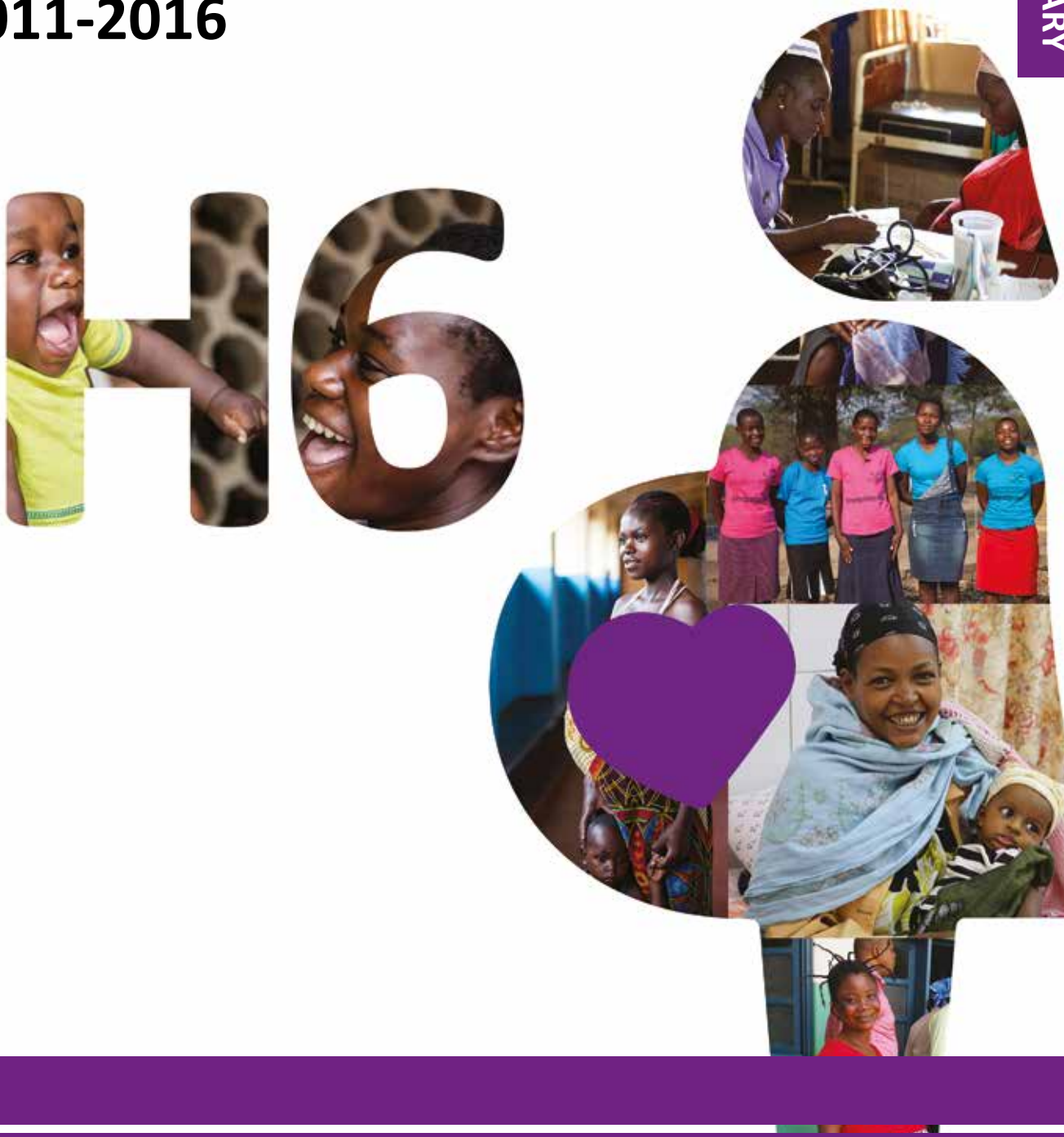
EXECUTIVE SUMMARY

End line evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011-2016



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PURPOSE AND SCOPE OF THE EVALUATION

The purpose of the evaluation is to support learning among key stakeholders from the experience of implementing the H4+ Joint Programme Canada Sweden (Sida), 2011-2016 (henceforth "H4+JPCS"). The lessons learned are intended to inform initiatives for delivery of comprehensive packages of services and support in the field of reproductive, maternal, newborn, child and adolescent health (RMNCAH). The evaluation also aims to support the H6 partners in the further development of their collaboration in support of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

The evaluation includes all ten countries participating in H4+ JPCS: *Burkina Faso*, *Cameroon*, *Côte d'Ivoire*, *the Democratic Republic of the Congo*, *Ethiopia*, *Guinea Bissau*, *Liberia*, *Sierra Leone*, *Zambia* and *Zimbabwe*. It covers the period from March 2011 to August 2016.

BACKGROUND OF THE EVALUATION

In 2008, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the World Bank launched the H4 partnership as a joint initiative. Its aim was to capitalise on the core competencies of each partner to ensure the continuum of care for maternal, newborn and child health. In 2010, United Nations Secretary General, Ban Ki-moon, launched the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) to accelerate progress to meet Millennium Development Goals 4 (a two thirds reduction in under-five mortality rate) and 5 (a three-quarters reduction in maternal mortality ratio and universal access to reproductive health). Also in 2010, H4+ became the technical arm of the Global Strategy and assumed the role of supporting the 75 high burden countries, where more than 85 per cent of all maternal and child deaths occur. The partnership was expanded to include UNAIDS (in 2010) and UN Women (in 2012) and was renamed the H6 partnership in 2016.

In an effort to accelerate progress toward meeting Millennium Development Goals 4 and 5, Canada (in 2011) and Sweden (in 2012) provided grant funding to the H4+ partners. In 2013, the H4+ partners developed a joint results framework, as a basis for jointly coordinated implementation of H4+JPCS as one programme.

METHODOLOGY

The overall approach to the evaluation is focused on identifying the contribution of H4+JPCS to accelerating and improving results in RMNCAH in the ten programme countries and to supporting the implementation of the Global Strategy. In doing so, the evaluation aims to assess the effectiveness and efficiency of the programme in strengthening national and sub-national health systems and improving access to integrated RMNCAH services across the continuum of care. It also identifies the programme's promotion of innovative methods and assesses the sustainability of the results achieved. By identifying ways H4+JPCS contributed to results, the evaluation also assesses the programme's added value at global and country levels. Contribution analysis serves as the central analytical framework for the evaluation.

Based on a review of programme documents, interviews with key stakeholders, and an exploratory evaluation mission to *Zimbabwe*, the evaluation team reconstructed the programme theory of change. This, in turn, guided the identification of key causal assumptions and evaluation questions. This information was captured in an evaluation matrix, which also identifies the indicators, data sources and analytical methods to be used to address the evaluation questions.

Methods of data collection used include country cases studies covering all ten programme countries. Field country case studies were conducted in four countries (*the Democratic Republic of the Congo*, *Liberia*, *Zambia* and *Zimbabwe*) and desk case studies in six countries (*Burkina Faso*, *Cameroon*, *Côte d'Ivoire*, *Ethiopia*, *Guinea Bissau* and *Sierra Leone*). Other sources of evidence include a comprehensive review of programme documents and interviews with key stakeholders at the headquarters of the H4+ partners and among regional and country H4+ teams. In the field case study countries, data collection encompassed a more in-depth review of country-specific documents, key informant interviews, focus group discussions and site visits. Interviews and focus group discussions included H4+ partners, national and sub-national health authorities, health services staff, implementing non-governmental organizations and individual women, girls, men and boys from communities receiving services, or participating in community engagement activities. Finally, the evaluation conducted an on-line survey of key stakeholders in countries with and without active H4+ country team (including countries outside H4+JPCS).

The analysis presented in this report is guided by the evaluation matrix (Annex 1 in Volume 2), where qualitative and quantitative data and information drawn from diverse sources is presented. The matrix structured the work of the evaluation team to test assumptions (from the reconstructed theory of change) and to systematically review the information collected (triangulation) with a view to confirming evaluation findings. Hence the evaluators could provide credible answers to the evaluation questions and identify the programme's contribution to results.

MAIN FINDINGS

H4+JPCS contributed to strengthening health systems in the ten programme countries by supporting initiatives aimed at addressing eight building blocks of health systems (health leadership and governance; health financing; health technology and commodities; human resources for health; information systems, monitoring and evaluation; service delivery; demand, including community ownership and participation; and communications and advocacy). At the country level, the programme applied a consistent approach to supporting health systems for RMNCAH which featured: positive alignment with national plans and priorities; the use of consultative planning and needs-identification processes; and engagement at both national and sub-national levels with a strong geographic focus on under-served districts. Interventions were planned and implemented to be complementary with existing support to the health sector and were sometimes catalytic in improving the effectiveness of related programmes (or mobilising resources for RMNCAH). In particular, the programme was effective in supporting efforts to strengthen national and local capacity for emergency obstetric and newborn care (EmONC) and maternal death surveillance and response (MDSR).

Taken together, programme efforts had the effect of contributing (along with other externally funded programmes and national efforts) to improvements in the availability of quality services in RMNCAH. These improvements came about despite some shortcomings in the delivery of planned support, including weaknesses in the flexibility and timeliness of programme systems and processes for procuring equipment, supplies and services. The fact that H4+JPCS supports national systems, such as maternal death surveillance and response (MDSR), as well as local capacities and capabilities, has helped to make national health systems function more effectively in delivering RMNCAH services. However, the gains in competencies and in quality of care supported by H4+JPCS are at risk. This is due to largely inadequate (or missing) effective exit strategies that would ensure continuing access to technical, financial and material support to RMNCAH, especially at the local level.

H4+JPCS made a significant contribution to expanding access to quality integrated care by those most in need in all ten programme countries. The joint programme was able to achieve this by building on the support it (as well as other programmes) provided to strengthen health systems and improve service quality. As a result, H4+JPCS contributed to improved outcomes, such as a reduction in home deliveries, improved attendance at antenatal care visits, and access to improved emergency obstetric and newborn care. Regarding the continuum of care, the programme was most effective in supporting the integration of HIV and AIDS programming into health services. However, it was not as effective in supporting the integration of family planning into RMNCAH services because family planning was not always adequately linked to H4+JPCS support.

The programme demonstrated that it is feasible to make progress in strengthening community demand for RMNCAH services within a restricted time frame. The role of UNAIDS and UN Women in supporting community engagements that challenge harmful sociocultural norms, including gender norms, was particularly notable. However, as its efforts to increase the quality and availability of service supply materialized, H4+JPCS faced the important challenge of finding a balance and raising the level of community engagement and demand for these services.

The ability of H4+JPCS to identify and systematically test and implement coherent, comprehensive policy and programming approaches to meeting the needs of adolescents and youth was uneven. While some country programmes were more successful than others, H4+JPCS, as a whole, did not effectively contribute to knowledge on how to design and implement measures to meet the sexual and reproductive health needs and rights of adolescents, in particular the needs and rights of girls and women.

The effectiveness of the programme's response to national and local needs was dependent on effective coordination all along the "coordination chain", from national to district and community level. For its own planning, coordination and review processes, H4+JPCS relied on a combination of existing country-led mechanisms for coordinating actions in RMNCAH and separate, programme-specific steering committees or technical working groups. The factor that most influenced the effectiveness of programme coordination (and responsiveness) was whether or not planning, coordinating and review mechanisms extended from national to local levels and whether they included effective participation by all implementing partners, including NGOs. Nonetheless, the **programme demonstrated a capacity to adjust and respond to changing needs and priorities at the country level**, including, for example, re-profiling support to countries affected by the Ebola virus disease crisis.

H4+ encouraged and supported innovation as part of its overall mandate to accelerate and catalyse action in support of improved RMNCAH outcomes, although adequate systems for supporting innovation as a learning process were not built into the programme from its beginning. As a result, this support was not fully developed until mid-way through the programme's implementation. Nonetheless, in each of the programme countries, there were attempts to implement innovative practices with the potential to improve outcomes in RMNCAH. The practical definition of "innovation" employed by H4+JPCS gave wide latitude to country programmes to identify interventions that made sense within their respective context and, in some countries, national authorities are in the process of adopting the supported innovations as national policy. Overall, however, the programme paid little attention to documenting the innovation design, its rationale or the baseline context for its implementation in order to garner buy-in. This lack of evidence-based documentation has hampered the ability of H4+JPCS to adequately serve as a knowledge broker, both within and outside its sphere of influence.

The H4+JPCS partners were able to achieve an efficient division of labour at country and global levels, drawing on each partner's mandate and comparative programming strengths. The partners were also largely able to avoid overlap and duplication in the investments and activities they supported. Over its five-year time frame, the operation of the programme helped the H4+ partners working at the country level to develop a level of collaboration and joint programming that was new to them and would not likely have been achieved otherwise. However, partly because of its different role in supporting national investments in health (and other sectors), the World Bank was not fully engaged in the H4+JPCS at the country level.

A similar improvement in the level of collaboration among H4+ partners can be seen at the global level. For UN Women and UNAIDS, one effect of the programme has been to provide them with the opportunity to demonstrate the value of community engagement as a means to improving results and outcomes in RMNCAH. For UN Women, it has been an opportunity to highlight the importance of women's empowerment in order to secure their right to RMNCAH services.

The H4+JPCS programme has contributed to the development of a significant body of global knowledge products that has been noted as useful and technically sound at both the global and country levels. However, there are indications that the generation of global knowledge products was not well linked to the needs of H4+JPCS country programmes. Experience gained by H4+JPCS at the country level does not appear to have informed the development of global knowledge products. By the same token, guidance developed at the global level has not been systematically communicated to the country level.

H4+JPCS has demonstrated an ability to provide added value at the global and country levels. At the country level, the programme enabled the partners to increase the volume and coherence of their policy engagement and advocacy activities. This more coherent and consistent approach to translating global guidance into national policy support has been recognised by health authorities in all programme countries. The programme has also directly supported improvements in the accessibility and quality of services in RMNCAH at national and sub-national levels. These improvements, in turn, have contributed to increased use and, to some degree, improved outcomes in RMNCAH. At the global level, H4+JPCS has contributed to widening participation in the development and advancement of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It has also contributed to deepening the level of collaboration among H4+ partners and to encouraging the development of unified messages on key issues.

CONCLUSIONS

Conclusion 1. H4+JPCS has contributed to strengthening health systems for RMNCAH at both national and sub-national level, by improving pre-service and in-service training and supervision, especially for emergency obstetric and newborn care and for maternal death surveillance and response systems. This resulted in a positive contribution to service quality and access in RMNCAH. However, the contribution to strengthening health systems could have been more significant. In particular, effort could have been directed at a better balance between supporting the supply of services and strengthening demand by engaging with communities to address socio-cultural barriers to access.

H4+JPCS support to health systems strengthening was focused on critical needs at both national and sub-national level as agreed between national and sub-national health authorities and H4+ partners. As a result, the funded initiatives were consistent with national plans and priorities in RMNCAH. Interventions also complemented existing and planned programmes of support to the health sector. However, demand generation and community participation activities were often too narrow in geographic reach and in duration, and suffered from a relatively low level of investment. Consequently, they did not achieve the same level of effectiveness as those supporting the supply of services. For investments in demand-generation activities to produce the same level of results, a broader engagement over a longer period of time is required.

Conclusion 2. At both national and sub-national level, the sustainability of improvements in service quality and availability in RMNCAH is at risk, due to weak or undeveloped exit plans and strategies for the H4+JPCS programme.

At national level, certain aspects of the programme's positive results are likely to be sustained after programme completion (e.g. improved and updated national policies, guidelines, or curriculum; system-wide improvements such as those in maternal death surveillance and response). However, in targeted, under-served and isolated districts or health zones, gains in the availability and quality of services are more at risk. This risk arises partly because new and pre-existing programmes of support to the health sector in H4+JPCS countries are largely not as flexible or as agile in identifying and responding to specific local needs. Local results are also more at risk because implementing partners often made significant gains in achieving results during the later years of the programme, yet were unable to find sources of support to maintain their presence and consolidate results achieved in the targeted districts after the programme ended.

Conclusion 3. In implementing the programme at the country level, the H4+JPCS partners missed an important opportunity to systematically engage collectively with national governments to address broader impediments to health sector effectiveness.

In all programme countries, efforts to strengthen health systems for RMNCAH were constrained by weaknesses in the overall enabling environment. In particular, constraints arose from problems in the policy and resource environment, in particular, in human resources for health, health financing, transport infrastructure, 24-hour electricity and lighting and a reliable supply of clean water in health facilities. H4+ partners engaged effectively in focused advocacy regarding effective policies and programming for RMNCAH. However, they were not as effective in attaining more unified interventions aimed

at working with governments to address these wider, cross-sectoral constraints in order to achieve a strengthened health system for delivering results in RMNCAH. H4+JPCS did not take advantage of the World Bank's role in supporting national governments in health sector programming and in other sectors critical to the enabling environment for RMNCAH.

Conclusion 4. H4+JPCS has contributed to expanding access to services in RMNCAH. It has done so, in part, by consistently targeting the provision of services to underserved and hard to reach geographic areas, and within those areas, populations most in need of services (including adolescents and youth, the poorest women, and people living with HIV and AIDS). H4+JPCS investments and activities have addressed the capability, opportunity and motivation of health service staff to provide quality services in RMNCAH while engaging in focused efforts at demand generation.

The programme's support to community engagement (combined with improvements in service availability and quality) has contributed to increased levels of trust between community members and health care providers, which has, further, contributed to increased demand for and use of services. In some countries, however, the programme did not adequately support the integration of family planning services in situations where it would have been appropriate. Further, gains in improving access and engaging with communities are at risk, due to inadequate or missing exit strategies.

Conclusion 5. H4+JPCS missed an important opportunity to develop, test, and promote new, comprehensive approaches to address the needs of youth and adolescents in most programme countries.

H4+JPCS supported a range of specific interventions aimed at meeting the needs of youth and adolescents, including young girls and women in and out of school, married and unmarried (as well as those of boys and young men). However, these interventions were often fragmented and of limited effectiveness in reaching the targeted groups. In addition, while H4+JPCS supported efforts to directly address gender inequalities, these interventions, instead of being mainstreamed, were mainly limited to programme output area seven: demand creation. As a result, gender equality initiatives had limited geographic reach, were under-resourced (as with all demand creation and community engagement activities), and were often implemented late in the programme.

Conclusion 6. H4+JPCS demonstrated a capacity to adjust and respond to changing needs and priorities at the country level, and to respond to specific national challenges, partly through participatory systems of planning and review, which sometimes extended from national to district and facility level.

Mechanisms for ensuring an adequate response to needs and priorities at the country level were most effective when they included H4+ partners, national and local health authorities and all implementing partners. When mechanisms for coordination did not extend down to the local level, and were not inclusive of all implementing partners, they led to operational problems in delivering H4+JPCS-funded inputs for RMNCAH. As the H4+ partners and national authorities gained experience with the programme, especially with joint planning and review processes, they strengthened and deepened their level of coordination and collaboration. This resulted in more coherent policy engagement and a programmatic response that better suited national and local needs and priorities and was highly appreciated by government partners.

Conclusion 7. H4+JPCS encouraged and supported innovation as an element in the programme mandate to catalyse and accelerate action in support of improved RMNCAH outcomes. However, H4+JPCS support to innovations seldom adhered to a systematic approach. It did not always support the shift from successfully testing an innovation to documenting the results necessary to develop national policy and scale up innovative practises across the health system.

In particular, there was a lack of evidence-based documentation that could adequately support policy makers. This weakness in documentation hampered the programme's ability to serve as a knowledge broker, both nationally and across the participating countries. It is also reflective of a general problem of underdeveloped systems and approaches to knowledge management in H4+JPCS.

Conclusion 8. H4+JPCS partners were able to arrive at an effective division of labour in programme countries. This division of labour drew on the mandate and comparative programming strengths of each partner. It also allowed the H4+ partners to largely avoid overlap and duplication in the investments and activities they supported. The experience of implementing the programme also helped the H4+ partners to develop a deeper level of coordination and collaboration at the global level. However, at the global level this collaboration has been more notable in relation to technical and administrative matters than for strategic issues.

At the country level, the division of labour for H4+JPCS was based on the use of joint programme planning, implementation, supervision and review processes and effective mechanisms for programme coordination. The availability of dedicated funding for joint programming in RMNCAH, combined with the requirement for a single, unified work programme and results framework, was an important factor contributing to effective collaboration among H4+ partners at the country level.

Conclusion 9. The primary added value of H4+JPCS in accelerating the implementation of the global strategy has been its positive contribution to improving the availability and quality of essential RMNCAH services in the ten programme countries. This contribution arises mainly from flexibility in jointly programming technical and financial support to RMNCAH in a manner which is also complementary to support provided by other programmes. Additional value can be found in the broader participation of the H4+ partners in the development of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

The experience of implementing H4+JPCS helped the partners to develop a deeper level of coordination and collaboration at global as well as at the country level. In addition to

strengthening participation by, for example, UNAIDS and UN Women in the development of the Global Strategy (2016 - 2030), the programme contributed to the development of a significant body of useful and technically sound global knowledge products. However, the experience gained by H4+JPCS at the country level was not systematically integrated into global knowledge products and, by the same token, the content of global knowledge products was not systematically communicated to H4+ country teams for use in programme planning.

RECOMMENDATIONS

Recommendation 1. H6 country teams in the ten H4+JPCS countries (in collaboration with global and regional teams and national health authorities) should undertake actions to make results sustainable by building options for a transition to new funding sources and to retrofit exit strategies to the extent possible.

While the H4+JPCS programme is reaching its end, there are still opportunities for the H6 teams in each programme country to work with national authorities to ensure that a combination of national and external resources is used to provide flexible, geographically-focused support to those provinces, districts and health facilities that have been critically reliant on the programme. This will require accessing new sources of funding for RMNCAH, as well as earmarking support to coordination mechanisms for RMNCAH programming at a both national and sub-national levels.

Recommendation 2. H6 partners' efforts to strengthen health systems for RMNCAH at the country level should be designed to achieve a balance between improving the supply of services and strengthening demand by engaging with individuals and communities to address barriers to access, including sociocultural barriers. This should, in particular, strengthen the H6 contribution to the individual potential and community engagement action areas of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It should also incorporate well sequenced and coordinated support.

The H4+JPCS programme has allowed the H6 partners, their counterparts in national governments, and implementing agencies, to demonstrate the effectiveness of efforts to engage with communities to increase demand for quality services in RMNCAH. There is an opportunity to build on these lessons by increasing the level of investment in community engagement, with a focus on specific barriers for girls' and women's access to (and use of) services and to knowledge for securing their rights. Action in this area would require strengthened technical support for country teams in the field of demand generation and community engagement.

Recommendation 3. At the country level, the H6 partners should build on the experience of H4+JPCS in order to engage with national governments with "one voice" and ensure that they can collectively influence broader impediments to the health sector (and beyond) including: weaknesses in human resources for health, health financing, and the general enabling environment.

This would allow H6 partners to address broader constraints to achievements in RMNCAH, which originate outside the mandates of their traditional counterparts. To be effective, action would require joint policy engagement outside the health sector with, for example, authorities for water and sanitation. It would also entail engaging collectively with country-led, multi-stakeholder national coordination platforms.

Recommendation 4. H6 partners supporting RMNCAH at the country level should ensure that programmes of support address key aspects of sexual and reproductive health and rights (including family planning) for those most left behind, especially for young women and girls. To this effect, H6 partners should invest (globally, regionally and at the country level) in the promotion and dissemination of evidence-based and comprehensive approaches to meeting the needs of adolescents, including young women and girls.

Thus, the H6 partners will be able to strengthen global, regional and national approaches, by promoting evidence-based, comprehensive solutions that have proven their effectiveness in reaching youth and adolescents. This will require support to the full spectrum of sexual and reproductive health and rights for adolescents and youth, including family planning services. It will also require ensuring that H6 regional and country teams have the required technical expertise and that they engage with actors outside ministries of health (for example ministries of youth and sport, education, employment, gender and social development) and those outside the public sector.

Recommendation 5. H6 partners should support efforts to strengthen the capacity of national authorities to lead programme coordination mechanisms. These mechanisms should extend to the sub-national level and include all implementing partners and local health service facilities. This will strengthen the contribution made by H6 to the country leadership action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

Effective action on this recommendation will require H6 partners to participate in, and support, harmonised and aligned platforms for coordinating support for RMNCAH. It will also require, at least in some countries, support to strengthening national authority capacities in the development and leadership of coordinating mechanisms in RMNCH.

Recommendation 6. H6 partners should strengthen the learning and knowledge management strategy of the partnership, including the generation and dissemination of evidence-based documentation. Further, in supporting the innovation action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), H6 partners should support systematic approaches to linking evidence to policy and practice.

The evaluation found that the H4+ partners missed opportunities for learning and knowledge management, in particular for the purpose of generating evidence-based documentation on the results of innovative practices. Effective implementation calls on the development of new learning

networks, or strengthened support to existing learning networks, as well as better linking the development and dissemination of global knowledge products to the experience and needs of H6 country teams. It also calls on strengthened technical support and guidance for country teams on evidenced-based approaches to documenting the results of H6 support.

Recommendation 7. H6 partners should ensure that the division of labour at both country and global level allows for full engagement by all partners to support the community engagement action area of Every Women Every Child and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030); and to strengthen the contribution made by H6 to each of the three pillars of the Global Strategy: (a) country planning and implementation efforts, (b) financing for country plans and implementation including the Global Financing Facility, (c) engagement and alignment of global stakeholders, including the Partnership for Maternal Newborn and Child Health.

H4+JPCS has been most effective in engaging with national authorities and supporting health systems for RMNCAH when it actively encouraged full participation by all H6 partners. Efforts at supporting increased community engagement and participation were more effective when the programme was able to address socio-cultural barriers to participation, especially for women and girls. H6 partners need to ensure that programme designs recognise each partner's different ways of working and incorporate those into work plans and funding allocations. It requires H6 country teams to seek funding opportunities and mobilise resources for collective action in support of RMNCAH. H6 partners should also secure funding for the operational components of joint planning, advocacy, review and supervision of their support to RMNCAH.

Recommendation 8. Within the framework of their collaboration in support of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), H6 partners should develop a clear definition of the work to be done at the regional level, including the corresponding role and responsibilities of regional offices in support of H6 country teams.

There are opportunities for regional H6 teams to play a stronger role in providing technical and operational support to country teams. This requires H6 global and regional teams, in consultation with country teams, to enhance the roles and responsibilities of regional teams to allow them to take advantage of opportunities for synergies and provide needed support to country teams. To this end, H6 global partners and regional teams will also need to identify and secure the resources necessary to fund regional teams' intervention.

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http://www.unfpa.org/admin-resource/evaluation-h4-joint-programme-canada-and-sweden-2011-2016

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