

COUNTRY CASE STUDY

END LINE EVALUATION OF THE H4+ JOINT PROGRAMME CANADA AND SWEDEN (SIDA) 2011-2016

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

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BEmONC	Basic Emergency Maternal, Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Maternal, Obstetric and Neonatal Care
CHT	County Health Team
CHX	Chlorhexidine (gel)
CM	Certified Midwife
DHIS2	District Health Information System Two
DHS	Demographic and Health Survey
EMG	Evaluation Management Group
EmONC	Emergency Obstetric and Newborn Care
ERG	Evaluation Reference Group
EVD	Ebola Viral Disease
FGD	Focus Group Discussion
GAVI	The Global Vaccine Alliance
GBV	Gender-Based Violence
gCHV	General Community Health Volunteer
GFATM	Global Fund for the fight against AIDS, TB and Malaria
GFF	Global Financing Facility
Global Strategy	The Global Strategy for Women's Children's and Adolescents' Health
GoL	Government of Liberia
GPRHCS	Global Program for Reproductive Health Commodity Security
HCC	Health Coordination Committee
HRH	Human Resources for Health
HSCC	Health Sector Coordination Committee
IDA	International Development Association (under the World Bank)
IP	Implementing Partner
IPC	Infection Prevention Control
JICA	Japanese International Cooperation Agency
KII	Key Informant Interview
KMC	Kangaroo Mother Care
LDHS	Liberia Demographic and Health Survey
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MNCH	Maternal Neonatal and Child Health
MNDSR	Maternal and Neonatal Death Surveillance and Reporting
MNH	Maternal and Neonatal Health
MoH	Ministry of Health

MVA	Manually Vacuum Assisted
NASG	Non-pneumatic anti-shock garment
NDS	National Drug Supply
NDS	National Drug Service
NGO	Non-Governmental Organisation
OIC	Officer-in-Charge
PIM	Programme Implementation Management system
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPE	Personal Protective Equipment
RBF	Results-Based Financing
RHTC	Reproductive Health Technical Committee
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RN	Registered nurse
SBA	Skilled birth attendant
SCF	Save the Children Fund
SDG	Sustainable Development Goal
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change
TTM	Trained Traditional Midwife
TWG	Technical Working Group
UNFPA	United Nations Population Fund
WASH	Water, Sanitation and Hygiene
WB	World Bank

GLOSSARY OF TERMS USED

H4+ partnership: the broad designation/ term used to describe the coordinated efforts of the six member agencies working together.

H4+ members: the six UN agencies that are part of the H4+ partnership (sometimes also referred to in the text as 'H4+ partners').

H4+ country team: the group of specific people from among the H4+ members who are tasked with the responsibility to plan, oversee the implementation of and account for the H4+ programme delivery.

H4+ programme delivery: any RMNCAH activities implemented under the coordination of the H4+ partnership regardless of funding source.

H4+ coordination mechanism: the designated processes, procedures and structures through which the H4+ country team fulfils its mandate.

1. INTRODUCTION

This note presents the results of the field country case study of Liberia, undertaken for the End Line Evaluation of the H4+ Joint Programme Canada and Sweden (H4+ JPCS). It is one of four field country case studies carried out during the evaluation (the Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe). The remaining six countries supported by the H4+ JPCS were Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau, and Sierra Leone. Each of these six countries is covered in the evaluation methodology by a document and telephone interview based country case study. Nine of the ten programme countries were supported either by the Canada grant to the H4+ or by a grant from Sweden. Zimbabwe received funding from both.

Table 1: Canada and Sweden Grant Funding for H4+ JPCS Programme Countries

Supporting Grant Funding	Eligible Countries
Canada	Burkina Faso, Democratic Republic of the Congo (DRC), Sierra Leone, Zambia, Zimbabwe
Sweden (Sida)	Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau, Liberia, Zimbabwe

1.1. Objectives of the field country case studies

As with all the data collection, analysis and reporting methods used for the evaluation, the purpose of the field country case studies is to provide essential input useful to addressing all six of the evaluation questions as they apply at country level.[1]

Box 1: Evaluation questions

1. To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH), especially by supporting the eight building blocks of health systems?
2. To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalized groups and in support of gender equality?
3. To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national levels?
4. To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?
5. To what extent has the H4+ JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities?
6. To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's and Children's Health (the Global Strategy) and the "Every Woman Every Child" movement?

The field and desk country case studies are the core of the overall evaluation of H4+ JPCS. Together, they cover all ten programme countries, which account, in most years, for more than 80 percent of programme expenditures. The remaining 20 percent spent at global level is, in turn, intended to provide essential support to the work of H4+ JPCS at country level. By helping to answering the six

[1] (UNFPA 2016c: 33-34)

evaluation questions, the field country case studies allow for testing the most important causal assumptions which underlie the programme theory of change. This in turn contributes to credibly verifying the programme contribution to results in RMNCAH.

1.2. Approach and Methodology

In keeping with the overall approach and methodology of the evaluation, each field country case study uses a theory based evaluation approach which begins with the identification and subsequent refinement of an explicit theory of change (ToC) for the programme at country level. This country-specific ToC is a modified version of the overall country-level ToC for H4+ JPCS developed during the inception phase of the evaluation.[2] The ToC for the programme in Liberia is presented in section 3.

The country level ToC developed during the inception phase allowed the evaluation to identify key causal assumptions essential to the achievement of results at each level of the chain of effects supported by the programme. These assumptions themselves can then be systematically tested for their validity, clarity and strength. The resulting assessment of the validity of key causal assumptions then forms the basis for identifying the contribution made by H4+ JPCS to outcomes in RMNCAH in Liberia.[3]

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The main data collection methods used in each field country case study are:

- Identification and review of core documents at country level including: annual workplans; results frameworks and results reports; minutes of H4+ planning, review and steering committees; programme review and evaluation documents; monitoring mission reports; national plans and programmes in RMNCAH; reports and documents produced by other bilateral and multilateral agencies supporting RMNCAH
- Review and profiling of quantitative data, including financial data, on programme investments at country level and on results in RMNCAH indicators at national, provincial and district levels
- Key informant interviews with a wide range of stakeholders at national level (see Annex 4)
- Site visits at provincial and district levels including: interviews and discussions with provincial and district health teams; group interviews with staff of district hospitals, rural health centres, health clinics and maternity waiting shelters; and focus group discussions and group interviews with community members being served by health facilities supported by the programme. Group interviews included: specific groups of in-school and out of school adolescents and youth (male and female); mother support groups; adult and youth (male and female) consultative forums; village heath workers (VHA) and community based advocates (CBA); and, traditional leaders, among others
- Debriefings of key informants at district, provincial and national levels in order to present preliminary findings and receive feedback on any gaps in the data used, and on factual errors or misinterpretation of the available data.

In each field country case study, a national evaluation reference group (ERG) was formed and charged with an advisory role in support of the study. The draft field country case study note was submitted to the national ERG for review and comments prior to submission to the evaluation management group (EMG).

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[2] Inception Report, (UNFPA 2016b: 11).

[3] For a full discussion of the analytical approach and methodology used in End Line Evaluation see the *Inception Report,* Chapters Three and Four (UNFPA 2016b).

1.3. Nature of the field country case studies

It is important to recognise that each field country case study is not an evaluation of the H4+ JPCS in the country under review. It is, rather, a case study in the service of the larger evaluation of the programme as a whole and seeks to build insight into how the H4+ mechanism operates in practice at country level. Country case studies complement other data sources collected for the global evaluation as well. The conclusions at the end of this note help to inform the global H4+ evaluation and identify the main implications of the Liberia Case Study for the global evaluation.

1.4. Carrying out the Field Country Case Study in Liberia

The Liberia field mission took place from 30 May to 15 June 2016. The team was comprised of three evaluators, two international and one national. An evaluation reference group was convened by the H4+ partnership in Liberia to oversee the process. The ERG was comprised of representatives from each of the H4+ members and two implementing partners and chaired by the Ministry of Health (MoH).

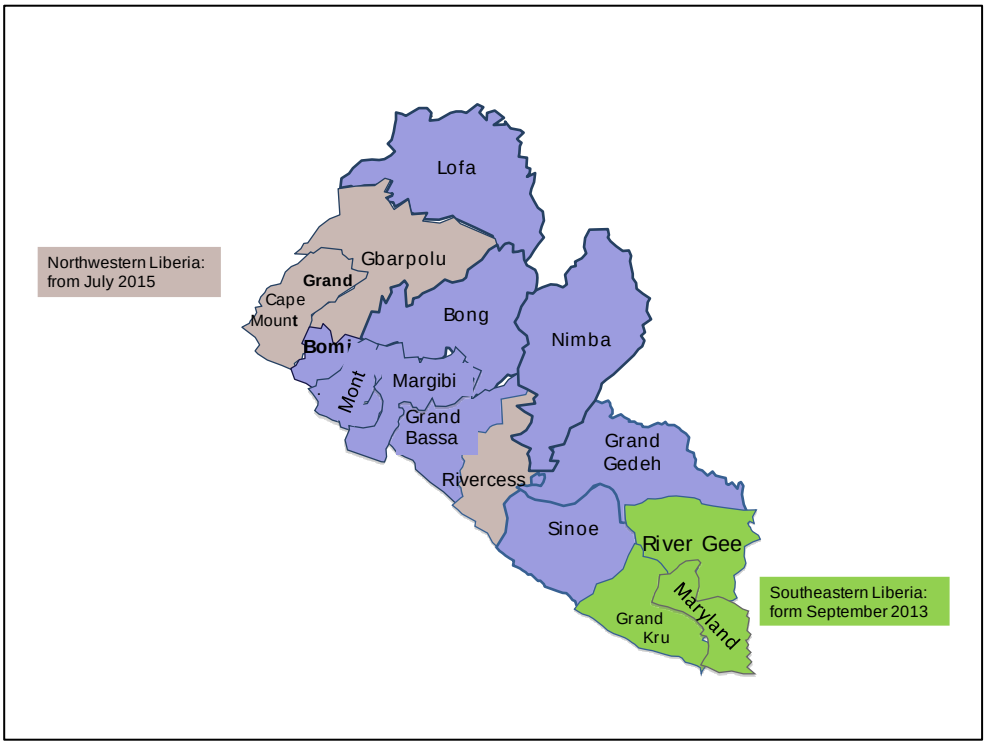
The country case study of the H4+ JPCS programme in Liberia began with a review of key programme documents including H4+ work-plans, results frameworks and reports, annual reports, minutes of the H4+ national steering committee and reports on quarterly provincial and district planning and review meetings.[4]

A review of trends in quantitative indicators of outcomes in RMNCAH at national level (Annex 3) was carried out prior to the field mission. This was supplemented with a review of indicators gathered from District Health Information System Two (DHIS2) data on the six target H4+ districts in Liberia. The DHIS2 data was provided by the Health Information Unit of the Ministry of Health.

The team spent 16 days in Liberia meeting with the H4+ team, government, implementing partners and major bilateral donor agencies. Two county field visits were undertaken to Grand Cape Mount on 2 June and to River Gee from 6-8 June (see map in Figure 1). Meetings were held with the County Health Teams in both locations. During these trips, the team visited two health facilities in Grand Cape Mount County, one of which was a large referral hospital, and five health facilities in River Gee County, including the county referral hospital. Altogether, the team visited seven districts across the two counties. Community discussions were held in five of these seven districts to supplement visits to the health facilities. In both counties, the evaluation team collected data through a range of methods including focus group discussions, key informant interviews, and health facility records. In Grand Cape Mount County, the team was able to observe a maternal death review. In River Gee County, the team undertook an additional analysis of maternal health commodities stock availability to resolve a specific question arising in the course of the evaluation.

[4] It became apparent in interviews and focus group discussions in Liberia that the H4+ JPCS has become synonymous with the work of the H4+ partnership over the past four years of active programming. The programme is also branded in stickers on equipment, logos on publications, and posters in offices and health facilities as the H4+ programme. For that reason, in this note the term H4+ is often used when referring to the H4+ JPCS programme. Non-programme activities of the partnership are identified separately.

Figure 1: Map of Liberia showing the locations of the H4+ JPCS supported counties



Prior to leaving Liberia, preliminary findings and emerging themes were communicated to the ERG and arrangements were made for continuing the ERG. A list of persons taking part in interviews and group discussions during fieldwork at provincial, district and local level is provided in Annex 4.

1.5. Limitations

The field country case study of Liberia is grounded in documentary evidence, quantitative data, and qualitative information. The supporting evidence is presented in detail in the evaluation matrix (Annex 1). The methodology used for the case study aims to identify, to the extent possible, the programme contribution to improving outcomes in RMNCAH at national, provincial and district levels. It does not, however, include the use of counterfactuals, such as comparison communities and randomised sampling, to develop a quantitative impact analysis.

Quantitative data has been used to help provide the overall context of developments in RMNCAH in Liberia; a financial profile of the H4+ programme; a mapping of the results reported by the programme, and an assessment of changes in the supply of, and demand for, RMNCAH services in the targeted districts. In every case, qualitative information gathered in key informant interviews, group discussions and site visits has been used to interpret and help triangulate the quantitative data.

An important issue arises regarding the availability of outcome data, as there is a tendency to under-report the number of maternal and neonatal deaths at county level as reflected in the DHIS2 data. This occurs partly because of apparent miscoding of maternal and neonatal deaths under other proximate causes such as malaria and tuberculosis. It may also occur because maternal and neonatal deaths occurring in the community may not be reported. Either way, since the Demographic and Health Survey (DHS) data is available only to the county level (and not below that), it is not possible to trace the main indicators of morbidity and mortality in RMNCAH to the district or facility levels. As a result, other indicators such as skilled delivery at birth or the percentage of mothers receiving more than one antenatal visit are used.

Despite these limitations, the Liberia country case study has been able to provide a detailed analysis of the validity of the theory of change which underlies the work of H4+ in the country.

2. THE COUNTRY CONTEXT

2.1. Trends in RMNCAH 2011 to 2016

Liberia has one of the highest maternal mortality ratios in the world (1072 per 100,000 live births)[5] meaning a woman's lifetime chance of dying in pregnancy is about 1 in 28.[6] Despite steady progress on a range of health indicators since the end of the civil war in 2003, the rate of decline in maternal deaths continues to be slow. For example, child mortality has almost halved since the war ended whereas maternal mortality has reduced by less than a quarter.[7]

Table 2: Trends in maternal and newborn health in Liberia 2000-2013

Indicator	2000	2007	2013
Maternal Mortality Ratio *		994	1072
Neonatal Mortality	** 68	32	26
Women 15-49 using contraception (Married Women/ Modern Methods)	8.1	10.3	20.2
Unmet Need for Contraception		36	31
Exclusive Breastfeeding for First Six Months		29	55
Births in a Health Facility		46	61

* Maternal mortality in the DHS is estimated using the sisterhood methodology.[8] The Countdown to 2015 data has modelled the maternal mortality ratio using a different methodology and estimates that current MMR is 725 per 100,000 live births. Whichever method is used Liberia has one of the highest maternal mortality ratios in the world.
** data from 1996 DHS
Source: (LISGIS 2014). All data are from the DHS published in 2014 and refer to previous DHS data from 2007, 2000 or earlier as noted.

Contraceptive prevalence rates are tracking upwards but only 39 percent of women have access to family planning services,[9] and unmet need is steady at 34 percent.[10] The main causes of maternal deaths are haemorrhage (25 percent), hypertension (16 percent), sepsis (10 percent) and complications from abortion (10 percent).[11] These conditions are exacerbated by poor access to health services, difficult road conditions, and poor quality services. Amongst adolescent girls, four in ten will have delivered their first child by the time they are 18 years old. Newborn deaths account for

5 Liberia draft RMNCAH Investment Case based on Countdown to 2015 data uses the estimate of 770 per 100,000 live births. There are two MMR estimates currently used in Liberia. The higher one, quoted in the main text and in Table 2, was estimated in the 2013 DHS whereas this lower estimate is the current figure from the Countdown to 2015 data set and is quoted in the RMNCAH Investment Case (MoHSW 2016b).

6 (World Bank 2016f)

7 During the evaluation visit, the team encountered four currently unfolding or recently occurring maternal emergencies. Two ended with a healthy mother but in one of these cases, the baby was stillborn (macerated). The two other mothers both died shortly after delivery, one from eclampsia and one from post-partum haemorrhage. One of the babies was stillborn (fresh). All four women were in health facilities in one of the six H4+ counties and were referred to H4+ supported county hospitals.

8 The sisterhood methodology is a WHO recommended approach to estimating maternal deaths where data quality is poor. It can only be used in countries with high maternal mortality and requires a sample of at least 4000 households. The method involves asking women a series of questions about their sisters (how many they ever had, how many are dead, whether they were pregnant or had delivered within 6 weeks prior to their death).

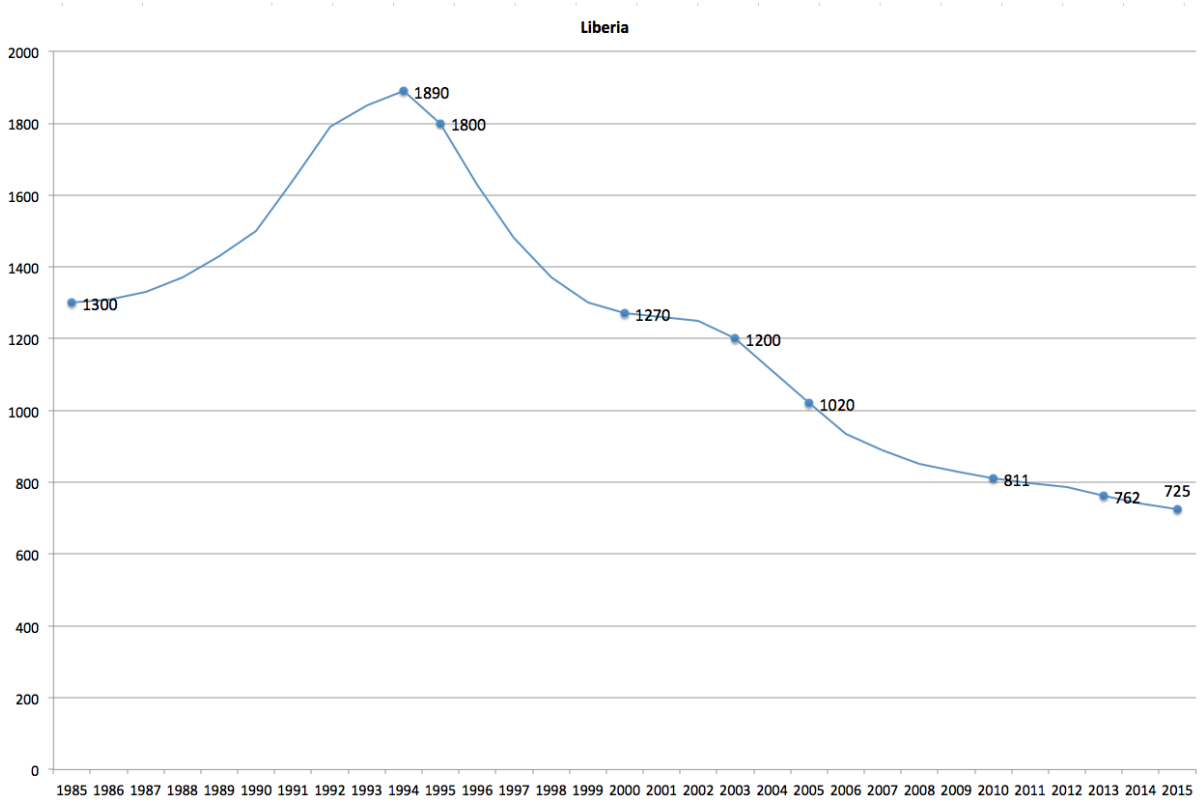
9 Countdown to 2015 data (Annex 3)

10 UNFPA interview 30 May 2016 (Assumption 2.5)

11 RMNCAH Investment Case; (Assumption 1.1) (MoHSW 2016b: 12)

more than a quarter of under-five deaths (28 percent), a large share of which occur with mothers under the age of 15 (about 55 percent of all neonatal deaths) whereas only 6 percent occurred with mothers over 19 years. In common with many other countries, intrapartum deaths and stillbirths are not systematically recorded but are, anecdotally, thought to be high in number.

Figure 2: Maternal mortality ratio trend in Liberia 1985-2015



Source: (Countdown 2015a)

For many Liberian women, their health status and their access to quality health services has been limited by weak demand, harmful cultural and social norms, low literacy and education attainment rates, a lack of gender empowerment, economic hardship, and low expectations about the quality of care they expect to receive at the health facility if they can get to the facility. These factors influence and delay the decision to seek care. In many parts of the country, community-based care is "*nearly non-existent*"[12] while, at the same time, communications are limited by poor mobile phone networks and other poor infrastructure so women are really isolated, having no help locally and limited access to help by phone.

2.2. National plans and priorities

The Liberian RMNCAH strategy is set out in several national plans. These include the national Health Sector Plan (2011-2021) which lays out the principle policy positions of the Liberian government, including the health priorities and chosen approaches to health sector strengthening. National priorities include strengthening health systems to address three key areas:[13]

(i) The **essential commodities supply chain**: closing gaps in the availability of essential drugs and reinforcing the National Drug Supply (NDS); stated problems include insufficient funding, weak management, pilferage, and storage.

[12] (Assumption 1.1) (H4+ nd)

[13] RMNCAH Investment Case 2016 (Assumption 4.1) (MoHSW 2016b)

(ii) **Human resources for health**: Liberia has half the number of health workers it requires to ensure 80 percent of deliveries take place with a skilled birth attendant (1.15 skilled health workers per 1000 population against the WHO recommendation of 2.3). Basic skill levels vary as well. For example, in 2010, an Emergency Obstetric and Newborn Care (EmONC) assessment found that only a third of health workers had been trained in basic lifesaving interventions during delivery.[14]

(iii) **Low demand for comprehensive RMNCAH** services across the continuum of care including for family planning, antenatal care and skilled delivery. This is exacerbated by poor quality of care, harmful social and cultural norms and practices, indirect costs of care and physical access including long distances (for example, in Gbarpolu, 68 percent of the population lives at least a sixty-minute walk away from a health facility).

The Reproductive, Maternal, Newborn, Child and Adolescent Health Investment Case (2016), supported by the Global Financing Facility (led by the World Bank) and the H4+ (now H6) is in draft form. The Investment Case sets out the RMNCAH plans for the next five years together with strategies, targets, required costs and returns expected. The total planned investment is 67 million USD over five years of which about 37 million USD is in hand through domestic or donor funding commitments, while the remaining 30 million USD will need to be mobilised.

Other key strategy and policy papers include the National Strategic Plan for Adolescents' and Young People's Sexual and Reproductive Health (2014) and the National Strategy for the Elimination of PMTCT 2014, both of which underpin the H4+ JPCS programme.

The National Community Health Services Policy and Strategy (2016-2021) aims to extend the reach of the primary health care system in Liberia by forging an integrated and standardised national community health model that can provide a package of essential life-saving primary health care services and epidemic surveillance within communities and to households. This will have implications for existing community health workers, many of whom will be absorbed into the new scheme.[15]

2.3. External support to health and to RMNCAH

Liberia continues to stabilise after a protracted conflict, which ended in 2003. The total health expenditure in 2013-14 was 179 million USD, of which 73 percent came from donors and the balance (27 percent) from the national budget.[16] It is difficult to separate out the RMNCAH component of this total but the most important external sources of support to the health sector are:

- A **pooled fund** managed by the Ministry of Health, spending in the region of 10-11 million USD per year, supported by several bilateral donors including DFID, Swiss Development Cooperation, the Agence Française de Développement, Irish Aid and Japan International Cooperation Agency (JICA). The pooled fund pays the incentives component of health worker salaries in many counties. Some 35 percent of health workers are not yet on government payroll and rely entirely on these incentives. The fund also supports medicines and commodities and in some years, including 2016, represents the bulk of funding to the national drug supply (NDS), contributing 3.5 million USD, while the domestic budget may allocate between half and one million dollars.[17]
- The **Fixed Amount Reimbursement Programme (FARA)** is one the main health programmes of USAID in Liberia. It operates in the heavily populated Bong, Nimba and Lofa counties with partial operations in a further three counties including Montserrado, where the capital city is located. Total funding amounts to about 15 million USD per year (59 million USD over four

[14] (MoHSW and H4+ nd)
[15] (MoHSW 2015c)
[16] RMNCAH Investment Case, 2016, (Assumption 1.1) (MoHSW 2016b: 40)
[17] Interview with Pool Fund managers, Ministry of Health, June 14 2016.

years). The FARA modality requires the government of Liberia to fund programmes up front and deliver against a service agreement in order to qualify for reimbursement.[18]

- The **World Bank health programme** is multifaceted and comprises an ongoing 70 million USD Ebola emergency grant that is being restructured with additional funding (4.9 million USD) to cover maternal and newborn death surveillance and response (MNCDSR) in five counties including Gbarpalu, Sinoe, Bomi, Grand Cape Mount, Rivercess. Additional funds continue to flow from the older (pre-Ebola) Health Systems Strengthening Program: 46 million USD over five years which supports: RMNCAH outcomes through performance based funding in referral hospitals; post-graduate medical specialist training and broader human resources support including building accommodation for nurses and doctors; and carry out civil registration and vital statistics. A forthcoming Global Financing Facility (GFF) application to support RMNCAH through performance based funding mechanisms is taking shape. The H6 (next phase of H4+) could be the main source of technical assistance to the government of Liberia in the delivery of the GFF.[19]
- Finally, there is a range of programmes funded by global mechanisms including the **Global Fund to Fight AIDS, TB and Malaria (GF)**, the Global Alliance for Vaccines (GAVI), individual bilateral funds and UN organizations providing support to health outside the H4+ JPCS programme.

No major funding programme supported the south eastern counties of River Gee, Maryland or Grand Kru at the time the H4+ JPCS initiated its programming. In the three H4+ JPCS-supported counties subsequently added to the programme (Rivercess, Gbarpalu, and Grand Cape Mount), there are other active partners, although they work less in health systems strengthening and more specifically in infectious disease control (primarily HIV/AIDS). World Bank loans and grants, including those anticipated under the GFF, are likely to have an overlap of facilities in some of the six H4+ counties in the future, although these programmes will not overlap with the H4+ JPCS. As the H4+ does not work across all districts in any given county, there continue to be large gaps in service delivery in H4+ supported counties and WB funding will not overlap with H4+ districts.[20]

2.4. Mechanisms and processes for coordinating action

2.4.1 National coordination mechanisms and processes

The health sector is coordinated through a series of related committees and mechanisms.

- The central mechanism is the **Health Sector Coordination Committee** (HSCC), chaired by the Minister of Health and convened quarterly. All donors and UN heads of agencies attend this forum, which sets policy and draws strategic direction
- The Health Coordination Committee (HCC) is chaired by the Chief Medical Officer (the Deputy Minister of Health). It is an operational committee, meeting monthly with the mandate to address all operational health issues and oversee the implementation, in broad terms, of national policy. The H4+ national coordinator sits on this committee. A series of sub-sector working groups report to the HCC. The most relevant to the H4+ programme are:
  - The **National Task Force for Human Resources for Health**: chaired by the Director of Personnel, Ministry of Health, this committee is empowered to address human resource issues, including identifying ways to fill resource gaps and consider proposals for resolving longer term human resource constraints. The H4+ coordinator and some of the H4+ focal points participate in the meetings convened by this task force

[18] Interview with FARA managers, Ministry of Health, June 14, 2016.
[19] Interview with World Bank officials, Monrovia, June 10 2016.
[20] Interview with World Bank, June 3 2016. (Assumption XX)

- The **Reproductive Health Technical Committee (RHTC):** chaired by the Director of Family Health, Ministry of Health, this committee is **r**esponsible for reviewing all technical issues in relation to RMNCAH programmes and services. A range of agencies, partners, implementers and key MoH programme leaders sit on this committee, including the H4+ coordinator and other H4+ representatives. The H4+ reports generally on its programmes to this committee; the World Bank led RMNCAH investment case was discussed and approved here as well.

2.4.2 H4+ programme coordinating mechanisms and processes

The system for coordinated planning, supervision and review of the H4+ programme in Liberia has four main elements:

- The H4+ National Coordinating Committee
- The H4+ Technical Working Group (TWG)
- Joint supervisory and monitoring missions to the H4+ counties comprised of H4+ focal points and MoH technical staff
- Bi-annual meetings of the heads of H4+ agencies

The H4+ coordinator reports active support from the Joint Steering Committee at the global level and from technical advisers based in respective regional offices.

2.5. The H4+ programme in Liberia

2.5.1 Programme Profile

Although the programme was announced in 2011 and funds were available from 2012, only five percent of the Liberia H4+ programme had been executed by the end of 2013. During its first three years (2013-2015), the programme expenditure was just under 4 million USD. During this period, the programme supported activities at the national level and in three underserved counties. As a result of the Ebola Viral Disease (EVD) outbreak in July 2015, an additional grant of 1.8 million USD was made available, enabling the H4+ programme to expand into three additional counties, selected specifically due to their vulnerability to EVD. Table 3 below shows the distribution of expenditure over the three operational years of the H4+ JPCS programme in Liberia to 2015.

Table 3: H4+ JPCS expenditure by H4+ member, 2013-2015

Year	UNFPA	UNICEF	WHO	UN Women	UNAIDS	Total	%
2013	139,393	1,102	2,060	51,021	22,960	216,536	5%
2014	868,835	191,056	294,924	183,526	129,936	1,668,277	38%
2015	965,093	407,305	565,014	536,479	69,976	2,543,867	57%
Total	1,973,321	599,463	861,998	771,026	222,872	4,428,680	
Total %	45%	14%	19%	17%	5%		100%

Source: UNFPA 2016

Figure 3: Total H4+ JPCS expenditure by H4+ member, 2013-2015

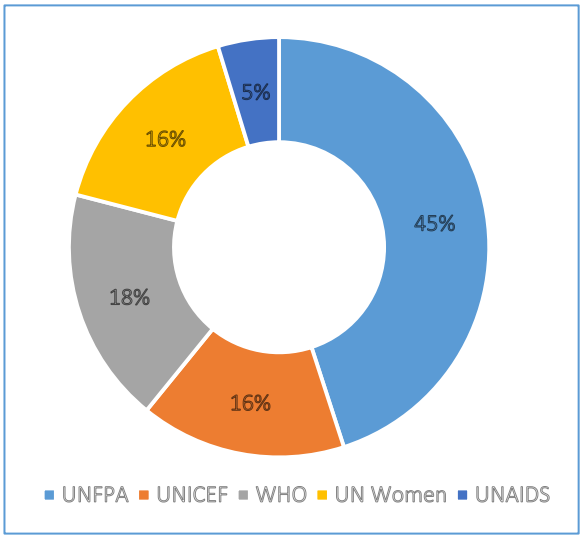


Table 4 below shows the actual expenditure to date by H4+ programme output. Analysis of expenditure across the outputs shows the largest components were for demand (27 percent) and technology and communications (23 percent) which includes equipment, drugs and other procurement. There was ostensibly no expenditure linked to communication and advocacy, although the UNAIDS component of the H4+ approach was largely delivered through media outlets including print and radio communications, counted under technology and communications.[21]

Looking at the three columns of the theory of change (see Section 3, Figure 4), the distribution of expenditure between the three columns was as follows: leadership, governance and financing (11 percent), supply side improvements, e.g. human resources, technology and communications, information systems, M&E, and service delivery (62 percent), demand side strengthening (27 percent).

Table 4: H4+ programme actual expenditure by output category 2013 to 2016

Output	2013-2014	2015-2016	Total	% of total
1. Leadership and governance	285,067	200,966	486,033	11%
2. Financing	0	6,614	6,614	0%
3. Technology and communications	458,770	558,379	1,017,149	23%
4. Human resources	133,314	170,693	304,007	7%
5. Information systems, M&E	366,618	298,141	664,759	15%
6. Service delivery	190,990	579,747	770,737	17%
7. Demand	450,055	729,327	1,179,382	27%
8. Communication and advocacy	0	0	0	0%
TOTAL	**1,884,814**	**2,543,867**	**4,428,681**	**100%**

Source: UNFPA 2016

2.5.2 The Programme Content

The H4+ JPCS aimed to deliver a package of health systems strengthening RMNCAH interventions at county[22] and facility levels combined with policy and technical investments and support at national

[21] Not shown in the table is that across the programme, expenditure was just under 50 percent of the budgeted amount by the end of December 2015, in some measure because the EVD outbreak led to a slowdown in programme delivery.

[22] The Liberian health system is structured into national and county-based levels and each has their designated responsibilities. The national level sets policy, allocates resources, manages the selection and distribution of human resources, drugs, commodities and technologies, and the management of tertiary hospitals. County level health authorities use their allocated resources to manage (1) their county referral hospital, (2) all health centres in their county and (3) the lower level health clinics. Thus, in Liberia, the health system structure is particularly flat. The county supplies and supports every individual health facility in its area. No health facilities have their own budget or resources. This means the County Health Team (CHT) is responsible for supplying health clinics, centres and hospitals alike with everything from lightbulbs

and county levels. The health systems investments at county level aimed to scale up community engagement in health prevention and promotion, demand for maternal and newborn health care, better quality service delivery and capacity improvements reinforced by referral and deeper accountability through the maternal and newborn death surveillance and response (MNDSR).

Box 2: H4+ Interventions in the South Eastern Counties 2013-2016

At community level:

- Training and equipping general community health volunteers (gCHVs) to support health promotion, service delivery including limited family planning services, referral, and community health engagement
- Training and equipping traditional midwives to form a new cadre of trained traditional midwives (TTMs) who support early attendance for antenatal care and referral of women to the local facility
- Building demand for services through wider community engagement with elders, men, and others specifically around maternal and newborn health promotion, antenatal attendance and facility based deliveries
- Challenging social norms and gender issues through men's groups, youth groups, and young mothers' groups
- Mobilisation to support youth and school-based health services in particular family planning services
- Increased uptake of HIV testing and counselling and prevention of mother to child transmission of HIV (PMTCT)
- Community engagement to provide practical support to health services, including engagement to build maternity waiting shelters
- Radio and print media communications to support and reinforce community action.

At facility level:

- Basic equipment and furniture to upgrade maternity facilities including antenatal, labour, delivery and postnatal wards
- Investments to support essential utilities at the facility, including power, water, sanitation, security and safety
- Training and mentoring of health facility staff in basic emergency maternal and newborn care, helping newborns breathe, family planning delivery counselling and delivery skills, and others
- Essential maternal and newborn drugs supplies and commodities
- Technical and material support to delivering the PMTCT programme
- Transport support including motorcycles, tricycles, ambulances
- Radios for communication between health facilities, especially those beyond the mobile phone network
- Support to strengthen staff engagement with critical community groups such as youth and adolescents as well as women, and to support mothers with Mama-Baby kits
- Maternity waiting shelters and strengthened relationships with community health workers including gCHVs and TTMs

At county level:

- Support to pre-service training facilities (one for midwives and one for general nurses) through the provision of materials, training aids, books and resources
- Motorcycles to support supervision

and cleaning agents, to infrastructure, human resources and medicines. Discussions about decentralisation are on-going.

- Ambulances to extend and strengthen referral services
- Technical support and advice to county health services

At national level:

- Technical support and policy advice to strengthen the reproductive, maternal, newborn, child and adolescent integrated health policy and care
- Technical support to the MNDSR process
- Logistical support to enhance reporting, supervision and supply chain

The H4+ Members

All six H4+ members are represented and active in Liberia. The H4+ JPCS is coordinated by WHO. Five of the six agencies are actively engaged in the H4+ JPCS, supporting programme development, receiving funds for implementation, attending coordination meetings and delivering activities. The World Bank in Monrovia did not have a resident health team until recently (May 2016).

Other stakeholders

At the national level, the H4+ members coordinated with other partners through a range of mechanisms (see section 2.4.1). The Ministry of Health leads coordination in the sector and the H4+ works closely with the Division of Family Health. H4+ JPCS implementing partners include a range of non-governmental organisations (NGOs) working nationally and at county level, including Africare, Save the Children, JHPIEGO, and a range of national implementing partners.

The Ebola Viral Disease Outbreak

In March 2014, the largest ever-recorded EVD epidemic began to unfold in Liberia. By April 2016, when the last case was detected, there had been 10,678 cases and 4,810 deaths across the country. WHO declared Liberia Ebola-free in June 2016.

The impact of the EVD outbreak on health systems and service delivery was significant and prolonged. Health workers were hit hard, and although more research remains to be done, WHO has estimated that at least 400 health workers in Liberia were infected. Government records show health worker numbers dropped dramatically over the EVD outbreak period. Across the six H4+ JPCS counties, for example, the head count for registered nurses dropped from 743 in 2013 to 283 in 2015. Among certified midwives, the numbers were 185 in 2013 and 82 in 2015.[23]

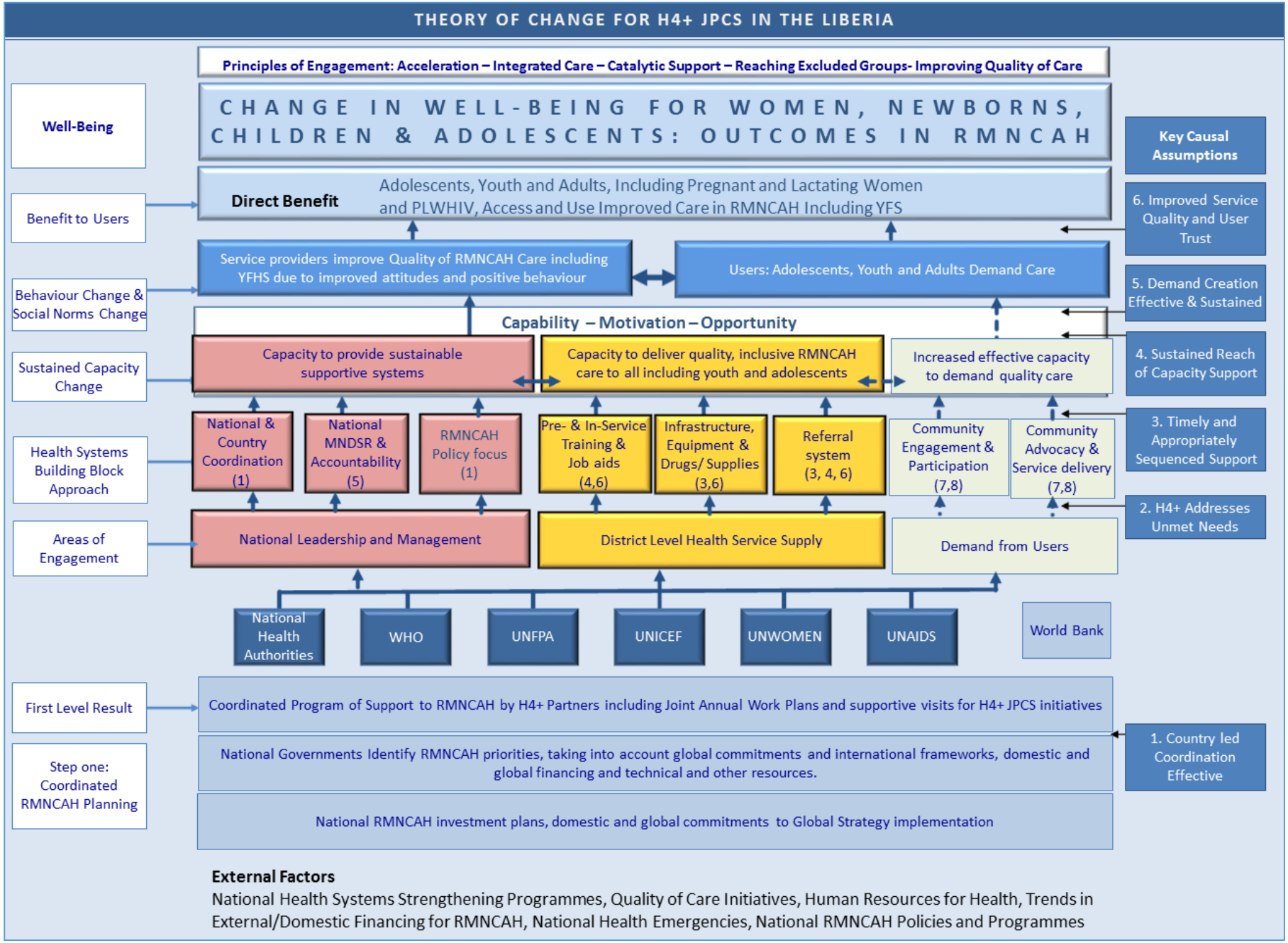
The EVD outbreak led to unprecedented training across the health services particularly around infection prevention control (IPC). Through the deployment of newly formed district teams, community surveillance expanded along with contact tracing and health promotion. Across all three affected countries (Sierra Leone, Liberia and Guinea), there are now over 10,000 EVD survivors who require on-going medical and psychosocial care and clinical surveillance. While the recovery of the Liberian health system continues, the aftermath of the EVD outbreak has created opportunities to strengthen infection control, invigorate community engagement and invest in building trust between health services and communities.

[23] Ministry of Health data supplied by the M&E department, June 2016. The cause of the collapse in numbers is not fully understood. While a large number of health workers died during the EVD outbreak in Liberia (over 400 according to WHO), a large number left the services or fled. Bureaucratic factors such as payroll cleaning may also have had an effect on the numbers.

3. THEORY OF CHANGE FOR H4+ JPCS IN LIBERIA

A detailed overview of the Liberia H4+ theory of change (ToC) is shown in Figure 4. The ToC was tested and validated during the field mission and the analysis phase of the country case study. The ToC reflects the H4+ JPCS focus on embedding its investments in national priorities, including national commitments to improving the health of women, newborns and adolescents. The ToC anticipates the leadership of and close coordination with the Ministry of Health and other national and sub-national authorities. The balance of the inputs and activities across the three pillars (leadership, supply of quality services, and demand for better health) illustrates the distribution of resources across the spectrum. This distribution and balance in H4+ JPCS investments will be discussed in more detail in section four. Detailed descriptions of the key causal assumptions identified on the right hand column of Figure 4 are provided in Annex 6.

Figure 4: Theory of change for H4+ JPCS in Liberia



4. EVALUATION QUESTIONS AND FINDINGS

This chapter presents the findings of the Liberia field country case study organised under the six main evaluation questions for the end line evaluation of the H4+ Joint Programme Canada and Sweden (H4+ JPCS) programme.

All sections of this chapter follow the same three-part structure. The first part is a summery box highlighting the main findings with regard to the evaluation question. This is followed by an analysis of the key causal assumptions identified in the evaluation inception report as they apply to each evaluation question.[24] By examining the validity of the causal assumptions informing the theory of change (ToC) as they relate to each evaluation question, the case study allows the evaluators to test the programme theory and to build a credible analysis of the H4+ contributions to key outcomes in Liberia.[25] The third and final part of each section addresses the evaluation question under review along with its attendant sub-issues.

The data and information supporting the evidence-based findings presented in this section are provided in detail in the evaluation matrix (Annex 1), and unless otherwise indicated, all of the evidence used to test each assumption is presented in the corresponding segment of the evaluation matrix.

4.1. Strengthening health systems

***Question One**: To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for reproductive maternal neonatal child and adolescent health (RMNCAH), especially by supporting the eight building blocks of health systems?*

Summary

- The approach taken to strengthening health service delivery at facility level is comprehensive and innovative. It aims to address many of the building blocks simultaneously. This has been possible largely because of the combined efforts of several H4+ partners[26] including a comprehensive approach to community engagement.
- The H4+ JPCS has advanced maternal and newborn health as a priority in Liberia through a contribution to: the maternal and newborn death surveillance and response process; the development of national strategies and plans including, most recently, the RMNCAH Investment Case; and, policy advice and advocacy through its role on the coordination committees convened by the Ministry of Health (MoH).
- The H4+ approach to health systems strengthening has been more successful at county/ district/ facility levels despite gaps, than it appears to have been at national level. However, it is unclear how many of the systems improvements will be sustained once funding comes to an end.
- Unsurprisingly, the national level health systems challenges and the wider enabling environment have not been addressed through the H4+ JPCS, although it is important to note these challenges are also not being systematically addressed by other partners and programmes.

[24] (UNFPA 2016c: 35-49).

[25] Where relevant, the possible influence of other factors is also considered although data limitations often make it difficult to judge this with certainty.

[26] The term 'H4+ partners' is used throughout this report to mean the six H4+ members. The term 'implementing partners' refers to the non-H4+ organisations contracted by individual H4+ members to support H4+ programme implementation.

- Maternal deaths declined by 43 percent in the three south eastern H4+ target counties between 2012 and 2015. Securing and maintaining this progress will require sustained technical, logistical and financial investments from national and county levels. The extent to which this happens will determine if achievements during the last four years persevere.
- There has been insufficient consideration given to an exit strategy or to sustaining achievements once the programme ends, putting at risk the results of H4+ investments. In this sense, the H4+ programme has, to some extent, functioned as a time limited project, rather than an on-going, sustainable programme.

4.1.1 Testing causal assumptions for health systems strengthening[27]

***Assumption 1.1**: H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify **critical and unserved needs in the eight areas of health systems support for RMNCAH**. The needs in each of the eight areas are not fully met by other sources of support and, importantly, **programme support can build on investments and activities underway** with national and external sources of finance and support to accelerate action**.*

Unless otherwise noted, for evidence cited in relation to assumption 1.1 see Annex 1, Assumption 1.1

The 2013 H4+ programme proposal[28] focused on the three south eastern counties due to their weak health systems, underserved populations and poor utilisation of services.[29] A lack of female (especially adolescent) empowerment along with deeply held cultural traditions and harmful practices were identified clearly as corollaries to low demand and below national average health outcomes. The absence of other significant donors or technical assistance in the three south eastern counties was also identified in the proposal as an important justification for the H4+ programming.

Based on interviews and document reviews, the evidence suggests that the MoH was closely engaged with the H4+ on the proposal development. The Director of the Family Health Department chaired the Technical Working Group (TWG) which was established first to develop the proposal and then to oversee the programme. Priority investments touched on most of the WHO health systems strengthening building blocks, excluding financing systems and information systems. The RMNCAH continuum of care was identified as a gap in the health system, particularly in the H4+ focus counties. The H4+ focus on maternal mortality reduction, newborn survival, the prevention of mother to child transmission (PMTCT), and adolescent health were consistent with the Liberia National Strategy and are clearly identified in the 2011-2015 Roadmap as high priorities.

The senior MoH staff reported that they selected the counties where they wanted the H4+ to work using criteria elaborated jointly with the H4+ team according to the 2013 proposal. This is confirmed in TWG minutes. The selection criteria included counties with no or few other partners; underserved poorly performing areas with difficult geographical access; and counties made up of mainly remote rural populations with limited means of income and surviving mainly on subsistence farming. The three selected counties (Maryland, Grand Kru and River Gee) have a combined population of 300,000

[27] While the term 'health systems strengthening' applies to the entire health system rather than a specific sub-element, the inception phase has shown that almost always, H4+JPCC support to national health systems is aimed very specifically at strengthening national systems for planning, prioritizing, budgeting, delivering and assessing services in RMNCAH. For that reason, the evaluation will focus mainly on health systems strengthening for RMNCAH. It will not, however, ignore broader support to national health systems wherever that becomes evident.

[28] As noted above, the global programme was given the green light in 2011 and Liberia started planning in 2012. The first Liberia H4+ operational programme proposal was for 2013.

[29] (Assumption 1.1). (H4+ nd)

(just under 10 percent of the national total) and are classified as remote, difficult to access and underserved.

The proposal to expand to three additional counties following the Ebola outbreak (EVD) followed a similar process of consultation between the MoH and the H4+ members. Minutes show that the Technical Working Group, led by the MoH, developed criteria for selecting the new counties. These included counties that were underserved, had little other development assistance, and were affected by, or at risk from, EVD. As clearly elaborated in early scoping documents, there were agreed criteria governing the selection of the three counties added in mid-2015 (Grand Cape Mount, Rivercess, and Gbarpalu) including vulnerability to Ebola, fragile health services, poverty levels and extent of underserved populations. While these three counties are also remote, there are other partners working in at least some parts of the counties. The proximity of Cape Mount and Gbarpalu to the Sierra Leone border increased the vulnerability of the population to EVD.[30]

Across all six counties, the enabling environment is challenging. Roads are few and in very poor condition; therefore walking or traveling by motorcycle are the main forms of transportation. Cell phone coverage is limited and large areas do not have access to the network. In some places, people described having to climb trees to try to get a connection. According to TWG meeting minutes, and confirmed in planning documents, criteria set out by the MoH were used to guide the selection of health facilities to be supported by H4+. The five primary level facilities and one referral hospital selected in each of these three districts met the agreed criteria including high utilisation rates, public sector ownership, accessible year round, staffed with a minimum number of trained health workers, and the potential to undertake referrals.

In the south eastern counties, because there was so little investment or support to health services, the H4+ JPCS approach was multifaceted and broad, reflecting the high level of needs.[31] According to the minutes of planning meetings, the H4+ undertook a process of identifying which programmatic and institutional components of the health system to support. Interviews with key informants, confirmed in the H4+ proposal to Sida, show that these components were then structured to address almost all the health systems building blocks as they affect maternal and newborn survival.

***Assumption 1.2**:* H4+ JPCS support to sub-national levels funds activities capable of *complementing other investments and contributing to strengthening service delivery in RMNCAH*. The funded activities are *matched with support to health systems strengthening provided by other programmes and sources*.

Unless otherwise noted, for evidence cited in relation to assumption 1.2 see Annex 1, Assumption 1.2

H4+ planning documents show that the H4+ support aimed to strengthen national policy and leadership while simultaneously supporting programme implementation, capacity strengthening and community engagement at county and facility level. For example, the H4+ invested in establishing, maintaining and technically supporting the maternal and newborn death surveillance and response (MNDSR) process at national level whilst also supporting the application of MNDSR reviews in the H4+ focus counties to ensure the process was maintained. Interviews with the County Health Team

[30] Note that Gbarpalu was one of the counties least affected of all Liberian counties despite bordering Sierra Leone, probably because it is very isolated with few roads or waterways so there is little traffic. During the EVD crisis, Gbarpalu recorded 22 Ebola cases (18 confirmed, two probable, and two suspected) from which there were 16 fatalities.

[31] The presentation of evidence testing these assumptions will be mainly drawn from the H4+ JPCS approach taken in three south eastern counties. There are important examples of weakness or failures in the three new counties that will be raised when appropriate, but in terms of evaluating the H4+ approach, it is clear that, with only eight months of experience and progress so far, the new counties are not far enough advanced to be evaluated.

identify H4+ engagement in the south eastern counties as the first sustained support many of these health facilities had received, other than some specific equipment and materials from NGOs.

Through key informant interviews, and as observed during the evaluation mission, the contributions by the H4+ at national level supported both the initiation of the MNDSR process and ensured it remained a high priority, revitalising national commitment following the end of the EVD outbreak.[32] As set out in the 2014 and 2015 annual reports, there have been efforts by the H4+ to engage parliamentarians and other ministries to understand the process and the results of the MNDSR. The H4+ JPCS TWG minutes identify attempts to support the MoH to engage other ministries around addressing the enabling environment, such as the state of the roads and the positioning of feeder roads.[33] The Weekly Epidemiological Report, widely used and circulated as part of the EVD response, included maternal deaths, which gave maternal and newborn mortality additional exposure and regular coverage.

Another example of simultaneous national and sub-national investment was the H4+ JPCS support to maternal and newborn health commodities. At the national level, the H4+ supported the National Drug Supply (NDS) in order to deliver essential maternal drugs to the six focus counties and help strengthen national capacity through the provision of essential maternal health commodities and drugs, as well as two trucks for national commodity distribution. At the county level, H4+ provided three tricycles to the south eastern county health teams to help with local distribution. This approach has improved but not eliminated stockouts at the H4+ JPCS health facilities. Annex 7 shows the stockout status for five maternal and newborn tracer drugs in the H4+ JPCS supported health facilities in River Gee County from July 2013 to April 2016. The data highlights long periods with no stock-outs but also some key periods with stock-outs, which did frequently (but not always) occur during the rainy season when the main road may have been impassable. The trucks have been used across the country, including in the south eastern counties but the tricycles were found to be inappropriate for road conditions and have been replaced by motorcycles for many months of the year (a helpful and rare example of innovation failure, with an appropriate compensating response).[34]

Rather than a means to support national scale reforms, the H4+ JPCS approach to supporting supply chain strengthening was geared to ensuring there were essential maternal health commodities in H4+ JPCS supported clinics. However, using national systems helped identify weaknesses and in principle, has the potential to support systems strengthening. There was no identifiable evidence found of H4+ JPCS follow-up regarding stockouts. Yet, in exit interviews conducted at several facilities, the main disappointment expressed by respondents was the lack of drugs at the clinic and the need to buy drugs at a pharmacy often located several hours walking distance away.

There were some sequencing problems with H4+ investments. One of these was the slow provision of maternity waiting shelters (as discussed under assumption 1.5 below). Another example of delay was the lag between placing misoprostol[35] into health facilities and closing gaps in prescribing skills and the confidence of midwives to use it appropriately. Based on the assessment of the County Health Director (who also reported that stocks were expiring), and confirmed through direct

[32] For example, interviews with the ERG and the H4+ country team focused on the H4+ supported revitalisation of the process after the EVD outbreak including the integration of maternal deaths into routine reporting.

[33] Following the meeting with Sida in Monrovia, the H4+ Coordinator mentioned that the H4+ team had tried unsuccessfully to engage the Ministry of Public Works on roads and infrastructure. They intended to try again through Sida (which focuses on feeder roads support) in order to integrate referral needs into criteria for road development.

[34] River Gee County Health Team 6 June 2016; reference made to this example in Assumption 4.1

[35] Misoprostol is on the WHO Essential Medicines List. It is used to induce the uterus to contract. It is thus used to control post-partum haemorrhage or initiate labour.

observation, there is a need for more training or supportive supervision around appropriate and timely use of misoprostol. Another example of sequencing or timing problems is the procurement delays with the provision of solar suitcases (discussed more fully in assumption 1.4).

Assumption 1.3: *RMNCAH managers and service providers trained with support from H4+ JPCS realise* ***intended gains in competence and skills****. These gains in skills and competencies are* ***tested and verified during and after training***

Unless otherwise noted, for evidence cited in relation to assumption 1.3 see Annex 1, Assumption 1.3

H4+ JPCS assistance included a significant share of training and capacity building support. According to H4+ partners, training and capacity strengthening support was planned to be delivered at three levels: pre-service training, in-service training and through on-going supervision and mentoring. For example, in terms of pre-service support, H4+ JPCS contributions to two training centres in the south east counties (for midwives and nurses) included training aids, manuals and other pedagogic materials aimed to improve the quality of trained health care workers into the future. The programme delivered in-service training to nurses and midwives to strengthen the relevant capacity and confidence among existing health workers including emergency obstetric and newborn care (EmONC) (in 2014 and 2016), "helping newborns breathe" (in 2016) and family planning counselling and prescribing skills (in 2014 and 2016).[36] County health staff reported that the in-service training made one of the most significant differences to quality of care because midwives were more confident about using available tools, including the partograph, and they recognised the point at which they had to refer to a higher level and were prepared to do so. The documents reviewed (including training workshop review reports, training needs assessments, and reports of post-training follow up and support missions carried out by county staff or H4+ partner staff) indicate that the H4+ JPCS supported efforts to assess the effectiveness of training and to encourage supportive supervision in the aftermath of training. For example, the County Health Team RMNCAH supervisor in River Gee reported that she visited each health facility once a month to supervise midwives and reinforce the training.

Most importantly, trained staff encountered at the health facilities were able to identify the key steps to managing different kinds of emergencies when asked, as well as how to use most of the equipment, drugs and procedures they had been taught, including the use of the non-pneumatic anti-shock garment (NASG),[37] chlorhexidine gel[38] and Kangaroo Mother Care (KMC)[39]. They also seemed confident about when to refer complex cases for higher level care.[40] One exception was in River Gee and concerned the use of misoprostol. The County Health Team commented that misoprostol was expiring everywhere due to a lack of practical skills among midwives; the H4+ JPCS had apparently included misoprostol usage in the training in early 2014 and again in 2016. However, only one midwife of those interviewed was confident about when and how to use misoprostol. The

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[36] River Gee Facility Findings Observation Note, June 6-8 2016; Save the Children Fund Progress Report, July – September 2014

[37] The non-pneumatic anti shock garment is used to manage post-partum haemorrhage and was introduced to the south east counties by the H4+. It is discussed in section 4.4.

[38] Chlorhexidine Gel is an antiseptic with a broad spectrum of activity against gram-negative and gram-positive bacteria. It is used for cord care in neonates and has been shown to dramatically reduce infections. See for example: http://www.usp.org/sites/default/files/usp_pdf/EN/PQM/chlorhexidine_technical_brief_jul_1_2014.pdf

[39] Kangaroo Mother Care (KMC) is an approach to nurturing small and sick babies using skin to skin contact.

[40] During the facility visits at five visited health facilities in River Gee staff were asked open questions about the use of the partograph (a tool for tracking the progress of labour), criteria for referral, conditions for using particular drugs or equipment, 6-8 June 2016. Altogether, in 2014, 34 midwives were trained in EmONC.

critical training courses reported by nurses, midwives, county health team staff, MoH staff and the H4+ technical team included:

- EmONC including referral
- Helping babies breathe
- PMTCT
- Option B+ management[41]
- Youth sexuality counselling and services

There was a clear difference between the level of knowledge, skill, and motivation among service providers benefiting from H4+ training support in the three original counties and those in the most recent counties. One result of this was that in the newer H4+ focus counties (those supported from mid-2015), health staff knowledge and confidence about EmONC was lagging and uneven compared to the three more established counties in the south east of the country. This finding was based on observation, staff interviews and focus group discussions, and the difference may illustrate a "before and after" H4+ intervention effect. For example, there was little collective or individual knowledge of KMC, and the understanding about national referral policy was weak. In one facility, the staff said that they could not refer a woman who arrived at the facility with post-partum haemorrhage, as "*she had no relatives with her*". The staff did not apply the anti-shock garment as they did not have one. Ultimately, this woman succumbed several hours later still in the hospital. Her relative arrived "*too late*" for a referral to be made to a higher level hospital. This anecdote, told to the evaluation team by the health facility staff in a focus group discussion, is repeated here mainly because in the south east counties nothing remotely like this was detected. In the south east counties, staff were very clear about the rights of women to be referred and their priority was to save the mother's life above all. Compared to the newer H4+ focus counties, there was a very different attitude and approach by staff towards emergencies and referral in the south east counties and a very thorough understanding at the community level about the referral system.[42] While there is not sufficient evidence to point categorically to the reasons for this, it is likely that three years of investments in staff training, supervision, maintaining a functional referral system and the whole range of accompanying community engagement, social norms change, and demand creation activities have made an impact.

The exit interviews conducted with patients in River Gee suggested high levels of satisfaction with staff attitudes and overall level of respect for the client. During preliminary meetings, especially in the smaller and more remote places, community leaders spoke warmly about their appreciation of health workers' contribution to the community.[43] Staff were perceived as knowledgeable and skilled. There is thus considerable evidence that H4+ support to staff training in the south east counties has resulted in improved skills and competencies for RMNCAH and that these improvements are being tested.

While efforts have been made to motivate and strengthen a professional approach among health workers, there are already signs that this is weakening as the project ends. As an example, in one clinic, an incentive to stay at or near the clinic through the weekend, paid to the midwife in the form of 20 USD per month, had stopped when the H4+ contract with one of the implementing partners was terminated. So far, the H4+ partner responsible has not continued the incentive scheme. This kind of *ad hoc* start and stop in health worker terms and conditions can be demotivating, leading to a loss of trust by staff. It also points to the need for the H4+ coordinating group to work on these

[41] Option B+ management is an approach taken to treating HIV infected mothers that incorporates a commitment to provide lifelong ART for all HIV-positive pregnant and breastfeeding women, regardless of CD4 count.

[42] Community focus group discussions in four of the five River Gee districts visited repeatedly raised referral as a benefit to the community and as an effective intervention to save mothers' lives.

[43] For example, in River Gbeh, the village chief expressed their appreciation for their local midwife who was integrated into community life and was prepared for deliveries "*day and night*".

underlying challenges of sustainability of activities simultaneously at national level. There are some good examples of the need to ensure sustainability from the community level as well (discussed in the next section).

Although there is evidence that the H4+ programme improved the skills of individual health staff in the target districts, the H4+ JPCS programme did not appear to be able to make the necessary investment into addressing the underlying structural challenges in the human resources for health (HRH) system as a whole in any kind of substantive way; neither at a national level nor at county or district levels. For example, several of the H4+ JPCS-trained midwives in the H4+ districts were scheduled to move to new locations but they did not know when or where they would be sent.

Key informants were vocal about the continued vulnerability of the H4+ programme (and indeed other health programmes) to the weaknesses of the HRH system. Examples of the weak HRH system, identified by key informants and through documentary evidence, included the overall size of the workforce (the number of health workers for the population falls well short of WHO guidelines); half of health staff are not on the government payroll but rather paid only by a donor funded "incentive" from the Pooled Fund; staff can be moved to a health facility anywhere in the country and many leave their families for many months at a time, even for years. Furthermore, there is no methodical promotion or career path available, nor are there incentives to encourage staff to volunteer to work in remote areas (such as further education after five years of service, or priority choice for the next posting).

Against this backdrop, the H4+ investments in training and supportive supervision were nonetheless important; despite only succeeded in addressing human resource challenges in a short term and local way. For example, at the facility and county levels, there is evidence that, on the one hand, the skills of individual health care workers improved as a result of H4+ supported training, while on the other hand, the H4+ was not able to shift underlying and structural constraints such as inequitable remuneration, clearer promotion pathways, and transparent transfer. At the national level, the H4+ did have the opportunity to use its experience gained in supporting health services at the facility level to inform its participation in the national Human Resources Technical Committee and try to shape national policy. However, although the Committee aimed to make the best use of available resources, there is little evidence that H4+ participation led to significant structural reforms to the HRH system in Liberia, largely seen as a problem beyond the scope of the MoH. The World Bank was not part of this committee and, as discussed, did not participate in H4+ delivery. However, given the ability of the World Bank to straddle the public financial and expenditure management sectors (like the Public Service Commission) and the line ministries or service sectors (like health), the opportunity for the H4+ to maximise its individual partners' strengths by linking the deliberations and efforts of the Human Resources Technical Committee to larger public expenditure management or public service reforms was missed.

The ability to reach women in the community and change their attitudes towards, and utilisation of, the fixed health facilities was seen as an important function of community health workers. These workers were given training and equipment that included clothing, rainwear, bags and torches to support them in their revitalised role. Community health workers were comprised of general community health volunteers (gCHVs) and trained traditional midwives (TTMs). Different programmes supported TTMs and gCHVs with different kinds of incentives. The H4+ investments into training and supporting gCHVs were significant in scope and based on views of health facility staff, communities and the volunteers themselves. H4+ made an important contribution to strengthening attendance for antenatal care and delivery through support to the community health volunteers. However, it was also evident that the investment in volunteers led to a number of secondary problems that would need to be tackled if their role is to be maintained. These secondary problems are discussed below using the TTMs as an example.

Trained traditional midwives were formerly traditional birth attendants who had been "re-purposed" away from assisting women to give birth in the community to encouraging women to attend the health facility early, and often, for antenatal care. They also accompanied women to the facility at the time of birth and supported them to access postnatal checks. Based on their own experiences (confirmed independently by health staff), TTMs often remained with women through their labour and delivery supporting the midwife and the mother. The repurposing of TTMs was supported by the H4+ programme in a number of ways including through focused training in emergency obstetric and newborn care (EmONC).

Re-purposing the work of TTMs represented an important strategy for encouraging women to deliver in a health facility rather than at home. Based on interviews with health staff and focus group discussions, volunteer community based health workers like TTMs were highly motivated to do their jobs. However, there were noted problems in maintaining the motivation and status of TTMs and their ability to realise a benefit from their new role. In every community visited, the same three issues were raised by TTMs about the H4+ programme, which affected their ability to perform their role:

- First, by becoming TTMs and abandoning their role as traditional birth attendants, they effectively lost their livelihood. The community used to support TTMs with small farm support such as providing them with eggs, carrying water, assisting them with farming, etc. as "payment" for their services in assisting the women of the community during labour and delivery. However, in their role to accompany mothers to the health facility, they were less valued in a material way, and their livelihoods had effectively disappeared. While they recognised that they were volunteers, they were constrained by a lack of resources. This meant they had to choose between tending their farms and accompanying women to the clinic as the community no longer helped.
- Secondly, and linked to this, TTMs were trained once and all of them said they wanted additional training and a stronger sense of being part of a professional cadre (for example, through ID cards or certificates).
- Thirdly, as volunteers, TTMs had to accompany women regardless of the distance and the time of the day or night. This meant they sometimes walked through the night to take women to the clinic. Torches received early in 2014 had not been replaced and batteries had long since run out. They all said (in focus group discussions across four different communities) that they had not had replacement equipment or consumables since the initial hand out. They had to use their own money to travel home and if they did not have money, no health authority seemed able to help them. In one case, a TTM from River Gbeh accompanied a woman first to the health centre, then on to the referral centre hospital (Town County Hospital in Fish Town County) and finally five hours via ambulance to Harper where a caesarean section was performed. The TTM was then 'stuck' in Harper as there were apparently no funds available to pay her transport home.

H4+ records indicate that while these issues were raised with H4+ members and their implementing partners at national level, there was limited capacity to respond. This may be partly due to the on-going development of an entirely new cadre of "community health assistant", discussed further in section 4.2.

Assumption 1.4: *Capacity development efforts in RMNCAH are supported with well-sequenced supervision and required equipment, supplies and incentives to allow service providers the ability, opportunity and motivation to improve service quality and access.*

Unless otherwise noted, for evidence cited in relation to assumption 1.4 see Annex 1, Assumption 1.4

In order to make use of the skills acquired, or revived, during training or through clinical mentoring, health facilities staff need proper equipment, functioning infrastructure, adequate stocks of essential medical supplies and supportive supervision. They also need an incentive structure to keep them in the post and keep them motivated to provide quality care.

The H4+ JPCS did not invest in extensive large scale infrastructure (refurbishment of buildings or construction of staff houses, other than maternity waiting shelters). However, it did support repairs to, or installation of, essential utilities including power and water, sanitation and hygiene (WASH) as part of its aim to be catalytic, improve quality and ensure health facilities could genuinely offer 24-hour delivery of care. Based on observations, monitoring records and interviews, the ability of the H4+ to identify, deliver and sustain critical infrastructure improvements to achieve this result appears to have been mixed. For example, all five health facilities visited by the evaluation team in River Gee had – in principle – the means to generate their own power through either a generator or a solar panel. However, none of the facilities had fuel to power a generator, and for several, the solar panel worked poorly or there were no suitable lightbulbs; so the end effect was little or no lights after dark. This curtailed the ability to offer a 24-hour service for deliveries, and in focus group discussions, it was very clear that women were reluctant to use the clinic in the dark.

The County Health Team raised this lack of sustained improvement to essential utilities as an example of poor coordination by H4+ JPCS members and their implementing partners. For example, one H4+ member (working through an implementing partner) was tasked with strengthening the water systems in the H4+ JPCS health facilities in River Gee and other south eastern counties. Despite specific investments to water and sanitation in 2014, the facility review found that *none of the facilities visited* had a functional water system in June 2016. Rather, all of the facilities visited, including the referral hospital in Fish Town, hand carried water from an outdoor well located up to 500 metres away.

One example of failed H4+ investments given by the River Gee County Health Team (CHT) concerned wells, which were fitted with submersible pumps operated by generators without consulting the CHT or its WASH team. As many wells run dry in the summer, the pumps had all burned out and were no longer working. In addition, despite generators given by the H4+ programme, none of the health facilities was able to access fuel regularly from the county, and when accessible, staff used their own funds to purchase fuel.

The H4+ approach to the maintenance of infrastructure may be improving as the programme progresses. For example, several of the VHF radios placed at each health facility to support referral, while still largely operational two years after installation, experience regular periods when they are not working due to battery failures, reducing the utility of the radios during a power outage (staff depend on a WHO managed repair service which takes several days). However, there are plans in place to extend maintenance skills to health staff so that they could maintain their own radios in the future.[44]

The H4+ investment in ambulances, VHF radios and training supported the strengthening of the referral network in a way that made a material and visible difference to maternal health. Despite the faulty radios (staff used personal mobile phones, sometimes by preference), the referral system was visibly operational and actively being used. For example, the evaluation team identified four referral cases including two maternal emergencies. Community focus group discussions confirmed the functionality of the referral system as a recent development. Community leaders, men, TTMs and mothers all talked about the referral service as a significant benefit to the health services available to them and an important reason why women did not die as often during delivery.

[44] Interview with the Medical Director, Fish Town Hospital, 6 June 2016.

On the other hand, procurement delays led to sequencing problems that affected H4+ support to infrastructure repairs and installation. As a further part of its objective to support 24-hour delivery care, the H4+ aimed to install a solar suitcase in the delivery rooms at each health facility. Delays caused by long UN procurement processes, compounded by the EVD outbreak and worsened by funding delays, meant that only 2 out of more than 30 planned solar suitcases had been installed. However, once installed, one advantage of the solar suitcase is that, in principle, it has much lower maintenance needs than other equipment, and the health staff will be trained by community based teams to conduct maintenance, making these more sustainable in the longer term.

***Assumption 1.5**: The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services and to overcome barriers to access which existed in the past.*

Unless otherwise noted, for evidence cited in relation to assumption 1.5 see Annex 1, Assumption 1.5

The effects of the EVD outbreak make it difficult to demonstrate growing and sustained demand for maternal health services in the H4+ facility locations using health facility utilisation data only. For example, there has been a clear decline in utilisation across each of the south eastern counties. Using DHIS2 data obtained from the Ministry of Health, the utilisation patterns across the south eastern counties are shown in Table 5 for all health facilities.

Table 5: Utilisation and service delivery in three South Eastern Counties, Liberia, 2012-2015

	2012	2013	2014	2015
1st ANC Visit				
River Gee	1.699	1.977	1.823	1.814
Maryland	5.566	5.010	4.626	3.874
Grand Kru	2.152	2.294	1.849	1.946
Skilled deliveries				
River Gee	1.385	1.591	1.239	1.371
Maryland	2.095	2.293	2.295	1.892
Grand Kru	777	919	760	696
Unskilled deliveries				
River Gee	67	11	14	20
Maryland	329	65	40	108
Grand Kru	107	72	53	52
Caesarean Sections				
River Gee	32	26	14	30
Maryland	177	168	164	146
Grand Kru	57	41	57	13
Still births				
River Gee	46	55	38	44
Maryland	244	84	59	74
Grand Kru	30	37	26	18
Neonatal deaths				
River Gee	14	16	13	22
Maryland	28	15	26	19
Grand Kru	3	10	3	5
Maternal deaths				
River Gee	2	5	3	3

Maryland	18	14	12	5
Grand Kru	3	3	4	5

The data includes all health facilities in each of the counties, not just the H4+ facilities and are difficult to interpret without triangulation. Generally, with some exceptions, the data show steady improvement in utilisation between 2013 and 2014. This improvement slowed, stopped, or even reversed in 2014. Given the effects of the EVD outbreak on facility utilisation, combined with clinic operational hours, the slow-down can be attributed to alternative patterns of health seeking behaviour during the outbreak, the effects of which seem to have persisted into 2015. Recovery in utilisation is slow as figures for 2015 show, but health staff report that utilisation seems to be picking up again. However, the effects of the EVD outbreak will be felt in a number of ways well into the next few years.

Focusing on data from H4+ facilities only,[45] a similar pattern emerges. For example, in River Gbeh, 1,829 people attended the clinic from January to March 2013 (all attendances). By 2016, the number had dropped to 1,235, up marginally from a low of 1,201 in January to March 2015. There are a number of confounding effects caused by the EVD outbreak and these reflect in attendance, utilisation data, and on all aspects of health service delivery during and after the outbreak. Simple data trends will not demonstrate whether the H4+ has successfully led to sustained utilisation in the Liberian context.

Other sources of evidence can be tapped into to assess trends. The testimony of communities during focus group discussions suggests the H4+ programme led to service delivery changes that were valued and which have had an effect on utilisation and sustainability of interventions. For example, there was a common thread across the focus group discussions with communities, especially with TTMs, identifying a change of attitude (at a societal level) towards women experiencing difficult labours. This included a greater acceptance and recognition that women can be helped to survive a difficult labour and that having a difficult labour was not a result of a woman's perceived transgressions or infidelities. This cultural shift, which was very prominent in all the River Gee County focus group discussions, is discussed further in section 4. These beliefs were voiced by TTMs, mothers and community leaders: *"we don't have to see our women die."* The wider prevalence of these beliefs was confirmed by behavioural change qualitative research in two of the newer H4+ counties, including Gbarpalu and River Cess, where it was common to believe that a difficult labour was the result of a woman's own transgressions (it was a punishment) or that it was not possible to avoid death in pregnancy and childbirth.[46]

Some inputs to the H4+ programme were implemented late or sequenced sub-optimally which could potentially have negative effects in the future. For example, a long delay in the construction of maternity waiting shelters was testing community engagement and trust. The desire for the "promised" waiting shelter was raised by community leaders in every focus group discussions.

4.1.2 Contributing to health systems strengthening

The evidence reviewed suggests mixed results of the H4+ JPCS health systems strengthening investments. Training materials, job aids, and specific devices or commodities to improve quality of care and clinical decision-making have been strengthened, are in use, valued and making a difference. Most community groups and individuals point to respectful, caring and hard-working staff. The referral system clearly works in the south eastern counties even if there are gaps. Most of

[45] Some utilisation data were collected from two health facilities (River Gbeh and Cheboken in River Gee County). However, it is worth noting that facility data is cleaned and sometimes modelled before it is entered into the DHIS2 system at county level. These facility data should be treated cautiously as they are essentially raw data, used here for illustration purposes only.

[46] Search for Common Ground 2015b

the essential medicines needed to support emergency management of mothers and newborns are largely, if not fully in place. Infrastructure has been refurbished or replaced. Despite these positive developments, there are examples of poorly sequenced, incomplete, or insufficient investments. The most notable were the delayed maternity waiting shelters, which was beginning to undermine community confidence in the programme, and the failure of the WASH infrastructure which had an adverse effect on quality, hygiene and service delivery capacity. Furthermore, there has been little thought given to an exit strategy or sustainability plan. The enabling environment is a major constraint in the development of better services and higher demand. The H4+ efforts to address – or circumvent – these constraints have been partially successful but even these efforts (including, for example, strengthening the referral system so that women can be transported to higher level hospitals despite road conditions) are at risk if the programme ends without sufficient considerations made to continuity and sustaining the gains.

Developing a common view of critical needs for health systems support
There is clear evidence that the H4+ programme responded to well documented RMNCAH needs. The programme was consistent with the National Health Strategy and the RMNCAH Roadmap. The H4+ National Coordinator was the RMNCAH technical lead in the Ministry of Health prior to joining the programme and moved to WHO with ministry approval. The approach taken was intended to demonstrate how counties could make faster progress on maternal mortality reduction and ensure coordination between the Department of Family Health in the MoH and the H4+ national team to build harmonised action and decision making. Global and regional policies, strategies and technical briefs heavily influence the approaches taken in the country. Occasionally, there is evidence of country approaches feeding into regional and global policy documents. An example is the contribution by the H4+ JPCS team to a policy statement on managing maternal health, and especially complicated deliveries, during an infectious disease epidemic (in this case EVD).[47]

Catalytic interventions building on existing or planned interventions and sources of funding
Some elements of the H4+ JPCS programme were designed and implemented to be catalytic. The evidence certainly points to a programme that aims to demonstrate what can be achieved. The approach could realistically be replicated across the health system given time and resources. The approach to strengthening the referral system, linked to EmONC training, job aids such as the partograph, supportive devices and commodities, and supervision from the County Health Team, could be strengthened further and rolled out nationally if resources were available. Many of the challenges experienced in H4+ JPCS-supported facilities were common across the health system, e.g. staff shortages. A major constraint everywhere is the difficult enabling environment and in particular, the road network, which was limited in scope, often impassable and not currently laid out to favour access to basic services.

Sufficient reach and duration to contribute to lasting change
The H4+ programme has been delivered over a period of three years although interrupted for several months as a result of the EVD outbreak. The question is whether three years is long enough to effect lasting change and where change was effected, how it could be sustained. The H4+ JPCS approach was effective in strengthening skills and knowledge, as well as the use of the partograph and other decision-making aids. It has supported community engagement in a very comprehensive way, leading to improved trust and willingness by the community to use health facilities for delivery and to accept family planning especially among adolescents. Investments have led to refurbished facilities and a functioning referral system.

Demonstrating approaches that can be taken to scale
The H4+ JPCS has demonstrated an approach to health service strengthening which can be taken to scale at sub-national and national levels. However, as the analysis in section 4.1.2 shows, there were

[47] (H4+ 2015a)

flaws in the approach and in the delivery. These included some aspects in the way the H4+ delivered the support, such as: long procurement processes, some sequencing challenges (especially around delivery of maternity waiting shelters), unsustainable maintenance arrangements, and inconsistencies in the programme approach to incentives. It also included challenges expressed at county and district levels that were national or systemic in nature and could not be addressed at a local level. These include staff shortages and challenges with terms and conditions including, for example, poor accommodation, and opaque posting and remuneration processes, stock-outs of some essential maternal and newborn commodities, difficult road conditions and physical access to facilities. There were also some cost related shortcomings which led to underfunding of interventions, which could have been more productive with very little additional funding (discussed more fully in section 4.5).

4.2. Expanded access to integrated care

***Question Two**: To what extent have H4+ JPCS investments and activities contributed to expanding access to quality-integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality?*

Summary

- The H4+ approach in the south east counties of Liberia has led to some important shifts in community attitudes and social norms about pregnancy and childbirth. This, combined with better service quality and other improvements appears to have increased trust, strengthened demand, and led to increased RMNCAH service utilisation in previously underserved, marginalised and difficult to reach districts and counties. Acceptance of, and demand for, RMNCAH services including skilled delivery at birth and PMTCT appears to have expanded under the H4+ JPCS in the three initial H4+ counties.
- The H4+ approach has been to adopt a combination of interventions. These included capacity building of staff to promote practical skills to manage maternal emergencies and refer with confidence, the use of job aids such as the partograph, the availability of the right equipment, maternal drugs and commodities, a functional referral network, and a growing track record of success (fewer women dying in pregnancy) creating a reinforcing cycle of improved supply and demand in H4+ JPCS supported facilities.
- This generally positive result was limited by some delays or missed opportunities. For example, the maternity waiting shelters were delayed and some communities have expressed anxiety about the long wait. There is no exit strategy for the programme and many of the gains made, while impressive, are reversible and there is evidence that some gains have already eroded.

4.2.1 Testing causal assumptions for expanding access to integrated care

***Assumption 2.1:** H4+ JPCS-supported initiatives are **targeted to increasing access for marginalised group members** (rural poor women, families in geographically isolated areas, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disabilities, indigenous people)*

Unless otherwise noted, for evidence cited in relation to assumption 2.1 see Annex 1, Assumption 2.1

On the demand side, H4+ JPCS members have made important efforts to understand the social and behavioural attitudes of the communities they supported. For example, they commissioned various

situation analyses[48] to help identify what attitudes, knowledge and practices were creating barriers to better RMNCAH results generally, and to specific interventions including family planning uptake, early ANC visits and skilled birth attendance. These analyses identified concerns by communities about the quality of services they were able to access, including the absence of trained staff, poor equipment and drugs, and the poor likelihood of the health staff being able to intervene. Furthermore, an important finding was the identification of beliefs about why women have difficult pregnancies (for example being a punishment for transgressions).

H4+ investments at the community level, in response to these findings, included formal training courses for health volunteers and TTMs, and informal discussion groups and clubs for men, youth and students and young mothers. These investments were delivered through UN Women and UNAIDS (through their implementing partners) and through UNICEF, UNFPA and WHO, either directly and or through their implementing partners. Each H4+ partner had a slightly different approach to community engagement and worked in various communities. Table 6 below shows the different approaches to engaging communities.

Table 6: H4+ members and their approach to engaging communities in Liberia

UNAIDS	UNFPA	UNICEF	UN Women	WHO
- Media engagement - Mass communication - Print material - Radio discussion programmes aimed at engaging men on gender issues including childbirth, childcare, violence, HIV/ AIDS.	- Support to adolescent engagement and training peer educators; support to weekly talks by the midwife and after school clubs - Training of gCHWs and TTMs - Engaging community leaders around RMNCAH issues - Training health workers to respond to community demand.	Community engagement to support girls, reduce violence against girls, early and forced marriage, and increase education outcomes.	Supporting the formation of community groups to discuss gender and RMNCAH issues including violence and HIV and AIDS through support to regular meetings convened by peer educators including groups for men, young mothers, and adolescents.	- In the H4+ programme, similar to UNFPA as they work together in Liberia - Support to training gCHWs and TTMs - Specific support to adolescent peer educators, and community leaders.

In focus group discussions and meetings with community leaders, it was evident that the approach adopted by the H4+ JPCS increased the willingness and openness of the communities to access antenatal care, skilled delivery and uptake of family planning, especially among adolescents. Among marginalised groups, it was difficult to find extensive specific evidence. In one sense, everyone in the community was marginalised since it was an underserved area with little targeted support, poor human resources availability and no functional referral system. Discussions with midwives and health staff confirm that the H4+approach to integrated care across the RMNCAH continuum focused on identifying and addressing several elements of demand in particular around women's access to reproductive health services, skilled delivery and newborn care. This includes reducing pregnancies in young people and eliminating mother to child transmission of HIV.

Among the H4+ interventions, several implementing partners worked with communities to engage them around challenging attitudes to gender based violence, patriarchy, PMTCT, youth sexuality and

[48] For example, (Search for Common Ground 2015b) (Assumption 2.1). There is little reason to think that the beliefs in the older south eastern counties were different when the H4+ started there. In fact, the evidence from focus group discussions and reported by health workers confirms that it was.

gender-based violence among youth. They did this through structured media campaigns, dialogue and radio programmes, smaller discussion groups, and by engaging leaders, community decision makers, teachers and health workers. Based on views shared during focus group discussions, key informant interviews and document review, there appears to have been some genuine shifts in knowledge, attitudes and skilled delivery uptake.

Supporting access to services by youth and adolescents was an important element of the H4+ programme, and reaching young people with sexuality education and reproductive health services was identified as a programme objective. Almost all the H4+ partners were engaged in some way with reaching young people (Table 6 above). Among urban based young people, access to sexuality education and services was identified as a high priority, and the H4+ investments into sexuality education and services were seen as valued, important and most needed although still insufficient. For example, among urban youth, gender based violence was reported as "*worse than among adults*" and at school, "*boys attacked girls often*" forcing them to have sex. Girls reported that boys resisted the use of condoms and that they had a poor understanding of what constituted rape. Young people in urban areas requested more comprehensive sexuality education, which they valued but said they wanted and needed more. They also reported that the hospital staff were not always welcoming to adolescents and in a group of 19 youth, 9 reported being "sent away" or shouted at such that they fear going back. Other gaps identified among urban youth were hygiene promotion, more written material and information for peer educators, family planning stock-outs and the lack of a youth friendly corner.

Community leaders in rural catchment areas spoke about their approval for young people to access family planning commodities, as this would prevent early pregnancies, thus enabling girls to stay in school. Community attitudes, as expressed through the focus group discussions and meetings with community leaders, had become open to adolescent health services delivery. H4+ supported services for young people were viewed as legitimate and an essential part of ensuring their well-being. Utilisation data show a steady annual increase in adolescent attendance in one rural clinic (Table 7 below). Among rural based adolescents, violence and forced sexual encounters were rarely reported. Clinic nurses met young people once a week either at school or in the clinic, providing them with structured information and creating the space for discussion. Nurses were seen as "*nice*" and "*easy to speak to*". H4+ inputs included a small budget for refreshments in some locations. Some peer educators had received a small incentive (10 USD) although only once, while others had never received any incentive.

Across all the communities where youths and adolescents participated in focus group discussions, two common issues were raised: the first was the long wait at the hospital or health facility due to the staff shortages; the second was the lack of resources to support peer educators with information materials, incentives, or bicycles to help them do outreach.

Table 7: Attendance data January to March 2014-2016 in River Gbeh Clinic, River Gee County

Year	Total attendances	Number of youth (10-19 years)	% of attendances 10-19 years	% of attendances under 10 years
2014	1.396	151	11%	45%
2015	1.201	232	19%	44%
2016	1.235	316	26%	47%

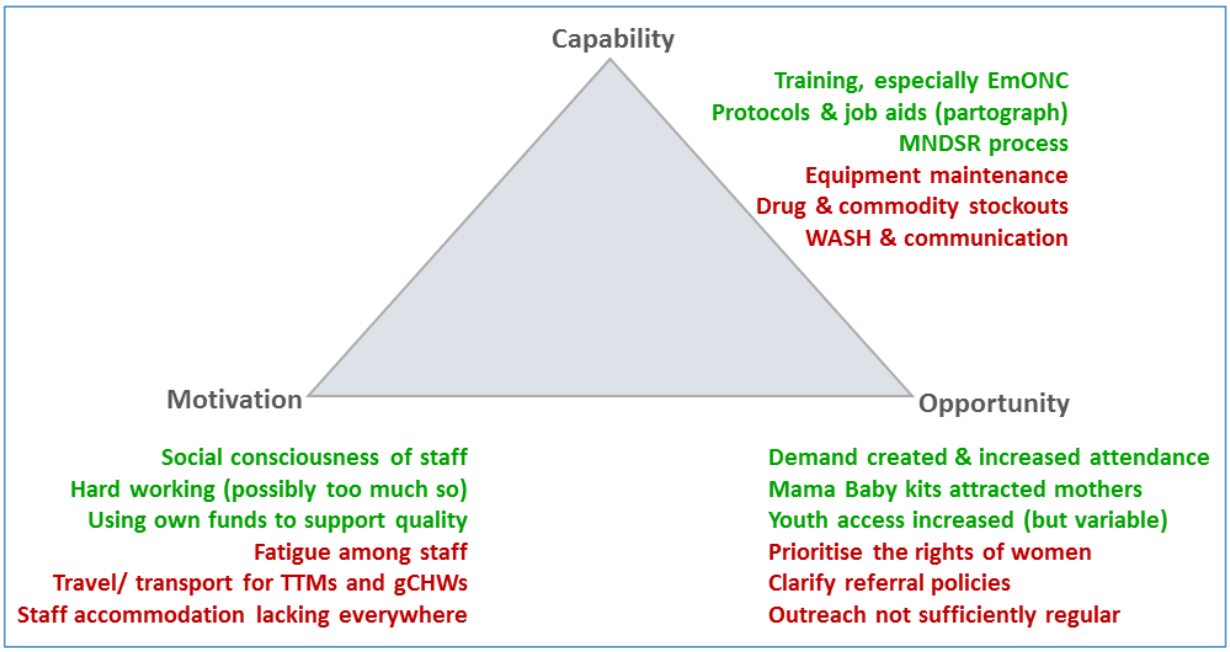
Assumption 2.2: *H4+ JPCS* ***support to capacity development, and to effective demand*** *by community members has* ***adequate reach*** *to effect access to quality services for marginalized groups. H4+ JPCS support addressed the three dimensions of* ***sustainable capacity improvement****:* ***capability, opportunity and motivation*** *for sustained provision of care.*

Unless otherwise noted, for evidence cited in relation to assumption 2.2 see Annex 1, Assumption 2.2

The number of maternal deaths in the three south eastern counties decreased steadily from 23 in 2012 before the H4+ JPCS began, to 13 in 2015, a reduction of 43 percent.[49] In some districts, particularly those supported by the H4+ like Jarkaken, there had been no maternal deaths or neonatal deaths in two years.

The evidence collected suggests that with training and on-going supportive supervision, staff in the south eastern counties were able to provide services that better met the needs of patients and communities. During exit interviews, patients commented on respectful staff, and in focus group discussions, many communities expressed appreciation for the efforts made by health workers. The H4+ JPCS programme also encouraged capacity development in several ways. Based on the capacity triangle model, Figure 5 below summarises H4+ contributions to capability, motivation and opportunity, and identifies continuing limitations. The figure is discussed in detail below.

Figure 5: The Capacity Triangle in Liberia



Looking at the three points of the triangle (capability, motivation and opportunity), the figure highlights some of the positive influences achieved with support from the H4+ programme (in blue). The figure also identifies continued limitations or barriers (in red) which include limitations created by the enabling environment, the larger health system or the national public budget and policies. These are discussed in more detail below.

Capability

The H4+ programme supported capability strengthening through a range of training courses primarily through EmONC and *helping babies breathe* training as well as other pre- and in-service training support. The trainings included the use of specific job aids, most importantly, the partograph, which were then distributed to health facilities. Health facility staff, MoH technical staff and H4+ focal points all pointed to the importance of the partograph in identifying the critical point for referral. They said that before, a midwife might keep trying to deliver the baby even well past the danger point. The maternal and newborn death surveillance and response (MNDSR) process was also identified by staff and MoH alike as supporting quality improvement. Despite the fact that a maternal

[49] Data supplied by the Ministry of Health and taken from the DHIS2, MoH, Liberia.

death review was not conducted consistently across all sites (according to H4+ partners), H4+ continued to promote its use and, following the decline of EVD, led the process to reinvigorate routine implementation. The MNDSR strengthens accountability and provides an important learning opportunity when it functions properly.

As mentioned already, although staff in H4+ supported facilities were better skilled and had important tools to support their clinical work, they did also have to work without functional equipment or medicines, and often in settings where there was no running water, electricity, solar power or functional radio.

Motivation

There is evidence that, despite challenging conditions in H4+ supported facilities, many health workers were motivated by the opportunity to improve their skills and knowledge of clinical procedures. This was reinforced by having access to functional equipment and medicines and the knowledge that they could call for back-up through a largely functioning referral system. Overall, they were also largely aware that deaths would be subject to the accountability process of a maternal death review. Staff at the H4+ supported facilities, particularly the rural based health centres and health clinics, were seen by communities and the CHT as hard working, knowledgeable, and dedicated. They sometimes used their own funds to compensate for equipment failures or to purchase fuel for generators as previously mentioned.

Motivation is challenged by poor or no accommodation. Staff often share small rooms, or must rent accommodation in the village or town nearby. Accommodation was mentioned by every health facility and every community as a major gap. The H4+ JPCS funds could not be used to support staff accommodation needs. For TTMs, as already discussed, the lack of resources for transport made it difficult sometimes to do their job and, as they received no incentives, meant that many TTMs spent their own funds to perform their role.

Opportunity

The H4+ JPCS spent more than a quarter of its resources on community engagement, education and mobilisation. This was clearly paying off as an increased number of women attended the clinic for antenatal care and delivery. With increased use, demand for services also increased and expectations grew. The skills and knowledge of the health workers were constantly put to the test. There was a growing opportunity to deliver quality services and the results were positive. For example, several H4+ supported clinics in River Gee had had no maternal deaths in two years. As noted earlier, services targeted at youth and adolescents were largely welcomed across the community and seen as a successful intervention to enable girls to stay in school. One innovation appreciated by the communities and mentioned by midwives, mothers, TTMs and even community leaders, was the mama-baby kit, a pack of useful baby gear including a hat, diaper, receiving blanket, Vaseline, and other products. The mama-baby kit was given to women after they had attended antenatal services and delivered in the facility. The kits were out of stock from mid 2015 despite the stated intention of the H4+ JPCS partners to procure more.

Lastly, opportunity to deliver timely quality services to as many people as possible was curtailed by the lack of outreach services in River Gee. For women (and children) who are unable to physically reach the clinic, including the disabled, sick or over-burdened, outreach would be an important alternative and would expand access to essential services including antenatal care, immunisations, and family planning. In most H4+ facilities visited, the staff said that outreach was carried out when there was a functional means of transport and fuel. However, as found in one county hospital, a vehicle for outreach existed, but not a reliable allowance for fuel. In one health facility, the midwife walked to some outlying villages to do immunisations but it was mainly the case that outreach activities were not conducted.

Assumption 2.3: *H4+ JPCS support at national and sub-national level has been* ***sequenced*** *appropriately with support to RMNCAH from other sources. H4+ JPCS supported investments and inputs* ***do not conflict in timing or overlap*** *with those provided by other programmes. Further, H4+ JPCS support* ***combines with other programme inputs*** *to allow services to be scheduled and delivered in manners appropriate to reaching vulnerable group members and building trust between providers and users.*

Unless otherwise noted, for evidence cited in relation to assumption 2.3 see Annex 1, Assumption 2.3.

MoH technical staff credit H4+ JPCS for bringing together the work of UN agencies, drawing on their collective strengths and providing input across the whole spectrum of the health systems building blocks, including community engagement and communication. The H4+ country team stated that the collaborative approach was a major achievement (and not easy at the start). In addition, several H4+ country team members described H4+ as the first time UN agencies had genuinely worked in a holistic way. They said they felt responsible for each other's achievements (or failures) and had a strong sense of unity about the programme.[50]

Thus, when one agency was unable to deliver the agreed programme inputs through no fault of their own, other agencies stepped in to help find a solution.[51] However, the bonds among the agencies have not been able to prevent some shortcomings in sequencing and timing. For example, the maternity waiting shelters were overdue and the procurement process has taken longer than expected. The shelters may be constructed before the end of the calendar year (2016) but the timing will mean most of the other H4+ inputs will have ended. The WASH inputs were installed in 2014, perhaps too quickly or without sufficient consultation according to the County Health Team, and by the following year were largely dysfunctional. Resources may apparently be available for a second attempt, and hopefully these will be planned and delivered in consultation with the county WASH team and have longer durability (as discussed under assumption 1.4).

Assumption 2.4: *The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability for service users to effectively demand care is sufficient to contribute to a* ***notable increase in the use of services and to overcome barriers to access*** *which existed in the past.*

Unless otherwise noted, for evidence cited in relation to assumption 2.4 see Annex 1, Assumption 2.4

Note: This assumption was also addressed as assumption 1.4 with regard to health systems strengthening. The focus here (in relation to evaluation question two) is on the resulting improvements in access for the marginalized and overcoming barriers to their participation.

Focus group discussions and interviews with community groups, trained traditional midwives and health facility staff suggest there has been a marked change in the level of trust and communication between communities and health facilities in the H4+ JPCS supported areas. This trend is not fully reinforced by the utilisation data but, as discussed in section 4.1, the utilisation of health services across Liberia declined during 2014 as a result of the EVD outbreak. Although there was general recovery in 2015, it has been slow in some places due to fragmented trust and mutual suspicion. H4+ focal points, facility staff and community leaders have all raised this aspect of diminished trust and agreed that by mid to late 2015, it was generally back to pre-EVD levels.

[50] See Assumption 3.1 however for a discussion of the World Bank's limited participation in the H4+ due to the absence of a health specialist in country until March 2016.

[51] This example concerns UN Women, WHO and UNFPA and is discussed in detail in section 5.2.

Engagement of communities, including through men's groups, community leaders, informal health workers, adolescents and youths, and young mothers' groups, supported by the H4+ through its implementing partners, was seen as an important contributing factor to the reduction of home births (confirmed by hospitals and clinics visited). This engagement has also contributed to increased awareness at the community level and among health staff of the importance of antenatal care, family planning and of adolescent health and better relations between the community and health facilities, including the active role of the *Community Health Development Committee* which in Jarkaken, for example, constructed the fence around the health facility (twice). In the facilities visited, evidence from interviews supported the reported increases in antenatal checks, institutional deliveries, and skilled birth attendance.

Key informants recounted the same narrative of a "before" and "after" H4+ effect. Before the H4+ JPCS, patients were less likely to visit the health facility. Women tended to deliver at home mainly because many lived far from the clinic, they did not think it was worth the journey, they preferred the traditional birth attendant, and critically, did not believe the clinic could do anything about improving the outcome of childbirth. After the H4+ intervention, most communities consulted had developed an understanding of what could be done at the facility to improve the outcome of birth. They also felt more trusting of the services as they could visibly see the equipment, furniture and commodity improvements. However, they complained that the medicines stockouts, while notably less, continued to be a problem.

H4+ focal points, facility staff and the County Health Team all refer to the change in quality and accessibility due to a combination of several factors, including the repurposing of TTMs; the engagement of community leaders and other "gate keepers" to promote skilled birth attendance; confidence building in facility staff through training and on-going supportive supervision; equipment and commodity availability and the visible experience of the referral system. The latter was considered important because everyone in the community could see that a woman experiencing a difficult labour could be taken to the hospital, and return to the community healthy (and usually carrying a healthy infant). Successful referral, and a significant reduction in maternal deaths, has changed views in the communities visited to the extent that death in childbirth is no longer seen as unavoidable. The functioning referral system was thus important to shifting attitudes.

This shift in attitudes, in turn, led to deeper changes in beliefs according to community leaders, TTMs, and based on discussions with women themselves. Whereas previously, women experiencing a difficult labour were blamed, or were thought to have done something wrong and were being punished, the positive experience resulting from H4+ programme investments, with more proficient, confident midwives, equipment and medicines more consistently available, as well as the functional referral system, was believed to have resulted in fewer women dying in childbirth. As a result, community confidence and trust grew. Community health workers and TTMs also commented that attitudes to a difficult labour were changing among the communities where they worked, and women were not blamed (so much) for complications in pregnancy and childbirth.

Interviews with county health team members support the importance of working with local leaders given the influence they have in their communities. For example, in River Gee community leaders were said to have contributed to an increase in skilled birth attendance and a commensurate reduction in home deliveries through expressing their views as leaders and in some cases, through levying fines on those who do not give birth at the health centre.

Assumption 2.5: Demand creation activities and investments have sufficient resources *and are sustained enough over time to contribute to enduring* ***positive changes in the level of trust*** *between service users and service providers in RMNCAH. Investments and activities aim to change service providers' attitude and behaviour towards users in an effort to build mutual trust.* ***Improvements in service quality and access are not disrupted*** *by failure to provide adequate facilities, equipment and*

supplies of crucial commodities in RMNCAH. H4+ JPCS support is not subject to disruptions, which can weaken trust and reverse hard won gains.

Unless otherwise noted, for evidence cited in relation to assumption 2.5 see Annex 1, Assumption 2.5

There is evidence (set out above) to suggest that the H4+ JPCS has been able to shift attitudes, increase trust, build demand and extend access to RMNCAH services in previously underserved, marginalised and difficult to reach districts. While there is also evidence to suggest an upward trend in utilisation of life saving services in the south eastern counties, it may be too soon to discern impact in the three new H4+ JPCS counties. There are also some clear threats to maintaining that trend into the future. These include the loss of programme contributions that were materially supporting community engagement such as funds to keep the men's clubs and youth groups going (the travel support and refreshments make all the difference to attendance, given the long walks involved).

Incentives paid to midwives encouraged them to stay near the clinic over the weekends rather than travelling away. These incentives have ceased (for example, in Jarkaken clinic) because the contract with the relevant implementing partner was not renewed in December 2015. It has meant that the 20 USD per month the midwife received is no longer paid. While she reported that she did continue to stay at the clinic over the weekend and was clearly proud of the track record achieved since she arrived at the clinic two years ago (zero maternal or newborn deaths), this break in what she had considered part of her compensation package could weaken her commitment over time (at least on weekends). Reliably finding a trained midwife at all hours of the day or night is one of the factors contributing to trust by the community and a willingness to travel a long distance to the clinic.

Community engagement efforts have been mobilised across the facilities visited and were expressed in a number of ways. One of these was around the commitment to support the construction of the maternity waiting shelters, an issue that was raised by every community visited. In particular, there was a strongly expressed interest in seeing the shelter built and a clear understanding that it had been promised. In one community, during the focus group discussion with the men, they identified a good site for the shelter and itemised the elements that they themselves could contribute. For example, they said they could make the bricks, collect and filter the sand and plane the boards if they could have access to a power saw. In another community, they had already made the bricks, which were starting to disintegrate with the onset of the rainy season. According to the H4+ national coordinator, the tenders for the construction of the maternity waiting shelters were in the final stages of negotiation. The main challenge was that they would only be able to construct four or five in each district rather than six (one at each health centre, plus the referral hospital). The decision they still needed to take was where to site the shelters and consultations were on-going.

Another threat to maintaining an upward trend would be weakening quality of care at the facility as a result of the persistent lack of vital medicines or the movement of trained staff. While there is evidence that attitudes have changed, it is not yet clear that these changes are so deeply embedded they could not slip back again once the programme ends if the quality improvements weaken. Other factors that could affect community attitudes and demand include staffing changes, the failure of the programme to deliver commitments (such as the maternity waiting shelters) or other quality of care weaknesses.

The lack of public or low cost transport options is a major barrier to access for everyone, but in particular, for those who require regular contact with the health facility such as HIV positive mothers and those who have non-communicable diseases. Overcoming this barrier has been difficult and, although it is not the role of the H4+ programme alone, it is nonetheless an obstacle to improving maternal and newborn health. So far, H4+ partners report that they have been unable to engage with other UN or government entities to start working on a solution.

4.2.2 Contributing to expanded access to integrated care

There is strong evidence to demonstrate how H4+ JPCS investments have engaged communities in a wide range of ways and through different mechanisms including mass media, regular clubs and groups, support to community based health workers, health education programmes and engagement of community leaders. Every active H4+ partner has participated in delivering some component of the community-focused programme, and this has led to helpful and mutually reinforcing programmes. This broad participation by H4+ partners has reinforced the importance placed on community engagement and demand creation. However, limitations become evident (in addition to those presented in section 4.1 above) including: late delivery of some key components of the programme including the maternity waiting shelters or uneven supply of medicines could test patience and confidence. Furthermore, the imminent end of the programme created doubt about the sustainability of many of the on-going activities. Against this backdrop, the enabling environment remains complex and challenging.

Contributing to quality, integrated services across the RMNCAH continuum of care

The H4+ JPCS has funded some interesting and important programmes aimed at shifting attitudes to health services, building trust, changing social norms regarding women's experience of difficult labour, and broadening acceptance and use of family planning. In these efforts, in the counties where the programme has been on-going for three or more years, there have been clear signs of widening use of services including delivering in facilities. However, there are no records of access targeted towards women living with disabilities. There are perpetual challenges in the community around transport and physical access, as roads are poor and difficult to use and there are few public transport systems or inexpensive private taxi arrangements.

Several of the activities were aimed specifically at men and there were qualitative data to suggest that they had an impact on individual male views about gender violence, patriarchal behaviours and women's access to health services. However, it was difficult to ascertain a methodical summary of the evidence. Overall, knowledge building in the H4+ programme has not been systematic.

Youth and adolescents in several communities report better access to information, education and services however for those seeking care in hospitals, this was not the case. From the facility data alone, it is difficult to use the records to try to assess whether there has been an increase in attendance by previously excluded groups. For example, records do not count disabled patients or those excluded for other reasons. This makes it difficult to assess with precision the extent to which access to routine health services genuinely improved for all women and children.

Strengthening the quality and appropriateness of RMNCAH care provided to marginalised and excluded populations

By opening up previously underserved areas and supporting the delivery of quality services, the H4+ JPCS programme has improved the prospects for all community members to benefit from better services. There is clear evidence that facilities had some of the equipment and medicines, trained staff, and lifesaving devices needed to provide quality services. Repurposing the traditional birth attendant into the trained traditional midwives (TTMs) whose main role was to help to encourage women to attend the clinic for antenatal care and birth enabled them to maintain their role and status in the community while reducing unsafe practices.

Expanding access to marginalised and excluded groups, especially adolescents, youth and the poorest women

Some evidence of expanded access to family planning and adolescent health services for young people in the H4+ JPCS counties was identified. In the catchment communities of H4+ JPCS supported facilities, there was remarkably – and unusually – open discussion about the value of young people, especially students, having access to family planning services so as to delay pregnancy and stay in

school. According to health facility staff and communities, the H4+ supported interventions have led to a better understanding of the value of antenatal care, a greater acceptance of having a skilled birth attendant, and more trust in the services. The experience has reportedly led to a rethinking about the causes of a difficult labour. The combined approach to shifting social norms around attending the clinic includes training informal and lay health workers (trained traditional midwives and community health volunteers), engaging men and women, as well as community leaders, on the demand side while ensuring the health facilities are ready to meet increased demand with quality, respectful and skilled services.

Strengthening the integration of services across the RMNCAH continuum of care
The H4+ programme approach addresses the full continuum of care including family planning, antenatal, delivery and postnatal care, care of newborns, infants and young children and increasing the availability and accessibility of services for adolescents. The approach includes examples of integrated services through its training modules. General community health volunteers (gCHVs) are trained to provide a range of advice, care and referral across the continuum, for example.

Developing and sustaining trust between service providers and users of RMNCAH services
As set out in previous questions, there is good evidence of increased trust building between service providers and users. This was seriously tested during the EVD outbreak and it took time to rebuild. Investments and activities aimed at improving quality and meeting needs reinforce trust. As the H4+ JPCS ends, there are risks to maintaining that trust if the quality of services falls off or investments in critical components end precipitously such as the mama-baby kits that created an incentive for women to deliver at the facility or the incentive paid to midwives to encourage them to remain near the facility over the weekend.

4.3. Responsiveness to national needs and priorities

***Question Three**: To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level?*

Summary

- **The H4+ JPCS programme works in counties and districts selected by the Ministry of Health; the activities were designed in conjunction with national authorities and are broadly consistent with national policy.**
- Although H4+ members speak in a more unified, coherent way on maternal health policy**, the H4+ JPCS programme has had little discernible influence on shaping or establishing new national coordination platforms.**
- **H4+ members have made efforts to raise funds and implement maternal health programmes jointly in Liberia building on their** experience of working together although that experience has not been systematically documented.
- Coordination at the sub-national level has missed opportunities to be more effective. For example, there was no coordination among H4+ implementing partners at national or at sub-national levels; the well placed sub-national monitoring and evaluation field officer had less impact on the whole of the H4+ JPCS programme as he reported to one agency and not to the group, did not attend quarterly review meetings and was not empowered to intervene to help solve problems.

4.3.1 Testing causal assumptions for responsiveness to national needs and priorities

Assumption 3.1 *H4+ partners supporting RMNCAH in JPCS countries have been able to establish effective platforms for coordination and collaboration among themselves and with other stakeholders using H4+ JPCS funds and with technical support from the global/regional H4+ teams.*

Unless otherwise noted, for evidence cited in relation to assumption 3.1 see Annex 1, Assumption 3.1

Coordination and collaboration within the H4+ at national level

The H4+ JPCS programme in Liberia established a Technical Working Group (TWG), chaired by a ministry of health official to oversee and monitor the delivery of the programme. The group met quarterly based on dated minutes of meetings. There is evidence of joint work plans and budgets, monitoring and evaluation reports and joint field mission reports on an annual basis.[52] In interviews, ministry of health officials at national level reported that they felt that H4+ members spoke more effectively as a single group with more coherent policy messages around RMNCAH. H4+ members raised the issue of policy coherence themselves as an important benefit of the H4+ programming experience. Furthermore, they gave several examples of programme funding applications that they have submitted. For example, the UNFPA country representation reported that they had submitted an application for additional maternal health funding (non-H4+ JPCS) jointly with UNICEF and WHO and that the three agencies had already been awarded funds from a different UN fund for maternal health support. There were no examples given, however, that included UN Women, UNAIDS or the World Bank.

The level of engagement in H4+ JPCS by individual H4+ members was not necessarily determined by the amount of funds each received. For example, based on attendance and minutes of meetings, and confirmed during interviews and in discussions with implementing partners, UN Women and UNAIDS were both highly engaged in the H4+ programme at national and sub-national levels but received a small fraction of the funds based on the expenditure data shown in section 2.[53] This is partly (but not fully) explained by the nature of their interventions which were focused on time-intensive, lower cost activities delivered across multiple communities through a number implementing partners.

However, both agencies, particularly UN Women, could have productively spent more funds on their activities and achieved more results in the programme timeframe. In interviews, implementing partners cited several examples of how they constrained their activities in ways that were potentially harmful to maximising results. For example, financing constraints forced the implementing partner to make trade-offs between getting participants to the meeting and running the meeting in a way that was conducive to achieving an outcome. In this example, the implementing partner created men's groups in the catchment areas of the H4+ JPCS focus facilities in the south east counties with the aim of challenging gender bias, rethinking men's roles in supporting women during pregnancy and childbirth etc. Each group had a budget of 50 USD per monthly meeting. However, the funding anticipated support to one united catchment population group per facility rather than the five or six that would actually have been more appropriate, given the geographical distribution of populations around the health facilities and the long walking distances between them. The implementing partner was obliged to choose between using the funds to serve refreshments to the participants, some of whom walked four to six hours to attend the meeting, or to support participants to travel by motorbike, which would shorten the time to two to three hours each way but would eliminate the possibility of offering a small refreshment. A small increase in funds would have been highly cost-effective allowing for the establishment of far more men's groups closer to population locations and enabling funds to be used to create incentives for participation (refreshments) rather than being

[52] Many of these are referred to in Assumption 3.1 and 3.2

[53] Judged by volume of work produced by UNAIDS and UN Women, number of implementing partners, consistent attendance at meetings. In interview, both UN Women and UNAIDS expressed strong commitment to the H4+ programme.

used on long distance transport. There is no evidence that the H4+ JPCS had discussions about the cost effectiveness of funds distribution or made detailed adjustments along the way.

Although the collaboration among five of the H4+ partners implementing the programme at facility and county level demonstrated several strengths (discussed in Assumption 1.3 and again in Section 5 below), the World Bank was not in any practical way engaged in the H4+ partnership prior to May 2016 when the first World Bank health adviser arrived in Liberia and started to attend H4+ meetings. The absence of this crucial member of the H4+ in both the national technical role played by the H4+ (as a body or a group, not as individual agencies) and at programme delivery level was evident in both the documentary evidence and in discussions with senior ministry officials. H4+ members participated in supporting the joint World Bank - Government of Liberia (GoL) process to develop a RMNCAH Investment Case as part of Liberia's next IDA application and associated funding application to the Global Financing Facility (GFF). The other H4+ JPCS members reported that they had participated in national meetings aimed at developing the Investment Case and that in their role as the technical assistants to the GoL, they had actively participated in and advised on critical policy content. This was confirmed by MoH technical staff. However, in interview with the World Bank, it was not clear the extent to which the H4+ experience in strengthening RMNCAH services had been taken into consideration. For example, there was no documentary evidence that the H4+ produced a lessons learned document or reflections on what combination of investments worked best and why. This is discussed further in section 4.

***Assumption 3.2**: Established platforms and processes for coordination of H4+ (and other RMNCAH initiatives) are led by the national health authorities and include as participants the H4+ partners, relevant government ministries and departments (including at the sub-national level) and key non-governmental stakeholders.*

Unless otherwise noted, for evidence cited in relation to assumption 3.2 see Annex 1, Assumption 3.2

The Ministry of Health chairs the H4+ JPCS Technical Working Group, which strengthens coordination considerably, and helps ensure that the H4+ JPCS programme is well embedded in national priorities. The H4+ focal points and H4+ national coordinator all participate in national coordination committees, as outlined in section 2.4 above, including the National Reproductive Health Technical Committee. Most of the H4+ focal points work on their areas of technical expertise in other programmes concurrently. As outlined above and in more detail in section 4.4, key informant interviews, results analysis, and minutes of meetings suggest that the H4+ country team introduced interventions, commodities, and processes to the national level coordination groups (for example, the non-pneumatic anti-shock garment) that had been successfully implemented at facility level. According to MoH officials, H4+ members were able to successfully promote a unified, coherent set of priorities in the technical support they provided to the development of the RMNCAH Investment case.

Coordination among H4+ implementing partners was managed by each H4+ JPCS member with its respective implementing partners. Implementing partners reported that they had not once met as a group during the implementation of the programme either at national or at county level. They therefore had no opportunity to coordinate their efforts among themselves to ensure they minimised duplication, or to develop a coherent policy approach (for example around HIV and AIDS education) or support each other in programme delivery. Naturally then, as they had not met and coordinated at national level, they also did not meet or coordinate systematically at the local district or county level.

***Assumption 3.3:** Programme work plans take account of and respond to changes in national and sub-national needs and priorities in RMNCAH as expressed in plans, programmes, policies and guidelines*

at national and sub-national level. H4+ partners consult and coordinate with stakeholders at both levels.

Unless otherwise noted, for evidence cited in relation to assumption 3.3 see Annex 1, Assumption 3.3.

Sub-national coordination was less cohesive and productive for the H4+ programme. One challenge at sub-national level was for the H4+ JPCS members to ensure their implementing partners were well briefed, delivered at the *right* time, in the *right* way and to the *right* standard. The County Health Team remarked on shortcomings in this area, suggesting that some implementing partners were not well coordinated in their programme delivery, which led to missed opportunities to build capacity, incorrect and ultimately wasteful programme delivery, and reputational risks for the H4+ members. Sequencing challenges have also been referred to in section 4.1 above. For example, based on reports by health facility staff and by evaluation team observation, none of the investments made into installing the submersible water pumps,[54] the generators to run the pumps, or the water towers in River Gee health facilities were still functioning in May 2016. The implementing partner tasked to deliver WASH services to fifteen health facilities across the three south eastern counties, including five health facilities in River Gee County, did not communicate with the Country Health Team either before or during the delivery of services according to the River Gee County Health Director. Either the health facility staff or the county WASH team staff could have informed the implementing partner which wells ran dry in the summer months and would therefore be unsuitable for submersible pumps without first drilling deeper boreholes. However, according to the County Health Director, his team was not consulted and they were not aware that the implementing partner was working at these health facilities until after they had gone. One health facility, some months later asked the CHT why they had a generator (especially as they had no fuel to run it) and the County Health Director expressed surprise as neither he nor his team were aware that the facility had a generator.

A second element of sub-national level coordination that illustrates this limitation was the selection and appointment of a field officer to be based in the three south eastern counties to support monitoring and evaluation efforts. The field officer was appointed and paid by UNFPA. He reported to UNFPA and was expected to report on UNFPA's activities first and foremost. The line of accountability (to one H4+ partner only) is clearly stated in his terms of reference, his routine reports, his annual reports, and in interview with both the field officer and the H4+ members at the national level. As a result, the field officer felt primarily accountable to one agency rather than to all of the H4+ members. He did not have direct contact with any H4+ members other than the agency that had hired him. His reports set out the full picture of progress (both the achievements and problems) in the delivery of the H4+ activities for which "his" agency was responsible. However, his terms of reference referred to specific tasks for UNFPA although after some months of reporting, he was requested verbally to identify the challenges or problems that he happened to encounter related to the other H4+ partners. The quarterly reports submitted were not shared systematically with all the H4+ partners and in fact, none of them reported having seen the reports themselves. The monitoring support offered by the field officer was further weakened by the fact that he was not routinely called to participate in quarterly TWG meetings in Monrovia, nor was he invited to join by phone. The monitoring and evaluation processes in the H4+ will be further analysed in section 4.4 below as part of the H4+ knowledge management process.

[54] Submersible pumps are used to automate water pumping from boreholes (as opposed using a manual or hand pump). Submersible pumps are placed in the water but they are fixed to the side of the borehole and do not sink with the water level. If the water level drops, as it does during the summer months, the pump can operate without stopping and burn out. Submersible pumps are usually linked to a mains power supply but they can be hooked up to a generator or solar panel where there is no mains supply or where there are frequent electricity outages as in River Gee County.

Responsiveness to EVD

The document review shows how the established H4+ JPCS funding was not fully implemented in 2014 and 2015 as a result of the slowdown caused by the EVD outbreak. Expenditure rates almost stopped, and according to minutes of meetings, confirmed through interviews with H4+ members, this was largely because the Ministry of Health suspended all routine activities for a protracted period of time. Most staff in UN agencies were deployed in support of the EVD response and H4+ JPCS focal points were tasked with other priorities by their agencies during the epidemic. A large proportion of maternal health facilities were closed across Liberia, especially through the middle and end of 2014. Training was abandoned and routine activities were delayed. As the outbreak ended, new funds were made available to the H4+ JPCS to implement programmes in new counties, and the established H4+ JPCS programme in the south east geared up again although with more focus on infection prevention control.

From a programme perspective, strictly speaking, the H4+ JPCS was not particularly responsive to EVD; it was *de facto* suspended for some period of time. For example, during late 2014 to early 2015 there seems to have been fewer H4+ TWG meetings than in other years according to the minutes and meeting records. Those that did take place in the first half of the year were focused on preparing programme inputs and finalising the 2013 annual report. H4+ meetings were mainly recorded as H4+ heads of agencies meetings. The regularity of H4+ technical meetings has been re-established in 2016. However, it is worth pointing out that the H4+ partners, based on their experience of delivering RMNCAH services in the south east counties and building a harmonised approach, were able to rapidly contribute to a global learning paper on safe delivery during an epidemic (see section 4.4).

***Assumption 3.4**: Platforms and processes for coordination of H4+ JPCS do not duplicate or overlap with other structures for coordinating activities in RMNCAH. Further, they provide a strong RMNCAH focus to national and sub-national health sector coordinating platforms.*

Unless otherwise noted, for evidence cited in relation to assumption 3.4 see Annex 1, Assumption 3.4

There is little overlap or duplication of health systems support in Liberia. The H4+ programme did not duplicate other investments mainly because there were few or no other partners working in these counties prior to the initiation of the H4+ JPCS interventions. Interviews with Ministry of Health and county health team officials suggest that the H4+ JPCS programme has had the longer term benefit of "shining a light" on neglected and underserved areas, especially in the south east counties, demonstrating that it is logistically and programmatically possible to support health service delivery improvements in difficult to access settings.

The H4+ counties in the south east had little donor support beyond a few national implementing partners at the time the H4+ JPCS was initiated. In the newer counties, and in the south east in the future, the situation may become more complex as the GFF grant and the Global Fund grant may cover some of the same counties with overlapping objectives (improving maternal and newborn survival) although they will reportedly work at different facilities.

At the community level, H4+ JPCS members took steps to ensure their activities did not duplicate or overlap with each other. UN Women and UNAIDS programming approaches contained elements that would have been duplicative at the community level. The issue was resolved by UN Women removing modules from its community engagement programme (specifically modules on HIV and AIDS), as confirmed by UNAIDS.

4.3.2 Responding to national needs and priorities

The review of the evidence suggests that the H4+ JPCS was, to a fair extent, responsive to national and sub-national needs and priorities. This section summarises this evidence in response to the evaluation assumptions and shows that, as a programme focused on strengthening the health outcomes of women and children, the H4+ JPCS was closely embedded in national priorities. There is good evidence to suggest that H4+ JPCS interventions raised the profile of MNDSR processes and helped reinforce national and county commitment. While much of the H4+ JPCS has been appreciated and valued, there are a number of ways it could have been improved that would have enabled H4+ partners to demonstrate even greater responsiveness including better sequencing of activities.

Responding to emerging and evolving needs of national and sub-national health authorities
The H4+ JPCS developed and implemented annual work plans approved by the Ministry of Health. Documentary records and interviews show that savings from some activities were reprogrammed to benefit the H4+ JPCS supported facilities. There are clear, established and persistent needs in Liberia around maternal and newborn health, and the H4+ JPCS programme was able to advance MoH efforts to meet these needs.

Placing country needs and decisions at the centre of the programme
The structure of the H4+ JPCS programme does not place the country (in this case Liberia) fully at its centre. There were limitations on how the funds could be spent. For example, H4+ focal points reported that they were not able to use the funds for either salaries or for large scale infrastructure. This was confirmed by county health teams in both Cape Mount and River Gee. Large scale infrastructure was defined by H4+ partners (in interviews) as refurbishment to the health centres; however, building maternity waiting shelters was allowed, as were repairs to maternity wards that were aimed at increasing quality of care and privacy, including the provision or repair of screens, lighting, furniture, equipment, and/or water and sanitation. The H4+ JPCS did not support investments into staff housing.

Although resources are rarely sufficient to meet needs, the recurrent expenditure associated with community engagement work may have been too limited to achieve the best value for money. Given the significant outcomes in terms of demand and changing attitudes towards skilled birth attendance and young people's access to sexuality education and services, additional support would almost certainly have been cost-effective.

The structure of the H4+ JPCS leans towards a traditional project approach. The emphasis is on achieving results on the ground and most of the available funds are absorbed in delivery at facility and community level. As the programme has a well-articulated aim to address health systems strengthening gaps, the focus of the programme is on strengthening health facilities and service delivery at the district level. This local, operational focus is vital to strengthening service delivery but it is always difficult to make sustainable health systems improvements at that level. The H4+ JPCS approach aimed to learn from the experience of strengthening services at the facility level and then, using this experience, to inform and promote policy dialogue and advocacy at the national level to encourage and guide national systems reforms. This link between county focused investments and national policy dialogue would be an important element in building programme sustainability and continuity through institutionalising changes introduced through the H4+ programme at county and facility levels and paving the way for their scale up by national authorities (discussed further in section 4).

The Project Implementation Management (PIM) system used by the H4+ was poorly understood by the H4+ team in Liberia. The challenges with using the proposed system were referenced and the H4+ members said they had found the PIM difficult to use and inconsistent with the system they

used in Liberia. Despite attending a workshop with other H4+ JPCS countries to learn about the PIM, it was considered difficult to grasp and in fact, was never used. The H4+ focal point said that she had been told by the global H4+ coordinator that the whole approach was being rethought.

Flexibility in responding to changing contexts and events, for example, the EVD outbreak
In relation to EVD, the response was in fact quite minimal. The programme slowed down during the EVD outbreak and most elements were suspended. According to key informant interviews, most programmes across the country were suspended as a matter of course and on the instruction of the President. In this respect, the H4+ JPCS did not particularly *adapt*. There was a period when all health facilities in River Gee country were completely closed (most of October 2014) due to a lack of infection prevention control (IPC) materials. There is no evidence that the H4+ JPCS programme made adjustments to procurement to respond to the EVD outbreak other than slowing and suspending delivery in the south eastern counties. Getting back on track has taken some time (for example, expenditure has been about 50 percent of available funds until 2016 when the rate of spending has again increased).

The new counties were added to the programme as a direct result of EVD. The donor made additional funds available to help the worst affected counties respond to the systems strengthening challenges. The H4+ JPCS elected to apply the same programme approach and the same package of interventions to the new counties as they had to the older south eastern counties. However, given the programme had a year or less to run before ending, and in light of the sustainability challenges raised in section 4.1 above, it is unlikely that the new counties will experience the same results as evidenced in the south east counties.

4.4. Innovative approaches to programming in RMNCAH

***Question Four**: To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?*

Summary

- A number of commodity or device focused innovations are being utilised in H4+ JPCS supported facilities, including the non-pneumatic anti-shock garment (NASG), the solar suitcase, the use of chlorhexidine gel as well as clinical processes or service innovations including kangaroo mother care (KMC). The combined delivery of a full range of investments to improve maternal and newborn health outcomes has been highly effective and has led to visible results
- In River Gee County, the H4+ has been able to demonstrate the combined impact across the RMNCAH continuum of care that can be achieved through simultaneous support to supply-side quality improvements, demand-side behaviours and social norms changes, along with strengthening the referral network and accountability through the MNDSR process (a 360^{o} approach).
- Despite this, knowledge management has been sub-optimal in the H4+ programme, especially around methodical documentation of innovation success, policy dialogue with national authorities to support adoption country-wide and systematic scale-up. There is insufficient evidence that the lessons learned in River Gee and other counties are being introduced into national policy and scaled up across the country. This is partly because of the fragmented donor support system in Liberia.

From the start, the H4+ initiative has emphasised the importance of innovation in country level efforts to catalyse and accelerate RMNCAH results. Innovation has not been formally defined by the

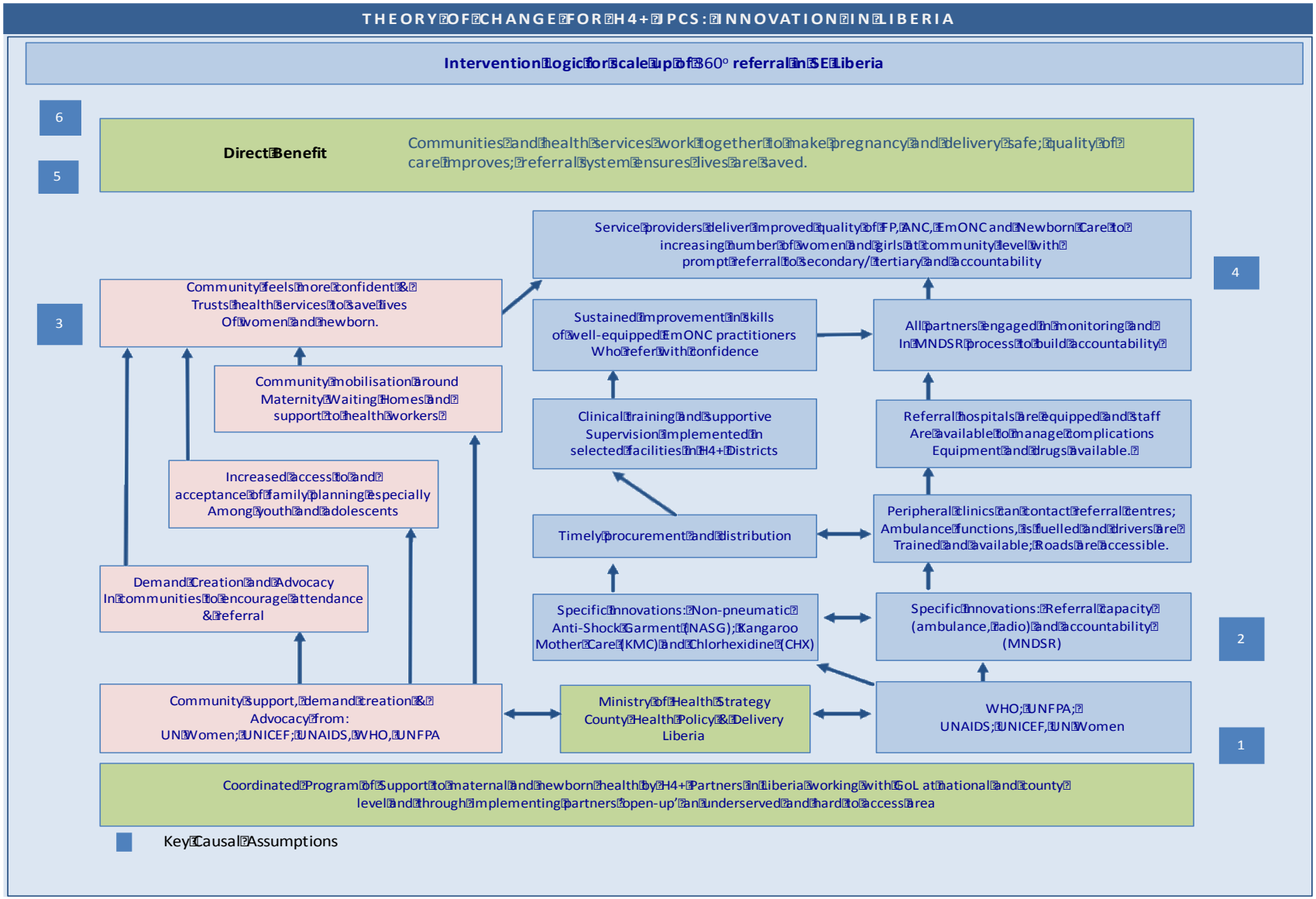
H4+ JPCS and therefore, for the purposes of the evaluation, innovation is considered a programme practice (including a commodity, process, adaptation etc.) that is new to the locale in which it is being introduced through a systematic and deliberate process. Ideally, this process would include the full cycle of innovation with all the stages shown in Figure 6 below, as well as identification of an opportunity for experimentation, documentation, communication and adoption of results.

Figure 6: The innovation to policy and scale up process

The theory of change for innovation in Liberia is presented in Figure 7 below. The causal assumptions for this ToC are discussed in detail in the section 4.4.3.

4.4.1 A theory of change for innovation in Liberia

Figure 7: Theory of Change for H4+ JPCS: Innovation in Liberia*



** The assumptions are set out in full in Annex 6.*

4.4.2 Testing Causal Assumptions for Innovation in Liberia

Assumption 4.1: *H4+ JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+ JPCS, from practices in other H4+ JPCS countries or from the expertise and experience of key stakeholders at all levels.*

Unless otherwise noted, for evidence cited in relation to assumption 4.1 see Annex 1, Assumption 4.1

The evaluation found evidence in River Gee County that the H4+ JPCS supported the implementation of several innovations. For example, there were a number of commodity or device type innovations in use. These included chlorhexidine gel for cord care and the NASG to treat postpartum haemorrhage. These innovations were having a demonstrable impact on the lives of mothers and newborns according to staff and communities themselves. Among the clinics supported by the H4+ JPCS, the NASG had been used several times in the days and weeks preceding the evaluation visit. One key informant suggested that while the NASG alone "*does not solve maternal haemorrhage*", it is one more way of supporting EmONC in a context where "*you need three, four or five ways of supporting maternal emergencies*". During 2015, the NASG was used on 34 women during delivery or with postpartum haemorrhage. All of these women survived. The MoH and the H4+ national coordinator both reported that the NASG will be scaled up throughout Liberia although it is not clear how this scale up will take place, and specific resources have not been set aside for the activity.

The NASG is a practical innovation that helps stabilise a haemorrhaging woman preventing shock while she is taken to more specialised care. It works at an operational level because the referral system, supported by the H4+ JPCS, enables affected women to be transferred to hospital for urgent treatment. The NASG and referral work together, where one without the other would be much less successful. The implementation of the system also relies on support from the community so at the community level, the engagement of leaders, women and men, young people and lay health workers was also a necessary step through mobilising support for clinic-based deliveries and referral in emergencies. In focus group discussions and meetings with community leaders, the role of the referral system, the importance of access to assisted deliveries and the life-preserving value for adolescent girls to delay pregnancy were repeatedly emphasised.[55]

The recent installation of the solar suitcase, a portable solar power system set up in several clinics to ensure power for delivery rooms, was another example of innovation applied in remote settings to overcome a barrier to care (to ensure light and power at night). Health workers and community members are trained to undertake the modest amount of maintenance required during their five-year lifespan, making these solar power systems more sustainable (in principle). Clinical innovations were also in evidence, including the implementation of Kangaroo Mother Care.[56]

Alongside this, efforts advanced to ensure young people had access to sexuality education and family planning services to take forward policies aimed at reducing adolescent pregnancies, a major driver of maternal and newborn mortality. The repurposing of traditional birth attendants into Trained Traditional Midwives (TTMs) whose primary role was to refer women for antenatal care and to accompany women to the clinic for delivery, enabled these community- based volunteers to retain an important function. Furthermore, mama-baby kits were considered a major incentive for women to deliver at the clinic rather than at home as well.

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[55] Every community leader in five districts visited mentioned each of these issues. (Assumption 4.3)

[56] The 2015 H4+JPCE Annual Report states that there were a total of 51 low birth weight babies admitted to KMC units, all of whose lives were saved and who were discharged in good health (H4+ 2015k). (Assumption 4.1)

There are thus many individual examples of problem solving, introducing new commodities or devices, or taking a practical intervention to scale across a district. **The most stand-out innovation in River Gee was that these supply side quality improvements, demand side behaviours and social norms changes, along with systems strengthening at the level of the referral network were brought together simultaneously across the RMNCAH continuum of care in a way that enabled the whole to become greater than its parts.** In terms of *innovation*, this evaluation suggests that, in adopting a/ through a 360º approach, the H4+ JPCS has been able to demonstrate that it is possible to have an impact on maternal and newborn health in a remote setting in Liberia within a relatively short timeframe (three years). The theory of change illustrating this 360º approach to *innovation* is in Figure 7.

Assumption 4.2: *H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.*

Unless otherwise noted, for evidence cited in relation to assumption 4.2 see Annex 1, Assumption 4.2

Despite the evidence supporting the 360º approach, there were notable gaps in delivery, and maintaining these outcomes into the future presents additional challenges. These have been discussed in sections 4.1 and 4.2. In brief, they include training in EmONC skills, the use of the partograph, specific interventions including the NASG, chlorhexidine gel, and KMC. There was little systematic evidence identified from the recently initiated counties (Gbarpalu, Grand Cape Mount and Rivercess).

There were also some examples of what clearly has not worked. For example, the three-wheeled bicycles procured for use by county health teams to move medicines to outlying health facilities have struggled to take off; the road conditions are too difficult and distances too long for pedal power. Another example was an attempt to use a mobile phone app to follow pregnant women and their utilisation of the clinic, which failed because there was insufficient network coverage. The introduction of misoprostol into routine delivery care has been slow based on evidence from the CHT and the nurses at facilities; therefore, additional training was recommended.

Assumption 4.3: *H4+ partners and national health authorities agree on the importance of accurately and convincingly documenting the success or failure of supported innovations and put in place appropriate systems for monitoring and communicating the results of these experiments.*

Unless otherwise noted, for evidence cited in relation to assumption 4.3 see Annex 1, Assumption 4.3

There is little evidence to suggest that documentation of the success or failure of innovations is a priority within the H4+ effort in Liberia. In discussions with H4+ members, it is evident that the documenting and sharing of innovation successes and failures has been limited other than through largely verbal presentations at H4+ JPCS country meetings.[57] Interviews suggest that when H4+ stakeholders identify an intervention as an innovation, there is no process of systematic documentation to assess information that would help others to generalise what makes the intervention a good practice, whether or how to replicate it and what are the cost and scale-up considerations. For example, despite its excellent promise, an assessment of the costs, logistics and training needed to roll out the NASG was not conducted.

[57] For example, in interview with the H4+ national coordinator, it was stated that H4+ JPCS countries met occasionally and each presented their best practices and innovations to each other.

This raises another related challenge for the H4+ JPCS around knowledge management more generally. The programme was working in a difficult to access area with high needs, working closely with all levels of the health system to support the delivery of innovative interventions. There is evidence of results in practice (for example, that 38 women used the NASG in 2015 in Liberia). The report of the regional meetings show that the Liberian H4+ partners reported on these results. However, there appears to have been little systematic accumulation, analysis and communication of all the H4+ JPCS activities or lessons learned either to communicate with others beyond the H4+ JPCS or inwardly to report new or emerging innovations within Liberia. A brief review of the implementation of the NASG in other H4+ JPCS countries did not suggest that any other country had embraced this innovation through its participation in the H4+ programme.[58] H4+ partners work on a range of programmes with little time, they said, to do in-depth reflection and lesson learning. They report that nonetheless, the most "*impressive*" of their innovations – the NASG, chlorhexidine gel, and possibly the mama-baby kits – are being adopted by national authorities in Liberia.

Taking the NASG as an example, the garment was tested for application in resource constrained settings in several countries by Pathfinder International, which says on its website, "*In 2012 the World Health Organization added the NASG to their guidelines and prices have decreased several fold.*"[59] The NASG is indeed listed in the WHO 2012 guidance for preventing and treating post-partum haemorrhage (PPH) specifically in a context where a woman requires to be transferred to a referral facility. However, the guidance identifies the evidence for NASG effectiveness as "weak" indicating a need for more and better research to reinforce knowledge.[60], [61] The NASG is listed in the inter-agency compendium of essential equipment for managing maternal and newborn emergencies,[62] published by the WHO, UNICEF and UNFPA in 2015. This document and the process behind it was funded by the H4+ JPCS and is one of the programme's global products.

In summary, the NASG was used in H4+ supported facilities with good results. It was presented to regional meetings as an innovation. The NASG was recommended as a useful device for PPH management while awaiting transfer to hospital but the need for more and better evidence was specifically identified. H4+ JPCS supported global knowledge documents include the NASG. Yet, there is no documented evidence from the Liberia experience and certainly no baseline. The experience in Liberia does not appear to have influenced other H4+ JPCS countries to explore the use of the NASG.

Looking at Figure 6 above, the experience in Liberia of the H4+ JPCS in relation to the innovation to policy and scale-up process becomes clearer. The evidence of the problem was well documented, and the options for intervening were identified using global guidance primarily from WHO, UNFPA and UNICEF. The intervention programme (the H4+ JPCS programme) was planned and implemented in the target facilities and counties. Documentation was primarily done for reporting purposes and for the regional meetings. Although the H4+ country team said that the approach taken by the H4+ JPCS programme would be rolled out beyond the JPCS, there was no clear documentation of this. The process thus stops at step 5 in Figure 6.

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[58] There was a trial underway in some countries including Zambia in a limited number of primary health facilities but this was entirely separate from the H4+ JPCS, which had not considered the use of the NASG (see Zambia Country Case Study Note).

[59] See this link: http://www.pathfinder.org/events/decreasing-maternal-mortality-with-the-NASG.html

[60] WHO (2012) WHO recommendations for the prevention and treatment of postpartum haemorrhage, Geneva. http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf

[61] The main questions for further research identified in the WHO 2012 guidance were around the use of misoprostol to prevent and treat PPH. As identified in Assumptions 1.1 and 1.3 above, the roll out of misoprostol has been inconsistent in Liberia.

[62] http://www.who.int/medical_devices/md_maternal_v12_web.pdf

Assumption 4.4: *National health authorities are willing and able to adopt proven innovations supported by H4+ JPCS and to take them to scale. They have access to required sources of financing (internal and external).*

Unless otherwise noted, for evidence cited in relation to assumption 4.4 see Annex 1, Assumption 4.4

The package of services delivered by the H4+ JPCS in the south eastern counties was centred on national policies. However, there were several elements of the package that were additional to national policy and which, according to the MoH, were still under discussion. For example, H4+ JPCS members reported that the NASG was to be scaled up first across the new H4+ counties (Cape Mount, Gbarpalu and River Cess) and then across the country. However, at the time of the evaluation, there was no evidence that the NASG had been integrated into national policy.

Given the importance of community mobilisation, it is relevant to note that a major new national programme, focused on community health assistants, was due to start rolling out in July 2016. This programme, based on the policy documents available, seems to potentially address some of the issues raised by TTMs and gCHWs interviewed, including: the lack of further training; having an opportunity to develop a career path; salary and professional identity. According to senior ministry of health officials, the H4+ programme had already shaped national policy well beyond the TTMs and CHWs found in the H4+ communities, and was designed at creating a professional cadre of health workers with a clear set of skills, competencies and responsibilities and who would be paid to work in the community. Both TTMs and CHWs would be eligible to apply to join the new cadre, provided they meet the entry criteria, which are based on literacy and numeracy rather than level of formal education achievement. The salary was discussed as likely to be set at about 70 USD per month, which is higher than the 50 USD requested by the TTMs.

4.4.3 Contributing to innovation for RMNCAH in Liberia

Recognising potentially effective innovations in RMNCAH

Individual innovations have been identified through the global policy processes associated with the Global Strategy for Women's Children's and Adolescents' Health and through the engagement of the H4+ global team. These include innovations promoted by the various platforms established to accelerate the Global Strategy, including *Every Newborn, A Promise Renewed, Family Planning 2020*, and *the Commission on Life Saving Commodities*. The H4+ JPCS contributes to testing the practical application of these innovations in different H4+ focus countries including Liberia.

Information on the success or failure of innovations gathered and made available to decision makers

The extent to which the H4+ JPCS has been able to engage in a structured approach to documenting and communicating progress in using or scaling up individual innovations has been limited. While innovation was a priority aspect of the programme, the routine and intensive act of programme coordination appeared to take precedence over investing in the implementation of the full cycle of programme innovation. Thus, a strong process around problem detection was found, using a bottleneck analysis methodology and a clear approach to designing an intervention programme. A baseline was drawn from existing data, and annual monitoring enabled interventions to be tracked to some extent. However, the methodical documentation around the progress of implementing innovations and identifying the impact of those innovations, the policy process around advocating for the inclusion of innovative devices, commodities and processes in national programme policy and support to scaling up or rolling out interventions were all absent. This does not mean they did not exist at all (and H4+ country partners stated that they advocated around RMNCAH innovation scale up in various national fora) but they did not document this citing a lack of time, insufficient skills and unclear audience.

Replication of innovations across districts and provinces
The H4+ JPCS approach in the south eastern counties is being replicated in the newer counties. However, the implementing partners are different and the processes are, understandably, taking a different path. Mainly, the timeframe in the newer counties is compressed, and it is unlikely that they will achieve the same results in the shorter timeframe. Elements of innovation are also replicated at national level. The clearest example is the approach taken to scale up the use of the non-pneumatic anti-shock garment, which has shown to be an effective, appropriate and practical intervention to resolve hypovolemic shock and stabilise women experiencing post-partum haemorrhage (accounting for 25 percent of maternal deaths in Liberia).

At the time of the evaluation team visit, the H4+ JPCS partners had not been able to write up and communicate their experience delivering the 360° approach to maternal and newborn survival in remote and underserved areas. They were able to identify some of the drivers and barriers to success through discussions. These included timing, high quality community engagement, sustained supplies and equipment, motivation of staff including better training, supportive supervision and remuneration, as well as the increased sense of professionalism that comes from working within a functional health system, the value of job aids like the partograph and the reinforcing value of a functional referral system. Although the H4+ partners hesitated to identify barriers, the evidence of the evaluation suggests they include poor sequencing, the failure of any link in the chain (ambulance or radio not working, stockouts, ineffective community engagement).

4.5. Division of labour in Liberia

Question Five: *To what extent has the H4+ JPCS enabled partners to arrive at a division of labour, which optimises their individual advantages and collective strengths in support of country needs and global priorities?*

Summary

- Division of labour was consistent with individual partner strengths and largely conformed to their individual comparative advantage. The H4+ JPCS modality levels the playing field among partners and enables the more anthropological approach of UN Women to be effectively integrated into a health programme focused on health systems strengthening. This has strengthened the programme
- The criteria and decision-making around budget allocation to H4+ members was not clear nor was the approach taken to identifying the importance of one element of the programme over another (supply side over demand side, for example). The evidence shows how relatively small amounts of additional funding for the demand side work might have achieved more but processes for making these decisions were absent.
- Monitoring and evaluation, documentation, and lesson learning have been ad hoc and informal in the H4+ JPCS so far. While the H4+ experience has contributed to at least one global knowledge product, there is evidence that there is clearly scope for more. As previously discussed, the lack of a sustainability plan undermines the catalytic nature of the programme.

4.5.1 Testing causal assumptions for the division of labour

Assumption 5.1*: H4+ teams at country level in collaboration with key stakeholders have established forums for coordinating programme action and the division of labour for H4+ JPCS financed and supported activities in particular and in RMNCH generally.*

Unless otherwise noted, for evidence cited in relation to assumption 5.1 see Annex 1, Assumption 5.1

The assignment of roles and responsibilities among H4+ partners was generally consistent with the areas of expertise across the H4+ members. H4+ country team members reported that they had some areas of overlap in the beginning and they said it took "*some hours of discussion*" to agree how to allocate roles in a coherent way, especially where more than one partner had the competence (for example, procurement, community engagement and training). It was unclear how the budget was established and agreed. Budget allocations were very different for each partner. UNICEF supported community-led activities aimed at reducing gender-based violence (GBV) and promoting the rights of girls and was also tasked to strengthen water, sanitation and hygiene systems at the H4+ JPCS health facilities. WHO and UNFPA were the major fund recipients and were responsible for most (but not all) of the procurement and multi-year systems support including medicines and commodities, training support, and equipment. UNAIDS and UN Women were the smaller partners, in terms of budget, but there was broad agreement from among many of those interviewed that the community engagement and mobilisation component of the H4+ support was enormously valuable and had a significant impact on the results achieved. As previously mentioned, the World Bank did not take on a formal role in delivering the H4+ JPCS programme in Liberia.

The H4+ JPCS coordinated RMNCAH engagement at the national level in two ways. One way was through a specific H4+ JPCS coordination group chaired by the Ministry of Health and concerned mainly with the delivery of the H4+ JPCS. The second way was through the participation of H4+ JPCS members in pre-existing national coordination forums as set out in section 2.4 above, including the Reproductive Health Technical Committee.

As the H4+ members are very different in nature, history, size and institutional culture, the H4+ JPCS has created a more level playing field for each partner to have a voice and make their contribution to the programme. For example, all H4+ partners said they have a voice in the planning processes and they are all "in the room" with the senior government officials or ministers when the H4+ programme is discussed. Some of the H4+ JPCS partners[63] have collaborated to apply for additional funding to work on RMNCAH together in the future (beyond the H4+ JPCS). The strength of the H4+ programme was its fusion of the demand side work (especially the very difficult, slower engagement of communities done using anthropological approaches by UN Women and its partners, but also the other partners including UNAIDS working through the media) with the significant investments in supply side support on training, quality improvement, accountability and referral. The combination of health systems investments, the anthropological approaches, engaging the media and so on, has demonstrated the value of simultaneous engagement at all levels. It is difficult to see how this programme could have achieved the same results without all the contributions.

It is also notable that the World Bank played a different kind of role in the H4+ in Liberia. Although there were World Bank funded health programmes, there were no resident health advisers until March 2016, and according to the minutes of meetings, confirmed by other H4+ partners, the World Bank staff rarely attended either technical or even heads of agencies H4+ meetings. The World Bank is an important partner in that it can potentially link the H4+ JPCS health investments at national, county and facility level to a larger process around public expenditure management, civil service reform and decentralisation.

***Assumption 5.2**: The assigning of activities and investments in support of H4+ JPCS programme goals in participating countries is based on both the distinct capacities and advantages of each H4+ JPCS agency in that country and the national and sub-national context for support to RMNCAH.*

Unless otherwise noted, for evidence cited in relation to assumption 5.2 see Annex 1, Assumption 5.2

[63] For example, one proposal was submitted by UNICEF, UNFPA and WHO while another one reportedly included UN Women as well.

Some challenges were noted around the flow of funds in the H4+ JPCS. Among other agencies, resource transfers from global to country levels have been slow, delaying the programme at certain points. Budget allocations to UN Women from the global to the country programme, for example, were halved in 2015 for an unknown reason (unknown to UN Women in Liberia). During interviews with H4+ focal points, they said that their solution was firstly, to help UN Women make adjustments to its proposed activities (scaling back from solar panels to solar suitcases) and then secondly, to cobble together the remaining shortfall from savings gained elsewhere in the programme. According to minutes of TWG meetings and as confirmed in interviews, WHO and UNFPA transferred 140,000 USD between them to UN Women to cover the outstanding costs.

Table 8: H4+ members and their roles and contributions in the H4+ JPCS, Liberia programme

H4+ Agency	
UNAIDS	• Media support (mass media, radio talk shows, print media) • Communications around PMTCT, and HIV and AIDS reduction • Defining PMTCT guidelines and integration into the RMNCAH continuum of care.
UNFPA	• Support to National Drug Supply (trucks, tricycles, essential maternal health medicines) • Procurement of equipment, furniture • Policy, advocacy, human resources and commodities support for RMNCAH including the areas listed under areas of work • Strengthening BEmONC and CEmONC as well as MNDSR process • Training community based health workers and TTMs.
UNICEF	• Focus on PMTCT and paediatric ART at the clinic level • Water, sanitation and hygiene lead for the H4+ • Reducing violence against girls programme.
UN Women	• Empowering youth and adults (especially girls and women) to access RMNCH, HIV and GBV services • Engaging men around RMNCAH issues, GBV, gender equality etc. • Identifying and understanding community views/ social norms around pregnancy, childbirth, maternal mortality, HIV in pregnancy and infant health/ early death • Provide solar suitcases to delivery rooms in response to community concerns about attending clinics in darkness.
WHO	• H4+ Coordination • Improving the policy environment for RMNCAH • Leading on human resources for health policy • Leading on MNDSR • Capacity building at facility level: training midwives, production of job aids like the partograph • Community health worker training including TTMs • Transport, hospital equipment to support CEmONC functions, furniture and stationery.

***Assumption 5.3**: H4+ JPCS agencies have used structures and processes established for programme coordination at country level to rationalise their support to RMNCAH and to avoid or eliminate duplication and overlap in support. This trend is reinforced by increasing levels of coordination contributing to improved operational effectiveness and strengthened advocacy.*

Unless otherwise noted, for evidence cited in relation to assumption 5.3 see Annex 1, Assumption 5.3

Interviews with health staff at national and county levels, as well as with NGO implementing partners, did not identify any areas of overlap or duplication of effort on the part of the H4+ partners and the services they provided. Initially, according to H4+ country team members, there had been duplication in the community engagement approaches undertaken by some implementing partners, particularly around HIV and AIDS prevention and sensitisation. However, once this was identified, adjustments were made and the duplication was eliminated.

The advantages of the H4+ approach to working together and building a coherent approach, according to MoH officials and the H4+ country team members included:

- More consistent messages and common approaches to advocacy
- A standardised approach to competency based training and follow up with supportive supervision
- An integrated monitoring framework (developed in Liberia rather than the global H4+ monitoring tool mentioned earlier which H4+ partners found difficult to use)
- An agreed focus on a limited range of interventions (EmONC) so that capacity was strengthened in a focused way and not spread across the whole RMNCAH continuum of care all at once.

Against this, some of the investments made have not been sequenced or timed ideally: maternity waiting shelters are still to be constructed; WASH investments have largely broken down already.

There was a specific problem with funding used by UN Women to support the installation of the solar panels in 2015. Funding was suspended, apparently because UN Women in Liberia did not receive the funds that were allocated in the workplan. This seemed to be based on a problem with global disbursements by UN Women, not one specific to the Liberia country office. Naturally, this caused consternation for the whole team and was damaging to the timeliness of delivery. In the end, as identified above, the H4+ partners worked together to substitute contribution from UN Women with the more portable solar suitcase and, assembled funds from savings to ensure the work was completed.

According to H4+ country team members, they worked together to develop a set of key messages around RMNCAH which were adopted by all partners. These key messages, including policies focused on: early attendants at ANC, skilled birth attendants during delivery and the use of critical interventions such as the NASG, KMC and chlorhexidine gel. On the demand side, the H4+ has combined its efforts to support community engagement on a number of levels that has contributed to overcoming barriers to access and shifted social norms and beliefs around why women have difficult pregnancies and births. This combined effort, consuming a quarter of the H4+ resources (and, as observed previously, could have absorbed more resources still), have contributed to building a new social norm around the unacceptability and unnecessariness for women to die in pregnancy and childbirth. The same messages were repeated by community leaders, ministry of health officials, county health team members, facility staff, peer educators and women themselves. This suggests that the H4+ members have been able to formulate, agree upon and effectively market a clear set of basic messages.

4.5.2 Achieving an effective division of labour in Liberia

The programme has led to a genuine experience of working together across all the agencies involved. Although UN agencies demonstrate collaborative efforts routinely in terms of the One UN initiative, they are rarely compelled to coordinate so closely at the programming level including through implementation, reporting and fund management. The pressure to work together and overcome institutional, personal and technical challenges to build and deliver a coherent programme of work was sustained through *the fact of the funding*. That is to say, without the funding, and in the absence

of other funding, it is considered less likely that the H4+ members would work so closely together to plan and deliver this multifaceted programme jointly. This is not necessarily because of a lack of perceived value in working together, but rather because of the inevitable (and possibly universal) pull towards prioritising funded programmes.

Has the H4+ JPCS programme contributed to the development of effective and robust platforms and operational systems for coordinating support to RMNCAH at country level by the partners?
There is no strong evidence that the H4+ JPCS in itself has led to stronger platforms for coordinating RMNCAH at country level. However, the H4+ JPCS has given the H4+ members purpose and focus, enabling them collectively and individually to participate in coordination groups and to discuss and agree on their policy positions, improving their ability to speak with one voice. It is likely (but difficult to prove) that the experience of delivering comprehensive systems changes at facility level has given both individual focal points and the group as a whole the opportunity to shape a collective understanding of priorities, challenges and needs on the ground. However, there is some evidence about policy coherence from community to national level and across the H4+ members. For example, as previously mentioned, the MNDSR process has been an important platform for accountability. It has not been possible to gather evidence about its impact at national level yet but these are difficult processes to establish and sustain.

Will these platforms and systems persist in one form or another beyond the period of programme funding?
The systems created specifically by, and for, the H4+ JPCS at country level include regular coordination meetings, bi-annual engagement of heads of agencies, annual monitoring and reporting processes and informal communication and joint working modalities. In balance, it is unlikely that the formal elements of these systems will persist without the funding stream. However, the coordination processes established through the H4+ programme implementation are likely to be retained and refined for other similar jointly funded RMNCAH programmes. A subset of the Liberia H4+ members have already received additional funds to expand their maternal health support, thereby increasing the likelihood of the systems and coordination arrangements continuing to some extent.[64]

Do the resulting programmes of support to RMNCAH at country level make best use of the individual strengths of H4+partners?
To some extent, the H4+ JPCS made best use of the individual strengths of partners. This was particularly noticeable in the support through UN Women and UNAIDS both of which, despite having smaller grants, pursued their area of expertise through well-chosen partnerships with implementing partners working on community engagement, behavioural change, raising awareness and building demand. UNICEF was tasked with WASH investments in addition to other areas of support (reducing violence against girls) and the WASH component is one of the least successful elements of the Liberia programme so far. This is largely because of the manner in which the support was delivered (see section 4.1); UNICEF was the right H4+ member to be leading this work though. The World Bank was not engaged at all in the H4+ JPCS programme. This may explain the limitations of the remaining members in being able to link into some of the critical larger national processes managed by the Ministry of Finance or Public Works.

Do efforts at coordination result in collaborative programming which is more effective than separate initiatives?
There is sound evidence to suggest that this is indeed the case. The H4+ JPCS has been able to identify priorities, articulate a comprehensive approach, speak with one voice to the government and other partners and combine resources to address the RMNCAH challenges on the ground, generally based on the area of strength of the individual H4+ member. There are some limitations to the approach currently adopted including insufficient sustainability planning.

[64] UNFPA reported this during interview 30 May 2016.

4.6. Value added for advancing the Global Strategy in Liberia

***Question Six*:** *To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Secretary General's Global Strategy for Women's and Children's Health (the Global Strategy) and the "Every Woman Every Child" Movement"?*

Summary

- H4+ JPCS advocated for and supported the delivery of adolescent and youth services from the start of the programme, demonstrating through its implementing partners how to reach and sustain service delivery and sexuality education for young people.
- The H4+ JPCS acted to focus H4+ members on how to work together to implement programmes at county and district levels which fostered mutual learning and helped identify a common set of policy priorities.
- The H4+ JPCS supported the establishment of the maternal and newborn death surveillance and response process at national and sub-national levels and crucially, invested in its revitalisation after the EVD outbreak ended.
- The H4+ JPCS members show signs of shifting their technical advice towards the implementation of programmes aimed to deliver strategies set out in the RMNCAH Investment Case including prospective Global Financing Facility funding. While this is far from certain, the H4+ provided technical advice to the Ministry of Health to develop the investment case in a structured way.

4.6.1 Testing causal assumptions for value added

Assumption 6.1*: The establishment of H4+ JPCS in 2011 and its expansion in 2012 helped strengthen the rationale for and extent of policy support for coordinated action in RMNCAH at national and sub-national level by the H4+ agencies*.

Unless otherwise noted, for evidence cited in relation to assumption 6.1 see Annex 1, Assumption 6.1

The H4+ programme was rooted in the strategies elaborated in the Liberia RMNCAH Roadmap 2011-2015. The Roadmap was, in turn, rooted in the Global Strategy for Women's and Children's Health (2010-2015) according to the H4+ members.[65] As the H4+ JPCS has developed over the last 4 years, it has also made some early progress on components added into the Global Strategy for Women's, Children's and Adolescents' Health (2015-2030). For example, the H4+ approach included from the start a work stream on adolescent and youth sexuality education and sexual and reproductive health services. Addressing the needs of adolescents and young people has been an important factor in the Liberia programme from early on.

According to the H4+ national coordinator, a significant H4+ focus was to support the translation of global guidance into national policy. For example, in 2013, H4+ agencies, working together, advocated for accelerated, focused action on maternal and newborn mortality reduction through engaging with national health authorities, other health partners, Parliament and other relevant line ministries, such as those leading on gender, youth and education, to update the EmONC training guidelines. Working closely with the MoH, the H4+ members invested in supporting a new National Strategic Plan for Adolescent Sexual and Reproductive Health.[66]

[65] Presentation 31 May 2016 (Assumption 6.1)
[66] (MoHSW 2014)

Assumption 6.2: *By providing targeted funding for global activities (and funding the coordinating office) H4+ JPCS programme funding facilitated the development of knowledge products and joint, coordinated advocacy in RMNCH by H4+ agencies, which would not have otherwise been undertaken*.

Unless otherwise noted, for evidence cited in relation to assumption 6.1 see Annex 1, Assumption 6.1

It is neither practical nor desirable to assess the level of output of knowledge products developed at the global level by the H4+ partners when conducting a country case study. However, it is worthwhile to consider which H4+ global knowledge products may have been of most direct use in the policy and advocacy activities when viewed from a country perspective. In June 2016, the global coordinator for H4+ JPCS produced a listing (by year and agency) of the global knowledge products funded by H4+ through its global workplan. The products with the clearest potential linkages to policy work undertaken by the H4+ programme in Liberia include:

- Toolkit for RMNCAH strategic planning, implementation, monitoring and review (WHO, 2012)
- An RMNCAH policy compendium developed (WHO, 2013)
- Technical guidelines for maternal death surveillance and response (WHO 2013)
- Final version of Rapid Assessment of RMNCH Interventions and Commodities (RAIC) (UNICEF, 2013)
- Development of the list of essential life-saving commodities/equipment for MCH/FP by the UN Commission on Life Saving Commodities with H4+ input (UNICEF 2013)
- Feasibility of indicators of Quality of Care for MNCH care in facilities tested in DRC, Chad, Tanzania, Zambia and Zimbabwe (WHO 2015)
- Midwifery Services Framework developed and CHW RMNCH training guidelines (UNFPA 2014)
- RMNCH training guidelines developed. A mapping of existing training tools for Community Health Workers (CHW) in SRH/MNH (UNFPA 2013)
- Core competencies for adolescent health and development for health care providers in primary care settings published (UNFPA 2015)
- Template for documenting innovations (UNFPA 2015)
- Zero Discrimination in Health Care and Putting Human Rights on Fast Track (UN Women 2014)
- Policy briefs and advocacy material on rights and equality for SRHR and RMNCAH – one global and two regional (UN Women, 2015).

It is difficult to know which of these products might have been produced at global level in the absence of the H4+ JPCS. What they do demonstrate is that H4+ partners have been active at global level in producing policy inputs, guidelines and advocacy tools that can support action at country level. H4+ partners specifically mentioned their use of the various RMNCH training guidelines, the technical guidelines for MNDSR and the materials to support RMNCAH strategic planning and implementation.

Based on the review of H4+ documents, the H4+ partners have sustained their efforts to focus on maternal and newborn mortality reduction over the lifetime of the programme. Technical and programme advisers have been engaged as H4+ JPCS focal points alongside other duties (other than the national H4+ coordinator based at WHO) and this has enabled regular dialogue between the H4+ JPCS coordinating group and national policy processes. For example, the H4+ focal points report being directly and actively engaged in shaping the National RMNCAH Investment Case, which is replacing the Roadmap as the policy and strategy platform that will likely become the main reference

point for both domestic and donor funded maternal and newborn health investments over the next five years. The fact that the H4+ has taken on this role as technical advisers over the course of the Investment Case development period, suggests that it may continue in this capacity and become closely aligned with providing technical advice and support through the implementation of the GFF funds (a combination of grants and loans from the World Bank and donor partners specifically for RMNCAH results).

Assumption 6.3: *H4+ partners, assisted by programme funding, were able to be more effective in advocating for commitments to Global Strategy principles and priorities than they would have been without programme support. Their communications and advocacy work was made more consistent through collaboration on common products.*

Unless otherwise noted, for evidence cited in relation to assumption 6.3 see Annex 1, Assumption 6.3

There is insufficient evidence to fully test this assumption and no counter factual. However, there is evidence (set out in sections 4.3 and 4.5 above) to suggest that the H4+ has been able to articulate a coherent set of policy priorities consistent with the Global Strategy principles (including addressing equity, meeting the needs of adolescents, reaching the marginalised). H4+ country team members suggest this is partly a result of their experience working together to implement a comprehensive programme. According to the H4+ team, and confirmed by senior ministry officials and county health team staff, the H4+ has particularly focused on strengthening commitment to the MNDSR process, investing effort and time in revitalising it after the EVD began to decline.

As identified in Assumption 5.3, H4+ partners worked together to develop a set of key policy messages aimed at strengthening RMNCAH quality. The H4+ supported community engagement through an effective combination of modalities that contributed to overcoming barriers to access and shifted social norms and beliefs around why women have difficult pregnancies and births.

Assumption 6.4*: Where H4+ JPCS has contributed to improvements in service quality and access for RMNCAH these have in turn made a contribution to positive outcomes in RMNCAH including the targeted operational outcomes of the Global Strategy and "Every Woman Every Child".*

Unless otherwise noted, for evidence cited in relation to assumption 6. see Annex 1, Assumption 6.4

The health system in Liberia is fragmented. Funds flow through several channels and it is particularly difficult to estimate the impact of one set of inputs on the RMNCAH outcomes nationally. Even within counties, given that the H4+ JPCS operated mainly at facility level, it was difficult to estimate or discern impact at the county level (which included up to 21 facilities) where the H4+ JPCS worked in only six facilities. In the six facilities, the H4+ programme has been shown to have made a significant impact on RMNCAH service delivery quality and effective community engagement, resulting in increased utilisation and some specific, notable results (for example, several of the H4+ supported facilities reported no maternal deaths in the last two years).[67]

Discussions with the County Health Team, facility staff and communities themselves reinforced the common belief that the combination of trained, helpful midwives, equipped and stocked services, backed by a referral system were all part of the larger result which was improved quality of care and fewer maternal and neonatal deaths. Although much of the evidence is qualitative, there was reportedly increasing trust between the community and the health services based on comments made by both community leaders and health staff, especially following the EVD outbreak. It was notable that many community members as well as ministry, county and facility staff were able to say quite clearly what difference the H4+ JPCS had made to the services. Lastly, there is qualitative

[67] For more systematic discussion about investments, see sections 4.1 and 4.2 above

evidence that attitudes had changed towards women's attendance at the clinic before and during delivery. Although utilisation data were complicated by the EVD experience, the number of community based deliveries was perceived by health facility staff and community members to be steadily declining.

4.6.2 The value added of H4+ JPCS

Working as a cohesive group, the H4+ partners have contributed to the development of the RMNCAH investment case ensuring it is fully in line with the revised Global Strategy for Women's, Children's and Adolescents' Health. The H4+ has engaged parliamentarians around maternal and newborn health. It has also engaged some line ministries, for example, those linked to gender, youth and education, during the adolescent and youth health strategy development process. Links to other parts of the government are weaker or entirely non-existent. For example, there is no evidence that the H4+ has been able to engage the Ministry of Finance. The H4+ national coordinator did, however, state that they have tried to engage the Ministry of Public Works, especially around the identification of feeder roads.[68]

H4+ JPCS advocacy for national commitments to accelerate actions to strengthen RMNCAH investments and systems

The H4+ JPCS has contributed to advocacy around the maternal and newborn death surveillance and response process. H4+ efforts following the end of the EVD outbreak were instrumental in revitalising the national MNDSR process. The MNDSR process is a vital component to accountability and, as discussed in section 4.4, underpin the referral system. While the H4+ has been active in keeping this process alive and on the agenda, it could and should do more, engaging all its members including UN Women and its implementing partners, to build community demand for accountability.

Lessons learned in implementing H4+ JPCS to inform the work of the H6 partnership

The H4+ has manifestly delivered programmes and supported policy evolution in Liberia. Maternal health outcomes (at least at a process and delivery level) show signs of improvement in the communities where the H4+ JPCS has operated despite serious setbacks including the EVD outbreak. H4+ JPCS partners have developed a platform at national level that has enabled them to influence policy and ensure the development of appropriate RMNCAH strategies. The combined efforts of H4+ partners have been able to bring about a visible, measureable change in previously underserved, neglected areas within the time frame of the programme. There are, however, a number of caveats to this statement.

- The first of these is to reflect on whether the role that the H4+ has played in supporting Liberia national policy processes has been embedded in and strengthened by its active engagement in translating policy into practice at H4+ JPCS funded facilities. Is H4+ policy advice *better* because individual partners work together more coherently and have accepted mutual responsibility for overarching outcomes? This evaluation would suggest that in Liberia, the answer is yes.
- As the programme delivery component of the H4+ is inherently unsustainable (as is most time-limited funding), the next question is whether the H4+ experience of delivering on the ground has led to a cultural shift at institutional level with better cooperation and more coherent working as a result? The evidence of this evaluation suggests that, like the old maxim, *capacity grows along funding lines*, and that this is true for the H4+ members in relation to the funding received through the JPCS. Like any institution or network, the H4+ has evolved a clarity of focus as a result of having to become accountable for a complex programme delivered jointly and requiring the achievement of defined outcomes using a finite set of resources.
- Clearly, the next question then, is whether and how the H4+ can achieve the same policy impact without specific H4+ funding and delivery targets.

[68] Comment made by the H4+ National Coordinator following the meeting with Sida in Monrovia, 1 June 2016.

5. CONCLUSIONS

This chapter presents the conclusions and implications of the field country case study of Liberia. The conclusions presented here are directly based on the findings provided in Chapter Four. They are drawn from the answers to the six evaluation questions and directly address all six areas of enquiry of the End Line Evaluation of the H4+ JPCS.

5.1. Conclusions

1. **National coordination and leadership enabled the opportunity created by the H4+ JPCS programme to be used effectively**. National authorities pointed the H4+ towards neglected geographical areas and identified maternal health as the most important component to address under the RMNCAH continuum of care. In 2012, as the programme was beginning to take shape, Millennium Development Goal (MDG) 5 was lagging everywhere in Liberia but particularly in marginalised areas and communities. The H4+ JPCS programme was effective in opening up previously underserved areas.
2. **In focusing on the critical points of the RMNCAH continuum of care, the H4+ JPCS has been effective in raising the quality and availability of maternal and newborn health services in the facilities where it has worked.** The H4+ programme has demonstrated how much can be achieved in a relatively short space of time. As a result of these investments, it is more likely (and there are signs of it happening to date) that other technical and financial support will be directed to these underserved counties, in particular the facilities and geographical areas not supported by the H4+ JPCS. This would increase the catalytic nature of the H4+ JPCS programme.
3. **The H4+ JPCS approach successfully demonstrated how to have material impact on maternal health outcomes within a reasonably tight timeframe (three years).** The combination of better quality supply of services, demand side engagement and trust, strengthened referral systems and the accountability of the MNDSR, worked together to increase the quality, utilisation and outcomes in the H4+ JPCS facilities, drawing on individual strengths of the H4+ partners and optimising their complementarity.
4. **A large share of the H4+ JPCS programme was delivered through NGO implementing partners rather than through national and sub-national county health authorities**. While this approach may have had some short-term advantages in terms of efficiency gains, it also had important drawbacks and led to missed opportunities to strengthen county health management capacity at least in regards to supply side, service delivery strengthening. The H4+ partners were not able to maximise the capacity building opportunities of the JPCS at the county level as a result. The H4+ partners did not coordinate their implementing partners in ways that would have enabled them (the implementing partners) to cooperate more effectively and optimise the synergies between them thus potentially missing an opportunity to increase the catalytic element of the JPCS.
5. **Shortfalls in programme delivery affected sequencing and timing, which in turn reduced optimal demonstration of the programme potential to improve service delivery**. These shortfalls included: long procurement processes leading to late or out of sequenced delivery of goods and facilities; poorly managed delivery of inputs such as the water pumps and generators; and the on-going challenges around maintenance of equipment and the replenishment supplies such as drugs, mama-baby kits and others commodities. These underscore the programmatic challenges inherent in raising service standards in the many ways necessary to reduce maternal mortality. But they also identify the limitations of project aid and suggest that, to the extent possible, delivery should be supported as close to national/ sub-national systems as possible. There were missed opportunities to mitigate some of these limitations by working through county authorities in the case of Liberia, or to

optimise the benefit of having the H4+ M&E officer on the ground by empowering him to support the delivery of the whole H4+ programme.

6. **In relation to demand side strengthening and community engagement and mobilisation, H4+ JPCS partners used NGO implementing partners effectively to extend their reach, sustain engagement and bring both specialist skills and local knowledge into the programme.** This was vital to success. The community engagement and social norms change elements of the H4+ JPCS programme in Liberia was one of its stand out achievements. However, the achievements in this area could have been strengthened significantly with more active and structured coordination of all the implementing partners at national and – critically – at county and sub-county levels on a regular basis. While the community engagement and demand side elements of the programme were funded reasonably well, additional funds might have significantly extended the reach of the programme.
7. **Despite its achievements, the H4+ JPCS has not identified an exit strategy to ensure the sustainability of gains made.** The absence of sustainability planning would put programme achievements at immediate risk. Although some elements of the programme may be sustained without further investments, for example the skills resulting from training, there are other aspects of the programme that need continued support such as the TTMs, social norms changes, behavioural change communication, increased attention to ensure maternal medicines are available and so on.
8. **The H4+ has been somewhat effective in supporting improved sexuality education and reproductive health services for adolescents and youth especially in rural areas**. This has been achieved through multiple investments in community engagement and mobilisation, peer educator training, support to youth engagement by the health and teaching staff, engaging community leaders and young people. Each H4+ partner engaged in the JPCS had some level of community engagement from training of TTMs by UNFPA, to reducing violence against girls by UNICEF, the major investments by UN Women and UNAIDS on PMTCT, gender issues, youth empowerment and so on. Taking a multifaceted approach to community engagement enabled the H4+ JPCS to develop an effective investment in youth and adolescent health. As with other investments, there is no sustainability plan and thus the achievements are unlikely to last.
9. **While there were some investments at county and national levels, the H4+ JPCS focused primarily on facility level interventions where it was able to demonstrate results**. It is difficult to transition service delivery improvements at the facility/ local community level into national level health systems strengthening. H4+ JPCS investments and engagement in MNDSR processes are an example of where there has been good progress with benefits at the sub-national and national levels. Human resources challenges, supply chain management and decentralised budgeting are examples of national health systems constraints that have not been visibly shifted as a result of the H4+ JPCS investments. Greater participation by the World Bank in the day to day delivery of the H4+ JPCS might have helped identify more influencing opportunities beyond the health sector, for example, supporting the Ministry of Health to engage with the Civil Service Commission, the Ministry of Finance or the Ministry of Public Works.
10. **Communication and the translation of findings to support and influence national health systems strengthening (policy and delivery approaches) was challenging and inconsistent**. This was partly because there was insufficient evidence from the programme that could inform policy recommendations. Some elements of the H4+ programme are being taken to scale, for example the non-pneumatic anti-shock garment (NASG). Yet, there are many lessons and experiences developed by the H4+ JPCS programme that could have been documented and shared both within and beyond Liberia. Critically, the approach taken by the H4+ JPCS has the potential to be the basis for a basic package of support that could be

replicated elsewhere. The H4+ is ideally placed to support the Ministry of Health to institutionalise the MNDSR process.

5.2. Implications for the H4+ (H6) at the global level

This section identifies the main implications of the Liberia country case study for the ongoing evolution of the H6 partnership. The points raised here are not exhaustive. They apply to the partnership as a whole and to any funded programmes the H6 may be responsible for in the future.

1. Whether it has programmable resources or not, **the H6 should agree on a set of clear and concise RMNCAH messages that all H6 partners will convey and deliver**. The H6 should focus on promoting national coordination and leadership and seek to engage more constructively and consistently across the cooperating partner group. The H6 can play an important role supporting national authorities to build leadership and consensus with the spectrum of cooperating partners.
2. To be catalytic and to support knowledge building, **H6 programmes should be designed as learning programmes, setting explicit policy goals**. The evidence from H6 experience should contribute to policy dialogues at the national level. Indeed, the H4+ approach has the scope to become a dynamic lesson learning super-highway by working to unblock barriers at local/ district level, helping translate practical experience into policy at sub-national and national levels and using its experience to support the Ministry of Health to construct coordinated approaches to tackling systems barriers at the national level and then ensuring the evidence and knowledge is shared at regional and global levels.
3. To support this learning process**, H6 programmes should thus set aside resources to support the systematic documentation of innovation, experience, and knowledge** which could then be used to inform policy formulation, advocacy and, where national authorities decide on it, scale up of the most successful approaches.
4. H6 partners could benefit from a code of conduct or something similar which sets out agreed ways of working, operational principles and values. Once there are programmable resources available, **H6 partners and their implementing partners should identify and agree minimum service standards and hold each other to account for delivering on these**. The basic Paris Principles should be incorporated into H6 best practices for aid delivery.

6. ANNEXES

ANNEX 1 EVALUATION MATRIX

Area of Investigation 1: Strengthening Health Systems

Question One: To what extent have H4+ JPCS investments effectively contributed to strengthening health systems for RMNCAH, especially by supporting the eight building blocks of health systems?[69] **a. To what extent has regional and global technical support from H4+ helped enable country teams and national health authorities to identify opportunities, develop innovative approaches and design technically sound initiatives to strengthen health systems for RMNCAH?** **b. To what extent have H4+ JPCS programmes at country level supported health systems strengthening interventions which are catalytic and have the potential to build on existing or planned interventions with international or national sources of funding?** **c. Are H4+ JPCS supported investments sufficient in reach and duration to contribute to lasting changes in capacity for service providers which can sustain behavioural change?** **d. Are H4+ JPCS supported investments at sub-national level (especially in high burden districts) capable of demonstrating approaches to health service strengthening which can be taken to scale at sub-national and national levels?**		
Assumption 1.1 *H4+ partners, in consultation with national health authorities and other stakeholders, are able to **identify critical and unserved needs in the eight areas of health systems support for RMNCAH**. The needs in each of the eight areas are not fully met by other sources of support and, importantly, programme support can build on investments and activities underway with national and external sources of finance and support to accelerate action.*		
	Information/data	**Information sources**
1	**Coordination and joint planning with Ministry of Health (MoH):** There exists close implementation with the national Ministry. This has contributed to results that would not have existed without the partnership. All agency strengths were integrated to have required results.	UNICEF Country Team, key informant interviews (KIIs), May 31, 2016.

[69] While the term 'health systems strengthening' applies to the entire health system rather than a specific sub-element, the inception phase has shown that almost always, H4+JPCC support to national health systems is aimed very specifically at strengthening national systems for planning, prioritizing, budgeting, delivering and assessing services in RMNCAH. For that reason, the evaluation will focus mainly on health systems strengthening for RMNCAH. It will not, however, ignore broader support to national health systems wherever that becomes evident.

2	Coordination meetings to plan for the H4+ global technical team visit in April show large MoH presence.	Minutes H4+ Technical Working Group (TWG) 17 March 16.
3	Original M&E Plan/ H4+ Liberia proposal: Identified risks as poor roads, delays in implementation by Government of Liberia (GoL) partners because of competing priorities; human resources for health (HRH) constraints. "*The Sida support will be both catalytic and gap filling in the sense that community based care is nearly non-existent in the project areas and then Sida grant will be catalytic in establishing and rolling out community care in those areas.*" Counties selected based on agreed criteria including no or few other partners, underserved; poorly performing; poor geographical access; remote rural populations; limited means of income; surviving mainly on subsistence farming. Three south eastern counties with 300,000 people (about 10% of the total population). Access impeded by poor HRH (only 38% of staff are skilled health workers in River Gee and only 21% of staff are skilled in Grand Kru County). The grant should increase coverage and access to services; strengthen maternal and newborn death reporting; strengthen community including men's participation for maternal and newborn care services and improving monitoring and evaluation (M&E).	H4+ Sida Collaboration on Accelerating progress in MNH: Liberia Proposals and M&E Plan (H4+ nd)
4	Orientation around Sida grant to H4+ mentions consideration to **prioritize a few counties with high population, those with vulnerable groups and those with inadequate access** to services to maternal, child and adolescent health services: TWG to revisit SWOT analysis … to focus on institutional and programmatic components across the reproductive maternal neonatal child health (RMNCH) continuum of care.	H4+ Heads of Agencies, minutes of meeting, March 12 2013.
5	Notes from planning meeting show that selection of health facilities for the H4+ at county level would be based on the following criteria: • MoH supported facilities • Accessibility by car or bike or walking not more than one hour • High catchment population area • Geography equity – be able to reach other areas not one-sided • Health facility utilisation • Facility without trained staff – MoH Intervention is needed • Staff accommodation to maintain staff • Facility with skilled staff but poorly performing.	Minutes of H4+ MNH TWG Planning Meeting, August 20, 2013.

6	Evaluation of the health system identifies some prevalent challenges across the whole system including supply chain management, HRH (supply, deployment and retention) and infrastructure.	Liberia RMNCAH Investment case (MoHSW 2016b: 5)
7	Situational Analysis pre-H4+ Sida programme identifies weak health system, poor utilisation, underserved areas, high anaemia, lack of female (especially adolescent) empowerment, deeply held cultural traditions and harmful practices.	Accelerating Progress in MDG 4 and 5: A proposal for Sida/ H4+ collaboration. Situational Analysis Liberia. Undated. Approved by Heads of Agencies in February 2013. (H4+ 2013a)
8	**Criteria for target group and H4+ county selection:** The H4+ Programme is implemented in six counties, selected on the basis of a number of key health indicators agreed upon by the GoL and the H4+ team. The selected counties, Maryland, River Cess, Grand Cape Mount, Gbarpalu, River Gee and Grand Kru, are underserved, with none or very few health partners; they have poor geographical access; they have very remote, large populations with very limited means of income and surviving on subsistence farming.	Behaviour Change for Maternal Health Study, Search for Common Ground, July 2015 (Search for Common Ground 2015b: 4)
9	**Project planning in the South East Counties:** On whether the H4+ should have taken on all 18 facilities in River Gee County rather than just 6 in each of three counties. "*It might have been better to try to cover all the facilities in one county*." The Assistant Minister suggested that the programme "*missed steps in project design*. *Why go for a narrow number of facilities?*" Participants had questions about what the H4+ was meant to do at county level and how, and to what extent it should help country health offices overcome core issues like stock-outs and HRH issues.	Ministry of Health Technical Team, KII, 1 June 2016. Also see entry #16
10	This report documents the outcome of an H4+ mission, which took place in July 2015 for the purpose of assessing and selecting additional health facilities within three additional counties to be included in the H4+. A total of five primary health facilities were selected. The following criteria for the selection of facilities was developed by the mission team: • Operated by MOH; facility accessibility; primary catchment population; number of primary and secondary catchment communities; equity; utilisation; certified midwives in post and other staff; triage and isolation area; water and electricity; means of referral. Recommendations from the field mission: • All referral hospitals in the three new project counties to be supported to increase access to quality comprehensive emergency maternal, obstetric and neonatal care (CEmONC) services	County Planning and Baseline Assessment Mission to three new H4+ Sida supported Counties, July 5-15, 2015 (H4+ 2015b: 12)

	• Advocate with the MoH to consider provision of additional skilled midwifery workforce to all project sites • Establish/strengthen community structures in catchment communities of selected health facilities • Provide performance base incentives for health facilities and staff to motivate and increase productivity • Establish an H4+ technical coordination team of two members each in the counties to provide technical support to county health teams, follow up on and monitor implementation of the programme activities. H4+ SIDA partner agencies should mobilise additional funding external to H4+ to support other facilities that are not covered by the current funding but serve as referral points in terrains that are populated and have limited access to the county hospital.	
11	**County selection:** A trip report from representatives from UN Women, UNFPA accompanying H4+ Coordinator to the county of Gbarpalu. The purpose of the field mission was to conduct an assessment for the selection of two health facilities that could benefit from H4+ and also to participate in the development of the County Investment and Operational Plan (with the aim to include H4+ activities in the plan). The report presents the data gathered on five potential sites surveyed for selection and shows how each scores against the agreed selection criteria.	Report from the Trip to Gbarpalu County of the selection of the Additional Health Centres. 2015
12	The RMNCAH Investment Case sets out the following: "*Main barriers include* • ***Inefficient supply chain system****: Critical gaps do exist in the availability of essential medicines, equipment and medical supplies in Liberia. Stocks-outs often occur at the sub-national levels with very weak distribution mechanisms and rampant product pilferage. Irregular availability and improper storage of medicines for most RMNCAH interventions especially oxytocin, are a major concern in health facilities. The National Drug Supply (NDS) has been found to be deficient in its operations…"* • ***Inadequate number and limited skills of health workforce*** *providing RMNCAH services. Nurses, physicians, and physician's assistants are all in short supply. It is estimated that a 1.2% increase in skilled birth attendants is needed to meet the 2015 health workforce targets. All combined, the country still has fewer than 1.15 skilled birth attendants per 1000*	Liberia RMNCAH Investment Case (MoHSW 2016b: 10)

	population, significantly fewer still than the WHO minimum threshold of 2.3 doctors, nurses and midwives per 1000 population. • ***Low availability of, limited access to and demand*** *for adequate health facilities and RMNCAH services. Evidence of inequality of resource division with the three south-eastern counties being the most deprived. There is widespread poor service delivery in relation to RMNCAH."*	
13	**Status of maternal health** Status of maternal health in the country is weak. Note the different ratio for maternal mortality in *Countdown to 2015* data, it is estimated at 770 deaths per 100,000 live births. *"Special attention should be given to sexual and reproductive health because an improvement in this area has a direct effect on maternal and child health, education, skills acquisitions, eventual employment and poverty reduction. Surveys have indicated that over 55% of neonatal mortality occurs among girls under 15 compared to 6% for over 19 years… More investments are especially needed in adolescent sexual and reproductive health to decrease the high maternal mortality and infant mortality…"*	RMNCAH Investment Case p. 12 (MoHSW 2016b: 12)
14	**Major causes of maternal deaths** • Delayed decision to seek care • Cultural practices linked to maternity, family power structures, permission needed by men, male control of women • Bad road network – delays in reaching care • Communication – no or limited cell phone network – people have to climb trees to make a call to request a referral.	Cape Mount County Health Team, KII, Sinje Palaver Hut, 2 June 2016.
15	Original M&E Plan/ H4+ Liberia proposal: Identified risks as poor roads, delays in implementation by GoL partners because of competing priorities; HRH constraints. "*The Sida support will be both catalytic and gap filling in the sense that community based care is nearly non-existent in the project areas and then Sida grant will be catalytic in establishing and rolling out community care in those areas.*" **Counties selected based on agreed criteria** including: - No or few other partners	H4+ Sida Collaboration on Accelerating progress in MNH: Liberia Proposals and M&E Plan, 2013 (H4+ nd)

	- An underserved area - Performing poorly - Poor geographical access - Remote rural populations - Limited means of income - Surviving mainly on subsistence farming.	
16	MoH technical and senior staff reflected on the H4+ selection of six facilities in each of three counties in the south east region of the country. They wondered why the decision was taken to operate in five primary health facilities plus one referral hospital rather than try to cover all the health facilities in one county only. For example, River Gee County has 21 health facilities in total including health clinics, centres and the county hospital. The H4+ selected five clinics and centres plus the hospital; but that meant that fifteen facilities across the county were not supported.	MoH Technical Staff, KII, 1 June 2016.
17	H4+ partners identified the challenge of selecting a few facilities in three counties rather than all facilities in one county. They aimed to demonstrate that it was possible to work in these difficult to access locations. Their criteria included a minimum level of service in each facility they worked in (in terms of accessibility, possibility of reaching the clinic by road within some hour or two of travelling in a car; minimum staff requirement such as midwives etc.). They wanted to be catalytic across the whole south east region and kick start quality improvement over a wider area. They pointed out that there are clinics and facilities in River Gee (let alone Maryland and Grand Kru) that are ten hours by road and then one still has to walk for an hour off-road. "*These places almost need a helicopter,"* as the County Health Officer suggested in River Gee.	H4+ country team partners (WHO, UNFPA, UN Women, UNAIDS, UNICEF) and discussions in the ERG, 31 May 2016.
Assumption 1.2 *H4+ JPCS support to sub-national levels funds activities capable of* ***complementing other investments and contributing to strengthening service delivery in RMNCAH****. The funded activities are appropriately sequenced and* ***matched with support to health systems strengthening provided by other programmes and sources****.*		
Information/data		**Information sources**
18	**What H4+ does not fund**	H4+ ERG, briefing to Evaluation Team, 31 May 2016.

	The H4+ Coordinator and the Evaluation Reference Group (ERG) confirmed that the H4+ does not invest in buildings and large scale infrastructure. The H4+ also does not pay salaries for staff or invest in activities to support staff terms and conditions. The County Health Team (CHT) and communities referred to these restrictions as well.	
19	The CHT said that the H4+ activities match their own priorities, but during implementation, the County was not fully involved. County operational plans are kept at the central ministry and partners can access these, the operational plan guides the implementation plan of each partner.	River Gee CHT presentation to the Evaluation Team, 6 June 2016.
20	**MNDSR**: The President of Liberia pronounced any maternal death as an emergency. Reports of maternal deaths were to be "*on her desk within 48 hours after the death*". A steering committee was set up in 2013 and it was recommended that all line ministries be part of the committee including the ministries of education, public works, etc. However, the line ministries were not regularly at the meetings. The committee meetings later became dormant as EVD gathered momentum. Under the H4+ programme, a national and county based process was developed to revitalise the national committee. A maternal death protocol was developed and approved. Using the protocol, 52 maternal deaths were reported. The MoH requested an assessment with support from the H4+ and based on this assessment report, the H4+ is helping the MoH develop an action plan. The joint efforts of the H4+, with all the partners speaking with one voice on the issue of maternal death, has contributed to the revitalisation of the maternal and neonatal death surveillance and reporting (MNDSR) process.	H4+ Country Team, May 30, May 31, and June 1, 2016.
21	**MNDSR**: *"There are a total of 18 MNDSR structures set up in 18 catchment communities in the three H4+ [south eastern] counties. Each structure is made up of three persons: a town chief, one general community health volunteer (gCHV) and one trained traditional midwife (TTM). These groups meet once every month to discuss challenges they are faced with while working in the field. The MNDSR surveillance activities are taking place at all levels including community, health facility, district and county. Regular reporting is still a challenge as chiefs and other traditional people are still considering maternal and neonatal death as sacred (being called to heaven). The purpose of the MNDSR is to guide the formulation of immediate and longer term actions to improve effective death surveillance and response."*	H4+ Draft Annual Report 2015 (H4+ 2015k)

22	**MNDSR**: Reproductive Health Technical Committee (RHTC) meetings are held at the county and district levels in the three H4+ counties by CHTs and gCHVs and TTMs trained to work with health facilities in the catchment communities to discuss maternal and neonatal death and to raise awareness, increase distribution of family planning commodities and to identify solutions to the problems that lead to maternal and neonatal death.	H4+ Draft Annual Report 2015 (H4+ 2015k)
23	Investments in building community demand for better health services funded and supported by the H4+. For example, funds support the county health teams to: • Conduct the reproductive health technical coordination meetings at county level • Deliver an awareness campaign in Q2/ 2015 aimed at galvanising support among youth, women, men's groups, community leaders, health facility staff and others about the interventions that can save a woman's live in pregnancy, and the idea that it is not necessary for women to die in pregnancy • Meetings with community leaders, staff, women, men and youth about building a maternity waiting shelter • Joint review meetings with communities to discuss the proposed activities and create ownership and involvement. Participants reiterated their commitment to reducing maternal and newborn death by encouraging the TTMs and gCHVs to continue with referral of pregnant women to health facilities for provision of maternal and child health (MCH) care.	H4+ Draft Annual Report 2015 (H4+ 2015k)
24	*Jhpiego* was asked to help deliver H4+ programmes in Cape Mount, Gbarpalu and River Cess Counties to support the post-Ebola viral disease (EVD) programme component. Jhpiego signed a contract with UNFPA from 15 Aug 2015 to 30 June 2016 (less than one year). Their programme includes the payment of incentives to TTMs and gCHWs. They also have a **results based financing programme** that means they pay $197 monthly to each H4+ health facility as a performance incentive when it achieves certain outcomes, such as cleanliness, record keeping etc. Funds are used to pay for staff incentives. Jhpiego has not outlined an exit strategy and no discussion about what will happen with regard to payments to individuals and facilities at the end of the programme was undertaken with beneficiaries.	Jhpiego Workplan, 15 August 2015 to 30 June 2016 (Jhpiego 2015)
25	Responses to the survey question, "Have you noticed any **changes or improvements in the health facility** in the last few years?" (River Gee)	H4+ Evaluation Team exit survey, River Gee, June 2016 (H4+ 2016e)

	"*Sometimes I am told to get my medicine outside of the clinic because it is not in stock*" (6 responses about the lack of medicines generally, not just maternal medicines); "*No improvement*" (4 responses); "*The radio isn't working*" (4 responses); "*Mama-baby kits are no longer available*"; "*Better facilities, need more space*" (4 responses).	
26	Letters from the WHO representative handing over vehicles, motorcycles, hospital equipment and radios show the procurement dates but no mention of **maintenance, consumables** or provision for these in the future.	WHO Country Representative, Letter to the MoH, 31 December 2015
27	**Medicines and commodities** – These are sometimes in stock and sometimes not. UNFPA supports the delivery of maternal health supplies through the National Drug Supply (NDS) but at the time of the evaluation, ampicillin, gentamycin, and chlorhexidine are out of stock in Fish Town County Hospital. Most clinics still had a small amount of chlorhexidine. **All H4+ facilities visited had oxytocin**. None had a full store of medicines (for example, no erythromycin anywhere and very uneven supplies of ampicillin and gentamycin). All have misoprostol but only one midwife (in Jarkaken) was found who actually used it regularly to treat post-partum haemorrhage where an initial dose of oxytocin has failed to stop bleeding. Misoprostol was approaching expiry dates. According to officers-in-charge, stock-outs are "regular" but there has been an improvement in basic maternal health commodities with the H4+ JPCS support. An evaluation-prompted tracer study of five drugs from mid-2013 to April 2016 for the H4+ supported facilities showed irregular supplies, and that some facilities were more stocked out than others (for example, Fish Town, the referral hospital, had a high level of stock-outs in 2015). In Cheboken, there are no cannulas so patient IVs can only be done if the patient buys a cannula from the pharmacy. There was no sign of the tricycle UNFPA purchased for the CHT. It is difficult to see how it could be used on the roads though. Motorbikes were clearly much more appropriate given the mud, sand and uneven terrain.	River Gee Facility Observations and Record by the Evaluation Team, June 6-8 2016 Results of an evaluation-prompted Tracer Study of 5 maternal health drugs (2013-2016) Annex 7.
Assumption 1.3 *RMNCAH managers and service providers trained with support from H4+ JPCS realise intended gains in competence and skills. These gains in skills and competencies are tested and verified during and after training.*		
Information/data		**Information sources**

28	The TTMs play an important role in maternal and infant health and wellbeing raising awareness of the health facility and its services. They remind pregnant women about the services available and encourage them to use antenatal care and deliver at the facility.	Nurses Sinje Clinic, KII, June 2, 2016.
29	H4+ support enabled the reproductive health supervisor to visit each H4+ supported health facility once a month to offer supervision, check progress and reinforce training. Staff were keen to have opportunities for training, more education, skill upgrading and promotion. They wanted a career that had defined pathways, some level of predictability, and some measure of control over their own careers. Many said they would value promotion and/ or further education as much or more than more salary and they would be more content to stay in a rural area if they could access these opportunities after a predictable length of time (like 5 years or 7 years or something like that).	H4+ Annual Report 2015 (H4+ 2015k) River Gee Facility observations and record by the Evaluation Team, June 6-8 2016.
30	**Staffing** **Complement** – All facilities had two registered nurses (RNs) and at least one certified midwife (CM). They were also staffed with laboratory assistants, pharmacy clerks (who sometimes doubled up as registry clerks) and cleaners/ janitors. Most facilities considered that they were understaffed. In Cheboken, the two CMs had not had a day off for over a year. Staff were on call through the night for emergencies and over the weekend as well. Across the county, there was only one nurse able to do anaesthetics and when she was away, patients needing caesareans were referred to Harper (about 5 hours away on a difficult road). Apparently, two more nurses are scheduled to be trained but it was not clear when that would happen. **Issues for staff in River Gee at five out of the six H4+ facilities:** **Pay** – All staff mentioned that the pay they received was difficult to live on. A couple of common points about this: **Financial incentives**: Staff were either on the GoL payroll and thus paid a salary or they were not on the payroll. All staff (including janitors etc.) are paid an 'incentive' from the Pool Fund. This ranged by rank and seniority it seems and the amounts varied from 163 to 212 USD. The amount has gone down in recent months. The incentive is paid to all staff whether they are on the payroll or not. Being on the payroll effectively doubles the salary. One nursing supervisor mentioned her salary of about 18,000 LRD (about 200 USD) and her incentive of 208 USD. Staff not on the payroll are thus working for less pay than those on the payroll. At every health	River Gee Facility Observations and Record by the Evaluation Team, June 6-8 2016

	facility there are staff waiting to be put on the government payroll. The determinants of inclusion on the payroll were not clear but the situation could persist for several years. One cleaner had been waiting for eight years and many of the nurses waited two or three years. **Accommodation** – Staff housing issues were raised at every site visited. Staff are posted to different parts of Liberia, and accommodation is required for most in order that they can deliver care 24 hours a day. Staff accommodation was considered vital but very inadequate. Many staff (for example in Cheboken and Gbepo) rented their own accommodation from their salaries. Staff in River Gbeh were given accommodation by the community. It varies from community to community. **Trained and qualified health care providers are leaving** the counties for better or attractive salary/ incentives which the GoL is not providing. This was confirmed by the manager of the pool fund which pays incentives to non-USAID funded health workers. There is not a single health worker employment, deployment, remuneration or promotion system in Liberia so sound data are difficult to find.	
31	Staff have had training in emergency obstetric and newborn care (EmONC) and Helping Babies Breath. Training was done in 2014 and again recently. The clinics at Jarkaken and Cheboken and the River Gbeh Health Centre practiced “kangaroo mother care”; staff at Fish Town had not heard about it. Only one midwife (trained in 2014) had enough knowledge of and confidence in herself to use misoprostol. There was misoprostol in every facility but most about to expire.	River Gee Facility observations and record by the Evaluation Team, June 6-8 2016
32	**Training Volunteers** Both TTMS and gCHVs have participated in training in the areas that they need to know in order to provide appropriate health services at community level. Both CHV’s and TTMs said they have attended training for diarrhoea, malaria control, acute respiratory infections, family planning and nutrition.	Community health volunteers, focus group discussions (FGDs), June 2-9, 2016
33	Community leaders in Jarkaken, Cheboken, Sinje and River Gbeh all spoke about the process of agreeing to invest in new structures to improve the outcomes of childbirth. Included among these interventions was the wish to see maternal waiting shelters built near the health facility. No health facility had yet had a maternal waiting shelter built and communities expressed impatience. They also saw the need for better staff accommodation to support the staff living conditions and increase their motivation to stay near the clinic during weekends.	Community Leaders, FGDs, 6-8 June and June 2, Jarkaken, Cheboken, and River Gbeh communities in River Gee County, and Sinje, Grand Cape Mount County.

34	In both communities, they stated that the education provided to TTMs and the level of coordination existing between the health facility and the TTMs as well as the support from the health facility staff has greatly helped in the reduction of home deliveries. "*TTMs are now one of the major cadres of health workers who are referring pregnant women to the health facility for ANC services and deliveries.*" Community leaders mentioned they would like the TTMs to have an ID card, more training, some basic equipment like torches and raincoats, and incentives.	Community Leaders, FGDs, June 7-8, 2016 River Gbeh.
35	**Lack of transportation to reach the clinic.** "*Some live four to five hours away and some end up delivering on foot*." The community articulated the need for another community ambulance. Some live great distances away and poor condition of roads makes travelling difficult and risky for pregnant women. Lack of transportation to reach communities and assist in transporting people to the health facility slows down referral. Both TTMS and gCHVs mentioned that walking on foot to carry out the work is tiring. They often pay their own way hiring motorbikes. More worrying for them are long distances that many women have to walk to give birth. While they manage the walk of up to two, three or four hours on a regular basis, this can be risky for women in the throes of labour. There are still cases of women giving birth on the way to the clinic.	Sinje Community Leaders, FGD, June 2, 2016. Community Health Volunteers (TTMs and gCVHs), FGDs, River Gee, June 7-9 2016.
36	Supplies for gCHVs: All said that a reliable supply of very basic items was needed. For example, flashlights would help them when escorting women to the facility during the night – especially those that give birth on the way. Rain capes would help during the rainy season. "*We want materials to work when bringing the pregnant woman in pain on the dark road*."	Community Volunteers (TTMs and gCHVs) FGDs, River Gee, 7-9 June 2016.
37	**Job aids were seen in every facility**: They appear to be actively used by the staff, including the partograph, which helps the midwife identify the point in the labour when a referral is necessary. What is missing is material to hang the job aids effectively.	River Gee Facility Observations and Record by the Evaluation Team, June 6-8 2016.
38	The Officer-In-Charge (OIC) from Gbepo Health Centre mentioned: "*One TTM escorted a pregnant woman to the health facility for delivery using her own funds for transportation. There was a complication that could not be managed at the health facility."* This patient was later referred to the Fish Town Hospital and again referred to J.J. Dossen Hospital in Maryland for further management. Again, the only person from her community with her was the TTM. No relative including her husband followed. The TTM along with the	County Health Team, River Gee, KII, June 6 2016.

	health staff went with the ambulance to J.J. Dossen. The woman's life was saved and she and her newborn are stable. She has been discharged but there are no funds to transport the TTM back to her community. The Officer-in-Charge (OIC) stated that at the time this meeting is being held, "*the TTM is still in Maryland County due to the lack of transportation.*"	
39	"*Sustainability of the [H4+] programme activity is key and was discussed during the programme development process. This discussion also continued with the county leadership and health staff during the assessment. It was agreed that a) Community structures be involved in the programme planning, monitoring and evaluation, b) Discussions may emanate at the national level but the CHT must be involved in the decision making and c) Non H4+ facilities and catchment communities should benefit from H4+ programme activities*"	H4+ National Coordinator, KII, June 13 2016.
40	UNFPA drew on evidence from Ebola experience (that community health workers and others can be incentivised to do surveillance and contact tracing which greatly expands the reach of the health system) to try to create a wider network of family planning distributors. Trying to get the Government of Liberia to agree to task-shifting so that community based distributors could do injectables, which so far is not allowed but would provide longer term continuity to women given HRH issues.	UNFPA Country Team, KII, 30 May 2016.
41	**Training of health workers and support staff** in essential newborn care, prevention of obstetric fistula and infection prevention control and care of pregnant women in context of Ebola with emphasis on early detection through triage at health facilities and community outreach. 72 health workers trained in 26 facilities across the six targeted counties. **Pre-test 38% to 78% and post training results** were 70% to 100%. 26,000 USD budget/ spent.	Ministry of Health Activity Report by UNFPA, July-September 2015.
42	**Maternal health policy/ practice at River Gee health facilities:** Maternal and newborn quality care was the leading focus in the River Gee County through the H4+ programme. All interviewees mentioned reducing maternal and newborn deaths as their primary goal. There are six districts in River Gee; the programme supports one facility in each district. The team visited five health facilities including a referral hospital, two health centres and two clinics. Addressing maternal health, reducing maternal and newborn mortality and supporting newborn survival are clear county policies and have been a major focus in the facilities and communities visited. The team did not visit any communities not in the H4+ programme, which makes it difficult to assess the extent to which the H4+ programme has made a	River Gee Facility observations and record by the Evaluation Team, June 6-8 2016.

	difference (as opposed to not having the H4+) but there are discernible impacts from the programme: 1. Staff have had training in EmONC and h*elping babies breathe*. Training was done in 2014 and again recently. The clinics at Jarkaken and Cheboken and the River Gbeh Health Centre practiced Kangaroo Mother Care (KMC). Staff at Fish Town had not heard about it. Only one midwife (trained in 2014) had enough knowledge of and confidence in herself to use misoprostol. There was misoprostol in every facility but most about to expire. 2. Job aids were seen in every facility. They are actively used by the staff. What is missing is material to hang them effectively. 3. All facilities had basic maternity equipment including beds for labour, delivery beds, sterilisation equipment etc. Most had a foetal Doppler but not always working. All of them had a foetal scope (for manual heart rate monitoring). One had a MVA (not working). The referral hospital does not have ultrasound capacity (nor do any facilities) so it is not possible in River Gee for a pregnant woman to have an ultrasound. The county health team supervises each level of the health system individually and separately (there is not a cascade system). The CHT supervises the hospital and the two health centres and the fifteen health clinics.	
43	"*All the facilities face serious issues with water for quality service provision. The provision of water at the facilities is important and thus must be fast tracked to prevent cross infection, especially nosocomial infections. UNICEF is starting the vetting process to get a contractor for the activity*."	UNICEF Country Team, KII, 1 June 2016.
44	**H4+ funded incentives**: Some staff and community health workers benefitted from small incentives paid by the implementing partner in the River Gee facilities and communities. For example, midwives received an extra 20 USD per month to remain near the clinic over the weekend in order to be available to support deliveries at any time. When Save the Children stopped being an implementing partner in December 2015, the incentives stopped and have not been paid since.	Interviews with staff at Jarkaken Clinic, River Gee, 8 June 2016 and from Save the Children, quarterly and annual reports, 2014 & 2015.
45	There are many problems identified in the delivery of health services: **Human Resources for Health** (HRH) is the most critical. A third of facilities in the south east counties do not have mobile phone coverage. The enabling environment is fragile (roads, banks, commerce,	Ministry of Health Technical Staff, KII, 1 June 2016.

	services, accommodation). There is a need to construct accommodation for staff. The MoH is trying to address HRH in a number of ways: • Medical education is free including for doctors, pharmacists, nurses/ midwives (subsidised by a grant from donors) and this is aimed at encouraging workforce production • Post graduate specialists are coming on stream as well with priority to paediatricians, obstetrics-gynaecology, internal medicine and general surgery • Technical working group on HRH includes WHO, USAID and the H4+. This group aims to consider and address all the issues associated with HRH. One contribution the H4+ programme has done is investment in pre-service training through the health training institutions in the South East. This has helped build capacity and supported them with materials and training supplies. They have helped update nursing policy.	
Assumption 1.4 *Capacity development efforts in RMNCAH are supported with well-sequenced supervision and required equipment, supplies and incentives to allow service providers the ability, opportunity and motivation to improve service quality and access.*		
	Information/data	**Information sources**
46	**Referral system:** The referral system relies on the radios, mobile phones, the ambulances and the knowledge of community health workers (gCHVs and TTMs) and clinic staff. It helps address the three delays most commonly associated with maternal emergencies: delay taking the decision to seek care, delay reaching appropriate care, delayed referral: The hospital is taking referral patients and the ambulance service was seen in action twice. First, during a visit to the hospital where a woman had been brought by ambulance the night before from Cheboken. At 11pm, the clinic called by mobile phone (the battery on the base station was not working) to say there was a woman in labour who was bleeding profusely (suspected Placenta Previa). The hospital director who lives on sight woke up the ambulance director and the obstetrics nurse and they went to the clinic and brought the woman back to hospital within an hour or two. The nurse opened the IV line on the way and got her ready. On arrival, she was fully dilated and delivered a stillborn chid but the doctor saved her life and	River Gee Facility observations and record by the evaluation team, June 6-8 2016.

	stopped the bleeding. She was recovering in the post-natal ward. The OIC travelled personally all the way to Fish Town to follow up with the patient and find out her status as he had not received news from the hospital. Second, during a visit to River Gbeh Clinic on 7 June 2016, the evaluation team noted the arrival of a man with hypertension and left side paralysis. He was being monitored at the clinic and his family were with him. On our departure from the area we passed an ambulance en route to the clinic (sirens going). An hour and 20 minutes later, the ambulance arrived at Fish Town Hospital with the man. The hospital director promptly left a meeting with the evaluation team to attend the patient. The delay (1 hours and 20 minutes) was in convincing the family to allow the man to come to hospital. In Jarkaken, an immune suppressed patient needed to be transferred to Fish Town the day before the evaluation team visited the clinic. The ambulance could not get through on the road from Fish Town, which was impassable due to mud and rain. The patient died two hours after in their home. Fish Town hospital will refer when their anaesthetist-nurse is absent and they cannot do surgery. There is only one anaesthetist in the county and if they have to deal with a C-section, they will refer to Harper. The TTM will travel with the woman if the family is not with her. The priority is to save a woman's life and she will be sent to a referral hospital alone or with a nurse if there is no family with her. In River Gee, it was clearly articulated by all health staff that a woman would be referred to save her life whether there is family with her or not. Many community members have mentioned the referral system as a major success and a notable difference to the quality of the system. The TTMs often said that women used to die but "*these days they don't die*". The main complaint from the staff regarding the referral system from both Cheboken and Gbepo (but not Jarkaken) was the lack of feedback on progress of patients sent by ambulance. The male community in Jarkaken thought the ambulance should "*bring their wives back*" since it took them away.	
47	**Community views about referral services:** In Jarkaken, the Clan Chief clearly discussed the ambulance service, which now provides a means of transport for sick patients to the hospital. He stated that before the introduction of	Community leaders in three River Gee communities, FGDs, 7-8 June 2016.

	the ambulance service in the community, they had to "*physically carry patients to the referral hospital in a hammock on foot with several men taking turns carrying, as it was hours away. It could take two days depending on the distance and by the time they finally reached the hospital, the patient's condition had worsened or the patient was pronounced dead."* What was worse was that when the patient was pronounced dead by the doctor, they *"had to walk back with the dead body with heavy hearts*".	
48	TTMs spoke about their role in helping women decide to go to the clinic for delivery rather than staying at home; the TTM is important for helping communities understand what the health services can do to support deliveries and reduce maternal and newborn deaths.	Community health service volunteers (gCHVs and TTMs), FGDs, River Gee Communities. 6-8 June 2016.
49	**CB radio**: All the six H4+ facilities are joined up by radio. WHO installed the radio but there is no specific radio operator and the **nurses have not been trained in how to manage or operate the radio**. While talking on the radio is not difficult, the receiver often goes down because the battery storage is lost, fluid decreases and needs maintenance (the radio and its battery need some maintenance given the frequent electricity outages). The staff use the radios to talk to each other, to facilities in Maryland, Grand Kru and even in Monrovia. Each of the six facilities should have a radio. This is the condition they were found in: • **Fish Town** – needs battery maintenance. Radio was down for the three days during the evaluation team visit. Three emergencies occurring during these days were dealt with by mobile phone, one of which came through a third party (the clinic radioed another clinic that had mobile signal and the nurse in the third clinic phoned the hospital) • **Cheboken** – functional and working • **Jarkaken** – functional when connected to the mains but if the power is off, the radio drains the solar panel too fast so they generally leave it unplugged. The battery was dysfunctional and it was taken for repair about a year ago and has not been returned. • **River Gbeh** – functional and working • **Gbepo** – antenna broke some time ago and the radio is not in use. The installer took it away in 2015 and it has not been returned.	River Gee Facility observations and record by the evaluation team, June 6-8 2016.
50	**Ambulances**: There are two for use in all 21 facilities in River Gee County. One from H4+ and one on loan from International Rescue Committee. Both currently working.	County Health Team presentation to the evaluation team, River Gee, 6 June 2015.

51	**Utilities (Water, sanitation, power):** None of the facilities had entirely functional power, water and sanitation systems. Generally, across the county, electricity is variable and a combination of generators and solar panels are used to provide light.	River Gee Facility observations and record by the evaluation team, June, 6-8, 2016.
52	**Solar panels:** All facilities had solar panels and usually two – one for the vaccine fridge and one for the rest of the facility. Other than in Fish Town hospital, we did not find a facility that had specific solar panels or a suitcase installed for the delivery room. • **Fish Town Hospital**: installed at Fish Town recently by UNFPA after a 2-year delay. However, the hospital electricians (there are 2) have not been trained in how to operate and maintain them. The hospital tried to communicate with the manufacturer on some aspects of the panels but proper training would be better • **River Gbeh**: one functional solar panel linked to the vaccine fridge. The solar panel to switch on the lights is not working so the centre has no lights or power when the electricity supply is cut. • **Cheboken**: solar panel is currently not working. Old style vaccine fridge but solar panel works. • **Jarkaken**: panel for vaccine fridge is new (as is the fridge). Solar panel for the lights is working. • **Gbepo**: solar panels are working but there is a shortage of DC bulbs. There are a couple of lights that will come on.	River Gee Facility observations and record by the evaluation team, June, 6-8, 2016.
53	**Water system:** • **Fish Town:** the water system is dysfunctional and has never really worked. The hospital water system was incomplete on delivery of the building and has been faulty since date of completion; instead, they use a well. The cleaners transfer all the water needed in the hospital from a well outside using buckets and a rain butt for storage. • **River Gbeh**: there is no water at the clinic. The staff take water from a well and from the river • **Cheboken**: water comes from a well. The pipe connecting the water tower to the clinic is broken and as the clinic has no budget for maintenance, it has been left broken. • **Jarkaken**: the well dries up in the dry season; the submersible pump installed in the well has burned out. The 5.5 kva generator is working, but the clinic has no funds for fuel so the	River Gee Facility observations and record by the evaluation team, June, 6-8, 2016.

	generator does not work. The clinic janitor carries water from the community well 500 metres away • **Gbepo**: there is little water. There are no cleaning materials at the moment.	
54	**Sanitation:** • **Fish Town:** a Liberian Army contingent was posted in the hospital just after completion around 2014 and they apparently wrecked the sanitation system, removing commodes when they left. The toilets are mainly not working. The hospital has one toilet in the whole of the Obstetrics Ward (labour, delivery, post-natal) • **River Gbeh**: there are two or three toilets but patients mainly use outside latrines. There is one toilet for the labour – delivery – post-natal ward • **Cheboken**: there are sufficient toilets but no bathroom/ shower room in the maternity section • **Jarkaken**: there are sufficient toilets and they are in good condition. There is no water in the clinic so toilets are flushed using water from a bucket (carried up from the community well by the janitor). Maternity patients have to climb the hill outside to use the staff shower after delivery • **Gbepo**: there is no bathroom in the maternity section.	River Gee Facility observations and record by the evaluation team, June, 6-8, 2016.
55	**Supplies**: Transfer of three ambulances, three long-range radios as a "*contribution to health system strengthening of the Country*". Donation valued at 200,000 USD (including the fifteen laptops listed). The Deputy Minister replied in a subsequent letter to acknowledge receipt and said the items will be used for data collection and reporting. Ministry of Health with support from H4+ turned over two laptops to the Data Office and County Reproductive Health Supervisor of River Gee County. This is to strengthen the data office reporting and enhance the RH supervision in reporting.	WHO Country Representative letter to the Minister of Health, Liberia, 31 December 2015. UNFPA Activity Report, December 31, 2015, (UNFPA 2015a: 2)
56	**Blood supplies were a major problem everywhere.** There used to be a functional blood bank in Liberia. It collapsed during the war and has not been reinstated. Blood is not free or freely available. People who need blood need to bring relatives or friends who will donate. The blood is taken from one and injected immediately into the other person. Blood is not stored as there is no functional cold chain (lack of generators, lack of fridges, etc.). The lack of a blood bank is a major obstacle to saving women's lives.	River Gee Facility observations and record by the evaluation team, June 6-8 2016.

57	**Blood safety** and effective medicines and commodities distribution is very critical. Blood banks are urgently needed to ensure that only safe blood is administered to mothers and babies. The roads in programme counties are very difficult. AG-100 type motorcycles are needed at health facilities to support distribution of medicines supplies. They are more effective than tricycles which cannot manage the difficult roads.	H4+ heads of agencies Meeting minutes, April 16th, 2015
58	**Lack of basic maternal drugs** is mentioned in this report including Ampicillin IV, Metronidazole IV and Diazepam IV. No sterilisation as there was a lack of kerosene for sterilisation equipment. No personal protective equipment (PPE) yet. No hygiene materials like chlorine, Dettol, Clorox.	Progress Report, Save the Children, July-September 2014 (Save the Children 2014c)
59	UNFPA contracts Save the Children (SCF) to deliver adolescent sexual and reproductive health activities to address high teenage pregnancy rate (177/1000). SCF supported recreational activities and school health clubs as well as training for health staff to welcome teenagers. Funds were sourced from the H4+ Sida grant, the Maternal Health Trust Fund and the Global Program for Reproductive Health Commodity Security. For example, in 2015, the amounts paid to SCF from these funds were 414,308 USD, 380,000 USD and 75,000 USD respectively. Annual activities include procurement of mama-baby kits, training for health staff and gCHVs and TTMs in 179 communities, dignity kits, performance based incentives for health facility staff and gCHVs, mentoring and supervision of health staff in use of non-pneumatic anti-shock garment (NASG), kangaroo mother care, family planning and other innovations. Maintenance for three motorbikes for the project, one vehicle, six CHT motorbikes including three tricycles to facilitate monitoring and commodity movement. The contract with SCF was not renewed after 31 December 2015. Incentives have not been continued by UNFPA in the River Gee H4+ facilities and communities. See also Assumption 2.2.	Workplan by Save the Children submitted to UNFPA 01/01/2015 to 31/12/2015 (Save the Children 2015)
Assumption 1.5 *The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services and to overcome barriers to access which existed in the past.*		
	Information/data	**Information sources**

60	Health facilities have reported that there has been **an increase in the number of clients** seeking and using prevention of mother to child transmission (PMTCT) services. Data show that in the January-March quarter, the number tested for HIV doubled.	IPs, KII, June 1, 2016.
61	**Increase in pregnant women using the health facility.** The Interviews suggested there has been an increase in the number of women who are referred to the clinic for deliveries and for family planning, and that generally the referral system has made significant progress for the health and wellbeing of women and children. Midwives in River Gbeh mentioned the Community Leader fines imposed on the father (Liberian Dollars 2,500), if the baby is delivered at home.	Community health volunteers (TTMs and gCHVs), FGDs, River Gee, 7-9 June 2016.
62	In River Gbeh, the leaders said that **the benefits to the community** from the H4+ include the mother baby kits, 2 beds for delivery and lots of equipment, free services, free medicines, an ambulance and the school health club, which gives the young people access to family planning. Enrolment is up and teenage pregnancies are down.	River Gee community leaders, FGDs, June 7-8, 2016.
63	The H4+ implementing partners said the impact of their work can be seen in: • An increase in the number of ANC visits • An increase in facility deliveries • Increase in referrals In the new counties, only H4+ facilities in Gbarpalu have mama-baby kits and 'Big Belly" cards.	IPs KIIs, June 3, 2016.
64	The community is concerned about the difficulties pregnant women and girls face (particularly those who live greater distance from the health facility). The **main problems and gaps in relation to maternal and child health** (particularly pregnant and postnatal women) were mentioned as: • Lack of **transportation** to reach the clinic. "*Some live four to five hours away and some end up delivering on foot."* The community articulated the need for another community ambulance • Some live great **distances** away and poor condition of roads makes travelling difficult and risky for pregnant women • **Living quarters for medical staff** posted to the county were insufficient and needed to be improved to support staff morale • **Communications** are poor and it is difficult to communicate with those who live far away • Need for a **maternity waiting shelter**. A waiting shelter would remove the risk of travelling when about to give birth as the woman and her carer would travel to the shelter ahead of	Community leaders, Sinje, Grand Cape Mount, FGDs, 2 June 2016.

	time. The clinic and its community has been aiming to build a waiting home for some time. They have been given the task of contributing local supplies and labour but need more information. Specifically, they need the H4+ to identify the plan for the shelter and tell them what is needed in the way of local materials (number of bricks, quantity of sand, planks of wood etc.) after which they will accumulate these supplies and get started with building. The H4+ programme is contributing part of the supplies for the waiting home as well. • **Medicines stockouts**: "*Most of the time you go to the clinic but they will say you have to go and buy it,"* as the clinic does not have it in stock.	

Area of Investigation 2: Expanded Access

Question Two: To what extent have H4+ JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality? a. **How have H4+ interventions contributed to strengthening the quality and appropriateness of care in RMNCAH provided to marginalised and excluded (encompassing skills and attitudes of staff, availability of equipment and supplies and timing of services)?** b. **To what extent have H4+ JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women?** c. **How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care?** d. **To what extent do H4+ JPCS investments and activities (alone or in conjunction with other programmes of support) contribute to developing trust between service providers and users of RMNCAH services and are these efforts sustained?**		
Assumption 2.1 *H4+ JPCS supported initiatives are targeted to increasing access for marginalised group members (rural poor women, families in geographically isolated areas, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disabilities, indigenous people).*		
	Information/data	**Information sources**
1	Information provided by the County Health Team – **Youth and Adolescent Health** Department: H4+ has supported the delivery of youth friendly services, focus groups discussions and the establishment of health clubs in the schools. As a result of these activities,	River Gee, County Health Team, KII, June 6, 2016.

	it was recommended that the government includes health education in the school curriculum. Most of these activities were supported by Save the Children (SCF). But at some of the schools, UNICEF is implementing the school health club project (outside of the H4+). The project trains health educators, peer educators, and established men and women health groups etc.	
2	The need for reproductive and sexual health for adolescents and youth is discussed in clubs meetings. When asked whether gender based violence (GBV) was discussed among young people and/or by peer educators, the group of peer educators responded that this issue was important indeed. They described GBV as rampant and said that, within the community, cases of violence were more frequent in their age group than among adults. Peer educators in Fish Town described GBV in terms of girls being forced into sexual intercourse. The group stressed the recurrence of acts of violence against girls as young as nine who have been assaulted by "*old men*" (30 and older) too. At school, "*boys attack girls often*." Also, it is not uncommon for boys to resist using condoms. Peer educators in Cheboken mentioned that it was an important role for them, which they chose to take one "*for the community*" as well as "*to take care of themselves/ protect themselves*". All of them would like a profession in the health sector (girls mentioned they wanted to be a nurse; the boys would like to become doctors). Insufficient number of staff at the local clinic affects the quality of service (time available for the patient; long wait). Youth also stressed the lack of staff in school as well as the lack of education material, which, they felt, limited their knowledge.	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.
3	**Peer educators for youth and adolescents**: Peer educators said they had been briefed on GBV and were able to respond to questions and advise young people on this theme. They said, "*a woman has the right to say no; men should never force women against her will; if not this results in rape*." They also explained what could be the psychological and medical effects of forced sex. They stressed the issue of equality between men and women and the fact that "*everyone is equal*" in the home, relationships, at work and in school.	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.

	Peer educators felt they were not sufficiently empowered: they would need more material to engage students on SRHR issues; they also felt that sex education should be integrated in the school curricula. The female participants in the group discussion stressed that peer educators provided them with **comprehensive information** on each commodity and felt like they made informed choice. When asked by the evaluator to list a number of advantages and side effects of modern methods, the peer educators were indeed able to provide comprehensive information.	
4	Regarding **health facility staff**, the group unanimously stressed that nurses at the clinic were "*nice*" and "*easy to speak to*" at the River Gbeh rural health centre. The group stressed that they received excellent advice and guidance at the heath centre, where the staff were very welcoming. Two young women aged 17 and 24 (one with a one year-old and the other with a 3 year-old) felt they were provided with all information to inform their choice of method (depo; implant).	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.
5	The quality of sexual and reproductive health services provided at the H4+ health centres showed **noticeable differences between rural** (Cheboken, Jarkaken, River Gbeh) **and urban** (Fish Town) areas. In Fish Town, health providers are less accessible to adolescents. In rural areas, all groups stressed the youth-friendliness of staff.	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.
6	**Adolescents and youth discussing helpfulness of health facility staff.** Nine out of 19 participants mentioned that they either had a bad experience at the Fish Town hospital, or heard of the health providers not welcoming youth when seeking family planning services. They "*don't talk nicely*" and, at times, "*shout at* [them]" and "*send* [them] *away*". This has resulted in a certain "*fear to go back*". Peer educators, on the other hand, gave a different picture, stressing that the health staff give students their "*full attention*". This observation, they said, was based upon their own experience as well as what they observe when they escort students to the hospital.	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.
7	**Community leaders said they were actively promoting family planning amongst youth**. Messages are shared with young people through posters and also through meetings held within the community. Both male and female youth are encouraged to learn about family planning. A person is assigned to a family planning role at the clinic. Plan International also support family planning and offer a package/ resource pack free of charge.	Sinje community leaders, Grand Cape Mount County, FGD, June 2 2016.

Assumption 2.2 *H4+ JPCS support to capacity development, and to effective demand by community members has adequate reach to effect access to quality services for marginalized groups. H4+ JPCS support addresses the three dimensions of sustainable capacity improvement: capability, opportunity and motivation for sustained provision of quality care.*		
	Information/data	**Information sources**
8	The **National Strategy for Adolescent and Youth Sexual Reproductive Health** states: "*The critical health problems affecting adolescents and young people include: STIs, teenage pregnancy, sexual exploitation and abuse (SEA), HIV/AIDS, alcohol and substance abuse, accidents and injuries, nutritional problems and other chronic diseases. Liberia is said to have one of the highest teenage pregnancy rates in Africa as per the LMIS 2011, which states that 38% of adolescent girls will have given birth before they are 18 years old*." According to the 2007 Liberia Demographic and Health Survey (LDHS), the HIV prevalence rate for youth aged 15-24 ranges from 0.9 percent to 1.9 percent. The LDHS 2013 states that the family planning usage of any method among currently married women age 15 – 49 years is 20 percent. Access to general health care services stands at 40 percent as per the MoH 2006 Rapid Health Assessment Report. **Objectives:** • Increase access to high quality comprehensive adolescent friendly SRHS • Increase utilisation of adolescent and young people SRH services • Strengthen management capacity of MoH at all levels for adolescent and youth sexual and reproductive health • Build partnership for provision of high quality comprehensive adolescent and youth services	National Strategic Plan for Adolescent and Young Peoples Sexual and Reproductive Health in Liberia, Ministry of Health and Social Welfare, May 2014 (MoHSW 2014: 5)
9	The **Bottle Neck Analysis** estimated that "*there are 165,864 annual births in 2013 in Liberia. Approximately 4,346 children are born to HIV positive women each year resulting to an estimated 1,434 paediatric HIV infections annually. The incidence of teenage pregnancy in the country is a major concern and many of the teenage mothers are between 12-14 years. The*	Report of Application of the Bottle Neck Analysis (BNA) Approach to plan the elimination of Mother-To-Child Transmission of HIV in the Maternal New-

	National Response for HIV in Liberia including PMTCT is regarding the provision of PMTCT, by December 2013, 639 (97%) of ANC facilities had integrated HIV counselling and testing in routine ANC; 345 (54%) of health facilities providing ANC are offering HIV counselling and testing, and ART for PMTCT. Only 51 (8%) of health facilities providing ANC are offering complete PMTCT interventions including maternal antiretroviral therapy, early infant diagnosis and paediatric ART."	born and Child Health platform in Liberia, Ministry of Health, Family Health Division, September, 2014 (MoHSW 2015d: 1)
10	**Search for Common Ground (SFCG)** Report of a baseline study which revealed how people see maternal, newborn, child, and adolescent (MNCAH) services (for example, men were not allowing their wives to go to hospitals). This study presents significant data, e.g.: "*the target groups' perception of maternal health care; social, economic and cultural factors undermining safe childbirth; their level of knowledge on the services provided by health facilities and how to access them.*" Counties selected for this study: River Cess, Gbarpalu and Grand Cape Mount. Key findings: *"Across the board, respondents of all genders, age groups and locations believe it is best for a woman to give birth in a health facility. Of those who reported pregnancy or birth in 2015, the majority of respondents of all genders, locations, and age groups reported that they or their spouse used maternal health services in 2015. Each parent believes they have the most significant role to play in reducing childbirth mortality. Men are more suspicious of modern medical practices than women. There is a dramatic gap between what men and women believe qualifies as men providing 'strong support' during pregnancy. Conservative or traditional expectations of masculinity are pervasive across locations, genders, and ages."*	Behaviour change study, Search For Common Ground, (2015) July 2015 (Search for Common Ground 2015b: 3)
11	In answer to the question "*did the nurse treat you with respect and courtesy?***"**, all but one of the 40 responses in the exit interview conducted by the evaluation team were positive.	Health facility exit interview, River Gee County, June 2016.
12	**Dedication and attitude to patients:** the evaluation team heard high praise for most of the staff in the health facilities visited in River Gee. With a couple of exceptions, the staff we encountered were clearly dedicated, motivated, keen to learn and do well at their jobs, and proud of their contribution to their communities. Patients, staff and community members reported several instances where staff used their own money to buy generator fuel to manage a night time emergency or to buy patients some food. As an exception, there were some	River Gee facility observations and record by the evaluation team, June 6-8 2016.

	reports that hospital staff were not always entirely respectful of TTMs (as opposed to clinic and health centre). The TTM in question said she was asked to stay at the hospital all day to monitor the pregnant woman that she had accompanied to hospital during the night. When the woman was fully dilated she had to then call the midwife once stage two had started. Thus she said she was in fact performing the duties of the midwife.	
13	**Training for TTMs** has included h*elping babies breathe*, breast-feeding practice, family planning and nutrition. TTMs have also been trained in child care, family planning counselling and how to escort the mother to the health facility. TTMs would like more training on safe delivery, using Chlorhexidine gel and helping during an emergency to support a mother's needs, especially when mothers give birth on the road to the clinic.	TTMs and gCHWs, FGDs, River Gee 6-8 June 2016.
14	All the **TTMs showed a good understanding about the aims of the maternal health programme** to reduce maternal death. They said they were motivated by a desire to "*educate my community about disease*", "*to minimise the risks to health and educate my community*", "*I want to work for the community's sake – to reduce the death rate of under-fives and pregnant women*". They also considered that they were having an impact which they said, "*is because of us – we are the bridge – and we are doing the awareness and things are improving*."	TTMs and gCHWs, FGDs, River Gee 6-8 June 2016.
15	H4+ procured **material and supplies to facilitate the work of the gCHVs**. After the training, each participant was supplied with a backpack, flash light, hand towel, soap, umbrella, a set of rain suits and boots, flashlight batteries, consoling booklet for the use during home visits, ledger for recoding client information and reporting forms as per the national guidelines. (See also assumption 1.4, #34 as the batteries for the torches were rarely, if ever, replaced).	Summary of trainings and activities supported under the H4+ Project, January-December 2015.
16	**Mama-baby kits**: these provided clothes and useful things for the baby including soap and diapers as an incentive to mothers to deliver in the facility. They were available until 2014 but have been out of stock for 18 months to date. The midwives everywhere were very enthusiastic about the kits and wanted them to be re-started as soon as possible. Gbepo and Cheboken had small packets with a blanket and soap that apparently comes from UNFPA as a holding measure. The County Health Team Reproductive Health Supervisor said that the buckets were in the store room and baby clothes were being procured so that the distribution of the kits could start up again. None of the other facilities had kits.	River Gee Facility observations and record by the evaluation team, June 6-8 2016.
17	**Peer educators** felt they were not sufficiently empowered: they would need more material to engage students on sexual and reproductive health and rights (SRHR) issues; they also felt that sex education should be integrated in the school curricula.	Youth and adolescents, River Gee communities, FGDs, June 11, 2016.

18	In both communities, they stated that the education provided to TTMs and the level of coordination existing between the health facility and the TTMs as well as the support from the health facility staff has greatly helped in the **reduction of home deliveries**. TTMs are now one of the major cadre of health workers who are referring pregnant women to the health facility for ANC services and deliveries.	Community leaders, River Gee, FGD, June 7-8, 2016.
19	**Anti AIDS Media Network (AAMIN),** a media development organisation supporting demand creation for maternal health services mentioned the below: • Have been working with radio stations for provision of information on RH and PMTCT services • Establish an association for demand creation at ANC sites and health centres • Creation of IEC/BCC messages • Media monitoring activities Health facilities have reported that there has been an increase in the number of clients seeking and using PMTCT services. Data show that in the January-March quarter, the number tested for HIV doubled.	H4+ IPs, KII, June 1, 2016.
20	**Liberian Women's Empowerment Network (LIWEN) is a local NGO supporting women living with HIV and AIDS.** They mentioned that the H4+ has afforded them the opportunity to conduct: • Home visit to terminally ill HIV and AIDS clients • Provision of care to terminally ill clients • Establishment of support groups with direct supervision • Water, sanitation and hygiene (WASH) facilities that were provided in the facilities • However, more needs to be done for women with HIVAIDS because "*every day, people are coming in with HIV*". "*H4+ has impact but we still need to continue. We need to show how to give birth to an HIV negative child.*"	H4+ IPs, FGDs, June 1 and June 3 2016.
21	**Jhpiego t**rained 46 midwives: 26 in Grand Cape Mount and 20 Gbarpalu, and trained community volunteers for referral and distribution of commodities.	H4+ IPs, FGDs, June 1 and June 3 2016.
22	**Africare** has been working in the south east counties and undertook the following activities: 1. Worked through community groups for demand creation and linkages to health facilities	H4+ IPs, FGDs, June 1 and June 3 2016

	2. Engagement of men and boys/ trained male groups in sexual reproductive health (SRH) issues which have led to the formation of network among themselves for coordination meetings 3. Establishment of p*eer mentors* 4. Establishment of the GBV component for SRH services. Activities included working with men to escort women to health facilities, encourage them to take medications 5. Engagement of traditional leaders/ influential individuals in the services by providing training 6. Encouraged influential leaders to support the referral pathway with reference to abuse 7. Created district monitoring teams for additional support in the absence of law enforcement officers	
23	**National Aids Commission (NAC)** undertook the following activities: 1. Conducted research which revealed that the south east was selected because of its location and limited number of partners 2. Subcontracted community based organisations such as the Family of Hope, RECEIVE, and others 3. Supported 189 catchment communities 4. Posted billboards, developed and distributed posters and flyers with visual messages 5. Worked with influential leaders to create a system where husbands pay a fine if their partners deliver at home 6. Developed jingles for radio, translated them into the local vernacular NAC view of their own impact: Decrease in the number of home deliveries	H4+ IPs, FGDs, June 1 and June 3 2016.
24	**Search for Common Ground (SFCG)** undertook the following activities: 1. Conducted a baseline study which revealed how people view MNCH services (e.g. men did not allow their partners to go to hospital to deliver) 2. Trained 13 community radios to develop and promote messages addressing their community needs and gaps 3. Evaluated messages produced by other partners (Africare and PSI) for effectiveness 4. Worked with communities to encourage more acceptance of Ebola survivors. They played an active role in fighting stigma (such as the fear people had of sitting near a survivor of Ebola).	H4+ IPs, FGDs, June 1 and June 3 2016

25	**Africare reported their work in this way: "***There has been increasing demand for support to maternal and newborn care. We established parent community groups. The second phase of work engaged men and boys as we live in a patriarchal society and the father has the say about what will happen to the pregnant woman and where she will give birth*." Africare said they were able to train small groups then **eventually males formed a network and held monthly meetings**. "*We had the officer in charge attending the meetings and certified midwives and the community nurse. Then we decided to establish peer mentors who were also trained to help their friends out (particularly as we work with individuals with low literacy rate). So we tried to work out how best to educate. We had a GBV component as some things keep women from attending the facility – e.g., if the partner is not supportive; if she is abused. Most of the time, she would be by herself – but even if she did go the facility, she [still] need her partner's support. [he would say], 'did you take pills?'"* "*So we encourage the male to escort her to the facility so they actually do want to access. On the note of GBV, even if we have rules 'they' still have the authority. We decided therefore to engage traditional leaders – the heads who have the authority. So they are also part of the awareness group. We had a lot of stories coming out, such as someone who said that they thought that, as a man, it was not his responsibility to escort [his wife to the clinic]*."	H4+ IPs, KII, June 1 and June 3 2016.
Assumption 2.3 *H4+ JPCS support at national and sub-national level has been sequenced appropriately with support to RMNCAH from other sources. H4+ JPCS supported investments and inputs do not conflict in timing or overlap with those provided by other programmes. Further, H4+ JPCS support combines with other programme inputs to allow services to be scheduled and delivered in manners appropriate to reaching vulnerable group members and building trust between providers and users.*		
	Information/data	**Information sources**
26	In the absence of coordination with the health facility, the **TTMs** had worked separately in the provision of care and delivery services to pregnant women based on what they had learned from their mothers and grandmothers. With the coordination, support and training acquired from the facility team and the county health team at large, their capacity has been built for the provision of services. They said they now understand the management of care needed before,	TTMs, FGD, Sinje, Grand Cape Mount County, 2 June 2016.

	during and after pregnancy and how they should best help pregnant women. TTMs have clear guidance for referral of a pregnant woman to the health facility and they would no longer try to deliver a baby outside the health facility. TTMs further mentioned that not since before the Ebola outbreak had the county health team conducted training for TTMs and they would really value additional/ further training. When asked about their level of satisfaction for the collaboration and support, they mentioned that they are satisfied but there needs to be additional training to build their capacity. They also mentioned the need for maternity waiting shelters, more health facilities, and support for the transportation of pregnant woman to the health facility.	
27	H4+ team members discussed the **challenges of coming together** to deliver the H4+JPCS programme including the time it took to build a common understanding, to apportion areas of responsibility and to agree how to overcome the structural barriers between them including the different financial and administrative systems of each H4+ partner. They consider that they are each able to deliver their part of the programme in an area consistent with their best strengths.	H4+ Evaluation reference Group, KII, 31 May 2016
28	**Taking into account the design of other projects:** "*UN Women is taking leadership on one output of H4+ country programme: focusing on community mobilisation and a rights-based approach for increasing demand and uptake of MNH services. The expected results include the availability of lighting and powering of the necessary equipment to ensure the delivery of BEmONC services in the selected health facilities. This document sets out the work plan activities against the estimated budget of 469,212 USD*."	Workplan for the Implementation of the UN Women Component of the H4+ SIDA Collaboration on Accelerating Progress in Maternal and Newborn Health in Liberia (UN Women 2015b: 1, 6)
29	**Mama-baby packs** were not widely available after the middle of 2015. They were widely reported as being an important factor in motivating women to come to the clinic. For example, in Cheboken Health Centre, the midwife named the Mama-baby pack as the most important intervention to increase attendance for skilled births at the clinic by women in the community. Mama-baby packs were mentioned during both County Health Team meetings and at every facility meeting or focus group discussion. They were widely seen as highly motivational, and a very successful activity to support changing community approaches to childbirth and delivery.	Nurses and midwives, FGD, Gbepo Health Centre, River Gee 6-8 June 2016.

30	UNICEF reported that that they were providing **WASH** in some of the H4+ supported health facilities and this helped especially where children were in hospital. But WASH needs to be provided in all hospitals so H4+ needs to do more for the provision of water in all hospitals. UNICEF was not constructing new wells but tried to use existing ones and these wells would not work in the dry season as the water levels were too low. See also Assumption 1.4, #53.	H4+ IPs, FGD, June 1 2016
31	Some MoH technical staff expressed surprise that the H4+ did not decide to take on all 18 facilities in River Gee County rather than just six in each of three south east counties. Some suggested also that there should be a county field office in each of the counties.	MoH Technical Staff KII, June 1 2016.
Assumption 2.4 *The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability for service users to effectively demand care is sufficient to contribute to a notable increase in the use of services and to overcome barriers to access which existed in the past.*		
	Information/data	**Information sources**
32	"*On combing the three counties, at least 60% (of 200 persons participating in the survey) agreed that they listened to the **radio programme**. 99% of those who listened to the programme understood its content.*" *"On the whole, the respondents gave two main reason why they think the programme content was important to their communities: 20% said it will help their husbands pay attention to their wives; and another 35% said it will encourage husbands to stop beating on their wives."*	Evaluation of PSI and AFRICARE Messages, Using Behaviour Change Communication through Radio to Minimise Maternal Mortality and Gender Based Violence in Liberia. December 15, 2015 (Search for Common Ground 2015c: 1)
33	Before the H4+ programme there was a preponderance of home deliveries as well as limited number of **referral by TTMs**. But under the programme, training and incentives to TTMs have increased referral and the introduction of the mama-baby kits encouraged mothers to deliver at facilities. Staff were trained to deliver better quality care.	County Health Team presentation to the evaluation team, River Gee, June 6, 2016
34	The community leaders in Cape Mount County have a close relationship with the **County Health Team** (this was validated by both sides). They meet on a regular basis and discuss health challenges of the community.	Community leaders, FDG, 2 June 2016.
35	**Structural and systems issues**: Many of the H4+ facilities were the most understaffed and underserved. Ministry staff suggested that the midwife was the most important cadre, "*If you want to deliver RMNCAH services, how do you do it without a midwife?*" There are many problems in the delivery of health but human resources is the most critical. A third of facilities	Ministry of Health technical staff, KII, June 1 2016.

	in the south east counties do not have cell phone coverage. The enabling environment is fragile (roads, banks, commerce, services, accommodation).	
36	The County Chief said that the health service in the town was making progress, especially in the wake of the Ebola crisis. Comments from **community leaders** suggest the health facility provides a valued and improving service. The community leaders in Cape Mount have a close relationship with the County Health Team (this was validated by both sides). They meet on a regular basis and discuss the health challenges of the community. The community is very involved in promoting and contributing to the development of the county health service for example by helping spread key health messages in the community like attending the clinic for antenatal care and for delivery (referred to as "Big Belly Business" in the community). They request TTMs to actively persuade people to use the clinic. They are also particularly keen to support youth and adolescents, having established a youth group which offers support and advice on sexual and reproductive health to both girls and boys. Regarding sexuality of young people, the elders said that they did not approve of it but accepted that it happened and it was important for young people to have access to services to avoid unwanted pregnancies. The community leaders promote and encourage use of the clinic amongst the community members – especially pregnant women. The community leaders recognise the importance of and try to fulfil their role in family planning. The Town Chief said they try to influence the youth so that girls and women do not to become pregnant too early. "*We try to encourage them not to do that.*"	Community leaders in Sinje, FGDs Sinje, Grand Cape Mount, June 2 2016.

Assumption 2.5

Demand creation activities and investments have sufficient resources and are sustained enough over time to contribute to enduring positive changes in the level of trust between service users and service providers in RMNCAH. Investments and activities aim to change service providers' attitude and behaviour toward users in an effort to build mutual trust. Improvements in service quality and access are not disrupted by failure to provide adequate facilities, equipment and supplies of crucial commodities in RMNCAH. H4+ JPCS support is not subject to disruptions, which can weaken trust and reverse hard won gains.

	Information/data	**Information sources**
37	**Communities promoting deliveries at health facility**	Community leaders, River Gee, FGDs, 7-8 June, 2016.

	Comments from community leaders in Jarkaken indicate an increased trust in the health facility and its capacity to the extent the leaders mentioned: "*They have instituted a law for the community with reference to home deliveries. Any community member (husband) as well as TTM who allowed a pregnant woman to deliver at home will be fined three thousand five hundred Liberian dollars."* (About 40 USD so actually quite a lot of money)	
38	**Increase in pregnant women using the health facility** The Interviews suggested there has been an increase in the number of women who are referred to the clinic for deliveries and for family planning and that generally the referral system has made significant progress for the health and wellbeing of women and children. Midwives in River Gbeh mentioned the Community Leader fines the father 2,500 LDR if the baby is delivered at home.	Community health volunteers (TTMs and gCHVs), FGDs, River Gee, 7-9 June 2016.
39	Across the board, respondents of all genders, age groups, and locations **believe it is best for a woman to give birth in a health facility**. Only three respondents do not believe it is best for a woman to give birth in a health facility. In practice, of the respondents who gave birth in 2015, the majority (95.1%) gave birth in a health facility. This finding contradicts a statistically significant national level survey in 2013, which found only 55.8 percent of women give birth in a health facility.	Behaviour Change Study, Search for Common Ground, July 2015 (Search for Common Ground 2015b)
40	Changes to **social norms** were taking place in H4+ supported communities in that communities were less likely to blame women who were having difficulties in pregnancy and childbirth as somehow responsible or being punished for their behaviour. This was still a tendency to blame women but part of the H4+ support was aimed at engaging communities about this belief and encouraging better knowledge and understanding.	UN Women, KII, 1 June 2016.
41	**Achievements of the H4+ approach** according to the coordinator: 1. The H4+ programme was built to support existing structures 2. Ownership by the government – the target population has taken ownership of the programme and we have built their capacity to take the lead 3. The programme has helped the community to see the need to use the services. The demand has been created 4. Through collaboration with the ministry and other partners, the trust from the Ministry has been built in the partnership.	H4+ Coordinator KII, June 3 2016.

Area of Investigation 3: Responsiveness to National Needs

Question Three: To what extent has the H4+ JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level? **a. Is the basic structure of the H4+ JPCS (decision making structures, management processes, approval mechanisms, disbursement rules and procedures) able to respond to evolving and changing contexts and situations in a timely and appropriate manner? Does the structure place countries at the centre of the programme?** **b. As the programme has evolved over time, has it become more flexible in responding to changing contexts and events, for example the Ebola Viral Diseases or to changing national plans and priorities?**		
Assumption 3.1 *H4+ partners supporting RMNCAH in JPCS countries have been able to establish effective platforms for coordination and collaboration among themselves and with other stakeholders (including work plans, activities and investments, and results monitoring frameworks and systems) using H4+ JPCS funds and with technical support from the global/regional H4+ teams.*		
	Information/data	**Information sources**
1	UN Women receives support from other H4+ members. The group could collaborate and coordinate more effectively. Better coordination would help them develop for example standardized approaches in their projects (where needed). An example was given where organisations did not collaborate to develop a common incentive package so each were providing **different incentives and motivational packages to implementing partners**, which led to competition and challenges getting results. The different incentives packages are a common problem across the aid community in Liberia and was a problem during the Ebola outbreak as well. But the H4+ did not have internally consistent incentive packages.	UN Women, FGD, June 1, 2016.
2	"*The Liberia H4+ Agencies and partners developed and implemented the H4+ programme. A **Technical Working Group** (H4+ TWG) comprising of the agencies and the Ministry was established and meets monthly and quarterly to review progress made in implementation of the programme. The team also forms part of a national reproductive health committee that meets monthly to discuss and join efforts in improving SRH/MNCH services in the country."*	H4+ Draft Annual Report for the three counties: Grand Kru, Maryland and River Gee, H4+ 2015 (H4+ 2015c)
3	"*Through MERCI the county received an ambulance. With the introduction of the H4+ and the provision of an additional ambulance, base radios, additional trainings, community distribution of family planning commodities etc., there is a reduction of maternal deaths*."	County Health Team, River Gee, KII, June 6 2016.
4	**Human Resources for Health**	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)

	"Reproductive Health Technical Committee meetings are held at the County and district levels in the three H4+ original counties by CHTs and gCHVs and TTMs trained and are working with health facilities in the catchment communities in the three counties. At these meetings, RH issues such as maternal death in the community, neonatal death in the communities and awareness and distribution of FP commodities by CBD are discussed, and solutions to the problems are put in place. ***Summary of RHTC Meetings held in the three H4+ Counties*** ➢ *County Level: 36 county level RHTC meetings were held with 18 health facilities OICs and 192 DHOs in the three H4+ Counties* ➢ *District level: 192 district level RHTC meetings held with 18 health facilities' OICs and midwives* ➢ *Clinic level: 216 clinic level RHTC meetings held with staff from 18 health facilities in the three H4+ counties"*	
5	During the year under review, the **Family Health Division** worked closely with health partners over the year. The Family Health Division received support for revision of sexual, reproductive, maternal, newborn, child and adolescent health (RMNCAH) policies, guidelines, standards and development of job aids. Also, with technical and financial support from the H4+ project, these documents were validated and awaiting printing for the 15 counties. H4+ supported training TOT in the south east where 46 participants were trained in Home Based Maternal and Newborn Care for health professionals.	Summary of Trainings and Activities supported under the H4+ Project, January-December 2015.
6	***"Commodity security** is another challenge and there are frequent stock outs and lots of leakages. Great that H4+ purchased two trucks but now there is a problem with **storage capacity** being available at the county level. Solving one problem leads to another."*	Ministry of Health KII, June 1 2016
7	**Patient demands from the health facility** In the exit survey, patients mentioned they most wanted the health facility services to be improved through: - More consistent supply of medicines - More staff with suitable staff accommodation - More and better equipment - Mama-baby kits as these had run out - Water supply and electricity	Exit Survey, River Gee County, June, 2016.

8	Minutes of meeting between H4+ partners (including WHO, three participants from the MOH, the H4+ Coordinator and the County Health Officer). The document details specific steps for establishing a **maternity waiting home** and also the responsibilities and required actions of each partner in preparing for and establishing the waiting home (including the County Health Team, MoH and other H4+ partners).	H4+ Support to Improving SRMNCH Services, Minutes of the Meeting on Maternal Waiting Home, River Gee, October 20 2015 (H4+ 2015i)
9	Need for a **maternity waiting shelter**. A waiting home would remove the risk of travelling when about to give birth. The River Gbeh clinic has been waiting to build a waiting home for some time. They have been given the task of contributing local supplies and labour but need more definition. They need the H4+ to identify the blueprint and tell them what is needed in the way of local materials (number of bricks, quantity of sand, planks of wood etc.) after which they will accumulate these supplies and get started with building. The H4+ programme is contributing part of the supplies for the waiting home as well.	Community leaders River Gbeh, FGDs, 6-8 June 2016.
10	**Resources - Lack of maternity waiting homes close to the health facility**. Several nurses stressed the need for a maternal waiting home as the road is impassable by ambulance. The staff gave an example of a woman who died in recent weeks because, although she was accompanied to the hospital by a friend, her relative could not make the journey in time because of lack of funds. The clinic staff said it was "*national policy*" only to refer when a relative was present (not a friend). They did not refer therefore, and the woman died before her mother arrived.	Nurses, Sinje Clinic, interview KII, June, 2, 2016.
11	**Building of maternal waiting home and extending referral** The H4+ team has said it could help but there is a delay with regard to receiving feedback from H4+ on the maternal waiting homes; Additional ambulances are wanted as well as the County Health Team said many women die because they cannot access the clinic in time so with more ambulances, they can station them further apart and closer to affected communities which saves time getting to women in need.	Cape Mount County Health Team, KII, Sinje Palaver Hut, June 2nd 2016.
12	The discussion revealed that in the absence of coordination with the health facility **TTMs** had worked separately in the provision of care and delivery services to pregnant women based on what they had learned from their mothers and grandmothers. With the coordination, support and training acquired from the facility team and the county health team at large, their capacity has been built for the provision of services. They said they now understand the management of care needed before, during and after pregnancy and how they should best help pregnant women. They have clear guidance for referral of a pregnant woman to the health facility and they would no longer try to deliver a baby outside the health facility.	Cape Mount trained traditional midwives (TTMs), FGDs, June 2, 2016.

13	**Coordination** – suggestion: "*H4+ coordinators should look at the **county level.** They should also meet to help assist all with sharing of ideas – just the H4+ partners – so we can have an agreed agenda*." The most recent PCA that was signed wanted this. H4+ concerns should be shared with all the other partners.	IPs, KIIs June 1, 2016.
14	The County Data Team including M&E officers, District Reproductive Health (RH) Supervisor, County RH Supervisor, County & District Child Survival Focal person and County and District Surveillance Officers was engaged to support monthly data collection and submission of MNH epidemiological reports from eighteen health facilities and catchment communities in three counties by providing gasoline supply to facilitate timely report collection and entry. The gasoline support provided by H4+ has increased timely data collection and analysis.	H4+ Draft Annual Report for the three counties: Grand Kru, Maryland and River Gee, H4+ 2015 (H4+ 2015c)
15	**National HMIS tools being used in the counties for reporting:** H4+ does not submit reports separately from the County Health Team. They suggested that the H4+ team should be updating the National Health Team. Suggested also that there should be a county field office."	Evaluation Reference Group (ERG) Power Point presentation, H4+ May 30, 2016 (UNFPA 2016a) MoH Technical Staff, KII, June 1 2016.
16	**Challenge of monitoring MNDSR Structures:** There is a total of 18 MNDSR structures set up in 18 catchment communities in the three H4+ counties that are functional. Each structure is made up of three persons; a town chief, one gCHV and one TTM. These groups met once every month to discuss challenges they faced with while working in the field. The MNDSR surveillance activities are taking place at all levels including Community, Health facility, District and County. Regular reporting is still a challenge as chiefs and other traditional people are still considering maternal and neonatal sacred.	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k) (County Coordinator/ Field Officer, Grand Kru, Maryland and River Gee).
17	The document highlights several issues to be addressed and action points including programme monitoring tool provided by HQ are not user friendly and may not work well.	Minutes to H4+ Heads of Agency meeting, April 2, 2014 (H4+ 2014d)
18	For **maternal death audit**, a committee was constituted that included the District Health Officer, Clinical Superintendent, partners, and RH Supervisor	Cape Mount County Health Team, KII, Sinje Palaver Hut, June 2 2016.
19	Maternal and newborn death reporting and review is gaining momentum, though still needs to improve.	County presentation on the implementation of H4+ Programme in River Gee County, April 26 2016 (H4+ 2016a)
20	"*Analysis from the assessment shows that the **MNDSR** systems at all levels are weak. Even in the counties that reported to be currently conducting MNDSR activities, there are gaps and challenges. There are counties without county level maternal and neonatal death review committee while there are counties conducting MNDSR activity at the county level but not at health facility and community levels. Health facilities are functioning without [midwives]. None*	Maternal and Neonatal Death Surveillance and Response, DRAFT Assessment Report, March 2016 (MoHSW 2016a)

	of the counties assessed is fully capacitated to implement MNDSR; this situation is the same for both health facility and community levels. Though there are traces of standardization and harmonization of MNDSR processes and clear understanding of the flow of surveillance information for MNDSR at the different levels, there are huge challenges."	
21	**Examples of data presented in the Disease Surveillance Weekly Bulletin: Integrated Disease Surveillance and Response.** **Week 11:** Maternal deaths reported: 8. Causes: post-partum haemorrhage (4), Eclampsia (1), ruptured uterus (1), placenta previa (1), pulmonary oedema (1). Neonatal deaths reported: 13. Causes: sepsis (3), pre term (3), asphyxia (3), prolonged labour (3), foetal distress (1). **Week 19** Maternal deaths reported: 6 from 5 counties (Lofa (2), Montserrado, Nimba, Gbarpalu, Grand Kru, (1 each) **Causes**: Post-partum haemorrhage (3), post-partum sepsis (1), anaemia (2) Since the start of 2016, 101 maternal deaths reported through IDSR. Ten neonatal deaths reported from 4 counties. Causes: asphyxia, neonatal sepsis, prematurity.	Integrated Disease Surveillance and Response Bulletin, May 9-15, 2016 (IDSRB 2016)
22	During the opening statement, the chair mentioned the need to invest in the **monitoring and evaluation** component of the programme, which will give a clear picture of the achievement. He emphasised the allocation of funds for monitoring and evaluation. In conclusion, there was an agreement that the funds for communication, advocacy, programme monitoring and joint programme visits are with WHO and as such should or will be covered for such activities.	Minutes of the meeting held with the H4+ TWG and heads of agencies, May 2 2016 (H4+ 2016h)
23	**What will happen in the absence of the H4+?** Coordination and some other activities will continue. This is due to the fact that existing support group structures will be used as a medium for implementation although it is evident that the support group is volunteer based and might not meet consistently. There will be less supervision. Decrease in achieving results due to the lack of presence of other H4+ partners due to the lack of funding. There will be no means of providing transportation to attend coordination meetings.	IPs, FGD, Monrovia, 1 June 2016.
24	Accurate data not collected on stillbirth and neonatal deaths. Still needs additional research, as deaths of children are not consistently reported. Civil registration is not available or used in all counties.	WHO, KII, May 30 2016.

25	Present challenges for reporting of data collection for the common indicators of the **M&E framework:** • Some key H4+ indicators not captured by national HMIS • National HMIS does not disaggregated RH indicators including maternal health and family planning information by age • Human resource (limited number skilled providers; low motivation of skilled and community providers) • Ensuring efficient supply chain of RH commodities remains a major issue • Delayed disbursement of funds for the implementation of project activities may have resulted in slow/ delayed implementation of activities thus hampering timely reporting.	ERG presentation of the H4+ Programme, Power Point presentation (up to 2016), May 30 2016 (UNFPA 2016a)
26	Senior MoH staff commented that H4+ partners are more likely to speak more consistently around the same policy messages and focus on the same priorities.	Senior MoH Department Director, 31 May 2016.
Assumption 3.2 *Established platforms and processes for coordination of H4+ (and other RMNCAH initiatives) are led by the national health authorities and include as participants the H4+ partners, relevant government ministries and departments (including at the sub-national level) and key non-governmental stakeholders.*		
	Information/data	**Information sources**
27	We have achieved **ownership** by the government; The target population has taken ownership of the programme and we have built their capacity to take the lead; Collaboration with the ministry and other partners; The trust from the ministry has been built in the partnership.	H4+ Coordinator, KII, June 3, 2016.
28	**Health Coordination Committee** (HCC): Chaired by the Minister and convened monthly to address all health issues. All heads of agencies and others sit on this committee. The RHTC reports to this committee.	H4+ Coordinator, KII, June 3, 2016.
29	**Heads of agencies, coordination meeting**, attendance: – several partners are listed: World Bank (absent), WHO (2 participants), UNFPA (2 participants), UNICEF (2 participants), UN WOMEN (2 participants), UNAIDS, (2 participants).	Heads of agencies meeting minutes, April 16 2015 (H4+ 2015l)

	An action point within the heads of agency meeting – H4+ team to hold a meeting with the parliamentarians to brief them on progress made and challenges confronting smooth implementation of the project so as to solicit their collective support and ensure continued progress.	
30	The president pronounced the death of any woman as an emergency. Reports of **maternal deaths** were to be on her desk within 48 hours after the death. A **steering committee** was set up in 2013 and it was recommended that all line ministries be part of the committee. The line ministries were not regular at the meetings. The committee meetings were later dormant. Under the H4+ programme, a national and county process was developed to revitalize the national committee. A maternal death protocol was developed and approved. Through the use of the protocol 52 maternal deaths were reported. The Ministry requested an assessment with support from WHO and the H4+ supported this assessment. The assessment report is being review for which the Ministry has requested the development of anaction plan which are yet to be developed. The H4+ – through both funding and the impact of six agencies working together, speaking with one voice, etc. – have managed to revitalise the maternal death review process.	H4+ Coordinator, KII, June 3, 2016.
31	**Implementing partners** referred to the lack of funding such that one meeting per facility (one group meeting per month) was insufficient. The team mentioned that implementation is done in the same area but due to the lack of coordination of the H4+ county coordination there is little or no information about who is working where. The IPs have never met each other before in the context of the H4+ programme work. They could have been more coordinated on the ground if there had been better coordination at the national level. Implementing partners mentioned that some of the activities that were successful under their programmes might be included in a forthcoming micro-planning process. This would be an example of continuity in that case but they are not sure whether they will be invited or how their experience will contribute. Also suggested that the H4+ should expand to all facilities in the county, not just a few.	IPs, KII, June 3 2016.
32	**H4+ coordination at the county level and between county and national levels:** The Field Coordinator was contracted by one of the H4+ partners and reports to that partner on a monthly basis, submitting a quarterly report of activities. That partner then reports to the wider H4+ country team and to relevant implementing partners. Because of the way the contract has been structured, the Field Officer focuses mainly on the activities and bottlenecks associated with his H4+ contracting partner's component of the programme. He	H4+ Field Coordinator KII, June 7 2014.

	also reports on bottlenecks in other partners' components as he comes across them but does not automatically report on progress. The Field Officer is not invited systematically to join the quarterly H4+ meetings in Monrovia and does not have direct contact with other H4+ member agencies. The Field Officer has no formal or specific role coordinating with implementing partners at the county level.	

Assumption 3.3

Programme work plans take account of and respond to changes in national and sub-national needs and priorities in RMNCAH as expressed in plans, programmes, policies and guidelines at national and sub-national level. H4+ partners consult and coordinate with stakeholders at both levels.

	Information/data	Information sources
33	**How to address shortage of human resource:** "***Used the evidence from the Ebola*** *experience [*that community health workers and others can be incentivised to do **surveillance and contact tracing** which greatly expands the reach of the health system*] to try to create a wider network of FP distributors. Trying to get the Government of Liberia to agree to task-shifting so that community based distributors could do injectables which so far is not allowed but would provide longer term continuity to women given HRH issues."*	UNFPA Country Team, FGDs, 30 May 2016.
34	**Education and Ebola Viral Disease (EVD): hygiene promotion (Fish Town High School)**: female participants mentioned that this should be part of the curriculum at school. They mentioned that schools and CHT should build upon the increased attention given to hygiene in the aftermath of Ebola.	Adolescents and youth, FGD, June 11 2016.
35	Expansion to include **three additional counties after EVD**, use of resources to support EVD, training in IPC for health staff etc. all part of the H4+ agencies' ability to support national priorities. However, H4+ was largely put on hold while EVD outbreak was at its worst and River Gee was shut down completely as there was no personal protective equipment at the facilities.	H4+ Annual Report 2015 (H4+ 2015k)
36	**Disruption due to Ebola:** The focus of this baseline study is the enhancement and involvement of males in supporting maternal and newborn health. However the study also refers to the immediate need for the attention to the restoration of basic health care services, particularly sexual and reproductive health care in Liberia after the Ebola crisis.	Search for Common Ground, Baseline Study – Enhancing Male and Community Involvement, July 2015 (Search for Common Ground 2015a)

37	The list of attendees shows that the H4+ Coordinator participated in EVD meetings indicating that due to the Ebola emergency the coordinators attention was diverted away from H4+ activity during the month of September 2014.	Infection Prevention and Control coordination meeting.
38	Minutes of a meeting between H4+ partners regarding potential Sida grant for MNH services in the counties following the Ebola response noted that Liberia could plan for up to 2 million USD programme for the three worst affected counties for the provision of RMNCAH for services over an 18-month period.	H4+ Sida collaboration, Liberia, minutes, January 26 2015 (H4+ 2015g)
39	Before the H4+, **Cape Mount County** did not have district health teams. Ebola revealed the need to constitute a team in every district. Therefore, through the H4+ grant there was surveillance team training. They also empowered the surveillance team through the provision of computers and motorbikes for collection of reports and information. The H4+ has supported the county in addressing issues associated with fear from community members about accessing health services due to Ebola. "They blame health workers and think they are the major cause of the Ebola outbreak".	Cape Mount County Health Team, KII, Sinje Palaver Hut, June 2 2016.
40	**CPR** was 19% in 2013 just before Ebola hit, up from 11% in 2007. Unmet need was steady at 34% in 2013 down from 36% in 2007. Most counties were making progress but the SE was making faster progress than other areas. One reason was because they used a community based FP distribution model whereby the Community Health Volunteers or community health workers or general community health volunteers (CHVs, CHWs, gCHVs) were able to promote and distribute condoms and oral contraceptives.	UNFPA Country Team, KII, May 30 2016.
41	The Ebola experience has shown that community involvement contributes to impact for the provision of services. For example, **distance to health facilities** contributes to maternal and neonatal deaths.	UNICEF Country Team, KII, May 31 2016.
42	Due to suspension of all routine activities by the central MoH, funds for country level implementation has also been withheld. This has also affected execution of training plans by central MoH (Family Health Department) for professional health workers and gCHVs in H4+ counties. Due to the national **EVD crisis**, most routine maternal health facilities remained closed due to the absence of health workers and a lack of basic PPEs. There were insufficient supplies for those staff that were available to provide needed services. The Ebola epidemic has contributed to low turnout of patients at health facilities due to misconceptions about Ebola, such as, the health workers are the ones infecting the communities. Most health facilities in River Gee were closed to the public due to the lack of PPEs and training during the period under review	Ministry of Health and Social Welfare Project Activity Report, October to December 2014 (MoHSW 2015a) MOHSW Project Activities Planning/Monitoring/Reporting July to September, 2014 (MoHSW 2015b)

<table>
<tr><td>43</td><td>Implementation of the programme was slowed by the EVD epidemic, however, on average, all agencies initiated two thirds of planned activities.</td><td>H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)</td></tr>
<tr><td>44</td><td>Counties at risk of EVD got most attention and H4+ was practically suspended during EVD</td><td>UNFPA Country Team, KII, May 30 2016.</td></tr>
<tr><td>45</td><td>Regular (daily during height of EVD) infection and Prevention Coordination Meetings held weekly with the objectives of ‘improving synergies among actors; source control; increasing safety of the three health care facilities; increase safety to workers and suspected patients in Ebola Treatment Units.</td><td>Infection and control coordination meeting, September 10 2014.</td></tr>
<tr><td>46</td><td>Community Development Services (CODES) report shows that they attached H4+ activities to their larger UNICEF grant. Their role was to ensure water supplies to the H4+ health facilities in River Gee, Maryland and Grand Kru. They set out to procure and install submersible pumps and generators across the health facilities. Records appear complete in terms of expenditure. Some savings made by using an NGO already engaged in the area. CODES has a sub-office in Grand Kru and may have worked from there.

[NOTE: River Gee County Health Team, through the County Health Officer, noted that the implementing partner did not involve the County WASH team in its activities. They did not consult about depth of boreholes and thus there is a problem with pumps burning out, lack of maintenance and generators with no fuel. They considered the WASH elements of the programme to be a wasted effort and missed opportunity.</td><td>CODES, Progress reports to UNICEF, Child Survival and Development Feb-May 2014 (CODES 2014a)

CODES, Progress reports to UNICEF, Child Survival and Development, Jun-Aug 2014 (CODES 2014b)

CODES, Progress reports to UNICEF, Child Survival and Development, Oct-Dec 2014 (CODES 2014c)</td></tr>
<tr><td>47</td><td>
<table>
<tr><th>Meeting</th><th>Meeting Agenda / key discussion points</th><th>Date</th></tr>
<tr><td>H4+ Technical Working Group (TWG) Meeting</td><td>▪ H4+ partnership & SIDA collaboration
▪ Situational Analysis (planning process); Plan for development of single country plan</td><td>21/02/13</td></tr>
<tr><td>H4+ TWG</td><td>▪ Briefing and planning
▪ Grant presentation and discussions</td><td>09/08/13</td></tr>
<tr><td>H4+ TWG</td><td>▪ Plan central team movement and support to county plan alignment (team composition etc.)</td><td>20/08/13</td></tr>
<tr><td>H4+ TWG</td><td>Field visit briefing</td><td>24/10/13</td></tr>
<tr><td>H4+ TWG</td><td>▪ Planning for H4+ retreat
▪ Status of H4+ grant implementation</td><td>19/02/14</td></tr>
<tr><td>H4+ TWG</td><td>▪ Review activities schedules at upcoming retreat.</td><td>16/04/14</td></tr>
</table>
</td><td>Compiled from the records of H4+ TWG meetings, heads of agencies meetings and ad hoc meetings.</td></tr>
</table>

	▪ Discussion of H4+ high level meeting ▪ Submission of activities summary for 'Quarter 1'	(10:00 hrs)
H4+ TWG	▪ Update of programme implementation status ▪ Develop presentation of High Level dialogue	16/04/14 (14:00 hrs)
H4+ Heads of Agencies Meeting	▪ Review progress on implementation of MNH Roadmap Situation of maternal and neonatal death reporting ▪ Funding proposal: SIDA grant, UNFPA	12/03/13
H4+ Heads of Agency Meeting	▪ Programme inception meeting ▪ Presentation of country and health facility assessment and retreat reports & covering catchment communities	02/04/14
H4+ Heads of Agency Meeting	▪ Refurbishment of health facilities; ▪ Adolescents – what does not work? ▪ Update on programme implementation	16/04/15
H4+ Heads of Agency Meeting	▪ Showcasing progress ▪ Responding to context including increase in teen births ▪ Strengthening synergies between agencies ▪ Update on programme Implementation	16/09/15 (14:00 hrs)
H4+ High Level Dialogue, Harper, Maryland	▪ County collaboration on Accelerating progress in reducing maternal and newborn mortality'	12/06/14
H4+ TWG	▪ Overview of Proposal for MNH services in the counties worst affected. ▪ Discussion on the management of the addition grant	26/01/15
H4+ TWG	▪ Maternal Waiting Homes, River Gee ▪ Roles and responsibilities of each H4+ partner in regards to assessing need, site selection for three new counties	20/10/15
H4+ TWG Review Meeting	▪ Planning participation in the health regulatory boards. ▪ Finalising date for H4+ Joint Review meeting.	17/03/16
H4+ TWG and Heads of Agency	▪ Funding situation of H4+	02/05/16

		▪ 'Fast tracking implementation since the level of implementation across agency was generally described as very low…'		
	H4+ TWG	▪ Agency review balance H4+ budget to assist sister agency (UN Women) ▪ Discuss End-line evaluation	3/05/16	

Assumption 3.4

Platforms and processes for coordination of H4+ JPCS do not duplicate or overlap with other structures for coordinating activities in RMNCAH. Further, they provide a strong RMNCAH focus to national and sub-national health sector coordinating platforms.

	Information/data	Information sources
48	There is **limited duplication of services** because the Ministry has in place the Fixed Asset Registry. So all support is recorded with mapping of partners and their activities. It is the hope of the county to upgrade Sinje Health Centre to a district Hospital for easy access to care. WHO has promised to supply an anaesthetic machine, which is yet to be delivered. Might have not been cleared from the Port. (Also there are motorbikes to be delivered – these are WHO donations not H4+).	Cape Mount County Health Team, KII, Sinje Palaver Hut, June 2 2016.
49	The River Gee CHT mentioned that **no H4+ partner discussed an exit strategy** with the CHT. They could have tried to do something if they had discussed it earlier. For example, to sustain water services provided by partners, some communities have initiated the cash box system for the maintenance of hand pumps. This system requires community dwellers to pay something at the end of a stipulated time for use of the service. This fund is then used for maintenance of the pump. Also, there is a county level WASH committee chaired by the Ministry of Public Works and co-chaired by the MoH to address issues related to water supply. **Are the activities provided by the H4+ part of the county priorities?** The CHT acknowledged that the H4+ activities match their own priorities but during implementation the county was not fully involved. County operational plans (developed by the county) are kept at the central ministry and partners can access these. The operational plan guides each partner's implementation plans. The county specifically mentioned their appreciation to UNFPA for the	River Gee facility observations and record by the evaluation team, June 6-8 2016.

	level of involvement although some of the implementation is slow as is the case of the supply of the solar lights. Several people mentioned implementation partners of UN Women (Africare) and said they worked really well with them.	
50	**On collaboration and cooperation with other H4+ members** In the beginning, there were many arguments about why the smaller agencies should get any funding at all. UN Women have participated in H4+ meetings actively since 2015 and tried to host meetings and participate actively in convening to raise their profile in the group. They have received excellent support from other members in developing and implementing their programmes including for example: UNFPA chaired their procurement process for the solar suitcases; UNAIDS sat on the committee to select their implementing partners (Africare, etc.). WHO helped them identify the solar suitcases as an alternative to panels; other agencies helped them develop their proposals and sometimes, they do each other's work in the field if needed. The H4+ team has given a lot of support to the work of UN Women. It would be good to continue the partnership whether there is funding in the future or not. UN Women has made the case for increased community engagement and addressing cultural issues and despite having a smaller budget, UN Women contributes to the H4+ by co-chairing and getting involved in other ways.	UN Women, KII, June 1, 2016.

Area of Investigation 4: Innovation

Question Four: To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)?

a. **How do H4+ JPCS partners and health authorities and other stakeholders at national and sub-national level recognized potentially effective innovations in RMNCAH?**

b. **How is information on the success or failure of innovations supported by the programme gathered and made accessible to decision makers within and across H4+ JPCS countries?**

c. **What evidence indicates that successful H4+ JPCS supported innovations have been replicated across districts, at national level or in other programme or countdown countries?**

Assumption 4.1

H4+ JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+ JPCS, from practices in other H4+ JPCS countries or from the expertise and experience of key stakeholders at all levels.

	Information/data	Information sources
1	**Supervision and Kangaroo Mother Care (KMC)** Progress by September 2014: 11 KMC cases of which 11 babies gained weight and were discharged. Caregivers had a negative approach to KMC initially as they saw it as an added responsibility. **Continuous supervision has helped change that view and it is received better now.** Application of NASG in the health facilities was done 17 times for obstetric haemorrhage with success. "*Even a doctor from Grand Kru County hospital applied the garment after a post c/s haemorrhage with success*." Reported that there were 8 maternal deaths in 4 counties with causes: PPH (4); anaemia (3); obstructed labour (1). During the quarter, a total of 1,792 chlorhexidine gel were used on 1,797 newborn live births in 4 counties. 5 Babies did not get it because of stock out in Zwedru.	Standard Progress Report July – September 2014, Save the Children (Save the Children 2014c)

2	Save the Children (SCF) procured 60 NASG at 300 USD per item (total 18,000 USD) and 20,000 doses of chlorhexidine at 1 USD per dose (total 20,000 USD). Fuel and freight charges for clearance and delivery were 5,000 USD. 15,000 USD to KMC units in 4 hospitals and 8 health centres. 100 health facility staff trained in EmONC including the use of the NASG, KMC and post abortion care with stepdown training in 4 hospitals and 15 primary and secondary health facilities. SCF support included helping to **re-purpose TTMs** to accompany women to deliver in the health facility. They provided a transport allowance to TTMs at 10 USD per time. Funds were also set aside in this plan to document best practice (1000 USD).	Save the Children 2014 Annual Work plan Output 2.1 Liberia 1 Jan to 31 Dec 2014 (Save the Children 2014d)
3	SCF progress report in first trimester of 2014 notes that following training, 40 **NASG** were handed to the Country Health Team along with 5000 doses of **Chlorhexidine gel** for cord care. 157 adolescent pregnant girls were identified and counselled.	Save the Children, Progress Report, Jan-March 2014 (Save the Children 2014b)
4	MOHSW reports that six pregnant women's lives were saved in the period **through the use of the NASG**. Eight low birth weight or premature babies were admitted to KMC units and discharged home after successful weight gain. 2,047 babies received Chlorhexidine; 161 pregnant adolescent girls were identified and mobilised to attend ANC; 91 of the 157 pregnant girls identified in the last quarter delivered at health facilities in the reporting period.	Ministry of Health & Social Welfare Project activities April 1- June 30, UNFPA, 2014 (UNFPA 2014a)
5	**UNFPA report: Kangaroo Mother-Care (KMC)** • KMC units established in four referral hospitals in River Gee, Maryland and Grand Gedeh counties • 51 premature newborn deaths averted (lives saves) using KMC.	UNFPA, Substantiating the Gains in Maternal and Newborn Health in Liberia H4+ Annual Report, Liberia, February 2016 (UNFPA 2016d: 6)
6	**Kangaroo Mother Care:** There were a total of 40 low weight babies who were admitted at the KMC units in the 18 health facilities in the three H4+ counties; 13 in Maryland, 15 in Grand Kru and 12 in River Gee. There are huge challenges, as mothers do not want to stay in the KMC units for fear of who takes care of the remaining children in the homes and who will continue the farm work to provide food for the rest of the family members. Mothers are also complaining of the challenges for food in the units and are making continual appeals to UNFPA to provide food in the KMC units for mothers and children admitted at the units.	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k: 3)
7	**KMC** services were set up at four county hospitals. Eleven babies were admitted to the units. All gained weight and were discharged. When the KMC method was introduced, the reception by the caregivers was poor and they viewed it as an added responsibility. However, with	Save the Children, Standard Progress Report, September 2014 (Save the Children 2014e: 9)

	continuous supervision, these caregivers and service providers have become KMC friendly. Protocols on KMC have been distributed to the four Hospital KMC Units.	
8	**Referral system** See evidence in Assumption 1.4, #46 and 47 about the referral system and perceptions by communities that women no longer die in childbirth.	
9	**Anti-shock garment**: The anti-shock garments are a real innovation and having rolled them out in the south east counties they will start introducing them in the north west as well. They are both an innovation and a success from the H4+ programme. They do not solve maternal haemorrhage but they are one more way of supporting EmONC in a context where you need three, four or five different ways of addressing maternal emergencies in case some do not work.	UNFPA Country Team, KII, May 30, 2016.
10	**Anti-shock garments:** The use of the anti-shock garment has become wide-spread in the H4+ health facilities in the three counties as **staff have been trained to use the garments** to **save lives of mothers experiencing bleeding**. The garments are effectively being used by our trained staff for referring of pregnant women and postpartum mothers with obstetric haemorrhage. For the periods under review, there were a total of 34 mothers who were placed into the NASG garment and then transferred to hospital by ambulance; five in Maryland county, fifteen in Grand Kru and fourteen in River Gee county. The compliance and results were good as all of these mothers' **lives were saved with usage of the garments.**	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)
11	**Solar Panels:** Installed a solar panel in the health centre and linked it to a TV. In communities where there is no electricity, this attracted a lot of people to the clinic especially for an evening antenatal session and people could watch a TV programme they liked during the ANC clinic. UN Women provides the solar panels to the smaller facilities.	H4+ Quarterly Report, 1st Quarter, 2014 (H4+ 2014a)
12	**Lessons Learned and Best Practices** as judged by River Gee County Health Team: • The regular supplies of **mama and baby kits** to health facilities increased health facility deliveries • The use of **chlorhexidine** gel has minimized neonatal sepsis • The utilisation of **KMC** for the management of pre-mature and low weight (<2.5kg) babies • The distribution of family planning commodities by **gCHVs** in catchment communities increased family planning uptake	River Gee County Health Team presentation of H4+ Programme, April 26 2016.

	• TTMs **referral of pregnant women for ANC** visits and facility delivery increased ANC and facility delivery • **Adolescents peer group educators** advocating on adolescence sexuality rights • The provision of **performance-based incentives** for health workers to maintain 24/7 service delivery for pregnant women and new-borns at six project facilities • Provide performance- based incentive for gCHVs and TTMs to promote utilisation of facility-based maternal and newborn health services and infection prevention control • Implementing partners working closely in partnership with the County Health Team and letting the CHT take a lead in decision making to enhance project implementation and creating a sense of ownership of the projects • **Women and men's groups** meetings discuss family planning issues at community level • Support to **HMIS** for data collection to have accurate and timely data.	
Assumption 4.2 *H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.*		
	Information/data	**Information sources**
13	**Supervision and coaching for KMC:** The reproductive health supervisors together with the County Health Team Conducted joint quarterly supportive supervision, and coaching of service providers at 18 project facilities of health care providers trained in KMC, partograph, and other key EmONC skills including postpartum and method-mix family planning in the three counties. The outcome of the supervision was that health staff did not enter information correctly in the reproductive health ledgers in three of the eighteen health facilities supervised. As part of their support to the clinics, corrections were made and the ledgers were updated.	H4+ Draft Annual Report, H4+, 2015.
14	**Kangaroo Mother Care:** Protocols on KMC have been distributed to the four Hospital KMC Units	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)
15	37 health care providers (M-23, F-14) in the six H4+ facilities were coached in **KMC care**, partograph and other key EmONC skills with six scratch cards provided, one at each facility and per diem for 20 supervisory team members during the exercise. It was also observed during	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)

	the exercise, that five staff members were not part of this EmONC training last year so they needed extra time.	
16	Training was provided for **KMC**. SCF provided training for 100 health facility staff (certified midwives, registered nurses, physician assistants and licensed practical nurses) – on EmONC, including NASG and KMC (in four hospitals and fifteen secondary health facilities).	Annual Workplan, Save the Children, December 31, 2014 (Save the Children 2014a: 9)
17	**Training for solar suitcases** Trained teams of women, including illiterate women, to set them up in the health facility and train health teams to do the maintenance.	UN Women Country Team, KII, June 1 2016.
18	Support given to nurses and midwives through **supportive supervision** sessions (e.g. at Sasstown Health Centre) to use the **NASG**.	UNFPA supervision trip report to Sass Town (no date but presumed 2015).
19	Having delivered 1,792 doses of chlorhexidine to newborns in the period July-Sept 2014, there are now **reports that chlorhexidine is out of stock** in ten of eighteen H4+ facilities. The RH Supervisor and the focal person for Chlorhexidine in Monrovia were informed, and orders have been placed.	UNFPA Standard Progress Report IP Save the Children 1 April to 30 June 2015 (UNFPA 2015c)
20	Application of **NASG** in the health facilities - 17 times for obstetric haemorrhage with success. "*Even a doctor from Grand Kru County hospital applied the garment after a post c/s haemorrhage with success*". Reported that there were eight maternal deaths in four counties with causes: four with post-partum haemorrhage; three from anaemia; one with obstructed labour.	Save the Children, Standard Progress Report to UNFPA, July to September 2014 (Save the Children 2014c)
21	**What did not work in terms of innovation** was using an app to follow women to the clinic and see which women went to the clinic to deliver. The app failed because there was no mobile network coverage. Without that, a paper system was deemed inappropriate. Who would follow the paper trail and be the custodian of the process? It was not clear so the idea was abandoned.	UN Women Country Team, KII, June 1, 2016.
22	**The introduction and piloting of tricycles in the programme (and in Liberia) has been well documented: Tricycles usage** In order to support and strengthen county-level supply chain management systems, three tricycles were supplied to the three CHTs. These tricycles are currently being used to move reproductive health commodities, family planning commodities and other supplies to more than six health facilities in the three counties that were identified and selected by the CHTs and Save the Children. However, the use of tricycles in rural Liberia is not effective and is very challenging due to the bad road conditions. The tricycles are not used during the wet/ rainy season as roads are not easily accessible even by a strong four-wheel drive.	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)

Assumption 4.3 *H4+ partners and national health authorities agree on the importance of accurately and convincingly documenting the success or failure of supported innovations and put in place appropriate systems for monitoring and communicating the results of these experiments.*		
	Information/data	**Information sources**
23	Innovations, such as **KMC, NASG and Chlorhexidine 7.1%** can be showcased to inform of efforts being made by the UN Agencies to address the issues of maternal mortality and to stimulate others to adapt or scale up such innovations.	H4+ Heads of Agencies Meeting, Minutes of meeting, April 16 2015 (H4+ 2015l)
24	The H4+ Annual Report mentions **the challenges of ensuring effective implementation of KMC**; *"… there are huge challenges as mothers do not want to stay in the KMC units for fear of who takes care of the remaining children in the homes and who to continue the farm work to provide food for the rest of the family members."*	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)
25	**Evidence of learning and documentation of review / lessons learned (in this case, in the use of chlorhexidine)** Since the introduction of the chlorhexidine gel in the 18 health facilities for core care, there has been a big reduction in neonatal death as a result of neonatal sepsis. Only a few cases were reported from four other non H4+ counties where mothers applied chlorhexidine gel in the eyes of the infant thereby leading to blindness of five children. At present, a nationwide awareness exercise is due to take place before chlorhexidine can again be given the mothers to take home as it is currently being applied ONLY at health facilities by skilled attendants and by trained gCHVs in the 18 H4+ health facilities.	H4+ Draft Annual Report, H4+, 2015 (H4+ 2015k)
26	H4+ country partners mentioned innovations and their interest in documenting them and sharing experience with other H4+ countries. However, it is difficult to find time.	H4+ Evaluation reference Group presentation to the evaluation team, 31 May 2016 (H4+ 2016c)
Assumption 4.4 *National health authorities are willing and able to adopt proven innovations supported by H4+ JPCS and to take them to scale. They have access to required sources of financing (internal and external).*		
	Information/data	**Information sources**

27	**Referral process:** The Ministry of Health has plans to recruit and pay community health assistants, a whole **new cadre of health worker**, which will help take the referral mechanism to scale. The new community health assistants will be paid a small salary. The H4+ Core Team, particularly TWG to seek the opportunities to buy into ongoing national health development initiatives such as the plan to increase health staff on government payroll to address **human resource concerns**.	H4+ Heads of agencies meeting minutes, September 16, 2015 (H4+ 2015d)
28	Community Health Assistant Programme. From the MoH Plan: ***"Vision*** *The MOH's vision for Liberia's National Community Health Services is a coordinated national community health care system in which households have access to life-saving services and are empowered to mitigate potential health risks.* ***Overall Goal*** *The overall goal of the Revised National Community Health Services Policy is to extend the reach of the country's primary health care system via an integrated and standardized national community health model that can provide a package of essential life-saving primary health care services and epidemic surveillance within communities and to households on an equitable basis.* ***Objectives*** • *To create an enabling environment for effective implementation and governance of the NCHS Policy* • *To establish a productive and motivated national community health workforce that is fit-for-purpose and able to deliver quality community health services*	Ministry of Health, National Community Health Services, Strategic Plan, 2016-2021, Liberia, 2016 (MoHSW 2015c)

	• *To implement performance, quality assurance, and quality improvement systems* • *To ensure the provision and utilization of a standardized package of community health services* • *To ensure a functional community supply chain, fully integrated into the national system and extending to the community level, that consistently provides safe essential medicines, medical supplies, and logistics* • *To collect, analyse, and report timely, quality information on the implementation and effectiveness of the Community Health Program"* ***<u>Maternal and newborn responsibilities:</u>*** ***"A. Reproductive Health*** *i. Family planning promotion, counselling, and service provision; referral for additional family planning counselling and services where needed* ***B. Maternal and Neonatal Health*** *i. Antenatal Care (ANC)* *a. ANC education and promotion and referral to health facilities for ANC visits* *b. Identification of danger signs in pregnancy and referral to health facilities* *c. Referral to facilities for deworming tabs, pre-natal vitamins and Insecticide-Treated Nets (ITNs)* *d. Birth planning and preparedness, including education on items needed for delivery and birth spacing* *e. Awareness on elimination of Maternal-to-Child Health Transmission of HIV (eMTCT) and referral to facilities for identified HIV positive mothers (collaborate with HIV/eMTCT officers where available)* *f. Treatment of malaria* *ii. Home-based Maternal and Newborn Care* *a. Post-partum home visits* *b. Well-being check for mother and newborn* *c. Identification and referral for maternal danger signs.* *d. Identification and referral for neonatal danger signs.*	

	e. *Counsel about danger signs for mother and newborn, the need for prompt recognition and care-seeking, and advise on where to seek early care when needed* f. *Promotion of essential care of the newborn and essential nutrition actions, including exclusive breastfeeding, supportive counselling, and troubleshooting of breastfeeding problems, and referral when needed* g. *Promote hygienic umbilical cord care, including chlorhexidine application, and skin care* h. *Support for Kangaroo Mother Care (KMC) application* i. *Identify and support newborns who need additional care (e.g. Low birth weight, sick, HIV-positive mother)* j. *Provide birth spacing and family planning counselling* k. *Promote birth registration and timely vaccination"*	
29	**NASG**: The ERG presented the NASG as an innovation and planned to take the NASG to scale. The first stage would be to roll it out to the next three H4+ counties (Grand Kru, Cape Mount and Gbarpolu Counties) with an ultimate ambition to integrate NASG into national policy.	H4+ Evaluation reference Group presentation, 30 May 2016 (H4+ 2016d)
30	**Solar Suitcase**: The provision of the solar suitcase is viewed as an innovative intervention and can be used in different terrains. The devise can be used in an emergency (for example, to provide light for a caesarean section) and also at night time for deliveries. The solar suitcase is simple to install and use. An assessment was completed which identified a widespread need for electricity in health facilities and linked electricity (and lights) to a higher likelihood that women would attend the clinic in the evening/ after dark. As a local team can be trained to install and maintain the equipment, sustainability is more promising. 'We Care Solar' installed two solar units after training a local team (including all women, some of whom are illiterate) who can now – theoretically – train others. Plan to monitor how the solar units change effect attendance at the health facility. It remains unclear whether a systematic assessment of impact is planned. There are plans to link up with GIZ to do an additional programme proposal to install solar suitcases in a wider number of health facilities.	UN Women Country Team, KII, June 1 2016
31	H4+JPCS annual reports and other communications material **highlight successful innovations** for use by non-programme countries. The report is silent on whether innovations are shared and how. The report identifies innovations but not how they can be scaled up or transferred to other countries.	H4+ Annual Reports, 2015 and 2014 (H4+ 2014b, H4+ 2015k)

32	Heads of agencies encourage **showcasing innovations** such as KMC, anti-shock garment, and CHX 1.7% (chlorhexidine) in order to "*stimulate others to adapt or scale up such innovations*". The H4+ team plans to hold a meeting with parliamentarians to brief them on progress made and challenges. The note refers to a desire to be "*looking for synergies with neighbouring counties*" and the possibility of organising an opportunity to explore and learn from the Sierra Leone adolescent sexual and reproductive health ASRH programme. **Extension of innovation to other locations has been opportunistic and inconsistent rather than structured**: UNICEF provided 15 ambulances – 1 for each county – for maternal health support. Reference made to dire state of blood banks and roads and commodity shortfalls. Also noted that motorbikes are better than tricycles. Reference to WHO working on funding blood banks and neonatal units. Programme to consider supplying AG-100 motorbikes. As with previous HOAs meeting, no MoH or WB members in attendance.	H4+ Heads of agencies, minutes of meeting, April 16 2015 (H4+ 2015l)

Area of Investigation 5: Division of Labour and Value Added (Country Level)

Question Five: To what extent has the H4+ JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities? a. **Has the H4+ JPCS programme contributed to the development of effective and robust platforms and operational systems for coordinating support to RMNCAH at country level by the partners? Will these platforms and systems persist in one form or another beyond the period of programme funding?** b. **Do the resulting programmes of support to RMNCAH at country level make best use of the individual strengths of H4+ partners? Is there a distinguishable value added over the existing programmes of the H4+ partners?** c. **Do efforts at coordination result in collaborative programming which is more effective than separate initiatives?**		
Assumption 5.1 *H4+ teams at country level in collaboration with key stakeholders have established forums for coordinating programme action and division of labour in H4+ JPCS financed and supported activities in particular and in RMNCH generally.*		
	Information/data	**Information sources**
1	**Coordination with the national authority** (government). The H4+ country team has good relations with the Ministry of Health at a senior level. The team reports close coordination and a high level of collaboration. National health authorities report that the process of consultation and coordination of H4+ JPCS programming was effective in avoiding or eliminating overlap and duplication of efforts.	Evaluation Reference Group presentation to the Evaluation Team, May 31 2016 (H4+ 2016c)
2	**Collaboration between H4+ partners**: UN Women has received excellent support from other members in developing and implementing their programmes including UNFPA chairing their procurement process for the solar suitcases and UNAIDS sitting on the committee to select their implementing partners (Africare, etc.). WHO helped them identify the solar suitcases as an alternative to panels while other agencies helped them develop their proposals.	UN Women, KII, June 1, 2016.
3	The issue of "*de-concentration*" of services in other parts of the country as well as strengthening synergies between agencies is key as UN agencies work together.	H4+ Heads of Agencies Meeting Minutes, April 16, 2015 (H4+ 2015l)
4	**What are the issues related to coordination among the agencies of the H4+?** • Agency regulations differ, making integration and reconciliation of finances a challenge • Pulling together reports from several implementing partners and with different internal reporting structures for the different agencies • Agencies' regulation for the release of funding at the different levels	WHO Country Team, KII, May 30, 2016.

	• Competing priorities by Government, such that it can be difficult to choose what to do • M&E: Project Management Tool provided by headquarters is not user friendly even with training. It will probably be abandoned or completely revised.	
5	Implementation of H4+ activities in the county is done mainly by different **implementing partners** and is variable in quality. The County Health Team (CHT) thought the implementation of H4+ activities had not been well enough integrated into the county management system. For example, sometimes implementing partners would arrive into the county, deliver an input and leave without contacting the CHO and working with the CHT. CHT recommendations to the evaluation team: The **County Health Team** requires full involvement in the project. There are activities implemented without the county involvement (e.g. UNICEF WASH programme: the wells are currently not functioning due to the fact that they were not dug at an appreciable level for continued provision of water during the peak of the dry season. The CHT WASH team was not included in the implementation due to poor community entry by IPs).	River Gee County Health Team KII, 6 June 2016.
6	One H4+ representative said, "*working together is harder but better. It takes more time to work together but it is appreciated*."	UNFPA Country Team, KII, 30 May 2016.
7	"*We were providing **WASH** and some of the facilities really helped especially where children were in hospital – but WASH needs to be provided in ALL hospitals. One hospital had no water – so H4+ needs to do more for the provision of water in all hospitals – otherwise it will not function well. We were not constructing new wells – rather using existing ones. H4+ must make sure the right process is followed in the community… so this can happen*." Did you know the wells would not work in the dry season? "*Yes – but we requested a pump and drill*."	H4+ IPs, KII, June 1, 201
8	"**The importance of the enabling environment** *and how investments into decentralised governance, public service delivery capacity, public expenditure management are all important to ensuring services delivered through the H4+ can be sustained. But also, the road network, utilities and development generally is vital or even a pre-requisite to the delivery of sustainable health services*." "*The H4+ investment may build interest in doing more in the south eastern counties and eventually, demand will build to improve standards of living. Also, there is an equity issue and considerations about the people's right to health services."*	Swedish Embassy Team, Monrovia, KII, May 31 2016

	NOTE: This issue comes up again with regard to the way midwives have to travel only every 3-4 months to collect their salaries in Monrovia because there is no bank where they live. The trip takes days and nurses stay for several weeks or months and sometimes, once they are on the government payroll, they abandon their post. Having decent roads, banking and other local services would increase retention and certainly improve use of nurses' time.	
9	**WASH activities:** Assessment of the 18 health facilities in the southeast counties - ten out of the 18 selected based on funding availability and ensure water supply. Most facilities had adequate waste disposal and those that had existing wells were assessed for pumps, generators and other repairs to make them functional again. That said, several had no water in the dry season so the fix was not effective. They purchased a generator to pump water at one facility but the facility had no fuel for the generator. At another facility, a pipe broke and the health centre did not have a maintenance team or capacity/ resources for fixing it. They will start a process of discussing maintenance plans with implementing partners. 2014: Installed pumps and supplied generators for water pumping; Facilities that did not have water sources was replaced by boreholes; 2015: No funding for follow on work because the H4+ budget had not allowed that possibility (and then Ebola); 2016: An assessment of the facilities showed that the interventions done in 2014 were mainly no longer functional as there was no maintenance or budget for repairs. They are going back to work with the same ten health facilities for adequate water supply; they used different funding grants for provision of water supply to one of the eight facilities that was left out in the beginning.	UNICEF Country Team, KII, May 31 2016.
10	The duration of **stockout** of medicines and medical supplies at service delivery points minimised.	River Gee County Health Team presentation on implementation of H4+ Programme in River Gee County, April 26 2016.
11	The evaluation team conducted a tracer drug study in River Gee to assess availability of 5 tracer drugs including oxytocin, gentamycin, ampicillin, chlorhexidine and depo Provera since mid-2013 to April 2016. The results show periods of **stockouts** for all these drugs and some for long periods.	H4+ Facility River Gee Essential Maternal Drugs Tracer study (Annex 7) (H4+ 2016f)
12	**Stockouts** of essential medicines are reported frequently in quarterly reports (see 4.2 below on chlorhexidine). For example, the MOHSW report says that "*stock-outs of essential drugs, RH*	MOHSW Project Activities Report April 1 to June 30 2014 (UNFPA 2014a)

	commodities and equipment in almost all the supported health facilities attributed to inadequacy of top-up system and irregular distribution of near expiry products to address actual consumption needs at field level".	
13	The **essential maternal and newborn tracer drugs** are sometimes in stock and sometimes not. UNFPA supports the delivery of maternal health supplies through the National Drugs Service but at the moment, ampicillin, gentamycin, and chlorhexidine are out of stock in Fish Town. Most clinics had a small amount of chlorhexidine gel. all had oxytocin. No facilities had a full store of drugs (for example, no erythromycin anywhere and very uneven supplies of ampicillin and gentamycin). All have misoprostol but only one midwife (in Jarkaken) was found who actually used it regularly to treat post-partum haemorrhage where an initial dose of oxytocin had failed to stop bleeding. **Stockouts** are common. The team traced five drugs from mid 2013 to April 2016, some facilities record more stock-outs than others (for example, Fish Town, the referral hospital, had a high level of stock-outs in 2015). In Cheboken, there are no cannulas so patient IVs can only be done if the patient buys a cannula from the pharmacy. There was no sign of the tricycle purchased by UNFPA in Cheboken. It would be difficult to see how it could be used on the roads though. Motorbikes are much more appropriate.	River Gee facility observations and record by the evaluation team, June 6-8 2016
14	A trip report from field mission of a joint MOHSW and UNFPA team visit to the three South-East counties. The aim of this mission was to 'prepare implementation modalities' and also enhance the CHT's understanding of the H4+ project. Meetings with key stakeholders, county civil authorities, staff, CHV leaders from project clinics and catchment communities were held. • Supply of essential medicines and **medical supplies is sporadic** and inadequate. • There is a high quantity of expired, essential medicines and medical supplies (including spinal needles) and contraceptives (Microlut) found in the Maryland County depot. (Summarised from a field mission trip report • Huge quantity of condoms stockpiled under improper conditions in Grand Kru.	UNFPA, travel report summary, May 4 2014 (UNFPA 2014b)
15	"*Both men's and women's focus group discussions highlighted the lack of access to free medicine in the hospital as a cause of maternal mortality."*	Minutes to H4+ heads of agencies meeting, April 2 2014 (H4+ 2014d: 8)
16	Save the Children Fund paid incentives to **gCHVs, TTMs and health staff**. Since ending their programme in December, no incentives were paid and therefore examples of TTMs putting their own funds to work to support their own travel.	Health volunteers (TTMs and gCHWs), FGD, June 8 2016
17	"*Used the evidence from Ebola experience (that community health workers and others can be incentivised to do surveillance and contact tracing which greatly expands the reach of the health system) to try to create a wider network of **family planning** distributors. Trying to get the*	UNFPA Country Team, KII, 30 May 2016.

	Government of Liberia to agree to task-shifting so that CBDs could do injectables which so far is not allowed but would provide longer term continuity to women given HRH issues."	
18	H4+ develops its own data completion, verification, and validation and update of H4+ M&E framework with MoH team invited to join UNFPA M&E officer in the field.	TWG minutes 3 May 2016.
Assumption 5.2 *The assigning of activities and investments in support of H4+ JPCS programme goals in participating countries is based on both the distinct capacities and advantages of each H4+ JPCS agency in that country and the national and sub-national context for support to RMNCAH.*		
	Information/data	**Information sources**
19	New implementing partners have come to the south eastern counties and are working there now because the H4+ opened the way and showed it could be done and how.	UNFPA Country Team, KII, 30 May 2015.
20	**What do you do differently with the H4+?** Allows concentrated effort in particular areas by all partners; each agency does different things in the same location; coordination, activities are not duplicated. UNICEF activities include: PMTCT, adolescent health, and WASH.	UNICEF Country Team, KII, May 31 2016.
21	UNFPA support through Save the Children International experienced **delayed fund transfers and delayed signing of an agreement**. Other issues noted such as "*Internal control for financing is not consistent with UNFPA*" and "*Save the Children's reporting system does not match with UNFPA reporting timelines in terms of report submission*".	Trip report to Sasstown by UNFPA for supervision.
22	**Helping babies breath – training for TTMS** Training for TTMs has included *helping babies breathe*, breast feeding practice, family planning and nutrition. The National H4+ Coordinator has said TTMs have been trained in child-care, family planning counselling and to escort the mother to the health facility. TTMs would like more training on the safe delivery (especially assisting with cases of difficult birth), using chlorhexidine and generally helping how to provide emergency support for mothers' needs, especially when babies are born "*on the road or on the way*" to the health facility.	Community Health Volunteers (TTMS and gCHV), KII, June 7-8 2016.
23	**Training and support for TTMs:** "*They (TTMs) said they now understand the management of care needed before, during and after pregnancy and how they should best help pregnant women. They have clear guidance for referral of a pregnant woman to the health facility and they would no longer try to deliver a baby outside the health facility*."	TTMs, FGD, Sinje, Grand Cape Mount County, June 2 2016.

<table>
<tr><td>24</td><td>Summary (training 2015) Training of Trainers: Support to training-of-trainers in south east Liberia for River Gee, Maryland and Grand Kru. There were 46 participants trained in home based maternal and newborn care for health professionals intended for participants to do a step down training for CHWs (accompanied by a MOH or H4+ person for back-up).
River Gee – 55 TTMs and CHWs trained;
Maryland – 75 TTMs and CHWs trained
Grand Kru – 45 TTMs and CHWs trained.</td><td>Summary of Training and Activities supported under the H4+ Jan-Dec 2015 (H4+ 2015n)</td></tr>
<tr><td>25</td><td>After UNFPA terminated its collaboration with Save the Children, meetings have been carried on with a member of the Country Health Team. However, peer educators do not receive incentives anymore.</td><td>Youth and adolescents, FGD, River Gee County, June 6-8, 2016.</td></tr>
<tr><td>26</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>Overview of H4+ Programme, Power Point presentation (up to 2016), May 30 2016 (H4+ 2016i)</td></tr>
<tr><td>27</td><td>Gains made by the facilities are hidden or not always identifiable, in part because there is no baseline and the facility data cannot capture community health status, especially as the H4+ efforts do not cover every facility in a district or every district in a county. Baseline data for all would help to see the progress and the impact of H4+.</td><td>H4+ ERG presentation to the evaluation team, May 31 2016 (H4+ 2016c)</td></tr>
<tr><td>28</td><td>Another issue raised is that there is one finance team and they cover three counties so cannot be everywhere at the beginning or end of the month. Also, delays in activities because neither the County Health Officer nor Acting in-Charge would sign the memorandum of understanding with Save the Children. There were also delays as the finance arrangements required finance officers to function, despite that there was only one team for three counties.</td><td>SCF, UNFPA Standard Progress Report, April to June 2015 (UNFPA 2015c)</td></tr>
<tr><td>29</td><td>Financial Progress (H4+ Coordinator Power Point Presentation, slide 12)

<table>
<tr><th>Agency</th><th>Funds received</th><th>Expenditure</th><th>Fund Utilization (%)</th></tr>
<tr><td>WHO</td><td>2,490,890.00</td><td>1,605,769.00</td><td>64.5%</td></tr>
<tr><td>UNFPA</td><td>2,061,600.00</td><td>1,799,052.00</td><td>87.3%</td></tr>
<tr><td>UNAIDS</td><td>217,806.00</td><td>343,902.03</td><td>157.9%</td></tr>
<tr><td>UNICEF</td><td>931,800.26</td><td>608,859.63</td><td>65.3%</td></tr>
</table></td><td>H4+ Country Team presentation to the evaluation team, May 30 2016 (H4+ 2016b)</td></tr>
</table>

	UN WOMEN	1,008,700.00	962,475.20	95.4%		
	Total	$6,710,796.26	$5,320,057.86	79.3%		
30	**Funding flow issues**: In 2015-16, all H4+ Sida countries will receive funds against the approved workplan in two tranches. The first 60 percent (4.2 million USD) of the approved budget will be released by March 2015, which in Liberia includes an additional 60 percent of the 2 million USD given to Liberia as part of the Sida grant to Ebola affected countries. The remaining 40 percent of both grants (2.8 million USD) is to be released after the utilisation of the first tranche. If the first tranche is unspent, the H4+ HQ group will determine how to spend the funds.					H4+ TWG, meeting minutes 26 Jan 2015 (H4+ 2015j)
31	Grant is for three years but "*specifically two years and three months starting now*".					WHO letter to H4+ supported county superintendents 30 July 2013 (WHO 2013)
32	Also to assess the timeline and cost implications of **channelling funds** from Sida to UNFPA, from UNFPA to agencies' HQ, and then to the field. [NOTE: No records were found as to whether this was ever done]					Minutes of H4+ heads of agencies meeting 12 March 2013 (H4+ 2013b)
33	**Pass through agreement** signed between UNFPA and participating agencies shows 1% pass through 'fee' to UNFPA and a further 7% for indirect costs. All other costs will be recovered by agencies as direct costs.					Standard memorandum of understanding (MOU) for multi-donor Trust Funds and Joint Programmes using Pass-Through Fund Management.
34	A support cost rate was agreed with Save the Children of 12 percent on a grant of 869,308 USD in 2015 of which 414,308 USD was H4+ funds.					Save the Children 2015 Workplan to UNFPA, December 2014 (Save the Children 2014a)
35	**The rate of implementation stands at 72.7 percent**. Programme activities halted due to the EVD are now being implemented and this has largely contributed to the implementation rate to date with an increase of 48.3 percent since the mid-year review in May 2014. Financial information in the table below represents expenses incurred from mid-2013 to 31 December 2014, based on provisional expenditure reports. The table shows the following expenditure and percent of expenditure: • UNFPA - 1,180,650 USD (100%) • UNICEF - 311,846 USD of 478,918 USD (65%) • WHO - 596,808 USD of 1,217,976 USD (49%)					H4+, Liberia Annual Narrative Progress Report 2014 (H4+ 2014c) H4+ Sida Initiative Accelerating Progress in Maternal and Newborn Health Reporting Period: mid 2013 to 31 Dec 2014 (H4+ 2015h)

	• UN Women - 302,714 of 451,812 USD (67%) • UNAIDS - 184,854 USD of 216,262 USD (85%)	
36	**Why is funding for the county not sent directly to the County Health Team instead of the IPs?** The County Health Team stated that they would have preferred the programme to be implemented through the county itself to the extent possible. No one was sure why it was not done this way and whether this was policy or whether there is another impediment. After the war, partners said the country did not have the capacity to manage funding and that is when the use of implementing partners started. If the funding comes through the county instead of the IPs, with the provision of technical assistance from partners, it would be more efficient and would build capacity.	River Gee County Health Team, KII, June 6 2016
37	The Country Representative of UN Women … reflected on the **challenges faced by UN Women** in implementing one of their main activities, which is reflected in the results framework of the H4+ programme. She also mentioned how effects have been exerted in retrieval of funds for UN Women Liberia but have failed, which has created a serious setback. The information of transfer of funds for Liberia to another Country Office has adversely affected work being proposed. There is a huge shortfall of 396,566 USD out of which 234,000 USD is for the procurement, clearance, training and installation of the 26 solar suitcases. UN Women restructured its programmes and reduced the 234,942 USD gap to 140,000 USD to cover the payment for the 26 solar suitcases. Considering the urgency of the suitcases, UN Women solicited the country team to help mobilise the resources from other agencies to achieve full implementation.	Minutes of H4+ TWG and heads of agencies meeting, May 2 2016 (H4+ 2016h)
38	Week of 24-28 August 2015: a "*busy and frustrating week*" as collecting data from both county and facility levels for reporting to (UNFPA) RH specialist for the H4+ mid-term report and following up on Save the Children International. "*No activities for quarter three have been carried out or implemented by Save the Children International and CHTs" despite a series of phone calls and emails. SCI says it has* ***no money for Q3*** *and cannot implement any activities. RHFA collected stock of Chlorhexidine himself and delivered them to facilities in River Gee to avoid a stock-out.*"	H4+ Reproductive Health Field Assistant Weekly Updates from 24 to 28 August and from 30 August to 4 September 2015 (H4+ 2015f)
39	"*Constraints common to all countries identified as* ***delayed funding disbursement*** *(to countries), competing government priorities and prolonged International procurement. Eight of ten countries wanted no cost extensions beyond June 2016. Meeting purpose was to update H4+ participants on post 2015 issues; review joint programme implementation progress, take*	UN Women, trip report on attendance at the regional coordination meeting in Cameroon with 10 H4+ countries, 2015 (UN Women 2015a)

	*corrective actions for optimum utilisation of funds ("**augment pace of spend**"); and learn about the evaluation. The meeting documented best practices for effective implementation (detail not noted specifically). Progress with H4+ identified as contributing to on UN programming. All **countries reported better relationships/ collaboration with governments**. Weaknesses included **inadequate documentation of programme implementation** across all countries. Only 10% of countries conducted triangular and south-south collaboration initiatives. Countries **encouraged to share best practices** with each other and work with them to take on those practices where necessary. HQ H4+ should clarify issues of fund transfer."*	

Assumption 5.3

H4+ JPCS partners have used structures and processes established for programme coordination at country level to rationalise their support to RMNCAH and to avoid or eliminate duplication and overlap in support. This trend is reinforced by increasing levels of coordination contributing to improved operational effectiveness and strengthened advocacy.

	Information/data	**Information sources**
40	H4+ coordinating team participated in an **orientation meeting** in Nairobi to review and plan to "*support the technical assistance needs of counties involved in implementing the SG's new Global Strategy in women's, children's and adolescents' health through the application of the Global Financing Facility created by the World Bank to support said implementation effort*". The workshop was designed also to support H4+ teams to help improve institutional capacity on the development of the investment cases on RMNCAH. It took place in Nairobi in March 2016. The outcomes listed include: • guidance to support national authorities to take meaningful leadership roles to develop the RMNCAH investment case • improved coordination and communication within H4+ family and country level to be able to provide UN harmonised and consistent guidance to national authorities and other partners • Utilisation of the one health tool for planning and data analysis purpose and comprehensive national RMNCAH investment case.	UN Women, mission brief and trip report Nairobi March 2016 (UN Women 2016)

41	"*Heads of agencies to follow up with the WB and the MoH to encourage them to participate in the meetings of the UN heads of agencies; MoH and H4+ and partners to hold a joint review meeting in the south east counties; parliamentarians to be invited*."	Minutes of heads of agencies minutes of meeting, September 16 2015 (H4+ 2015d)
42	**H4+ coordination:** Overall, coordination could be improved. In 2015, UN Women recognised "*potential duplication of activities (i.e.: overlap between UN Women and UNAIDS community engagement activities in the H4+ counties). This issue was resolved in a technical working group meeting but only by UN Women leaving out some of its community engagement activities rather than by expanding the scope of activities to a larger area".*	UN Women Country Team, KII, June 1 2016.
43	Each agency reported on early progress implementing the H4+. Group considers **August 2013 as start of implementation** and plans high level visit to south east counties in quarter two of 2014.	H4+ TWG Meeting April 16 2014.
44	Terms of reference for **the H4+ Coordinator** sets out functions as leading the TWG to collaborate with other actors in MNCH, ensure the H4+ project remains in line with the national strategic plan, mobilise resources for MNCH, liaise with non-UN partners working in MNCH to ensure complementarity and synergy. Also, knowledge management, and documenting emerging lessons learned. No other posts were formally funded but the H4+ was allowed to contract M&E assistance. UNFPA funded one part time M&E post. The post holder supported the different H4+ agencies to prepare their contributions to the annual reports.	ToR, H4+ National Programme Coordinator, 2013 (H4+ 2013c)
45	H4+ supported visit in July 22-26 anticipates an activity driven response rather than an agency driven response. [**Note**: all the reports, including minutes of meetings, are structured by agency rather than input or objective or output, and activities are structured by agency]. Anticipates role for regional inter-country support team and AFRO to mobilise technical assistance as requested by the WHO Country Office.	H4+ country support visit, Monrovia, Liberia 22-26 July 2013.
46	Liberia began working on a concept note in September 2012 and gathered in February 2013 to make more rapid progress. "*The group agreed to have a **single consolidated country plan/** proposal but with specified costed contributions/ activities per agency (agency specific budgeted actions within the one plan). This is in the spirit of one UN support to the government for MNCH.*" At this meeting, WB informed the chairperson it does not have a health focal point in country.	TWG H4+ meeting note for the record 21 February 2013 (H4+ 2013d)
47	Decisions taken during March 2014 retreat about formation of **routine meetings** (TWG monthly; heads of agencies + MOH quarterly) plus agreement in principle that visits to the field be done jointly to maximise use of time and resources. It was also discussed and agreed that agencies plan and conduct joint field visits as much as possible and agencies that are working	H4+ retreat March 17-24 2014.

	with IPs also make some **joint visits** with these IPs not leaving monitoring and supervision to them alone during the entire implementation period.	
48	Activities of each **H4+ partners identified and itemised**. Thus the H4+ gathers together a consolidated plan with operating principles/ **code of conduct around good partnership** behaviour (avoiding duplication, joint travel, joint meetings etc.). [**NOTE**: Code of Conduct not seen]	H4+ retreat March 17-24 2014.
49	This UNFPA report presents achievements against the six major outputs. It provides some quantitative detail. **Coordination strengthened at all levels** through logistical and technical support to central MOH, CHTs and community levels. For example, RH coordination meetings have been decentralised from central to county and down-wards. Efforts are ongoing to cascade this initiative down to the community level to empower the health facility officer-in-charge to take charge of issues in maternal and newborn healthcare. • Supported RHTC meetings, 30 at county level (10 in each county) and 4 at central level through provision of fuel, communication cards and motivational incentives • Donation of two trucks, 4x4 Toyota Land Cruisers, to support monitoring and supervision as well as trainings at various levels • Supported advocacy on MNH at county, district and community levels.	Substantiating the Gains in Maternal and Newborn Health in Liberia H4+ Annual Report 2015 (H4+ 2015m)
50	**Technical Working Group Meetings**: minutes show attendance of WHO, UNFPA, MoH, UNCEF and UN Women.	WHO H4+ TWG meeting minutes, May 9 2016 (WHO and H4+ 2016)
51	**Meetings held:** 8 H4+ Technical Working Group meetings 3 heads of agencies meetings 1 planning retreat (July 2013) 1 high level national advocacy meeting (August 2013) 1 high level national advocacy meeting (June 2014 4 international meetings among agencies attended 2 Regional / HQ mission team received in July 2013 and April 2016	ERG presentation to the evaluation team, H4+ May 30 2016 (H4+ 2016b)

Area of Investigation 6: Value Added in Support of the Global Strategy

Question Six: To what extent has the H4+ JPCS contributed to accelerating the implementation and operationalisation of the Global Strategy and the "Every Woman Every Child" Movement"? **a. To what extent has H4+ JPCS contributed to more effective advocacy for international and national commitments to operationalize Global Strategy principles and accelerate actions to strengthen RMNCAH investments and systems?** **b. During the life of the programme, how well did the H4+ partners support existing global structures (for example, the PMNCH, the iERG, the Commission on Information and Accountability) for supporting action in RMNCAH?** **c. As programme funding ends, to what extent can the lessons learned in implementing H4+ JPCS inform the work of the H4+ partnership, allowing it to better contribute to energizing global structures and processes in support of the Global Strategy 2.0**	
Assumption 6.1 *The establishment of H4+ JPCS in 2011 and its expansion in 2012 helped strengthen the rationale for and extent of policy support for coordinated action in RMNCAH at global, regional, national and sub-national level by the H4+ agencies.*	
Information/data	**Information source**
1 **Sustainability of the programme results achieved include:** • Capacity building of local institutions • The development of laws and policies to ensure access to, and delivery of, quality SRMNCH services • Sensitising stakeholders and developing buy-in at central and district levels • Integrating/ coordinating H4+ efforts with those of other national initiatives • Ensuring up-to-date technical quality of materials for training and strengthening service delivery systems.	H4+ Liberia Country Team, Annual Narrative Progress Report 2014 (H4+ 2014c)
2 **Programme achievements listed as:** <u>Policy level</u>: • Advocacy with MOHSW, health partners, Parliament and line ministries • Programme management and monitoring capacity at the reproductive health division of the MoH strengthened – 1 laptop, Internet gadgets and subscription, stationery, communication support and 1 4x4 high-top vehicle to support supervision	H4+ Liberia Country Team, Annual Narrative Progress Report 2014 (H4+ 2014c)

	• Supported the MoH health regulations and training institutions to develop review and revise SRMNCAH policy document and conduct PMTCT and supply chain bottle neck analysis to inform policy decision making • Programme indicators integrated in national HMIS. <u>Programme level achievements</u>: • Maintenance system instituted alongside referral and water system provided in programme supported counties • Radios installed in all programme health facilities to enhance referral programme counties • MDSR introduced • Available health care providers trained through the national MoH • Skills laboratories materials according to training institutions needs and specification provided • District and community leadership and parliamentarians mobilised to support and participate in programme implementation • Provided essential medicines and medical materials in support of EmONC through the national supply chain. • County, district, and health facility management capacity build to ensure monitoring mentoring data collection analysis and interpretation for decision making at their levels • Community capacity building to identify and address SRMNCH issues at their level • Initiated media networking at county and community levels for continuous mobilisation and sensitisation mitigate socio-cultural barriers on accessing essential SRMNCH services.	
3	**Policies and Guidelines** Supported by H4+ 2013-2015: • EmONC needs assessment and training strategy • MNDSR assessment and data collection/ MNDSR review • National and county MNDSR committees formed + 18 community based committees • Revised PNC guidelines adapted and rolled out • National Adolescent And Youth Reproductive Health Strategy and training materials developed • Revised WHO National HIV Guidelines (Option B+) and paediatric ART • Prevention of mother to child transmission communication strategy developed • Draft RMNCAH Investment Case	H4+ Monitoring and Evaluation Report 2015 (H4+ 2015e)
4	RMNCAH policy, protocols, MNDSR guideline and protocol, adolescent programme training manual, job aids, preservice midwifery curriculum:	H4+ Monitoring and Evaluation Report 2015 (H4+ 2015e)

<table>
<tr><td></td><td>Progress: Revision began in 2014 but was not validated for production due to the EVD outbreak. The validation was finally done in 2015 and is being used in programme facilities. Mass production for dissemination and distribution nationwide is ongoing.</td><td></td></tr>
<tr><td>5</td><td>From the 2015 monitoring report:
“3.1 Proportion of health facilities reporting no stockout of selected essential medicines for mothers (oxytocin, misoprostol, contraceptives, HIV tests, magnesium sulphate) during the last three months
3.2 Proportion of health facilities reporting no stock-out of essential medicines for newborns (bag and masks, suction devices, training manikin) during the last three months
4.1 Proportion of health care workers trained (with adequate skills and knowledge according to national norms) to provide EmONC services in the targeted districts during the last 2 years
4.2 Proportion of active community health workers/village health workers trained on community-based RMNCH services, including essential newborn care in the targeted districts during the last two years.”
<table>
<tr><td></td><td>2013</td><td>2014</td><td>2015</td><td>2016 targe</td></tr>
<tr><td>Target 3.1</td><td>47% (8/18)</td><td>83% (16/18)</td><td>67% (17/26)</td><td>90%</td></tr>
<tr><td>Target 3.2</td><td>47% (8/18)</td><td>83% (16/18)</td><td>88% (22/26)</td><td>90%</td></tr>
<tr><td>Target 4.1</td><td>32% (23/72)</td><td>144% (104/72)</td><td>170% (214/126)</td><td>100%</td></tr>
<tr><td>Target 4.2</td><td>0</td><td>50% (75/150)</td><td>64% (175/275)</td><td>90% (248/27</td></tr>
</table></td><td>H4+ Monitoring and Evaluation Report 2015 (H4+ 2015e)</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="3">Assumption 6.2:</td></tr>
</table>

By providing targeted funding for global activities (and funding the coordinating office) H4+ JPCS programme funding facilitated the development of knowledge products and joint, coordinated advocacy in RMNCH by H4+ agencies which would not have otherwise been undertaken.		
	Information/data	**Information source**
6	**Global knowledge products** identified which can be linked to policy and advocacy outputs described under Assumption 6.1: • Toolkit for RMNCH strategic planning, implementation, monitoring and review (WHO, 2012) • RMNCH policy compendium developed (WHO, 2013) • Technical guidelines for maternal death surveillance and response (WHO 2013) • Compilation of WHO recommendations on MNCAH (WHO, 2013) • Development of the list of essential life-saving commodities/equipment for MCH/FP by the UN Commission on Life Saving Commodities with H4+ input (UNICEF 2013) • MNDSR sub-regional workshops (WHO 2014) • Midwifery Services Framework developed and CHW RMNCH training guidelines (UNFPA 2014) • RMNH training guidelines developed. A mapping of existing training tools for CHWs in SRH/MNH (UNFPA 2013) • Core competencies for adolescent health and development for health care providers in primary care settings published (UNFPA 2015) • Template for documenting innovations (UNFPA 2015) • Zero Discrimination in Health Care and Putting Human Rights on Fast Track (UN Women 2014) • Every Newborn Action Plan.	H4+ Global Coordinator, *RMNCH Global Knowledge Products and Global Public Goods (2011-2015)*, June, 2016 (H4+ 2016g)
Assumption 6.3 *H4+ partners, assisted by programme funding, were able to be more effective in advocating for commitments to Global Strategy principles and priorities than they would have been without programme support. Their communications and advocacy work was made more consistent through collaboration on common products.*		
	Information/data	**Information source**

7	**Key Elements of the Global Strategy** • Country-led, costed health plans supported by all partners • Comprehensive, integrated package of essential interventions and services (family planning, ANC, PNC, EmONC, skilled delivery, prevention and treatment of HIV, IMNCI and nutrition) • Health systems strengthening (reaching the underserved and managing resources) • Health workforce capacity building • Coordinated research and innovation. • Accountability	UN Secretary General, *Global Strategy for Women's and Children's Health,* September 2010 (UN 2010: 7-8).
8	MoH has stated that improved coordination has strengthened H4+ partner **policy engagement and advocacy** at a senior technical level more coherent and effective. The H4+ Coordinator was a ministry technical staff member before joining WHO to coordinate the H4+ JPCS.	KIIs with H4+ Country Team, May 2016. KIIs with senior MoH officials, June 2016.
9	It was difficult at the beginning of the H4+ programme with different H4+ agencies communicating with the ministry. This took some time to alter but eventually did improve. **Coordination was weak** and the H4+ agencies took some time to start coordinating their approach and to act in a joined-up way. H4+ partners now apply for some funds together as a group (although not always as a group of five or six). For example, UNFPA, UNICEF and WHO applied for funds from the global Maternal Health Fund and successfully attracted one million USD to be divided as: • UNFPA 650,000 USD • UNICEF 200,000 USD • WHO 150,000 USD.	H4+ Country Team members (UNFPA, WHO, UN Women) KII, 31 May 2016.
10	Examples of areas where **strong common agreement** was reached and supported by H4+ at national level based on their joint working: • Targeting the hardest to reach and most neglected counties that had little other major donor support • Targeting underserved populations, particularly adolescents and youth • The need to strengthen the MNDSR system (for example by establishing a national MNDSR committee as well as county and local committees) to improve accountability for results • The need to strengthen the HIV and AIDS response for women and children including better PMTCT services, expand the number and quality of paediatric ART sites. • The need to increase the effective response to obstetric fistula • The need for better supportive supervision and training follow up	MoH senior staff at Director and County level, KII, June 2016. H4+ Country Team, KII, 30 May 2016.

	• The need to build up a range of options to deal with maternal health emergencies including effective management, functional referral, innovative interventions to manage a crisis like the NASG.	

Assumption 6.4

Where H4+ JPCS has contributed to improvements in service quality and access for RMNCAH these have in turn made a contribution to positive outcomes in RMNCAH including the targeted operational outcomes of the Global Strategy and "Every Woman Every Child".

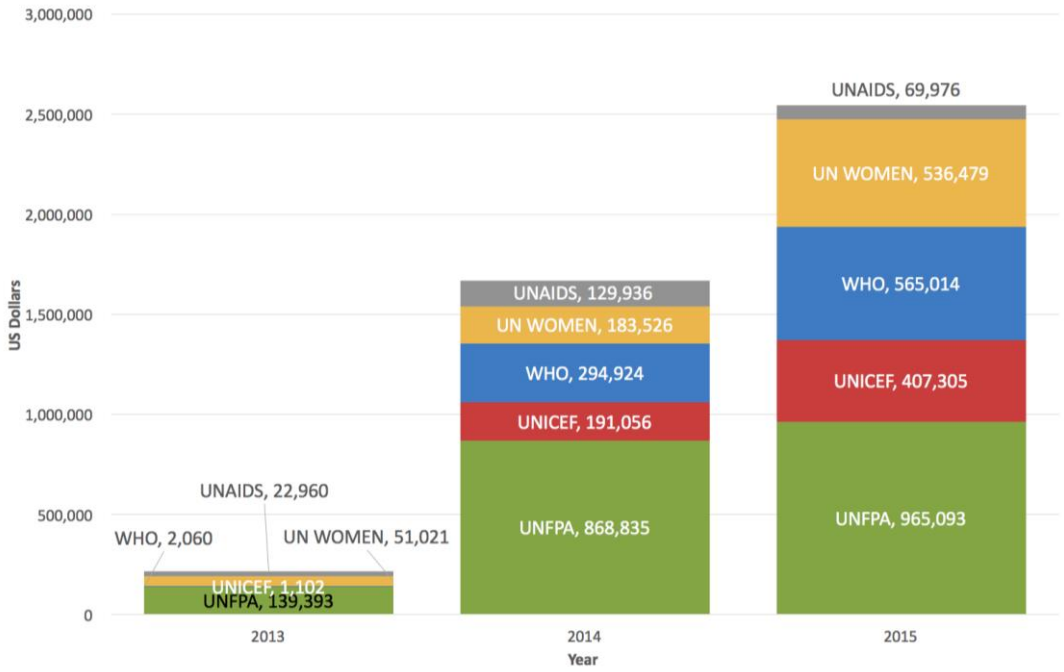
	Information/data	Information source
11	*"So far, while there has been good success, the story is fragile. Building health systems is not a one off job."*	H4+ Evaluation reference Group, KII, 13 June 2016.

ANNEX 2 FINANCIAL PROFILE OF H4+ JPCS IN LIBERIA

Table 9: H4+ JPCS Expenditures in Liberia

US$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	139,393	868,835	965,093	1,973,321	45%
UNICEF	0	0	1,102	191,056	407,305	599,463	14%
WHO	0	0	2,060	294,924	565,014	861,998	19%
UNWOMEN	0	0	51,021	183,526	536,479	771,026	17%
UNAIDS	0	0	22,960	129,936	69,976	222,872	5%
TOTAL US$	**0**	**0**	**216,536**	**1,668,278**	**2,543,867**	**4,428,680**	**100%**

Figure 8: H4+JPCS Expenditures by Year and Agency in Liberia



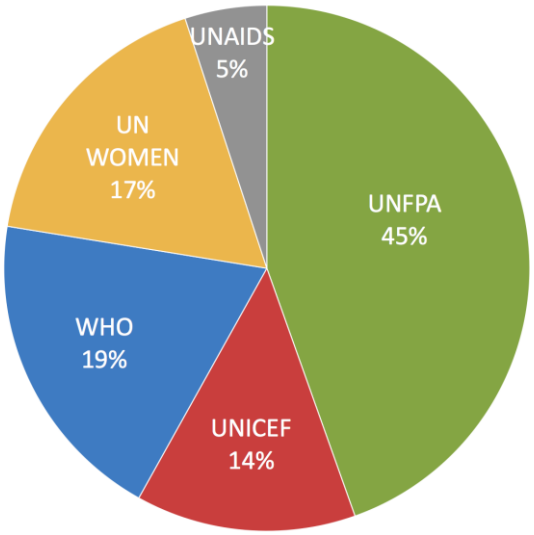


Figure 9: H4+JPCS Expenditures in Liberia: 2011-2015

Source: (UNFPA 2016)

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ANNEX 3 OUTCOMES IN RMNCAH

Liberia

Table 1: Basic info

Country income level	Low-income	
Population 2014	4.4 million	(World Bank 2016j)
Literacy rate 2007	42.94%	(World Bank 2016a)
Political/administrative system	15 counties, 90 districts	

Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2014	6.9%	(World Bank 2016d)
Total expenditure on health	Public	% of GDP, 2014	3.2%	(World Bank 2016e)
Out-of-pocket health expenditure	Public	% of THE, 2014	30.7%	(World Bank 2016i)
Out-of-pocket health expenditure	Private	% of PHE, 2014	44.8%	(World Bank 2016h)

Table 3: H4+JPCS Profiling Indicators 1990-2015

Indicator	1994	1999	2007	2011	2013	Source
Demand for family planning satisfied, % women age 15-49	-	-	24%	-	39%	(Countdown 2015a)
Indicator	**1998**	**2004**	**2006**	**2010**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	135	137	177	147	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Teenage mothers, % women age 15-19	…	…	32.1%	37.6%	31.3%	(World Bank 2016k)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	1,800	1,270	1,020	811	725	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	…	…	…	…	24	(Countdown 2015b)
Infant Mortality, per 1,000 live births	…	…	…	…	53	(Countdown 2015b)
Under Five Mortality, per 1,000	237.4	181.8	124.7	89.3	69.9	(Countdown 2015a)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	…	10%	11.4%	…	20.2%	(World Bank 2016c)
Indicator	**1995**	**2000**	**2007**	**2010**	**2013**	**Source**
Unmet need for contraception, % aged 15-49	…	…	35.7%	…	31.1%	(World Bank 2016l)
Indicator	**1995**	**2000**	**2005**	**2007**	**2013**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	-	-	66%	78%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	18.7%	31.5%	52.8%	52.0%	(Countdown 2015a)
Lower bound	<1%	16.4%	27.4%	45.8%	45.0%	
Upper bound	<1%	21.6%	35.8%	60.5%	59.9%	
Indicator	**1994**	**2000**	**2007**	**2013**	**2015**	**Source**
Skilled attendant at delivery, %	…	51%	46%	61%	…	(Countdown 2015a)
Postnatal care for baby, %	…	…	…	35%	…	(Countdown 2015a)
Postnatal care for mother, %	…	…	…	71%	…	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	…	35.4%	29.1%	55.2%	…	(Countdown 2015a)
Facilities providing BEmONC, number						
Facilities providing CEmONC, number						
C Section Rate, % of live births, women age 15-49	…	…	4%	4%	…	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	…	…	0.04	…	…	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	…	…	0.3	0.27	…	(World Bank 2016g)

ANNEX 4 PERSONS MET

H4+ Partners		
Asije, Anthony O Mr	Child survival specialist	UNICEF
Duworkor, Musu Dr	Reproductive Health Technical Advisor	WHO
Gobeh, Woseh Dr	National Program Officer RH	UNFPA
Karloweah, Ghoma Ms	Focal Person	UN Women
Kollie, Robert Mr	Communication Officer	WHO
Korvah, Steven Z Dr	PMTCT Specialist	UNICEF
Lincoln, Esther King Ms	H6 Focal Point	UNFPA
Livingstone, Maybe Ms	National Program Officer SRH	UNFPA
Mabanda, Dhogba Ms	Programme Officer	UN Women
Mambu, Andrew AZ Mr	FP Program Associate	UNFPA
Ogunlayi, Munirat Dr	Health Specialist	World Bank
Page, Hawa Ms	Adolescent & RH Program	UNICEF
Rogers, Edwin Mr	WASH	UNICEF
Sogunro, Oluremi Dr	Country Representative	UNFPA
Suwo, T Woibah Mr	M&E Officer	UNFPA
Tehoungue, Bentoe Z Dr	H6 National Coordinator	H6/WHO
Wei, Morris Mr	H6 Focal Person	UNAIDS
Widiati, Yolia Dr.	UNICEF	UNICEF

Ministry of Health (MoH)		
Clarke, Adolphus T Dr	Expanded Program on Immunisation	MoH
Dahn, Emmanuel YS Mr	Planning/ Monitoring and Evaluation	MoH
Gayson, Naney J Ms	Family Health Department	MoH
Gbanyan, Miatta Ms	Pool Fund Manager	MoH
Jallah, P Mr	Family Health Department	MoH
Katakpal, Emma Ms	Family Health Department	MoH
Katteh, Francis, Dr	Chief Medical Officer	MoH
Kerkula, Joseph L Dr	Director/Family Health Department	MoH
Kerkula, Jre S, Mr	Monitoring and Evaluation,	MoH
Mandainl, Y Mr	Family Health Department	MoH
Marpleh, Louise Ms	FARA Manager	MoH
Walker, Ruth Dr	Family Health Department	MoH
Washington, Musu Sr	Nursing Department	MoH
Wesseh, C Stanford Mr	Planning Department	MoH

National Implementing Partners	
Alladin, Janneh Ms	Liberia Women's Empowerment Network
Andrew, Necus Mr	Anti-AIDS Media Network
Barh, Lucy W Ms	Liberia Medical Association
Brown, Celestine Ms	Africare
Bundor, Tamba W Mr	CODES
Cooper, Stephen Mr	Africare
Dukuly, Abrahim Mr	Global Fund for the fight against AIDS, TB and Malaria

Ewing, Helen Ms	Clinton Health Access Initiative
Flomo, Cecelia C.K Sr	Liberia Board of Nursing and Midwifery
Gonleh, Cynthia Ms	Liberia Women's Empowerment Network
Kanneh, Foday Mr	Clinton Health Access Initiative
Korkpor, K Maigaet Mr	Africare
Mulbah, Zubah T Mr	National AIDS Commission
Nuahn, Helena L Prof	Jhpiego
Quiqui, Kula K Ms	Jhpiego
She, Z Momo Mr	Planned Parenthood Association of Liberia
Watkins, Solomon Mr	Anti-AIDS Media Network
Weah, Aaron Mr	Search for Common Ground
Zoegar, Edith ZM Ms	Liberia Women's Empowerment Network

Grand Cape Mount County

Grand Cape Mount County Health Office

Briggs, Simeon T
Bropleh, Wokle B
Cooper, LC, Dr (County Health Officer)
Godeon, James K
Jallah, Massayan K
Kaba, Mark M
Kallah, Timothy S
Kortee, Zoe PT
Kpedebah, Tenneh S
Kromah, Hakla K
Kromah, Hawa K
Massad, Janneh
Mewa, Marry
OSI, Michel
Patrick L Kamara
Sheriff, Sao
Shilling, V
Snch, N Teta
Tuma, Agustine
Wile, Abraham T
Zarbay, Gladys K

Sinje Health Center

Aerson, Naomi L
Kallah, Timothy S
Kamara, Patrick L, Dr
Snch, N Teta
Tokpa, Gbolu
Turay, Musuline H
Zawoo, Melvina T

Sinje Community

Canah, Mohammed	Pastor
Kiadii, Kason	District Commissioner
Kiadii, Lawrence B	Youth Leader
Kiazolu, Seaku	Elder
Perry, Siata J.	Town Chief
Queye, Mary	TTM
Safula Sonii	Women's Group leader

Sanko, Mary	TTM
Sonii, Mulielu	Town Elder
Sonii, Siafa	Elder
Toe, Dekey	TTM
Zolduah, Armah	Imam
River Gee County	
River Gee County Health Office	
Bpley, David N Sr	
Cassel, Euelyn M	
Chief James P. Sayee	
Dokie, Pharm George S. Jr	
Dwehswen, Bolton	
Gbanlon, Ellen M.	
Geleplay, Marthalyin T.	
Gramoe, Moses D	
Haluane, Nathaniel W.	
Hinneh, Benson G	
Huntington, Eugema T.Q	
Jackson, Hokie W.	
Jah, Leoma Kon Martor	
Kancemey, Komah G	
Karlea, Charles W	
Kenda, John S.	
King, Dr Detoh T	
Mooe, John B	
Morris, Malee Y	
Parker, Roger	
Quenneh, Benjamin	
S. Taryee Toe	
Sawo, Koiyan J.	
Sayee, Farley	
Seakor, George S.	
Shilue, Moses C.M	
Sinatue, Haevodotus	
Swen, Saylee	
Terry, N. Quayeton	
The, Henry W.	
Toe, Moses W	
Tulay, Anna T.	
Washington, Trokon, Dr	County Health Officer
Wesseh, Macfred Q	
Gbepo Health Center	
Florma, Geraldine W	
Haluane, Nathaniel W.	
Sumoku, Deddeh V.	
Tanyon, Bennim N.	
Tartue, Emily G.	
Wrueh, Vanessa Y	
Jarkaken Clinic	
Brown, Gary	
Choloplay, Curtis	
Doe, Robert B.	
Harris, Yamah	
Musus, Augustine	

Weah, Joseph	
Wesseh, Macfred	
Yangbie, James	
River Gbeh	
Konneh, Abu	
Mason, Mary	
Massaquoi, Gbondo Kebbeh	
Cheboken Clinic	
Doe, Victoria	
Grace	
Jackson, Hokie	
King, Getoe, Dr	
Mandia, Solomon	
Socro, Lynch	
Thomas, Samuel	
River Gee Communities	
Jarkaken	
Barfeh, Aasia	Community member
Chea, Prince B	Student
Chenakan, Easter B	Student
Cholopary, Deseyne	Youth Leader
Collins, Emmanuel N	Club Member
Davis, Henry N	Student
Davis, Jewel N	Student
Davis, Patience	TTM
Deagba, Easther T	Teacher
Doe, Patience	TTM
Dweh, Ewina	Women's Group Member
Dweh, Margretta	TTM
Dweh, Morris	Farmer
Dweh, William	Community member
Dwel, Briggsford N	Clerk
Elliott, Zedebee	Peer Educator
Freeman, Adam	Peer Educator
Geegba, Abigirl	Student
Harris, Florence	Women's Group Member
Harris, Sam W	Club Member
Jackson, Agnies	Student
Jebleh, Caroline M	Peer Educator
Jerbo, B Mclhdseleh	Disk Clerk
Joe, Gibson T	Student
Johnson, Myerlyn	Student
Jowah, Cynthia	TTM
Keh, Daniel	Clan Chief
Kenta, Jackie	Student
Martin, Blessing	TTM
Moore, Ahday	Student
Moore, Oretha J.	Peer Educator
Noring, Evon	Women's Group Member
Nyaun, Mercy J	Peer Educator
Nyefor, Sam	Community member
Nyenah, Sarah	TTM
Parse, Fulton S	Township Commissioner
Paye, Comfort	Student

Quayee, Mark	Student
Quie, Paul P	Peer Educator
Sagbeh, Amos	Community member
Saibo, George	Community member
Sankon, Mary T	Student
Sartee, Alice	Club Member
Seabo, Willie	Farmer
Tarwreh, Philomena	Student
The, Joseph W	Community member
Toe, Dekey	Student
Toe, Jeremiah	School Health Teacher
Toe, Jerryline	TTM
Toe, Joseph P	Farmer
Toe, Otis N	Student
Toe, Pbebe	TTM
Toe, Rita	TTM
Toe, Robert B	Farmer
Toe, Sylvester	Farmer
Waka, Louis S	Peer Educator
Waypo, Chebo	Township Chief
Weah, Joe T	Chief Elder
Weah, Joe T	Chairman
Weah, Verorica	TTM
Weal, Lawrence Q	Pastor
Wesseh, Peter W.	Peer Educator
Wesseh, Phillip	Community member
Wesseh, Terah T	Club Member
Winn, S Kpadeh	Township Clerk
Winn, Tina	TTM
Woart, Patience	Peer Educator
Wreh, Kelvin Jebleh	Peer Educator
Yegbh, Wilson	Club Member
Cheboken	
Batchea, Shad	Community Leadership
Billy, J. Dartyea	Chairman
Chenakah, Albert	gCHV
Chorkosr, Patrick C	Community Leadership
Martin, Marthe	TTM
Noring, Alice	Community Member
Noring, Victoria	Community Member
Nyenmah, Sophia	Community Member
Parley, Evon	Community Member
Quayee, Mancy	Community Member
Sackie, Esie	Community Leadership
Sankon, Johnson	gCHV
Sweh, Regina	Community Member
Swen, Diana	gCHV
The, Elizabeth	Community Member
The, Felecral	TTM
Toe, Rachel	Community Member
Toe, Rachel	TTM
Trullah, Oretha	Community Member
Wah, Harrison	Community Leadership
Weah, Ellen	TTM

Weah, Ruth	Community Member
Wesseh, Emily	Community Member
Wesseh, Mabel	Community Member
Winn, Elizabeth	Community Member
Yougba, Perry	Community Leadership
Yassaken (River Gbeh)	
Bolee, Thomas G	Community Leadership
Brown, Nungba	Community Leadership
Charles, Betty	Women's Group
Chelor, Elizabeh	Women's Group
Cooper, Elizabeh	Women's Group
Desuwah, Oretha	Community Leadership
Dweh, Janet	Women's Group
Fameh, Healen	Community Leadership
Freeman, Martha	Women's Group
Gbeh, Dorris	Women's Group
Hanwea, Timothy W.S	Community Leadership
James, Morris	Community Leadership
Kesseh, Alice	Women's Group
Koffa, Felecia	Community Leadership
Moses, Barehea K.	Community Leadership
Nagbe, Mark S	Community Leadership
Pah, Mary	Women's Group
Pan, Winstom	Community Leadership
Pawoo, Esther	Women's Group
Quayee, Lucy	Women's Group
Sampson, Ellen G.	Community Leadership
Sampson, Lucy	Community Leadership
Smith, Theresa	Community Leadership
Swen, Ezekiel D	Community Leadership
Tarkor, Paul C.	Community Leadership
Tarpeh, Josephus K.	Community Leadership
Togbo, Betty	Women's Group
Tolh, Victor	Chairman
Weleplay, Hamilton S.	Community Leadership
Wesny, Robert Y	Community Leadership
Wesseh, Dorris	Women's Group
Wobogbo, Janet	Women's Group
Wongbaye, Moses	Community Leadership
Youlo, Annie T.	Community Leadership
Youmeh,. Mark MB.	Community Leadership

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ANNEX 6: THE IMPACT OF EVD ON THE LIBERIA HEALTH SYSTEM: CAUSAL ASSUMPTIONS

As we have noted, Liberia was one of the countries hardest hit by the Ebola epidemic (EVD). The theory of change tries to identify how the EVD affected the delivery of the H4+ JPCS programme in Liberia.

Causal assumptions for understanding the effects of EVD on the H4+ Programme

1. H4+ partners, in a process led by national authorities and encompassing key stakeholders, are able to develop and implement a coordinated process and platform to adjust to the EVD outbreak in the three counties maximising flexibilities available in resources. H4+ continues to function in an integrated and coordinated way.

   (*Relates to area of investigation three: Responsiveness to national needs and priorities and area of investigation five: division of labour and coordination*).

2. H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unserved needs in the eight areas of health systems support (or seven in Liberia which has not focused on financing) before, during and in the wake of the EVD outbreak in the three counties. These include needs which are not fully met by other sources of support and, importantly, where programme support can build on investments and activities already underway.

   (Relates to area of investigation one: Strengthening health systems for RMNCAH).

3. H4+ JPCS support at national and sub-national level was timely during and in the wake of EVD with support to RMNCAH as needed. Support is timely and appropriate to conditions and includes all elements needed to achieve the result.

   (Relates to area of investigation one: Strengthening health systems and two: Expanded access to integrated services along the continuum of care).

4. H4+ JPCS support to capacity development before the EVD outbreak has continued impact after the outbreak is over (i.e. it has been sustained over time) so that it can effect access to quality services for marginalized groups. H4+ JPCS support addresses the three dimensions of sustainable capacity improvement before and after the EVD outbreak:

   - capability in terms of skills and supportive supervision;
   - opportunity in terms of the availability of adequate facilities, equipment and supplies;
   - incentives for provision of quality care.

   The reach of H4+ JPCS support is extended by identifying and implementing experimental innovative approaches to health systems support and the provision of quality care in RMNCAH.

   (Relates to area of investigation two: Expanded access to integrated services along the continuum of care and four: Innovation and scale up).

5. Demand creation activities and investments have sufficient resources, and are sustained enough over time, to make enduring positive changes in the level of trust between service users (especially including youth and adolescents and other members of marginalised groups in the community) and service providers. These investments and activities are not limited to

demand side interventions, but also aim to change the attitude and behaviour of service providers toward users in an effort to build mutual trust especially in the wake of the EVD outbreak.

(Relates to area of investigation two: Expanded access to integrated services along the continuum of care)

6. The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services, and to overcome barriers to access which existed in the past.

   The focus here is on the impact of EVD on the realisation of this level of performance. What combination of investments and capacity building has led to the achievement of outcomes and how did the EVD outbreak affect progress with this?

   (Relates to areas of investigation one: Strengthening health systems for RMNCAH; two: Expanded access to integrated services along the continuum of care; three: Responsiveness to national needs and priorities; and six: accelerated implementation of the Global Strategy for Women's and Children's Health).

The causal assumptions underpinning the innovation are below and correspond to the blue numbered boxes in Figure 5.

1 H4+ JPCS partners, in collaboration with national health authorities, are able to identify potentially successful and innovative approaches to supporting improved RMNCAH services. These innovations may be chosen from examples in global knowledge products supported by H4+ JPCS, from practices in other H4+ JPCS countries or from the expertise and experience of key stakeholders at all levels. They should respond to a pressing problem or challenge.

2 H4+ country teams have been able to access required technical expertise to assist national and sub-national health authorities to support the design, implementation and monitoring of innovative experiments in strengthening RMNCAH services.

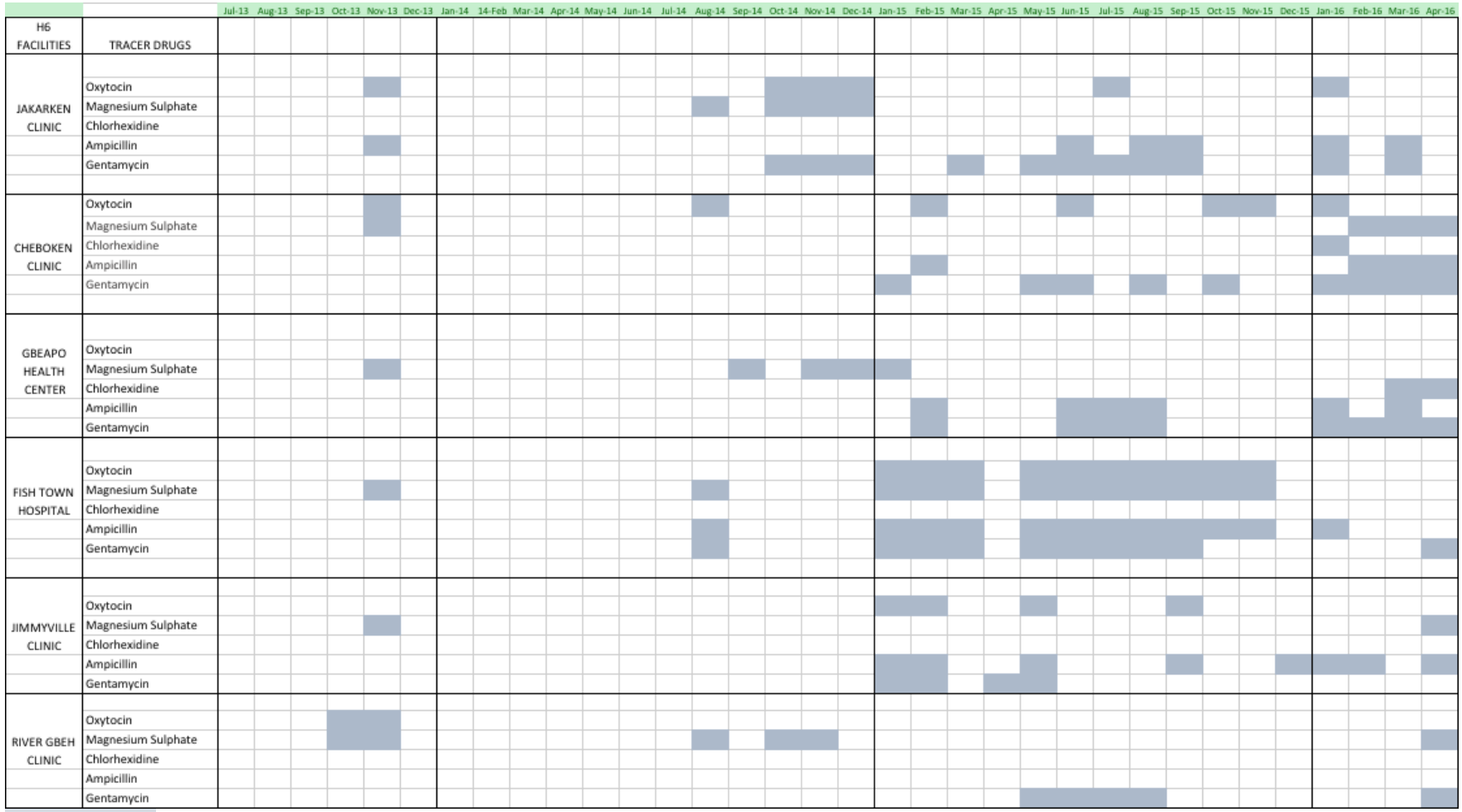
3 H4+ partners and national health authorities agree on the importance of accurately and convincingly documenting the success or failure of supported innovations and put in place appropriate systems for monitoring and communicating the results of these experiments.

4 National health authorities are willing and able to adopt proven innovations supported by H4+ JPCS and to take them to scale. They have access to required sources of financing (internal and external).

5 H4+ JPCS mechanisms for promoting successful innovations across the 10 programme countries and among non-programme countdown countries are effective.

6 Global knowledge products produced with support of H4+ JPCS incorporate examples of successful innovations for strengthening RMNCAH that can be adopted in non-programme countries.

ANNEX 7: STOCKOUTS OF FIVE TRACER DRUGS IN H4+ JPCS SUPPORTED HEALTH FACILITIES IN RIVER GEE COUNTY



Months during which there was a stock out reported the County Health Team. Data provided by the River Gee Pharmacy Department June 2016