDOS software (server capacity, Internet connectivity) to ensure that data is available when it is needed.
- Issues of finance, communication, post-training supervision and equipment are addressed in the 2014 work plan.
Is the programme on track in Burkina Faso?
Despite these challenges, after two years the programme is on track and the progress that has been achieved to date should enable it to reach its goals. The administration of home-based newborn care is in place and the implementation of this strategy in the two programme regions will enable CHWs to make home visits to examine newborns and their mothers. This will reduce the number of newborn and maternal deaths, which remains high in Burkina Faso; it will also increase the number of postnatal consultations. Furthermore, advocacy at policy level is also yielding positive results to support SRMNCH programs.

Democratic Republic of the Congo:
Main challenges faced and remedies applied:
- There were delays in the delivery of equipment, manikins and medications. To reduce such delays a process of close follow-up was adopted and funds were allocated to improve the delivery of orders in 2014.
- The dilapidated state of health infrastructure that requires repairs in order to provide quality services. The H4+ partners lobbied the government and other donors to rehabilitate health facilities. For the first time the government has allocated funds for the construction and rehabilitation of 1,320 health centres and 198 general referral hospitals.
- To ensure that the quality of the training provided by the seven health care training institutions supported by H4+ Canada is monitored over the long term, US $30,000 has been allocated for 2014. In addition, US $75,000 has been allocated for the provision of training equipment and US $25,000 for the Training of Trainers.
- To reduce the cost to mothers of EmONC services, funding has been provided in 2014 to study the feasibility of establishing additional Mutual Health Care insurance plans in the target regions, to increase the number of Mutual plans available in these regions and to improve the ability of these plans to serve their intended customer base.
- In order to ensure the quality of health services provided by health facilities, a system of performance-based incentives has been put in place. US $40,000 has been allocated for 2014 for implementation.
- For raising awareness about maternal, newborn and child health, Family Planning and PMTCT, line items on SRMNCH have been included in the national and provincial budgets.
- In order to ensure that quality data on MNCH and PMTCT are available and are analyzed regularly, MNCH databases will be established at all levels. Funds have been allocated for 2014 to strengthen HMIS (training, computer equipment and data-gathering) in health care facilities and at the provincial and central levels in the nine programme health zones.
- MDSR meetings will be held (focusing on neonatal deaths, serious complications and narrow escapes); research will be conducted and the results published; information will be shared through meetings and the publication of printed materials.

Is the programme on track in the Democratic Republic of the Congo?
The programme is mainly on track. Significant progress has been made in the proportion of health care providers who have been trained in EmONC in the three target regions. Similarly, the proportion of
providers trained in PMTCT and MNCH has increased. The proportion of facilities offering modern Family Planning methods is close to the 2015 target of 75 for each of the three regions. The numbers of pregnant women tested for HIV increased in 2013. In 2014 and 2015, it is expected that the numbers of CHWs trained in each of the three target regions will be more evenly distributed.

**Sierra Leone:**
In 2013 the implementation of the H4+ Canada programme in partnership with the MoHS was extremely challenging due to the reorganization of key units, including the RH/FP and the Directorate of Policy Planning (DPI), which meant that the units did not function from February to September. This affected the implementation of the m-health project and the in-kind package and voucher system for pregnant teenagers.

The main challenges included:

- Inadequate skills in human resources,
- Poor infrastructure and lack of equipment,
- Socio-cultural and geographical barriers to MNCH.
- Inequitable distribution of qualified staff, especially in hard-to-reach areas, coupled with weak referral systems are the main barriers to access to MNCH services.
- The scaling up of key interventions has been inadequate and the quality of care remains sub-standard.

Recommendations to increase access include:

- Undertaking integrated outreach services in the communities.
- Scaling up pre- and in-service training of human resources.
- Support for, and supervision of, DHMT.
- Training of community health workers to provide health promotion in ANC/PNC, including Family Planning, in hard-to-reach areas.
- Advocacy:
  - To scale up emergency obstetric care and referral systems,
  - For improved living conditions for staff of PHUs,
  - For “hardship” allowances for staff posted to hard-to-reach, remote areas,
  - To strengthen OJT, mentoring and supportive supervision at all levels,
  - To strengthen MDSR,
  - To support outreach services in communities
  - To strengthen M&E to improve the availability of data and support innovations such as m-health for access to real-time data.
  - Continuous advocacy and awareness-raising activities for more resources

*Is the programme on track in Sierra Leone?*
The Sierra Leone programme was modified in 2013 to focus on two districts instead of the entire country. Taking this into account, the various activities are mainly on track. Experience gained from working at the national level in 2013 will strengthen efforts focused on the two target provinces in 2014 and beyond. It is expected that the MoH will start functioning well in 2014.
**Zambia:**
The main challenges include:
- Critical shortages of human resources for health, particularly in rural areas, as well as infrastructure and equipment for MNCH services.
- Geographical barriers, long distances and weak referral systems also hinder the effective provision of, and access to, MNCH services.

All of the districts supported by H4+ are rural and sparsely populated. Hence, the Ministry recommends that there be at least four BEmONC and one CEmONC facility per district, regardless of the population. Although it cannot be confirmed that all four facilities per district provide all seven essential BEmONC functions, there is at least one functioning CEmONC per district.

It should be noted, however, that all BEmONC facilities have deficits. Some lack the skills to perform manual vacuum aspiration for retained contraceptive products and/or assisted deliveries with vacuum extractors or forceps. Some midwives are not skilled in conducting a neonatal resuscitation. Very few midwives administer magnesium sulphate to clients in need.

Remedies to address these challenges include:
- The conduct of integrated outreach services,
- Pre- and in-service human resource capacity development,
- Recruitment of retired staff,
- Improved maternity infrastructure, including the provision of maternity waiting shelters,
- Address the limitation of HMIS to H4+ Canada core indicators,
- The rehabilitation of maternity waiting shelters and delivery rooms.
- A National Human Resources for Health Strategic Plan 2011-2015 and a National Training Operational Plan are in place. This will address shortage of skilled healthcare providers.

**Is the programme on track in Zambia?**
The H4+ Canada initiative is now embedded in district and national plans. The capacity-building of healthcare providers and the process to promote community participation and demand have been implemented as planned. The program is on track.

**Zimbabwe:**
Although national HIV prevalence steadily declined from 24.6 per cent in 2003 to 15 per cent in 2010, it remains a big challenge. Approximately 145,000 people living with HIV are children under 15, and among this group 90 per cent of HIV infections are transmitted from mother-to-child. In other words, the single leading indirect cause of maternal and child mortality in Zimbabwe is HIV, which contributes to 23 per cent of maternal and 21 per cent of child mortality.

Major challenges include:
- The low uptake of ASRH services and pediatric ART, including in Youth-friendly Corners.
In some districts, integration of MNCH and PMTCT was on track, while pediatric ART services were not – primarily due to a lack of health worker skills. The provision of quality IYCF services varied from district to district. Stigma and discrimination remain major challenges for young people living with HIV, affecting their meaningful involvement in general ASRH activities. Poor road infrastructure in rural areas hinders the effective provision of, and access to, MNCH services. Capacities of health facilities to deliver full range of EmONC services. Socio-cultural and religious barriers to MNCH.

Remedies applied include:

- With support from identified nurses, some adolescents living with HIV have initiated support groups in their districts to educate and support each other on issues related to relationships, disclosure of HIV status and treatment adherence.
- Health workers will be training in pediatric ART in 2014.
- The provision of IYCF is being standardized through the training of HWs and community workers.
- The use of technology will facilitate wide-spread sensitization of young people on the availability of youth-friendly services.
- Community mobilization and awareness campaigns are helping to overcome socio-cultural and religious barriers to access to SRMNCH.
- Clinical mentorship and EmONC health facilities strengthening will be taking up in 2014.

Is the programme on track in Zimbabwe?
The H4+ Canada programme in Zimbabwe is having an important impact on improving MNCH and on enabling young people living with HIV to become productive members of society. The H4+ program has gained momentum and is on track regarding 2013 progress.

3.6 Moving Ahead

Priority areas of intervention by country for 2014-2015 are:

**Burkina Faso:**

- Support the implementation of modular teaching for obstetric personnel, such as certified midwives.
- Expand the cost-sharing system in two districts to cover obstetric emergencies.
- Strengthen the medical/technical platform in health training to provide quality EmONC services.
- Improve monitoring of RH products.
- Maintain thematic training (pre-natal visits including PMTCT, IMCI, EmONC, etc., and essential newborn care) and post-training supervision of service providers and CHWs.
• Support the delegation of responsibilities and supervision through training generalist physicians at the district level in basic surgery to handle obstetrical emergencies in district hospitals in the two regions.
• Support the Development Plan for Health Human Resources.
• Support mid-term M&E of H4+ Canada interventions, especially the need for EmONC.
• Support the documentation of best practices and lessons learned.
• Support the establishment of the RAPID SMS system to monitor maternal deaths and stocks of RH products.
• Strengthen the capacities of the national H4+ coordination team to carry out geographic analyses of access to EmONC using the One Health tool.
• Develop the IFC approach to improve maternal and neonatal health in the seven districts not yet covered by the programme.
• Support the training of trainers and CHWs as well as their post-training supervision for the administration of home-based newborn care.
• Support the development of the “School for Husbands.”
• Support the ability and willingness of parents to be involved in the sexual education of adolescents and young people in the two target regions.
• Support the establishment of integrated RH/FP services for young people.
• Support the launch of a regional Family Planning advocacy plan based on the RAPID SMS model.
• Support the broadcasting of the radio soap opera on maternal health, FP, gender, fistula, FGM/C, vaccination, key family practices, etc.

**Democratic Republic of the Congo:**
Priority areas of intervention for 2014:
• Continue to establish mutual health insurance plans in other provinces in order to reduce and facilitate the payment of health care costs.
• Launch a results-based financial system based in targeted Health Zones.
• Establishment of a Maternal and Newborn Death Surveillance and Response system.
• Post-training monitoring of individuals trained in M&E, FP and EmONC.
• Give special attention to the problems of adolescents and youth.
• The H4+ project to monitor stock-outs will be implemented in two districts in 2014.
• The B+ approach, a new WHO recommendation for PMTCT, which was launched in Lubumbashi in the context of H4+, provides lessons on scaling up throughout the nine zones of the project.
• The implementation of performance-based funding will begin 2014.

**Sierra Leone:**
In 2014, funds provided by H4 will be used in only two districts in order to facilitate the identification of those interventions that are attributable to the H4+ Canada grant. However, the interventions identified for 2014 have not changed much; they include the following:
• The H4+Canada collaboration will continue to complement on-going interventions of the national agenda for SRMNCH, prioritizing: quality Primary Health Care, including PMTCT and Family Planning; quality EmONC and the use of real-time information and communication for
performance review and accountability (m-health) in the two programme districts. Technical support will be needed for training and installation of the m-health system by the end of March.

- Scaling up in-service training of health workers; pre-service training of midwives and MCH Aides,
- Outreach activities to create demand for RMNCH,
- Uptake of services, as well as quality, will be strengthened by introducing voucher and in-kind packages to marginalized groups, as well as pediatric referrals and RBF for community health workers.
- Supportive supervision, mentoring and institutionalized M&E,
- Youth-friendly facilities in the selected districts,
- MDSR reports will benefit from improved notification and investigation.

**Zambia:**
Priority areas of intervention for 2014 are:

- The Canadian financial support for 2014 will be invested in strengthening the enabling environment, supply and demand side interventions aimed at achieving the project goal of accelerating maternal and newborn survival and improving access to family planning services. The catalytic planned activities are high-impact interventions based on recommendations made by the five H4+ Canada partners. These activities support underserved and highly vulnerable districts and, by building on what has been achieved in 2012 and 2013, they are contributing to complete coverage of the target districts for the project period.
- In 2014, technical assistance, programme management and supportive supervision will be provided to develop the capacities of district health managers and healthcare providers in adolescent sexual and reproductive health, EmONC, MDSR, EMTCT, newborn health and family planning. Increases in the number of skilled human resources and in quality infrastructure (delivery rooms, waiting shelters, referral systems) will improve service delivery – in particular, access to institutional delivery/skilled birth attendance – and address the challenges of unqualified staff and dilapidated facilities that are often located far from pregnant women living in remote areas. Support will also be provided for essential logistics and commodities for facilities and communities.
- The districts will continue to sensitize the community and engage community leaders on issues of SRMNCH/FP to ensure community ownership and participation in maternal health programmes. Community outreach activities will be supported in all the districts to improve access to integrated services, bringing services closer to people, especially those in hard-to-reach areas. The funds will also be channeled towards programme monitoring, evidence generation, documentation of best practices and visibility. The targets for the annual work plan outputs will be guided by the limitations of the allocation.

**Zimbabwe:**
Priority areas of intervention for 2014 are:

- Adaptation and production of guidelines for Emergency Triage Assessment and Treatment (ETAT),
- Support for the provision of needs-based EmONC,
- Initiate MDSR in the identified districts,
• Operationalize clinical mentorship for the MNCH programme,
• Strengthening PMTCT, EID and Pediatric ART,
• The provision of youth-friendly services and processes for improved utilization of services
• Support for Integrated Outreach Services by health care workers and CHWs,
• The promotion of infant feeding at the community level,
• Increasing community mobilization and awareness campaigns to promote demand for MNCH services.

In summary, in 2014 the H4+ Canada will continue to support interventions at the policy and programme levels. These interventions are aimed to fill gaps in access to quality SRMNCH services and to generate demand for such services.

4. MONITORING AND EVALUATION

4.1 Strengthening in-Country M&E Capacity

Country M&E Focal Points

Country M&E focal points have been identified in all five countries. They are responsible for the coordination and overall management of country-level activities related to the implementation and M&E of the H4+ Canada programme.

In Burkina Faso, DRC and Sierra Leone, the M&E focal point is based at the Ministry of Health. However, in Sierra Leone, political restructuring resulted in the MoHS being closed for nine months in 2013. UNAIDS is the focal point in Zambia and UNFPA is the focal point in Zimbabwe, working closely with the MoH.

National Institutions for M&E

In each country, national institutions have been contracted to provide coordination and technical support to country M&E activities during the duration of the programme. Their responsibilities include: baseline surveys; collection and analysis of routine data from national HMIS and other surveys; documentation of important contextual factors that might impact programme implementation or outcomes (e.g., other programmes operating in the same area, economic or political instability, etc.); assistance in identifying and documenting innovative approaches/interventions; advice on the quality of the implementation of interventions; support to the mid-term and end-of-programme evaluations undertaken by external institutes/organizations.
Table 16 shows the national-level institutions in each H4+ country that are responsible for M&E.

### Table 16 National M&E Institutions

<table>
<thead>
<tr>
<th>Country</th>
<th>National M&amp;E Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>The <em>Institut de Recherche en Sciences de la Santé</em> (IRSS)</td>
</tr>
<tr>
<td>DRC</td>
<td>The <em>École de Santé Publique de l'Université de Kinshasa</em> has carried out an evaluation of baseline data, including an EmONC study. The <em>Direction d’Etude et Planification (DEP), Ministère de la Santé</em> and the <em>Direction de la Santé Familiale et des Groupes Spécifiques (D10)</em> are responsible for monitoring at the national level. The M&amp;E focal point is based at the DEP. The <em>Division Provinciale de la Santé</em>, in coordination with the <em>Coordination Provinciale du Programme National de la Santé de Reproduction</em>, is responsible for monitoring at the provincial level.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>The Department of Planning and Information from the MOHS is the unit responsible for the coordination of M&amp;E for the H4+/CIDA programme, as a way to develop capacity in M&amp;E for the MOHS. No national institution (public health, research, university) could be identified with the capacity to be responsible for the M&amp;E of this programme.</td>
</tr>
<tr>
<td>Zambia</td>
<td>The University of Zambia, Institute of Economic and Social Research (INESOR) has been contracted as the national M&amp;E institution. Orientation of INESOR on the project proposal and adaptation of research tools (informed by the WHO global guidance on how to generate baseline surveys) was conducted in May 2012, including the development of the survey implementation roadmap. INESOR was also oriented on results–based planning.</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>The Collaborating Centre for Operational Research (CCORE) has been chosen as the national institution responsible for M&amp;E for the H4+. The H4+ partners have assigned M&amp;E staff from UNFPA and MOHCW to work closely with CCORE to ensure the implementation of a coordinated M&amp;E strategy. CCORE has assumed responsibility for the oversight of the overall M&amp;E component of the project, including data collection, data entry, quality assurance, timely reporting and documentation of the intervention at all levels in all sites. The National level SC comprising representatives from MOHCW, UNICEF, WHO, UNFPA and CCORE serve as the consultative group for the M&amp;E process and meet as required. CCORE is mandated to report to the National SC every two months.</td>
</tr>
</tbody>
</table>

**Country M&E activities**

**Burkina Faso:**
Weekly data collection on maternal deaths, as well as on stocks of health care and Family Planning supplies, was institutionalized in 2012 and continued in 2013. Members of the Society of Gynecologists and Obstetricians of Burkina Faso provide MDR support to the two main hospitals in the target areas. At
the community level, 140 health service providers were trained in data collection, enabling them to identify bottlenecks and take corrective measures.

**Democratic Republic of the Congo:**
A detailed M&E framework was developed, including indicators for maternal mortality, under 5 mortality, low birth weight, teenage pregnancy and incidences of new HIV infection in children under 5.

Two studies were carried out. One recorded the levels of satisfaction of clients of RMNH (including FP) in the target provinces and identified those aspects of the service that contributed most to client satisfaction, as well as those that caused the greatest concern among clients.

The second study focused on the low level of uptake of FP services in the nine programme zones. This study produced very useful findings on the perceptions of women and men with regard to FP and the facilities where it is provided, shedding light on the socio-cultural values that prevent people from using the FP services offered at the health centres.

**Sierra Leone:**
The H4+ M&E plan has been harmonized with the national health plan. The Service Availability and Readiness Survey (SARA) and the National EmONC survey for 2013 were completed and the data is being analysed.

The Health Information System is implemented using the existing national health M&E system, which is primarily based on the HMIS. It operates on four levels: information flows from the community to health facilities to the district and thence to the national level. There is also a feedback mechanism from the national level to districts, to health facilities and down to the community. Routine health data are collected using the standard HMIS tools developed and produced by the MoHS. In addition, periodic surveys such as the Demographic Health Survey (DHS), the HIV Sero-prevalence Surveys, the Service Availability Readiness Assessment Survey, the MICS, and the Malaria Indicator Survey are used to provide data on the outcomes and impacts of programme interventions.

A data analysis plan is based on the indicators specified in the Results and Accountability Framework of the MoHS, which provides clear definitions of indicators and their parameters. Maternal health data are reported using standard HMIS tools developed and produced by the MoHS. This is done monthly, quarterly, semi-annual and annually in order to support all programme reviews.

In 2013 the Directorate of Policy, Planning and Information organized Integrated Supportive Supervision (ISSV) with co-funding from JICA and H4+ Canada to build the capacities of the DHMT to effectively administer key management and programme areas. Training in data management was also organized for district M&E officers and data-entry clerks using CSPro version 4.0. The Directorate also improved the Internet system of the MoHS for effective management of HMIS data at the district level.

**Zambia:**
The H4+ Canada grant provided financial and technical support for capacity-building on disaggregated target setting for the districts and facilities supported by the grant. The H4+ team conducted quarterly joint supervisory and monitoring visits in the five districts, as planned. The University of Zambia Institute of Economic and Social Research (INESOR) received support to conduct quarterly field monitoring visits.
to collect data and to equip 15 district health managers with skills in routine data collection and management. An MNCH score card and monitoring dashboard have been developed to enhance performance. Under the leadership of the Ministry of Community Development, Mother and Child Health, the 2013 H4+ Canada national annual review and 2014 planning meeting was held.

The government also received support for the development of tools to strengthen the national civil registration and vital statistics systems. H4+ Canada is one of several partners supporting the MoH in assessing the HR information system to create a national observatory for HR for health.

**Zimbabwe:**
The M&E framework, which was revised to capture output indicators relevant to H4+, will be able to demonstrate the impact of the project at the output level. It was also synchronized with the Sida logframe. A monthly data collection tool was developed and shared with all districts to facilitate the submission of monthly reports. Quarterly M&E visits to the six districts were conducted by H4+ Canada, in collaboration with MoHCW and ZNFPC, to assess the implementation of the ASRH programme, specifically Youth-friendly Corners. H4+ participated in a National HMIS planning meeting and advocacy included the use of disaggregated data on young people in the national MNCH HMIS – from data collection tools to reporting formats at every level.

**Independent mid- and end-term evaluations**

In 2013 the inception report for the mid-term and end line evaluations of the H4+ Canada programme was published. It was written by an independent evaluation team, Ipact, who had made preparatory visits to the five countries in February and March 2013. This document provides an overview of the evaluation design to support the implementation of the Global Strategy for Women’s and Children’s Health. In this report, Ipact:

- Describes the methodological approach, including the evaluation framework
- Provides a list of evaluation questions with judgment criteria
- Presents the implementation plan for the mid-term evaluation
- Outlines a schedule for the final evaluation.

In the last quarter of 2013, data collection for mid-term review was initiated by the independent evaluation agency (Ipact). It is expected that the mid-term review will provide insights on the progress of the implementation of the activities in each country (based on output indicators) and will identify issues and needs to be addressed to strengthen the H4+ Canada programme.
5. FINANCIAL RESOURCES

The financial allocations made by the H4+ agencies, and subsequent country implementation rates (IR) averaging 72 per cent, are presented in Table 17 below. These amounts represent expenses incurred from 1 January to 31 December 2013, based on provisional expenditure reports. The financial report based on certified expenses will be submitted separately by 31 May 2013.

Table 17 Financial Expenditures from 1 January to December 31, 2013 (in US$) (Funds available includes unspent amounts from 2012 and the 2013 allocation. Expenditure includes direct, indirect and M&E costs)

<table>
<thead>
<tr>
<th></th>
<th>UNFPA</th>
<th>UNICEF</th>
<th>WHO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Funds available</td>
<td>Expenditure</td>
<td>IR %</td>
<td>Funds available</td>
</tr>
<tr>
<td>Global</td>
<td>$1,299,619.00</td>
<td>$ 998,672.00</td>
<td>77</td>
<td>$1,203,769.00</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>$ 953,460.00</td>
<td>$ 817,979.00</td>
<td>86</td>
<td>$ 467,796.00</td>
</tr>
<tr>
<td>DRC</td>
<td>$ 723,264.00</td>
<td>$ 642,796.00</td>
<td>89</td>
<td>$ 825,195.00</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>$ 872,322.00</td>
<td>$ 533,097.00</td>
<td>61</td>
<td>$1,156,100.00</td>
</tr>
<tr>
<td>Zambia</td>
<td>$ 631,728.00</td>
<td>$ 503,443.00</td>
<td>80</td>
<td>$ 794,047.00</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>$1,176,028.00</td>
<td>$ 600,705.00</td>
<td>51</td>
<td>$ 484,663.00</td>
</tr>
<tr>
<td>Programme and SC Management</td>
<td>$ 250,000.00</td>
<td>$ 210,707.00</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$5,906,421.00</td>
<td>$4,307,399.00</td>
<td>73</td>
<td>$4,931,570.00</td>
</tr>
</tbody>
</table>
5.1 Implementation Rates

Table 18 below shows the relative expenditures and implementation rates of 2012 and 2013:

<table>
<thead>
<tr>
<th>Expenditure from inception to 31st December 2012</th>
<th>Expenditure from 1st January to 31st December 2013</th>
<th>Expenditure from inception to 31st December 2013</th>
<th>Expenditure rate from inception to December 2012 (against $20 million)</th>
<th>Expenditure rate from Inception to 31st December 2013 (against $30 Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$11,074,744</td>
<td>$11,738,999</td>
<td>$22,813,743</td>
<td>56%</td>
<td>76%</td>
</tr>
</tbody>
</table>

The implementation rate against reported expenditures since the launch of H4+ Canada to 31 December, 2012, remained at about 56 per cent. This was the result of delays in initiating activities at the outset, with actual implementation starting in mid-2012. In the last quarter of 2012, detailed plans for 2013 were developed and their implementation was closely monitored. This contributed to increased utilization of the available funds, especially at the country level. The pace of implementation gained considerable momentum during 2013.

Pattern of fund utilization among H4+ partner agencies:

During the current reporting period (2013), a total expenditure of US $11,738,999 was reported. Of this amount, 79 per cent was spent on country-level activities, whereas for global-level activities the expenditure rate was 21 per cent. This is in line with the distribution of the Canadian grant for the entire collaboration period (2011 to 2016).

An expenditure of US $2,469,850.00 was reported for global-level activities in 2013. When we exclude payments for programme management and those made to the independent evaluation agency Ipact, the expenditure shares among H4+ partners UNFPA, WHO and UNICEF are about equal: UNFPA spent 34 per cent, while UNICEF and WHO each spent 33 per cent (See Figure 5) during 2013.
Pattern of fund utilization among five programme countries:

Out of a total reported (provisional) expenditure at the country level of US $9,269,149, during 2013 the following pattern of expenditure emerged among the five programme countries (see Figure 6).

On average, about 20 per cent of country-level reported funds were spent in each programme country.

It is expected that the implementation rates and funds utilization rates will increase with the pace of maturity of the H4+ Canada programme.
ANNEXES
### ANNEX I. Country Teams

<table>
<thead>
<tr>
<th>Country</th>
<th>Implementers</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burkina Faso</strong></td>
<td><strong>Implementation in 2 regions</strong>&lt;br&gt;- At the central level: Direction générale de la santé, Direction générale des études et des statistiques sectorielles (DGESS), Direction des ressources humaines (DRH), Ecole nationale de santé publique, Unité de formation et de recherche en sciences de la santé, IRSS.&lt;br&gt;- At the intermediate level: Directions régionales de la santé du Nord et du Centre Nord and NGOs for capacity building.&lt;br&gt;- At the operational level: five district health offices in the North region, four district health offices in the Central region, two Regional Hospitals (Ouahigouya and Kaya) and community associations recruited by the capacity-building NGOs</td>
<td>H4+ agencies:&lt;br&gt;• WHO (lead)&lt;br&gt;• UNFPA&lt;br&gt;• UNICEF&lt;br&gt;• UNAIDS&lt;br&gt;• World Bank</td>
</tr>
<tr>
<td><strong>Democratic Republic of the Congo (DRC)</strong></td>
<td><strong>Implementation in 3 provinces, 9 districts</strong>&lt;br&gt;- Ministère de la Santé Publique (Directions et Programmes spécialisés)&lt;br&gt;- Ministère du Genre&lt;br&gt;- Ministère de l’Enseignement Supérieur&lt;br&gt;- NGOs: Association de Bien-être Familial (ABEF-ND); Radio Okapi&lt;br&gt;- Ecole de la Santé Publique, Université de Kinshasa&lt;br&gt;- Programme National Multisectoriel de Lutte Contre le SIDA (PNMLS)&lt;br&gt;- Professional Associations : la Société Congolaise des Gynéco-obstétriciens (SCOGO); la Union Nationale des Accoucheurs et Accoucheuses du Congo (UNAAC)</td>
<td>H4+ agencies:&lt;br&gt;• UNFPA (lead)&lt;br&gt;• UNICEF&lt;br&gt;• WHO&lt;br&gt;• UNAIDS&lt;br&gt;• UN WOMEN&lt;br&gt;• World Bank</td>
</tr>
<tr>
<td><strong>Sierra Leone</strong></td>
<td><strong>National implementation; during 2013, focus changed to 2 provinces.</strong>&lt;br&gt;- Ministry of Health and Sanitation:&lt;br&gt;- National Midwifery school&lt;br&gt;- Expanded Programme for Immunization/Child Health, EPI/CH&lt;br&gt;- Reproductive Health/Family Planning (RH/FP) Divisions&lt;br&gt;- School Health programme(ADH)&lt;br&gt;- Directorate of Policy, Planning and Information&lt;br&gt;- National AIDS Control Programme&lt;br&gt;- Ministry of Social Welfare, Gender and Children’s Affairs (CAGs: community advocacy groups and FINE-SL: male peer educators)&lt;br&gt;- LAWYERS (female lawyers supporting GBV cases),&lt;br&gt;- Health For All Coalition (CSO)&lt;br&gt;- District Local Councils, Doctors with Africa CUAMM , Voluntary Services Overseas (UK)</td>
<td>H4+ agencies:&lt;br&gt;• UNFPA (lead)&lt;br&gt;• WHO&lt;br&gt;• UNICEF&lt;br&gt;• UNAIDS&lt;br&gt;• World Bank&lt;br&gt;• UN Women</td>
</tr>
<tr>
<td>Country</td>
<td>Implementers</td>
<td>Key Partners</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Zambia</td>
<td>• Ministry of Health (MoH)</td>
<td>H4+ agencies:</td>
</tr>
<tr>
<td></td>
<td>• Ministry of Community Development, Mother and Child Health</td>
<td>• UNICEF (lead)</td>
</tr>
<tr>
<td></td>
<td>• Institute of Economic and Social Research (INESOR) for M&amp;E</td>
<td>• UNFPA</td>
</tr>
<tr>
<td></td>
<td>• District Health Management Teams in Project Districts: Kalabo, Lukulu, Chadiza, Chama, Serenje</td>
<td>• WHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• World Bank</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• UNAIDS</td>
</tr>
<tr>
<td></td>
<td><strong>Implementation in 4 provinces</strong></td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>• Ministry of Health and Child Welfare (MOHCW)-MNCH, Sexual Reproductive Health (SRH), Prevention of Mother-to-Child Transmission (PMTCT), Opportunistic Infection/ Antiretroviral Therapy (ART) Nutrition units</td>
<td>H4+ agencies:</td>
</tr>
<tr>
<td></td>
<td>• Centre for Collaborative Operational Research and Evaluation (CCORE)</td>
<td>• UNFPA (lead)</td>
</tr>
<tr>
<td></td>
<td>• Kapnek Trust for PMTCT</td>
<td>• UNICEF</td>
</tr>
<tr>
<td></td>
<td>• Zimbabwe National FP Council (ZNFPC) (for Adolescent SRH)</td>
<td>• WHO</td>
</tr>
<tr>
<td></td>
<td>• National Aids Council for Coordination HIV</td>
<td>• World Bank</td>
</tr>
<tr>
<td></td>
<td>• Zimbabwe National Network of People Living with HIV/AIDS (for meaningful involvement of PLWHA)</td>
<td>• UNAIDS</td>
</tr>
<tr>
<td></td>
<td><strong>Implementation in 6 provinces</strong></td>
<td>• UN Women</td>
</tr>
<tr>
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</tbody>
</table>
## ANNEX II. Total numbers of SRMNCH providers trained in all H4+ countries in 2013

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Burkina Faso</th>
<th>DRC</th>
<th>Sierra Leone</th>
<th>Zambia</th>
<th>Zimbabwe</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EmONC/ BEmONC/ CEmONC Midwifery MCH Aides SRMNCH MDR IFC approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 143 EmONC providers</td>
<td>• 21 national-level trainers</td>
<td>• 673 health care providers were trained in 2012 and 2013 according to national norms in EmONC and deployed in 65 BEmONC and 22 CEmONC facilities</td>
<td>• 40 EmONC providers and 31 nurses received midwifery training scholarship</td>
<td>• 144 EmONC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 100 maternal death auditors</td>
<td>• 80 providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 754 CHWs trained in IFC approach to MNH</td>
<td>• 60 trainers in midwifery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 262 service providers trained in IFC</td>
<td>• 410 CHWs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 20 generalist physicians trained in basic surgery</td>
<td>Total: 1,279</td>
<td>Total: 571</td>
<td>Total: 673</td>
<td>Total: 71</td>
<td>Total: 144</td>
<td></td>
</tr>
<tr>
<td><strong>Newborn and infant care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 356 community-based IMCI</td>
<td>None in 2013</td>
<td>• 46 district trainers/mentors</td>
<td>None in 2013</td>
<td>• 122 community- based IMNCI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 160 basic newborn care</td>
<td>• 191 PHUs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total: 516</td>
<td>Total: 237</td>
<td>Total: 1,412</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HIV prevention and treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• 68 IMCI providers, including PMTCT, in the context of HI</td>
<td>• 30 provincial trainers</td>
<td>• 50 health service providers (MCH-Aides, Midwifes, Nurses, etc.) trained in the integration of HIV prevention and treatment with FP</td>
<td>Healthcare staff trained in use of SMS for sending HIV results for infants: Chadiza: 38 ; Chama: 22; Lukulu: 24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 120 care-givers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 50 patient educators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total: 68</td>
<td>Total: 200</td>
<td>Total: 429</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 FP clinical health service providers</td>
<td>• 50 family planning health workers</td>
<td>• 10; i.e., 10% of the target 100 healthcare providers were trained in long-acting FP methods</td>
<td>None with H4+ funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1,200 community-level distributors of contraceptives</td>
<td>• 18 Community-Based Distribution Agents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total: 1,260</td>
<td>Total: 68</td>
<td>Total: 1,338</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Youth-friendly health care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 56 peer educators and facilitators</td>
<td>None in 2013</td>
<td>• 120</td>
<td>None in 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total: 56</td>
<td>Total: 120</td>
<td>Total: 26</td>
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<td>Total: 202</td>
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</tr>
<tr>
<td>Health care management</td>
<td>2 (1 coach and 1 supervisor for School of Husbands)</td>
<td>51 supportive supervisors</td>
<td>None in 2013</td>
<td>None in 2013</td>
<td>37 Child Health Managers trained in Programme Management</td>
<td>112 health workers trained in IMCI case management</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td>Technologies</td>
<td>None in 2013</td>
<td>None in 2013</td>
<td>None in 2013</td>
<td>None in 2013</td>
<td>35 health workers trained in use and maintenance of PIMA CD4 PoC machines.</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>3,321</td>
<td>941</td>
<td>1,080</td>
<td>165</td>
<td>1,080</td>
<td>6,536</td>
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