H4+ Sida Intermediary Report

(2013 – May 2014)
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Part 1: Country reports

Cameroon
Côte D’Ivoire
Ethiopia
Guinea Bissau
Liberia
Zimbabwe
1. COUNTRY CONTEXT

Cameroon

**MMR 590, insufficient progress.** Based on the results of a regional disparity analysis in the ten regions of the country, the Far North region was selected because it presents: a low coverage in RMNCH health interventions, the highest proportion of home deliveries, the lowest contraceptive prevalence rate, one of the highest maternal, neonatal, and child mortality rates and the highest prevalence of poverty (4th and 5th quintiles). This program prioritizes strengthening human resources, increasing availability of essential medical products, improving the health management information system and increasing financial accessibility to quality health services. The intervention zone covers 5 health districts and 69 health areas with a total population of 852,541 (= 25% of the region’s population and 5% of the country’s population) of which 170,508 are children under five, 42,627 are pregnant women and 196,084 are women of child bearing age (15-49yrs). The outputs 4, 5, 6 and 7 have been targeted. An H4+ coordinator was recruited (UNICEF). Achievements: 11% and 81% ongoing activities.

Côte D’Ivoire

**MMR 720, insufficient progress.** The main objective in implementing the H4+ Sida grant is to complement the existing funding (international and domestic) available to accelerate the implementation of the national SRH plan in 8 districts of 3 regions (Center-North and North-West) particularly affected by the recent socio-political crisis, with a special focus on availability, accessibility and quality of SRH/MNH services. The intervention zone has a total population of 1.429.183 of which 370.587 are women of childbearing age, 53.594 expected pregnancies and 51.022 expected births, 40.129 newborns and 221.431 under five. The outputs 3, 4, 5, 6 and 7 have been targeted. Achievements: 18% and 62% ongoing activities. An H4+ coordinator has been recruited (UNFPA).

Ethiopia

**MMR 420, making progress.** The grant is aimed to support the implementation of the Health Sector Development Plan IV with focus on the production of midwives, health officers and anesthetists; on improvement of the national Monitoring and Evaluation capacities and MDSR implementation; on increasing access to equipped EmONC facilities for delivering of integrated RMNCH/PMTCT services and on enhancing gender mainstreaming in the health sector and developing Youth friendly services; and on increasing demand for quality SRH/MNH services, through empowerment of women’s groups and training of Health Extension workers (HEWs). The outputs 1, 2, 3 and 4 have been targeted. Achievements: 11% and 57% ongoing activities.

Guinea Bissau

**MMR 560, making progress.** One of the poorest and less assisted among the African countries, Guinea Bissau is looking for political stability and improved governance and has just elected a new President and Prime Minister after the Coup d’état of 2012. The lack of competent and deployed workforce in the health sector the lack of inefficient commodity distribution mechanism, limited financial access to services and a weak HMIS were identified as major issues to be addressed. A strong H4+ is working to improve access to and quality maternal and child health services and developing synergies and partnerships, with the European Union, the World Bank and the Global Fund, in particular. The outputs targeted were outputs 1, 2, 3, 4, 5, 6 and 7. An H4+ coordinator is
currently under recruitment, and the position is currently encumbered by a Consultant on a temporary basis. Achievements: 3% and 76% ongoing activities.

**Liberia**

*MMR 640, making progress.* In support to the national Health policy and plan (2011-21) the h4+ Sida grant is aimed to strengthen the delivery of quality rights based health services through the implementation of the National- Essential Package of Health Services (EPHS) (2012-15), as well as to increase demand, and access to and utilization of maternal newborn health care services, particularly in the three South-eastern counties (Grand Kru, Maryland and River Gee). The strategic activities are including (1) Increasing the coverage and access of quality comprehensive MNH care services; (2) Strengthening Maternal Newborn Death Reporting at all Levels; (3) Strengthening community including men’s participation for maternal and newborn care services; and (4) Improving monitoring and evaluation of maternal and newborn health services. Outputs 1 to 6 have been considered. An H4+ coordinator has been recruited (WHO). Achievements: 12% and 71% ongoing activities.

**Zimbabwe**

*MMR 470, insufficient progress.* Zimbabwe is receiving H4+ Canada and Sida funds, which are managed in strong coordination. The focus is on national scale up and replication, focusing on the six H4+ Canada grant’s supported districts (Chipinge, Gokwe North, Hurungwe, Mbire, Chiredzi, Binga) with a total population of about 1.2 million. These districts were selected with consideration to high maternal, neonatal and child mortality. Two provinces (Mashonaland West and East) are also supported to set up a comprehensive maternal death surveillance and response system. The outputs 1, 3, 4, 5, 6 and 7 have been selected. An H4+ coordinator has been recruited (UNFPA). Achievements: 16% and 59% ongoing activities.

### 2. FINANCIAL ANALYSIS

**Expenditure rate per country and agency**

<table>
<thead>
<tr>
<th>Country</th>
<th>UNICEF</th>
<th>WHO</th>
<th>UNFPA</th>
<th>UNAIDS</th>
<th>UN Women</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bissau Guinea</td>
<td>39.20</td>
<td>56.85</td>
<td>46.30</td>
<td>-</td>
<td>23.17</td>
<td>46.11</td>
</tr>
<tr>
<td>Cameroon</td>
<td>36.93</td>
<td>15.00</td>
<td>29.80</td>
<td>54.00</td>
<td>19.00</td>
<td>30.76</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>21.60</td>
<td>7.56</td>
<td>42.12</td>
<td>-</td>
<td>7.94</td>
<td>28.15</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>49.00</td>
<td>42.1</td>
<td>62.00</td>
<td>8.20</td>
<td>36.70</td>
<td>51.50</td>
</tr>
<tr>
<td>Liberia</td>
<td>32.00</td>
<td>36.00</td>
<td>19.00</td>
<td>14.00</td>
<td>10.00</td>
<td>24.40</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>33.00</td>
<td>67.70</td>
<td>4.60</td>
<td>43.20</td>
<td>27.00</td>
<td>35.10</td>
</tr>
<tr>
<td>Average</td>
<td>35.29</td>
<td>37.04</td>
<td>33.97</td>
<td>29.85</td>
<td>22.30</td>
<td>36.00</td>
</tr>
</tbody>
</table>
Reception of funding

- Bissau Guinea  July 2013
- Côte d’Ivoire  August 2013, Nov 2013 (WHO), Feb. 2014 (UNAIDS)
- Cameroon:  July to October 2013
- Ethiopia  August to October 2013
- Liberia  August to October 2013
- Zimbabwe  October 2013

Issues

1. Delays in receiving the funding – important differences between agencies, due to internal mechanisms. Disbursement period for the majority varied between July to August 2013.

2. Implementation rates in May 2014 are between 28 and 51%, average 35%, when rates of 50-60% could be expected. These low rates and the important differences between countries at 9-10 months of programme implementation (August 2013 – May 2014) can be explained by a number of factors, the most important being delays in receiving funding, administrative financial management (internal and national) and slow take off in the implementation due to sometimes long and hard preparatory steps (remote and neglected districts).

3. Low implementation and expenditure rates have been discussed at the Victoria Falls meeting, 26-29 May 2014 and countries have fine-tuned their 2014 plan of action and made decisions on ways to accelerate the implementation of the interventions. The overall goal is to have expenditure rates above 90% in December 2014.

3. STATUS OF THE ACTIVITIES

Cross-Country: Execution Rate

<table>
<thead>
<tr>
<th>Country</th>
<th>Achieved (%)</th>
<th>Ongoing (%)</th>
<th>Not started (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>11</td>
<td>81</td>
<td>8</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>18</td>
<td>62</td>
<td>20</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>11</td>
<td>57</td>
<td>32</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>3</td>
<td>76</td>
<td>21</td>
</tr>
<tr>
<td>Liberia</td>
<td>12</td>
<td>79</td>
<td>9</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>16</td>
<td>59</td>
<td>25</td>
</tr>
</tbody>
</table>

Achieved activities: 3-18%; ongoing: 57-81%; not started: 9-32%. Countries have reviewed in June the status of their planned activities and made some decisions to ensure that these activities will be implemented before the end of 2014. It is important to note that a proportion of activities are ongoing activities, to be continued over time. In this case they are not listed as achieved even when successfully implemented.
Achievements per country

CAMEROON

1. **Policies**: National Strategic RMNCH Plan 2014-2020 finalized
2. **Coordination**: Launching at central and regional levels with presentation of the project; Project Coordinator recruited, regular meeting technical Sida H4 team
3. **Planning**: Acquainting and planning workshop; Integrated Micro planning finalized and the implementation is ongoing
4. **Standards**: IMCI guidelines being developed; Newborn care guideline drafted; integrated tools for data collection produced and disseminated
5. **Human resources for Health**: Expert coordinator for training of midwives recruited; the definition of a mechanism for adequate deployment and retention of staffs especially in areas with low health staff/ population ratio established.
6. **Capacity-building**: Training of health workers on IMCI in Koza district; Clinical maternal and neonatal deaths reviews/ audits conducted
7. **Health Services**: Drugs and commodities procured for treatment of malnutrition related diseases in children; Commodities provided for HIV testing of 43,000 pregnant women and children; Five district hospitals equipped with blood transfusion kits and refrigerators; Obstetrical Kits Strategy expanded to 10 new health facilities.
8. **Community participation/empowerment**: Support to community engagement in assessment of health service quality, monitoring and accountability; Development of community based strategies on demand creation around RMNCH; Awareness on community health workers (CHW) activities’ created in 126 villages, 87 CHW selected for training on integrated health package in Guidiguis, Kits and 140 bicycles available for community workers.
9. **Research**: Study on gender related barriers/obstacles; Study of client satisfaction in health facilities.
10. **M&E**: Conduct a Baseline analysis of Sida/H4+ Basic indicators
1. **Advocacy/communication**: Development of an integrated communication plan around the H4+ Sida grant

2. **Midwifery workforce**: 37/80 planned midwifery school teachers trained in 10 schools; Equipment of midwifery schools; Support to MoH for adequate deployment and retention of staffs (in 5 /10 Regions)

3. **Capacity-building**: 29/ 300 health workers trained on clinical IMCI

4. **Health services**: Provision of RMNCH-related equipment and materials (in 50% of health facilities); Provision of essential drugs for the treatment of 25,000 cases of children (50%); Strengthening of service delivery through health center outreach activities

5. **ASRH**: Develop adolescent & reproductive health (ASRF) corners in existing youth centers (CMPJ)

6. **Community participation/empowerment**: Support to 200 community based structures for the implementation of RMNCH and PMTCT services taking off. Advocacy sessions for traditional and community leaders to promote their involvement in RMNCH and PMTCT

### CÔTE D’IVOIRE

1. **Capacity-building**: Training of 34 health service providers and pharmacists in the provision of RMNCH activities; Maternal death reviews in 6 CEmONC services. As part of improving the health of adolescents and youth, 81 Health Workers in school and universities have been trained to offer integrated FP-HIV STI services, manage sexual violence among youth and teenagers, and prevent unwanted and early pregnancies, STIs and HIV in schools and among uneducated youth

2. **Coordination**: Launching at regional level with presentation of the project; coordination mechanisms strengthened at all levels

3. **Drugs, Commodities and Technologies**: Essential drugs (SRO: 254,088 sachets, Zinc 20 mg: 760 217 tablets, 125 mg Amoxicillin syrup: 223,344 bottles) have been made available in health facilities in 8 targeted health districts in order to manage childhood illness

4. **Health services**: Integration of services FP, HIV, ANC, EmONC, PMTCT in 7 facilities; Outreach RH/FP services helped to support 219 cases of prenatal consultations, 171 cases of curative care, 981 cervical cancer testing, recruit 1093 new cases of PF users; make 733 HIV testing, detect 1 case of obstetric fistula that was referred to the University health center of Bouaké for its support, 1 case of induced abortion supported by a Manual Vacuum aspiration (MVA)

5. **Research**: Maternal and Infant mortality’s socio-demographic determinants

6. **M&E**: In order to improve the availability of quality data, develop a culture of evidence based decision making and a good monitoring implementation of interventions, 19 focal points for monitoring and evaluation in the 8 targeted health districts were trained to collect and analyze data; Baseline data on maternal, newborn and child health were collected at the district covered by the H4 + AIDS initiative to afford the basic situation and appreciate the contribution of interventions initiative
1. **Policies**: Strategic and technical documents were reproduced. These are 200 copies of the policy document reproductive health, 405 copies of the document protocol guidelines SR 300 copies, 250 copies of memory using Family Planning and 167 copies of the document context of accelerating MDG 5

2. **Drugs, commodities, technology**: Equipment of 38 health facilities with RH drugs, supplies and commodities; Equipment of 38 Health centers

3. **Capacity-building**: 26 midwives were trained in EmONC; 60 care providers were trained in Integrated Management of Diseases of the Newborn and Child (PCIMNE) and delivering quality clinical services

4. **Health services**: 159 providers of maternal health services have been trained to use the Recommendations guide for Clinical Practice EmONC (RCP/ EmONC) and to offer a quality and effective obstetric and neonatal emergency care; 11 gynecologists and obstetricians and midwives were trained to organize review sessions of maternal deaths; 1000 copies of obstetric record and 200 copies of grid analysis reviews of maternal deaths were produced

**Community participation/empowerment**: engaging men in SRH/FP in 6 communities; 25 agents of community-based distribution and 5 supervisors were trained and equipped (kits: logistics and management tools); 3390 men and women were sensitized in the community to use services of RH / FP and HIV / AIDS; Communication materials in maternal health, child health, FP and STI / HIV / AIDS have been developed

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**ETHIOPIA**

1. **Human resources for Health**: Training of additional 1,364 Midwives achieved, mentorship of newly graduated midwives

2. **Capacity building**: Newborn Care Training Clean and Safe Delivery Training MDR review dissemination

3. **Standards**: PMTCT Guidelines/EID registers, launching of eMTCT plan

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1. **Human resources for Health**: Training 60 Midwife Tutors, Training 240 IESOs

2. **Capacity building**: M & E of HR Development; Training of Health Managers; GBV Training; NICU Training

3. **Health services**: Quality of Care Assessment; CEmONC equipment (10 hospitals); BEmONC

4. **M&E**: PMTCT

5. **Advocacy**: Safe Motherhood Campaign

6. **Community participation/empowerment**: Training of Women’s Association Members
### GUINEA BISSAU

1. **Policy**: National plan of action for prevention and eradication of GBV validated (December 2013); National Gender Policy approved by the Ministerial cabinet (7 May 2014)

2. **Midwifery workforce**: Training of 88 health providers of 5 regional Hospitals and National Hospital Simao Mendes in support to CEmONC; Training of 64 PVVH (NGO RENAP+); CHWs recruited, Establishment of MWHs

3. **Health services**: equipment and materials for community actors (CHW)

4. **M&E**: strengthening capacities for M&E of the H4+ grant

5. **Financing**: Feasibility Study of the Free care mechanism conducted (WHO)

6. **Community participation/empowerment**: Train members of NGOs and community associations on SRMNI / HIV / VBG for the implementation of communication activities

### LIBERIA

1. **Coordination**: Supporting the functioning of the CCSS and its sub-committees at central and regional level: One coordinating committee of the health sector has been established

2. **Drugs, commodities, technologies**: Providing all structures-with medicines, vaccines, therapeutic foods, medical supplies for child care; Providing all structures-with medicines and consumables for maternal, neonatal, care for PLHIV and abused women and adolescents; Equipping and developing hardware structures of the seven target areas for the delivery of maternal, newborn, HIV, women victims of violence and adolescents

3. **Health services**: Acquiring the means of transport (3 ambulances and 30 motorcycles adapted to transport at the rural level) to achieve the references against references; Five formative supervisions have been conducted, 7 more progressive supervisions are planned

4. **Midwifery workforce**: recruitment of international experts for a year

5. **M&E**: Harmonize the National health information system (HIS), incorporating indicators SRMNI (SRH / HIV / GBV), disaggregated by sex and age: a workshop was organized

6. **Advocacy & Communication**: High level advocacy meeting held with parliamentarians and authorities at National, County and district levels; Media engagement through community radio talk shows for awareness creation at county level; Collaboration with media networks on population and development; Sensitization meetings held with county, district and community leaders, community members, CBOs and CSOs and radio talk shows held at the project sites

7. **Drugs, supplies and technology**: Supply chain bottleneck analysis and Commodities availability survey conducted in 2013 (reports available); Essential drugs, equipment and medical supplies procured and supplies movement to health facilities supported

8. **Health services**: Health facility assessment conducted; One 4x4 Land cruiser, 6 motocycles (2 per county), 3 covered-tricycles provided to project counties (1/ county) to facilitate drugs and supplies distribution; Instructional and skills laboratory materials procured and delivered; CHS and CHSWTs,
200 CHVs (150 TTM s and 50gCHVs) identified

8. **M&E**: monitoring and supervision visits to project sites, Some H4+ indicators integrated into National M & E frame work

1. **Standards**: Developed/adapted standards and protocols (pre-eclampsia, eclampsia, postpartum hemorrhage, ANC and PNC, ENC) printed and disseminated

2. **Capacity-building**: strengthening central and County Health Teams through quarterly review meetings in targeted counties; Supporting women solar technicians locally to install and manage solar lighting system at all primary facilities (UN Women); Support the rollout of adolescent strategy and standards through training of service providers and establishing adolescent friendly services in selected communities in the target counties.

3. **Drugs, supplies and technology**: Equipment and supplies listing developed in collaboration with project County Health Teams procurement process on course

4. **Midwifery workforce**: 47 out of 72 health workers from the 3 counties trained in EmONC, Kangaroo Mother Care and use of Anti Shock Garment for PPH prevention; Review & update the Registered Midwifery Curriculum; Upgrade the skills of 42 laboratory techs and assistants in targeted facilities providing BEmONC and CEmONC services; Training in essential new born care

5. **Health services**: Provide essential utility/services such i.e. water as appropriate, infection prevention supplies at all 15 BEmONC and 3 CEmONC facilities in targeted (10 out of 15); Equipment with solar lighting system in 3 hospitals (CEmONC facilities; Assessment of Pediatric AIDS care services, Improve neonatal services in 3 hospitals with comprehensive neonatal units and helping baby breathe kits for 15 clinics; Support the implementation of postpartum family planning activities in all health facilities in targeted counties

6. **Standards**: revision of the National PMTCT guidelines; Development of the national eMTCT plans

7. **Advocacy, communication**: Advocacy and social mobilization activities through media, women and men groups to mitigate socio-cultural barriers on accessing essential MNH services targeting community leaders (especially men) individuals and families

8. **Community participation/empowerment**: Training 150 community leaders including men, women and youth in community self-assessment to increase community involvement and participation including priority setting and oversight on uptake of MNH Services; Training 160 community health volunteers (CHVs) on home-based MNH care and support related activities on Family Planning Counseling, community based distribution of commodities and services within catchment communities of 18 health facilities

9. **M&E**: Rapid assessment for the National HMIS to report on the agreed indicators and establish baseline for selected programme indicators; MDSR: Strengthen Maternal and Newborn death reporting through the integrated disease surveillance system; Building capacity for data collection, reporting and quality assurance
1. **Policies**: National Post Natal Care (PNC) strategy revised and Food & Nutrition strategy developed; Food & Nutrition strategy developed;

2. **Human resources for Health**: computerized IMNCI training introduced in Medical school; 150 VHWs and community volunteers trained on IYCF; 39 Peer Educators & 20 Health Workers trained on YFSOs; TOT on Growth standards conducted;

3. **Health services**: Strategic planning: needs assessment of identified 6 CEmONC, 10 BEmONC, 21 BEmONC; EmONC Facility Assessment conducted (infrastructure, commodities & capacity building);

4. **M&E**: Monthly and Quarterly reporting formats for districts developed

1. **Policies**: Advocacy for contraceptive failure inclusion for the criteria to access safe abortion; Development of the MDSR framework: stakeholder meeting; Advocacy campaign to mitigate socio-cultural and religious barriers to access essential MNCH, SRHR, GBV and HIV services

2. **Coordination**: MoHCC National and District H4+ Focal Persons identified and notified; Quarterly review meeting under MoHCC leadership; Regular H4+ meetings

3. **Standards**: Standards: adaptation and reproduction of new 2013 WHO Guidelines for PMTCT & Pediatric ART; Consultation to revise delivery room and operation theatre registers

4. **Strengthening coordination and partnerships**: regular H4+ Monthly meetings; Monthly and Quarterly reporting formats for districts developed; Support quarterly national subcommittee on POC EID, Pediatric ART and MNCH

5. **Capacity building** for Health managers: DMOs, DNOs, hospital matrons; Identify a lead medical institute/technical agency for capacity building of key resource persons

6. **Human resources for Health**: Needs assessment of 3 provincial hospitals and 3 district hospitals for strengthening training sites; On-site training of 3 health workers per facility to perform lab tests; Training and support of community workers in infant feeding counselling; Training in pediatric ART covering at least 37 health workers

7. **Health services**: Procurement of 34 motor bikes for EID, DNC/PCR blood sample transportation; Regular quarterly supervision: site support visits;

8. **Community participation/empowerment**: Partners for community engagement for creating and capacitating community women’s and men’s forums on RMNCH issues identified; Creation of women’s and men’s forums on MNCH, SRHR and HIV services; Supporting 120 traditional leaders to carry out campaigns to reach under-served populations for motivating to access RMNCH

9. **M&E**: National Quarterly planning/review meetings with districts

10. **Research**: Study on “determinants” of high adolescent fertility; Study on health seeking behavior promotion
4. MONITORING AND EVALUATION

Challenges vary but all countries with field activities recognized difficulties in collecting accurate and quality data at sub-national level. These difficulties are related to weak NHMIS, lack of specific mechanism to collect interventions related indicators, absence of effective mechanisms to transfer data from sub-national to national level. This has not always been anticipated and solutions need to be proposed. H4+ principle is to strengthen existing NHMIS and not creating parallel mechanism.

It is noted that all countries implementing at district level have developed an appropriate base line. No country has contracted an institution (national or sub-national) to assist in data collection and analysis.

Zimbabwe: The main challenge is the availability of information / data, especially at sub-district level and the use of the same in regular programme review at every level. Though the HMIS exists yet the timely availability of data for use in programme improvement is a challenge. Districts generally do not have correct and complete HMIS data for use. It follows that the mechanism of data based monthly review and feedback at every level is weak. This is also due to poor capacity in data handling, timely flow, analysis, dissemination, and feedback at district and sub-district levels. The problem is acute in Zimbabwe also due to lack of human resource, challenges in the universal availability of modern communication technology, especially in H4+ districts that are relatively remote and under-developed. Nevertheless, as highlighted above, the national HMIS does exist and has mechanism of collecting regular data; for the same, there are standard registers and reporting formats. However, there is a need for ensuring correct use of these at facility levels. Enhanced supportive supervision visits to facilities for on-the job training / capacity building on data element definitions and use of recording registers and reports can improve the data collection at facility levels. The use of HMIS can further improve by strengthening the capacity of the existing system in ensuring availability of monthly indicator based analysis to districts and provinces and the use of the same by them in their monthly reviews to inform programme implementation.
<table>
<thead>
<tr>
<th>Country</th>
<th>Challenges</th>
<th>Proposed solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>The first baseline survey carried out in 2013 was incomplete, low reliable, with data of poor quality. There is a need of additive data collection and analysis.</td>
<td>Active data collection has been done to complete M&amp;E template; but there is a need of implication of an institution to assist in data collection and analysis. Because of the NHMIS weakness, projects and programs are using their own tools for M&amp;E. It is strongly recommend organizing a high level meeting for harmonization of the M&amp;E in country. Adoption of the H4+ Implementation monitoring tool to monitor the essential data and following up activities and financial progress.</td>
</tr>
<tr>
<td></td>
<td>The NHMIS is weak and weak coordination at all levels nationwide, particularly in the far north region where data completion rate is low (70%) and data of poor quality.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Three different tools used for M&amp;E: activities, data, and finance.</td>
<td></td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>Low completeness of data at the local level</td>
<td>Baseline data collected at the local level to review the interim and final targets</td>
</tr>
<tr>
<td></td>
<td>- Delay in the production of data by the national health information system</td>
<td>- Collaboration with the Ministry of Health (DDS, DR, responsible for epidemiological surveillance) for the systematic collection and monthly quarterly analysis</td>
</tr>
<tr>
<td></td>
<td>- Frequent breaks for data collection tools</td>
<td>- Support for the provision of data collection tools to health facilities</td>
</tr>
<tr>
<td></td>
<td>- Low quality of data collected</td>
<td>- Quarterly Meeting validation</td>
</tr>
<tr>
<td></td>
<td>- Inadequate supervision of providers</td>
<td>- Organization of training supervision (DDS) to improve the quality of data collection</td>
</tr>
<tr>
<td></td>
<td>- Lack of routine data for the calculation of some indicators (exclusive breastfeeding)</td>
<td>- Organization of technical coordination meetings two times each month to review the progress in the implementation of the activities and adoption of corrective action when necessary;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Organization of monthly and quarterly financial and technical review. Each sequence is accompanied by follow-up report to better track quickly any implementation issue.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- During each meeting, the weaknesses will be identified and a plan will be systematically designed to address the key issues</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Some outcome indicators (in this project) are not captured by the HMIS</td>
<td>Engage the MOH to explore ways of capturing the outcome indicators, including the possibility of conducting surveys</td>
</tr>
<tr>
<td></td>
<td>Competing priorities hampering implementation of M&amp;E activities</td>
<td>Emphasize prioritization of M&amp;E activities in high level meetings between MOH and the UNH4+</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Lack of investment in national HMIS</td>
<td>Advocacy towards the upcoming government to own the process and invest more national</td>
</tr>
<tr>
<td>Country</td>
<td>Problem</td>
<td>Solution</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Liberia</td>
<td>Some key H4+ indicators not captured by national HMIS</td>
<td>H4+ indicators integrated in national HMIS (June 2014)</td>
</tr>
<tr>
<td></td>
<td>National HMIS does not disaggregated RH indicators including maternal health and family planning information by age</td>
<td>H4+ team will work with Central MOH and County Health Teams to collect disaggregated data from routine data sources at the health facilities</td>
</tr>
<tr>
<td></td>
<td>Delayed disbursement of funds for the implementation of project activities may have resulted in slow/delayed implementation of activities thus hampering timely reporting</td>
<td>Continue working with Central MOH on present funding mechanism while discussions on direct implementation with the project counties is being discussed</td>
</tr>
<tr>
<td></td>
<td>Limited program funding space in WHO Country Office</td>
<td>Continue advocating with AFRO to increase the funding space so that unbudgeted funds can enter the system</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Non availability of correct information at district and subdistrict levels</td>
<td>Regular monitoring of districts in the correct use of existing registers and formats and if required training in their use</td>
</tr>
<tr>
<td></td>
<td>HMIS based monthly review mechanisms at districts is weak</td>
<td>Establishing a mechanisms of monthly review of RMNCH programmes at districts based on the monthly HMIS report for the district</td>
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<tr>
<td></td>
<td>Lack of adequate number of qualified Human resource at district and subdistrict level</td>
<td>Advocacy for making available this critical human resource at districts</td>
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<td></td>
<td>Lack of capacity of existing staff at district and subdistrict level in data handling, analysis and feedback</td>
<td>Capacity building of existing district level officials responsible for data handling</td>
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<td></td>
<td>Lack of adequate number of qualified staff at national HMIS division of Ministry of Health to monitor districts</td>
<td>Providing M&amp;E HR support to HMIS division of MoHCC</td>
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</table>
5. MAIN CHALLENGES

Cross-Country: main challenges

<table>
<thead>
<tr>
<th>Country</th>
<th>Cameroon</th>
<th>Côte d’Ivoire</th>
<th>Ethiopia</th>
<th>Guinea Bissau</th>
<th>Liberia</th>
<th>Zimbabwe</th>
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<tbody>
<tr>
<td>Delays in receiving funds</td>
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<td>Delays in financing/administrative processes</td>
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<td>Delays in purchasing/reception</td>
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<td>MoH capacity/competing priorities</td>
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<td>Contracting IP</td>
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<td>Recruitments</td>
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<td>Lack of HR</td>
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<tr>
<td>Low salaries/motivation</td>
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<tr>
<td>Context</td>
<td>Polio epidemic</td>
<td>Ebola</td>
<td>Political instability</td>
<td>Ebola</td>
<td></td>
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<td>Supervision</td>
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<tr>
<td>Additional funding</td>
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<tr>
<td>M&amp;E</td>
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<tr>
<td>Sustainability</td>
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</table>

*For Zimbabwe, salary top ups are being provided by some projects. This provides bigger motivation for staff to focus more on them. Thus, indirectly it affects the programme performance.

Main challenges per country

CAMEROON

- HMIS and local collection of data ++
- Polio emergency
- Insecurity in program areas with delayed implementation in some zones.
<table>
<thead>
<tr>
<th>Country</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>CÔTE D’IVOIRE</td>
<td>Delays in receiving funding that delays implementation of RMNCH activities</td>
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<tr>
<td></td>
<td>Changes in national priorities</td>
</tr>
<tr>
<td></td>
<td>Competing priorities slowing implementation</td>
</tr>
<tr>
<td>ETHIOPIA</td>
<td>Delays in receiving funding that delays implementation of RMNCH activities</td>
</tr>
<tr>
<td></td>
<td>Changes in national priorities</td>
</tr>
<tr>
<td></td>
<td>Competing priorities slowing implementation</td>
</tr>
<tr>
<td>GUINEA BISSAU</td>
<td>Critical shortage of skilled health workers at all levels of care where there are health workers</td>
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<tr>
<td></td>
<td>often there is inequitable distribution in the periphery</td>
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<tr>
<td></td>
<td>limited training and supervision at health facilities</td>
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<tr>
<td></td>
<td>recurrent strikes over poor remuneration</td>
</tr>
<tr>
<td></td>
<td>Absence of M&amp;E system at MoH</td>
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<tr>
<td></td>
<td>poor data collection at health facility</td>
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<tr>
<td></td>
<td>lack of funding for a recently opened midwifery school</td>
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<tr>
<td>LEBERIA</td>
<td>Capacity building at all levels</td>
</tr>
<tr>
<td></td>
<td>Limited network of facilities</td>
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<tr>
<td></td>
<td>HMIS not comprehensive enough (Adolescent health)</td>
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<tr>
<td></td>
<td>Delay disbursement of funds for implementation to project site (Counties)</td>
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<tr>
<td></td>
<td>Lack of motivation package for Community Health Workers</td>
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<tr>
<td></td>
<td>Implementation limited by MoH capacities as well as national NGOs</td>
</tr>
<tr>
<td>ZIMBABWE</td>
<td>M&amp;E – HMIS: difficulties to get data from districts</td>
</tr>
<tr>
<td></td>
<td>Lack of manpower at district level for the H4+ activities and competing interests related to pop-ups</td>
</tr>
<tr>
<td></td>
<td>Effective use of district H4+ Nodal Officers</td>
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<tr>
<td></td>
<td>Difficulty in assuring timely flow and availability of accurate data from districts to national level to H4+ despite having the reporting formats</td>
</tr>
</tbody>
</table>
## 6. INNOVATIONS and LESSON LEARNED

### Cross-Country analysis

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INNOVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>• Obstetric kits,</td>
</tr>
<tr>
<td></td>
<td>• priceless phone network</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>• SRH mobile services</td>
</tr>
<tr>
<td></td>
<td>• Community-based FP distribution</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>• Quarterly bulletin reflecting H4+ joints programme activities</td>
</tr>
<tr>
<td></td>
<td>• Maternity waiting homes keeping women on higher risk nearby health facilities</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>• Health Development Army initiative</td>
</tr>
<tr>
<td></td>
<td>Integrated Emergency Surgical and Obstetric Officers (IESO)</td>
</tr>
<tr>
<td>Liberia</td>
<td>• Use of Motorcycle wagons for the transportation of RH commodities to nearby health facilities</td>
</tr>
<tr>
<td></td>
<td>• Use of Anti Shock Garments for the management of Post-partum Haemorrhage and Chlorhexadine for umbilicus care</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>• Use of social media to reach young people with information and education on SRH.</td>
</tr>
<tr>
<td></td>
<td>• Mobile technology for facilitating referral linkage between facilities and communities</td>
</tr>
<tr>
<td></td>
<td>• Use of PoC PIMA CD4 Count machines</td>
</tr>
<tr>
<td></td>
<td>• Plans to pilot seal of quality for BeMONC facilities</td>
</tr>
<tr>
<td></td>
<td>• Socialising health messages in health campaign</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>LESSON LEARNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>Strong collaboration with local partners</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>Coordination Stronger collaboration with partners and within the H4+</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Involvement of the MoH and HMIS from the first day of the grant’s plan of work development. Engagement of Parliamentarians and local leaders to support and sustain project interventions</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Strong engagement with government and filling critical HR gaps in the Ministry of Health either by way of providing additional hands or by building capacity have potential to pay huge dividend</td>
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</tr>
</tbody>
</table>

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### 7. COORDINATION (H4+ and inter-partners)

<table>
<thead>
<tr>
<th>Countries</th>
<th>H4+ Coordination</th>
<th>Partners coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>Strong, WB not involved yet but will be as the WB is extending strategy PBF to Northern regions Coordinator recruited (Unicef)</td>
<td>Strong at regional level Monthly meeting in national level coordinated by MOH with participation of partners. Quarterly meetings of Sida H4 head of agencies</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>Good collaboration between agencies, technical meetings are held regularly Coordinator recruited (UNFPA) WB participated in meeting of the Technical Coordination</td>
<td>Strong at national and regional level (8 Monthly technical coordination meetings were held (agencies and the Ministry of Health) quarterly meetings at the regional level</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Strong, with regular technical meetings WB: weak collaboration</td>
<td>Strong national and regional level coordination of partners by MOH. An Inter-Agency Task Team on MNCH (EIATT-MNCH) also works to coordinate the USG offices with UNH4+</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>Strong – monthly technical meetings with participation of head of agency H4+ Coordinator under recruitment</td>
<td>Coordination meeting between EU partners (PIMI) Global Fund, SNLS and H4+ (every 2 months) and extraordinary meetings held when necessary</td>
</tr>
<tr>
<td>Liberia</td>
<td>Good – regular technical and head of agency meetings H4+ coordinator recruited (WHO) Collaboration with the World Bank is poor until now</td>
<td>H4+ contributing to improve coordination of partners At county level coordination has to be strengthened – on progress</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Strong. H4+ National Steering Committee just established to improve coordination with MoH WB is associated</td>
<td>Strong</td>
</tr>
</tbody>
</table>
Part 2: H4+ Sida grant - Global activities

Are included in this report all activities started and/or achieved. Funding was made available after approval of the Global plan of work by the Steering Committee at the New York meeting which occurred on the 12 March 2014. A number of activities in fact started before the final adoption of the plan of work, using other sources of funding. These activities, pertaining to the H4+ Sida grant, are reported here.

Area 1: Community based interventions

1-A To harmonize UN H4+ efforts in regards to the social determinants of RMNCAH and develop a common UNH4+ approach to address community empowerment, women’s empowerment, and mobilization towards addressing barriers to access and utilize RMNCAH services (UN Women on lead)

A concept note is under development based on UNW priority issues, including structural factors such as child marriage, legal empowerment, SGBV and SRHR access.

1-B Tools to assess and plan community engagement in improving quality of RMNCAH services (WHO on lead)

1-B. 1 Tools to analyse and address barriers of women, children and adolescents to access RMNCAH services

Toolkit for participatory community planning for MNH updated, including module to develop subsequent district plan with key partners, and to monitor progress and evaluate impact.

1-B. 2 Draft module for health care workers and providers at all levels on human rights standards of RMNCAH care

- Toolkit for participatory community planning for MNH was updated to include comments from reviews by gender and human rights experts;
- CHWs materials for Caring for newborns and children in the community is being updated to integrate actions for HIV and TB care
- A self-evaluation tool for rights based primary health care service for children and adolescents is being developed. Planned to be field tested in 2014.

1-B.4 Adapt indicators of community systems strengthening to RMNCAH

Key indicators for strengthening community participation and community based interventions for MNH identified and reviewed by teams in Haiti, el Salvador and Burkina Faso

1-C Communication for development (C4D) (UNICEF on lead)

To strengthen development, implementation, and monitoring of community-based reproductive, maternal and newborn interventions. To facilitate the achievement of desired behavioral and social change objectives towards increased utilization of RMNCAH services.
UNICEF’s work on Communication for Development (C4D) seeks to support the creation of a conducive environment for children and their families through the adoption of safe and healthy behaviors and norms. C4D is a systematic, planned, and evidence-based approach to promote positive and measurable behavioral and social change by engaging communities and decision-makers at local, national, and regional levels, in dialogue toward promoting, developing, and implementing policies and programs that enhance the quality of life for all.

1-C.1 UNICEF, in collaboration with partners, is planning two regional workshops on MNCH and C4D in June 2014. The aim is to build the capacity of country teams from different sectors on identification of C4D evidence-based interventions for MNCH, provide technical guidance for development and implementation of C4D strategies in MNCH using the global C4D guide; Country participants are also expected to share experiences and learn from others to strengthen the quality of C4D programmes for MNCH. Participants are expected from the following countries:

- C4D/MNCH Workshop in West and Central Africa: 4 Sida H4+ countries (Cameroon, Guinea Bissau, Liberia, Cote d’Ivoire) and 1 H4+/Canada country
- C4D/MNCH Workshop in East and Southern Africa: 2 H4+/Canada countries (Zimbabwe and Zambia) and 4 additional countries (Tanzania, Somalia, Kenya and Uganda)

1-C.3 UNICEF coordinated the development of a Global Communication Strategy Development Guide for Maternal, Newborn, and Child Health Programs Guide. The C4D global guide has been conceived as a step-by-step tool to assist program managers and program planners to determine the behavioral, social and communication context for MNCH C4D programs and to follow strategic program planning steps for evidence-based, equity-focused, multi-level, culturally- and population- appropriate, coordinated communication activities. The focus is on shifting the C4D paradigm from programs that mainly address change at the individual and/or household levels, to a more holistic assessment and engagement with the environment and social system. The Guide consists of 3 modules that address the various steps in developing a communication for development strategy, with an example of how to develop a strategy specifically for Maternal, Newborn, and Child Health (MNCH) programs. Draft available.

**Area 2: Quality of Care (WHO on lead)**

2.1 Regional capacity building

- Facilitated and provided support during the national mid-term review of the implementation of the paediatric quality of care improvement initiative, in Ethiopia (29.10-2.11 2013) (Wilson) (Swedish grant has contributed to this activity, main donor is Russia)

- A joint WHO/UNFPA mission to Guinea Bissau demonstrated the dearth of midwifery personnel and midwifery education. WHO is making available resource materials and actively reaching out to Portuguese speaking midwives in order to support the country.

- Contributed to the organization and facilitation of the orientation of East Africa Countries on the QOC in first level facilities June 2014 (Zimbabwe, Ethiopia, South Sudan, Botswana, Mozambique, Zambia, Malawi & Uganda). Representatives from UNICEF, USAID, ECSA and UNFPA were also present.)
• Capacity building workshops were organized in September (global –London) and October 2013 (regional-Addis Ababa) for MDSR implementation

2.3 Human right assessment of quality

A self-evaluation tool for rights based hospital care for children developed at regional level. This is being adapted for global application.

2.4 Quality of health standards for adolescent health

A meeting is being planned in September 2014 to gain global consensus on indicators, including service indicators, for adolescent health and development

2.6 E-learning modules

A Request for Proposals to develop the Essential Childbirth Care Course (ECBC) has resulted in the selection of the University of Manchester’s School of Midwifery (a candidate for a WHO Collaborating Centre). A workplan is in place and a working group is being established.

WHO modules on Essential Newborn Care and Ante-natal Care are being updated and placed in the E-learning platform (ICATT).

Area 3: Human Resources/midwives

3A Human Resources for RMNH (UNFPA on lead, with WHO and H4+ support at country level): To inform a review of the existing Human Resource for Health strategy/plan and the annual implementation priorities and to highlight the importance and added value of focusing on HRH planning and horizon scanning.

3A.1. Assessments of Midwifery Workforce (MWA) in two countries (Mozambique and Nigeria)

This activity, to be fitting in the national agendas, is facing constraints and challenges. It consists of two steps: a first step related to desk review and national stakeholders meeting, and a second step related to additional targeted data collection and secondary analysis. In Mozambique, the first step has been conducted successfully but it took more than four months to obtain the authorization from the National Research Ethical Committee to conduct additional surveys. The second step will therefore start as soon as possible. In Nigeria, the step one has started and contacts established with a number of stakeholders. We are looking at the possibility to build upon human resources assessments conducted recently in five Northern States with the support of the Clinton Foundation. It is expected that security situation in the Northern States will slow down the research process.


3-A.4.1 Printing and shipping of the report: Report printed in English, French and Spanish, (and Executive summary translated into Arabic); dissemination ongoing, including hard copies, CDs and USBs

3-A.4.2 Communication and advocacy: materials developed, including Press releases, media interviews, videos, twitters. With Johnson & Johnson financial support Family Care international has developed SoWMy2014 Advocacy toolkit (English, French, Spanish) to support national launches.
3-A.4.3 Launch at ICM Congress, Prague: 3\textsuperscript{rd} of June

3-A.4.4 Country launches: ongoing work – Around 20 countries have already planned to have a national launch of the SoWMy2014 report

The State of the World’s Midwifery report has been successfully launched on the 3\textsuperscript{rd} of June at the ICM Congress in Prague, as initially planned. 73 countries have collaborated to the report, representing 92\% of the maternal mortality in the world. The Sida funding, together with funds provided by Canada, France and Johnson and Johnson, has played an important role in the development of the report, in its publication and shipment to Prague and concerned regions, in the launch at ICM Congress, and in country launches.

The publication of the report, led by UNFPA, WHO and ICM, has requested the contribution of a number of experts, the Core group coordinated by Integrare ICS, with the support of a Steering Committee with representatives of many donors and international NGOs.

The report is providing cross-country analysis of the availability, accessibility, acceptability and quality of the midwifery workforce. It includes 73 country briefs summarizing the current situation of the midwifery workforce and proposing projections based on possible informed policy decisions and investments to fill the identified gaps.

The report is providing a cost-effectiveness analysis based on Bangladesh data and is developing the Midwifery 2030 Vision, addressing the key issues in regard to the global and national maternal and newborn mortality targets, the Elimination of the preventable maternal mortality and the Universal Health Coverage. This report has now to be used to influence the national policies as well as the international community: the Midwifery workforce is critical for any progress toward the elimination of the preventable maternal and neonatal mortality and to respond to the right of any woman, any adolescent girl and any man to have access to efficient and quality sexual reproductive health services. The report will be presented at the MHTF Partners’ Forum, at FIGO regional Congresses, at the UNGA and during more than 20 national launches.

3-B.1 The WHO-ICM-FIGO statement on SBA policy updated (WHO lead)

A Conceptual Framework has been developed that sets out the rationale, process and research question for analysis of the joint WHO-FIGO-ICM SBA Statement 2004 on the impact of quality of care in MNH services. A WHO convened meeting on “Quality of Care in Midwifery Services” (October 2013) enabled analysis based on a presentation of (pre-publication) evidence from the Midwifery Lancet Series and resulted in agreement between WHO-FIGO-ICM to review the statement. Both the Conceptual Framework and the QoC meeting created opportunities for leverage with additional partners, and discussions are ongoing with the WB and DFID. Further analysis on benchmarking for quality midwifery services was presented at the QoC Midwifery meeting, and WHO has established, and is leading, a partnership with DFID, USAID, the London School of Hygiene and Tropical Medicine (LSHTM), and the Liverpool School of Tropical Medicine (LSTM).

3-B.2 (WHO lead)

Work has been initiated to update two midwifery toolkits, the Strengthening Midwifery Toolkit (SMTK) and the Standards for Midwifery Practice. This links closely to the Area 2 focus on QoC , contributing to the strengthening of capacity and development of tools to enable QoC through standards.
3-B.3 (WHO lead)

Progress towards a Global Action Consensus to improve QoC through the empowerment, respect and safety of midwives includes a systematic mapping of the socio-cultural, economic and professional barriers (final draft under peer review). The key findings were presented at the ICM Triennial Congress as part of the WHO Partner Panel on QoC, and a workshop held on “Midwives Realities” (in Spanish, Arabic and English). A Survey Monkey has been developed for all midwives in four languages and is on the ICM website. TOR’s for a systematic review of interventions are in process, and a WHO Collaborating Centre identified. Discussion with MCA and RHR rights experts have opened up dialogue with the ILO Gender Unit on their “decent work “programme. The WRA and the ICM continue to be key partners .Additional donor support (USAID) is enabling expansion of this agenda.

3-C.1 (WHO leading)

Assessments of the adolescent content of pre-service curricula have been completed, followed by a workshop to identify the key domains. A User Guide on “Core Competencies in Adolescent Health for Primary Health Care Workers” is in its final draft and under peer review. This gives focus to pre-service training, addressing competencies through improving knowledge, skills and attitudes.

In addition to the above:

- A UNFPA-WHO visit was made to Guinea Bissau to jointly assess the situation in midwifery services, education, regulation and association and identify key areas for support. The current inputs from WHO and UNFPA to the H4+ plan were reviewed, key officials met, and the seriousness of the crisis in maternal and newborn mortality and morbidity better understood through visits to the central and 3 district hospitals. A follow-up meeting was held between the WR and MCA, with actions points focused on ensuing health workers will be oriented to WHO tools and guidelines on QoC in MNH, the ENAP, MDSR and others, with quarterly virtual meetings and monthly online support. Through a regional PAHO Midwifery meeting, WHO, supported by the Latin America Associations of Midwives (FLO), has identified Portuguese speaking midwives (from Brazil) willing to work in Guinea Bissau.

Area 4: Evidence based protocols and Standards (WHO lead)

4-1 Convening H4+ partners at global level, regional, and country levels

4-1.2 Synthesize and disseminate technical updates on RMNCAH guidelines

The WHO Recommendations for Postnatal Care of the Mother and Baby were published in December 2013 and is being disseminated.

4-2.1 Conduct orientation workshops with country team to facilitate the uptake of new guidelines

24 consultants were briefed on the core RMNCH guidelines, strategies, and plans during the training of consultants in the “RMNCH Country engagement workshop” held in Geneva in February 2014.

4-2.2 Document the uptake of guidelines in the six countries
A Global MNCAH policy indicator database based on policy indicator surveys tracks the implementation of policies and guidelines prompted by the MCA/FWC/WHO. A recent survey was conducted in 2013-14. There are 108 countries in the database, including 69 out of 75 high priority countries. All countries covered by the Sida grant are included. A consolidated report and policy indicator dash boards is under preparation prepared for wider dissemination of this data through MCA/FWC/WHO website. Some of the policy indicators are listed below

- 32 out of 69 high priority countries have a national policy requiring all maternal deaths to be notified within 24 hours to a central authority
- 50 out of 69 high priority countries have a national policy requiring all maternal deaths to be reviewed
- 28 out of 69 high priority countries have a community maternal death review (audit) process in place
- 41 out of 69 high priority countries have national guidelines on management of pneumonia in the community or at home by a trained provider
- 66 out of 69 high priority countries had a national guidelines on the use of low osmolarity ORS
- 65 out of 69 high priority countries had national guidelines on the use of Zinc for the management of diarrhoea?
- 49 out of 69 high priority countries had national standards for delivery of health services to adolescent ages (10-24 age group) with a clearly defined package of health services

4-2.3 Develop policy products to facilitate uptake of guidelines in English and French

4-3 Develop and test tools to fills gaps in uptake of RMNCAH guidelines

MCA tested the handbook for community interventions in Liberia in February 2014. The selection of the site responded to a request by the WHO country office for assistance in reviewing current approaches and tools for training CHWs. The field test was well received and assisted in clarifying who should be trained and what how supportive conditions should be put in place. The workshop led to a better understanding between partners on way forward.

**Area 5: Monitoring and evaluation**

5-A **Improved contribution to strengthened health systems through an increased focus on quality in programme implementation processes (UNFPA on lead)**

5-A.1 Monitoring tools developed

*H4+ Programme implementation monitoring tool.* A first version of a Programme Management and Monitoring tool (Excel tool) has been developed and field tested in three H4+ Sida grant countries. The tool has also been introduced to all H4+ partners who have welcomed it and provided feedback for improvement. Following this feedback, a more convenient online tool, called “di Monitoring” (Dev.Info Monitoring), already used by other UN agencies (eg: UN Women, UNDP) was presented to the countries supported by the H4+ Sida and Canada grants. “di Monitoring” facilitates the tracking and reporting of the status of activities and related indicators and ensures that all stakeholders use the last updated work plans. Critical features from the initial Excel tool, such as
a dashboard and a cost management module, are currently added in “di Monitoring” and will be available in Q3-Q4 2014. Trainings and use will then be field tested in some countries.

This new Programme implementation monitoring tool will be presented to the Muskoka French Fund and will be used by the RMNCH Trust Fund in 2014.

Additional achievements (WHO)

- Developed a global core set of indicators for measuring quality of MNCH care in health facilities
- Service Availability Readiness Assessment tool (SARA) revised to include quality of RMNCH care assessments
- Conducted a review on RMNCH monitoring tools in emergency settings

5-A.2 Unplanned obstacles and constraints in implementation removed or addressed - US$ 100,000

Training sessions and continuous support will be organized for all H4+ Sida and Canada grant countries to ensure effective ownership and implementation of the Programme Implementation Management and Monitoring tool. At country level, the tool will improve the implementation of the programme and facilitate H4+ coordination meetings by helping country teams identify and address activities that are off-track or pending. It will also facilitate the reporting of indicators and ensure proper documentation of meetings and source of data. At Global level, the tool will improve the overall management of the programme and facilitate communication with countries and donors by providing access to last updated work plans, costs, and indicators.

WHO: Meta-review of facilitators and barriers to quality of care performed in 2013. Finding published in peer reviewed journal in May 2014

5B Monitoring and evaluation including progress tracking (UNICEF on lead)

5-B.2 Provide global/regional technical assistance to facilitate evidence-based planning

WHO: Contribution to development of RMNCH quality of care scorecards using DHS and MICS data for 74 priority countries. (last quarter of 2013)

5-B.5 Facilitate monitoring and reporting

WHO: Contribution to the development and analysis of the data collected through MCA policy survey. Up to now, data are analysed from 79 countries, among which 61 are priority countries. (first 2 quarters of 2014)

5-B Monitoring and Evaluation including progress tracking (UNICEF on lead)

UNICEF is a co-chair of the Every Newborn Group and recently coordinated, in collaboration with WHO, UNFPA, partners and countries, the development of the Every Newborn Action Plan (ENAP) to be launched in June 2014.

5-B.1 One of the milestones of the ENAP is implementation of the Every Mother Every Newborn (EMEN) quality improvement initiative. UNICEF and WHO, including partners, are working on the development of accreditation standards and criteria for the EMEN, as well as the development of quality of care indicators. In May 2014 a 1.5 day technical meeting on quality of care was organized with over 20 experts including midwives, obstetricians,
gynecologists, maternal and newborn experts. The outcomes of the meeting include an agreement on the broad domains for the EMEN quality standards and indicators. During the next three quarters UNICEF and WHO will work together to develop the EMEN quality improvement toolkit.

5-B.2 UNICEF, in collaboration with partners, developed the *Every Newborn Bottleneck Analysis tool* to provide technical guidance to countries to conduct bottleneck analysis for maternal and newborn care. The tool was used by more than 20 countries including H4+ countries (DRC, Cameroun, and Sierra Leone). Results from the bottleneck analysis informed the development of evidence-based strategies to address the key challenges that were identified at the country level, as well as the development of the global ENAP.

5-B.3 UNICEF provided technical support to H4+ Sida countries to strengthen their M&E systems.

- In March 2013, UNICEF conducted a follow-up mission in Cameroun to assess progress, discuss challenges and identify potential remedial actions, to provide technical support in strengthening the monitoring of the H4+ Sida grant and define linkages between M&E framework and implementation tool, and to provide technical guidance to identify innovative approaches to MNH and initiate discussion on the documentation process. Five working sessions with the H4+ Coordinator and focal points (Yaoundé & Maroua), three working sessions with the H4+ focal point at the regional level and the three DHMTs, and two field visits were organized. Key outcomes of the mission include the review of the M&E framework, Review of the implementation tool to ensure regular monitoring and availability of data for annual reporting, and agreement on next steps to strengthen the monitoring and reporting mechanism.

- During the H4+/Sida annual planning meeting the results of the mid-term review of the H4+/Canada Initiative were shared with all H4+ countries that participated in the meeting to disseminate lessons learned and strengthen the monitoring and evaluation on the H4+ Sida Initiative.

- A side meeting was organized with Zimbabwe country team to review the M&E framework.

5-B.4 Ten H4+ country fact sheets (funded by Canada and Sweden) were developed and shared with countries and Sida to provide brief update on programme implementation and progress.

**Area 6: Documentation of innovative approaches** (UNICEF on lead)

6.1 A guidance note for documenting innovative approaches to MNH was developed to enhance active documentation of best practices. The document was shared with countries during the recent H4+ annual planning meeting and also disseminated through the H4+ website. The template for documenting innovative approaches to MNH is available in English and French.

6.2 UNICEF is currently working with all H4+ UN Agencies in Cameroun (H4+ Sida grant), Burkina Faso, Zambia, Zimbabwe, and Sierra Leone (H4+ Canada grant) to develop a report compiling innovative approaches to MNH for the year 2014.
Conclusion

In less than one year, the country and global H4+ teams have started implementing important strategic activities, some being already achieved. This intermediary report 2013-May 2014 is demonstrating this well. After delays in the reception of funding the teams have been able to mobilise the energies at national and local level to contribute to achieve the substantive expected progress on access to and quality of the Sexual Reproductive/Maternal, Neonatal and Child health services. Challenges are still important however and the recent Victoria Falls meeting has been the opportunity to measure and address them, in particular in regard to the necessary focus on measurable results and the need to strengthen the monitoring and evaluation.

We would like to thank Sida for the critical support they are providing to the countries with high maternal, neonatal and child mortalities through the H4+ at global and national levels, and also thank the H4+ country coordinators and all colleagues for contributing to develop this report.