



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	Ante Natal Care
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BEmONC	Basic Emergency Maternal, Obstetric and Neonatal Care
CATS	Community Adolescent Treatment Supporters
CBA	Community Based Advocate
CCM	Country Coordination Mechanism
CEmONC	Comprehensive Emergency Maternal, Obstetric and Neonatal Care
DBS	Dried Blood Spot Test
DHE	District Health Executive
DHIS2	District Health Information System Two
DHS	Demographic and Health Survey
EMG	Evaluation Management Group
EMNDSR	Electronic Maternal and Neonatal Death Surveillance and Reporting
EmONC	Emergency Obstetric and Neonatal Care
ERG	Evaluation Reference Group
ETAT	Emergency Triage Assessment and Treatment
GBV	Gender-Based Violence
H4+ JPCS	H4+ Joint Programme Canada Sweden (Sida)
HCC	Health Centre Committee
HDF	Health Development Fund
HTC	HIV Treatment and Care
HTF	Health Transition Fund
IEC	Information, Education and Communication
IMNCI	Integrated Management of Newborn and Childhood Illnesses
ISP	Integrated Support Programme
IYCF	Integrated Young Child Feeding
M&E	Monitoring and Evaluation
MDSR	Maternal Death Surveillance and Reporting
MNCH	Maternal Neonatal and Child Health
MNDSR	Maternal and Neonatal Death Surveillance and Reporting
MNH	Maternal and Neonatal Health
MoHCC	Ministry of Health and Child Care
MVA	Manually Vacuum Assisted
MWAGCD	Ministry of Women's Affairs, Gender and Community Development
MWH	Maternity Waiting Home
NGO	Non-Governmental Organisation
NIHFA	National Integrated Health Facilities Assessment
OPHID	Organization for Public Health Interventions in Development

PHC	Primary Health Centre
PHE	Provincial Health Executive
PLWHIV	People Living with HIV
PMD	Provincial Medical Director
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PoC	Point of Care
PPH	Post Partum Haemorrhage
RBF	Results-Based Financing
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
Sida	Swedish International Development Cooperation Agency
SRH	Sexual Reproductive Health
ToC	Theory of Change
VHW	Village Health Worker
VMAHS	Vital Medicines Availability and Health Services Survey
WAG	Women's Action Group
YFC	Youth Friendly Corner
YFS	Youth Friendly Services
ZDHS	Zimbabwe Demographic and Health Survey
QoC	Quality of Care

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 Zimbabwe, 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 by a document and telephone interview based case study. Nine of the ten programme countries were supported either by the Canada grant to the H4+ or by a grant from Sweden. Only Zimbabwe received funding from both.

1.1 Objectives of the field country case studies

The purpose of the field country case studies is to provide essential input useful to addressing six 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 level?
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. Together they cover all ten programme countries, which account for more than 80 percent of programme expenditures. By helping to answering the six evaluation questions, the country case studies serve to test the causal assumptions which underlie the programme theory of change (ToC). This in turn allows the study to credibly verify the programme contribution to results in RMNCAH.

1.2 Approach and methodology

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

¹ (UNFPA 2015c: 33-34)

H4+ JPCS developed during the inception phase of the evaluation.² The ToC for the programme in Zimbabwe is presented in Section three.

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 Zimbabwe.³

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 committee meetings; programme review and evaluation documents; monitoring mission reports, national plans and programmes in RMNCAH; and reports and documents produced by other bilateral and multilateral agencies supporting RMNCAH
- Review and profiling of quantitative data, including financial data on programme investments and data on results in RMNCAH indicators at national, provincial and district levels
- Key informant interviews with a wide range of stakeholders at national level (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 maternal waiting homes; 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 health workers (VHW) and community based advocates (CBA), and traditional leaders
- 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 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 EMG.

1.3 Nature of the field country case studies

It is important to recognise that each field country case study was not designed to serve as a stand-alone 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. The findings and conclusions presented in the note are based explicitly on the experience of the programme in Zimbabwe as assessed by the evaluation. However, the lessons learned, as presented in Section five, focus on the implications of those findings for the ongoing operation of the H4+ (now H6) partnership.

² (Global Affairs Canada, UNFPA et al. 2016: 11)

³ For a full discussion of the analytical approach and methodology used in End Line Evaluation see the *Inception Report*, Sections three and four (Global Affairs Canada, UNFPA et al. 2016).

1.4 Carrying out the field country case study in Zimbabwe

The country case study of the H4+ programme⁴ in Zimbabwe began with a review of key programme documents. This was supplemented further by a review of documents gathered during the exploratory and main evaluation missions in March and June 2016 (Annex 5).

A review of trends in quantitative indicators of outcomes in RMNCAH at national level (Annex 3) was carried out prior to the exploratory and main missions. This was supplemented with a review of indicators gathered from District Health Information System Two (DHIS2) data on the six target H4+ districts in Zimbabwe. The DHIS2 data was provided by the Health Information and Diseases Surveillance Unit of the Ministry of Health and Child Care (MoHCC) based on data provided by the Family Health Department.

Key informant interviews, site visits, and focus group discussions were carried out in two stages. The first was the exploratory mission carried out from March 7 to March 15, 2016. This included interviews with the H4+ country team members and key stakeholders in Harare (relevant directorates and units of the MoHCC, the Ministry of Women's Affairs, Gender and Community Development (MWAGCD), and non-governmental organisations (NGOs), along with implementing partners. The exploratory mission also included interviews at the Provincial Health Executive (PHE) for Manicaland, as well as with the District Health Executive (DHE) staff, staff of hospitals and health centres and community groups in Chipinge district.

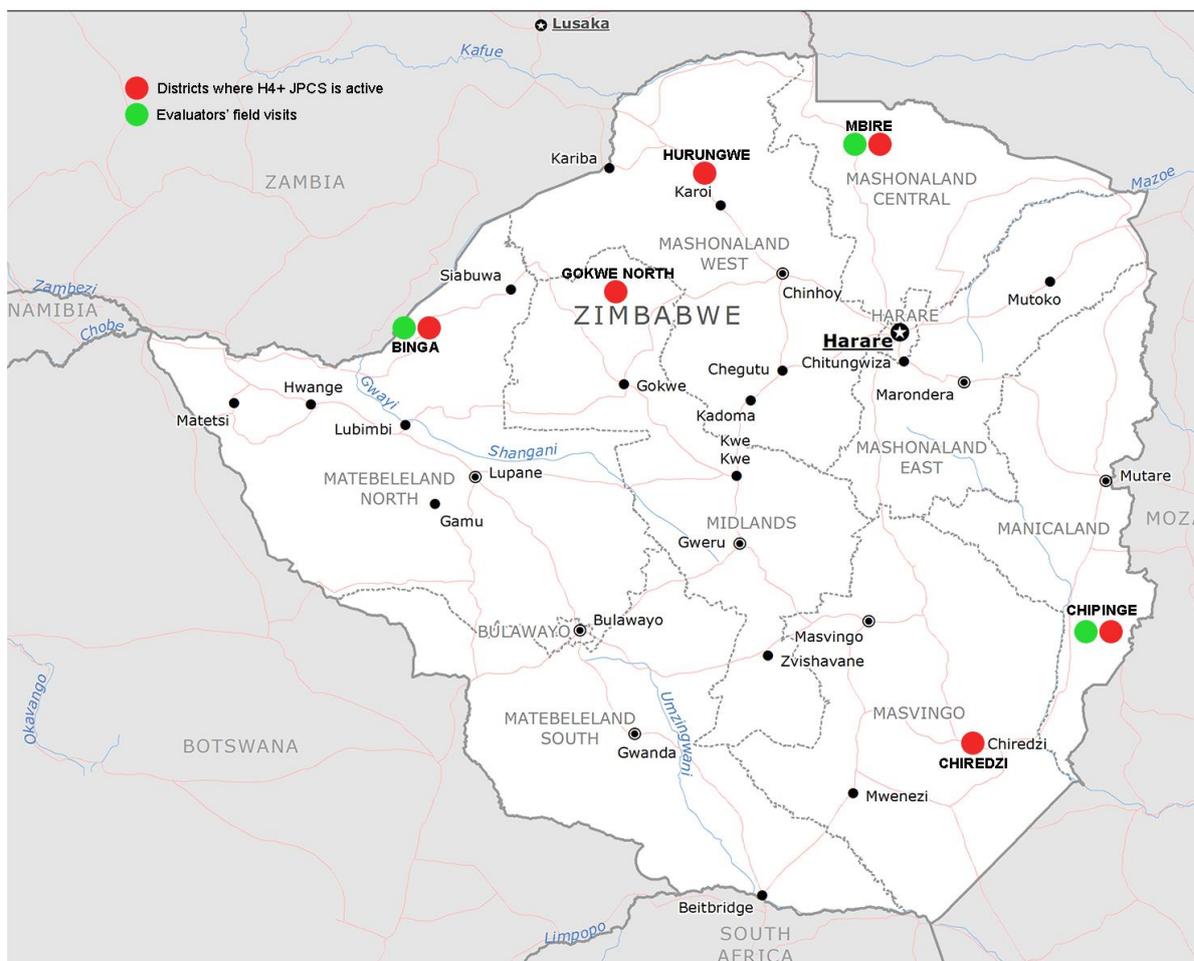
During the main case study mission from June 6 to June 22, 2016, many of the key informants met in March were re-interviewed to deepen the understanding of the context and operation of H4+ in Zimbabwe. New key informants were also interviewed in Harare, including representatives of bilateral donors contributing to RMNCAH, World Bank staff and representatives of NGO implementing partners. Most importantly, during the June mission, field work was undertaken in two more provinces (Mashonaland Central and Matabeleland North) and two districts (Mbire and Binga).

Provincial and district level work included interviews with PHE and DHE staff and site visits to district hospitals, rural mission hospitals and health centres, including mother waiting homes. It also included group discussions with a diverse set of community groups in both Mbire and Binga districts. These included: traditional community leaders, young mothers, in-school boys and girls, VHWs, CBAs, community adolescent treatment supporters (CATS) for young people living with HIV, adults support groups for people living with HIV (PLWHIV), mother support groups, and youth peer educators. A list of persons taking part in interviews and group discussions is provided in Annex 4.

The June case study mission also included start-up and completion briefings to the Zimbabwe ERG. At the de-briefing, the study team presented preliminary findings for discussion and comments.

⁴ It became apparent in interviews and focus group discussion in Zimbabwe 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 H4+ JPCS active districts and field visits in Zimbabwe



The six hard-to-reach districts targeted by H4+ in six different provinces. Three districts were visited; Chipinge during pilot study in March 2016, Mbire and Binga in June 2016.

1.5 Limitations

The field country case study of Zimbabwe is grounded in documentary evidence, quantitative data, and qualitative information (from interviews, group discussions and site observations). 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’s 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: provide the overall context of developments in RMNCAH in Zimbabwe, to present a financial profile of the H4+ programme, to map the results reported by the programme and, to assess changes in the supply of, and demand for, RMNCAH services in the targeted districts. In every case, qualitative information has been used to interpret the quantitative data.

An important issue arises regarding the availability of outcome data at district level due to a tendency to under-report the number of maternal and neonatal deaths, 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 also may occur in instances when maternal and neo-natal deaths reportedly occur most often in cases of referrals to provincial hospitals which are not traced back to the originating district. Either way, since Demographic and Health Survey (DHS) data is available at the provincial level only, it is not possible to trace the main

indicators of morbidity and mortality in RMNCAH to the district level. As a result, other indicators, such as the number of live births occurring in health facilities or percentage of mothers receiving more than one ante natal visit are used.

Despite these limitations, the Zimbabwe 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. This has been done by examining each key causal assumption in the theory of change, the case study presents an informed assessment of the contribution made by H4+ (along with other programmes and initiatives) to positive results in RMNCAH in Zimbabwe.

2 THE CONTEXT OF RMNCAH IN ZIMBABWE

2.1 Trends in RMNCAH - 2011 to 2016

In many ways, the trend in indicators of RMNCAH in Zimbabwe leading up to, and following the effective start of the H4+ programme in 2012, was one of recovery. Between 2000 and 2008, Zimbabwe experienced an extremely challenging politico-social environment, leading to the breakdown of health services and worsening of virtually all indicators.⁵ The period before 2010 was characterized by “*lack of investment, low wages, decreasing motivation and capacity of the civil service, and absolute shortages of essential supplies and commodities, resulting in the near-collapse of the health sector in late 2008 and early 2009.*”⁶

Since 2010, there has been a concentrated effort on the part of the Government of Zimbabwe and external development partners, including the H4+ partners, to “*revitalize the health sector and increase access to care.*”⁷ This initiative has seen improvements in some key Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) indicators.

Table 1: Selected Indicators of RMNCAH in Zimbabwe - 2005 to 2015

Indicator	2005	2010	2015
Maternal Mortality Ratio	555	960	651
Neonatal Mortality	24	31	29
Contraceptive Prevalence Rate (Married Women/Modern Methods)	60%	59%	67%
Unmet Need for Contraception	16%	15%	10%
Exclusive Breastfeeding for First Six Months		31%	48%
Births in a Health Facility	68%	65%	72%

Source: (ZNSA 2016). All data are from the 2005, 2010 and 2015 DHS.

2.2 National plans and priorities

During the 2011-2015 period, Zimbabwe’s national priorities for RMNCAH were expressed most clearly in the *National Health Strategy for Zimbabwe (2009 to 2013)* (hereafter “National Health Strategy”) and the *Zimbabwe National Maternal and Neonatal Health Road Map 2007-2015* (hereafter “MNH Road Map”).

The National Health Strategy places a high priority on health systems strengthening to scale up primary health care services with specific reference to six success factors corresponding to the pillars of the health sector as defined by the WHO:⁸

⁵ (H4+ Zimbabwe 2015a: 3)

⁶ (MoHCW 2011: 8)

⁷ (MoHCW 2011: 8)

⁸ (MoHCW 2009: 10)

1. Provision of adequate skilled and well remunerated human resources for health
2. Continuous supply of medicines and medical supplies
3. Provision of functional equipment and infrastructure
4. Provision of transport
5. Ensuring a predictable and stable financial base
6. Effective leadership at all levels.

Within the overall umbrella of the National Health Strategy, most H4+ supported activities fall under the strategic direction of the national MNH Road Map. The MNH Road Map is “a national framework for planned activities aimed at significantly improving maternal and newborn health services at institutional and programme levels”.⁹ The conceptual framework of the MNH Road Map is built on four pillars of safe motherhood and newborn health: family planning, antenatal care, safe delivery and essential obstetric and neonatal care.¹⁰ It also focuses on efforts to address the three delays that seriously threaten the life and well-being of mothers and newborns: first, in making the decision to seek care; second, in reaching a health facility and third, in receiving appropriate care.¹¹ It also includes a logical framework table which identifies as priority interventions to be supported by all partners providing resources for MNH.

In discussions with staff of the Ministry of Health and Child Care (MoHCC), it became clear that the MNH Road Map was the most important guiding document used in programme planning discussions with the H4+ partners.

2.3 External support to RMNCAH

Zimbabwe relies heavily on external development assistance to fund expenditures in the health sector. In 2015, external funding accounted for over 50 percent of the 937 million USD of public health spending in the country.¹² As a sub-sector, RMNCAH (excluding HIV) also receives over half of its funding from donors. Among the thirteen health sub-sectors reviewed, only HIV programming, vaccines and malaria programming were more dependent on external financing.¹³

From 2011 to 2015, external support to RMNCAH in Zimbabwe was dominated by three large programmes: the multi-donor Health Transition Fund (HTF) managed by UNICEF, the Integrated Support Programme (ISP) funded by the United Kingdom, Ireland and Sweden, and the World Bank-managed Results Based Financing (RBF) programme. All three of these large programmes operated in one or more of the six districts supported by H4+.

Table 2: Key Programmes in RMNCAH Operating in H4+ Districts in Zimbabwe

H4 + Districts	HTF Staff Retention Allowances	HTF Results Based Financing (2014 onward)	World Bank Results Based Financing	Integrated Support Program (ISP)	PEPFAR Support to PMTCT and Paediatric ART
Binga	◆		◆		◆
Chipinge	◆	◆			◆
Chiredze	◆		◆		◆
Gokwe North	◆	◆			◆
Hurungwe	◆	◆		◆	◆

⁹ (MoHCW 2007: 5)

¹⁰ (MoHCW 2007: 14)

¹¹ (MoHCW 2007: 15)

¹² (MoHCC 2016, World Bank 2016d: 31)

¹³ (World Bank 2016d: 14)

The HTF was specifically focused on the health of women and children under five years of age with programming in three thematic areas: MNCH and nutrition; medical products, vaccines and technologies; and human resources for health (including training and staff retention bonuses). The planned budget for HTF was 435.3 million USD over five years.¹⁴ In 2014, the HTF adopted an RBF model for support to health facilities in 42 districts, including four of the six districts supported by H4+.

The World Bank supported RBF programme was piloted in two districts in 2011, and has since expanded to cover 18 districts. It provides financial resources to health facilities based on independently verified service delivery indicators. The funding for RBF was provided in order to eliminate fees for MNCH services (for example, registration fees, fees for supplies used during delivery, fees for medicines and fees for antenatal and postnatal care).¹⁵ It operated with a budget of 40 million USD provided by the Health Results Innovation Trust Fund and the government of Zimbabwe.¹⁶

The ISP for sexual and reproductive health and HIV prevention was launched in March 2013.¹⁷ It focused on the four priority areas of family planning, cervical cancer, gender based violence and HIV prevention. The programme included a budget of 95 million USD provided in support of the MoHCC and MWAGCD and operated in two of the six H4+ districts (Hurungwe and Mbire). In 2016, the mandate of the ISP was assumed by the successor programme to the HTF, the Health Development Fund (HDF).

A fourth programme supporting RMNCAH in Zimbabwe during the H4+ programme period has been the Maternal and Child Integrated Health Programme (MCHIP) supported by USAID and provided through international NGOs. The MCHIP programme focused on supporting policy development in MNCH at a national level and strengthening service management and delivery in two districts in Manicaland – Mutare and Chimanimani.¹⁸

Planning support to RMNCAH from the H4+ programme, with its budget of 9.3 million USD, has required careful attention to ensure complementarity and avoid overlap between H4+ and these larger initiatives in support of RMNCAH.

2.4 Mechanisms and processes for coordinating action

2.4.1 National mechanisms for coordinating support to the health sector in Zimbabwe

Key informants described a complex, interlocking set of committees and working groups for coordinating external support to the health sector in Zimbabwe, including:

- The Country Coordinating Mechanism (Global Fund/Global Vaccine Alliance)
- The HTF/HDF steering committee chaired by the Permanent Secretary of the MoHCC
- The H4+ steering committee chaired by the Director of Family Health
- The Adolescent Sexual and Reproductive Health Forum
- The Ministry of Health and Donor Committee (MODO) which reviews all health programmes.

¹⁴ (MoHCW 2011: 4)

¹⁵ (World Bank 2012)

¹⁶ (World Bank 2016m)

¹⁷ (World Bank 2013)

¹⁸ (USAID 2014)

The relationship among these different committees is discussed in detail in section 4.3.

2.4.2 H4+ programme coordinating mechanisms and processes

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

- The national H4+ steering committee (established in 2014)
- The quarterly joint provincial and district planning and review meetings with participation by MoHCC headquarters, provincial health executive (PHEs), district health executive (DHEs) and some health facilities staff. These meetings also feature participation by H4+ partners and non-governmental organisation (NGO) implementing partners
- Joint supervision and review missions (including visits to health facilities) to the provinces and districts supported by H4+.

2.5 The H4+ programme in Zimbabwe

2.5.1 Programme expenditures

Programme expenditures under H4+ JPCS began gradually (Table 3) and reached their maximum levels in 2014 and 2015. These two years accounted for over 69 percent of total expenditures in the five years of programme operation in Zimbabwe (up to December 31, 2015).

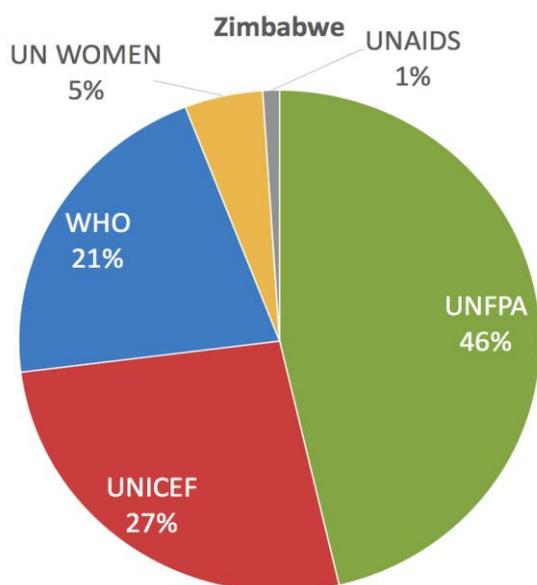
H4+ country team members confirmed that both the Canada and Sweden grants are operating in 2016 in Zimbabwe under no-cost extensions. The Canada grant finished at the end of June, while the Sweden grant continues to the end of September, 2016. Many key informants at provincial and district level reported that they were unaware that the programme had an intended life of five years. They often asked if it was true that H4+ was “pulling out” of their province or district in 2016 and expressed their concern at the expected loss of support from the programme.

Table 3: H4+ JPCS Expenditures in Zimbabwe (Canada and Sweden Grants)

USD	2011	2012	2013	2014	2015	Total	%
UNFPA	0	310,598	609,761	1,508,298	1,906,372	4,335,029	46%
UNICEF	0	678,142	363,017	637,373	818,190	2,496,722	27%
WHO	0	291,549	659,016	702,527	322,267	1,975,359	21%
UN Women	0		11,754	94,913	346,499	453,166	5%
UNAIDS	0			20,000	76,779	96,779	1%
TOTAL US\$	0	1,280,288	1,643,548	2,963,111	3,470,107	9,357,055	100%

Table 3 and Figure 2 also illustrate the relatively modest share of H4+ expenditures by UNAIDS and UN Women. This is at least partially explained by the fact that the Sida grant only became operational in Zimbabwe toward the end of 2013 with implementation becoming operational in 2014.

Figure 2: Programme Expenditures by H4+ Members 2012 – 2015 (Canada and Sweden)



It is also worth examining the distribution of H4+ expenditures across the eight H4+ JPCS programme output areas over the period 2012 to 2015. The Canada and Sweden (Sida) grants are presented separately in Table 3, as they are allocated and expended over different time frames. The Canada grant is budgeted and expended on an annual basis while the Sida grant was budgeted and expended over an 18-month cycle. The combined data in the final columns of Table 3 covers both the Canada and Sida grants from the beginning of 2012 to the end of 2015.

Table 4: H4+ JPCS Expenditures (US\$) by Output Category (2012-2015)¹⁹

H4+ Output Categories	GRANTS					
	Canada		Sweden/Sida		Combined Canada and Sida	
	2012-2015		2013-2016		2012-2016	
	<i>Final spent</i>	<i>% of Total</i>	<i>Final spent</i>	<i>% of Total</i>	<i>Final spent</i>	<i>% of Total</i>
1. Leadership and Governance	527,051	13%	237,625	5%	764,677	8%
2. Financing	0	0%	0	0%	0	0%
3. Technology and Communications	929,266	23%	832,162	16%	1,761,428	19%
4. Human Resources	1,069,946	26%	1,239,023	24%	2,308,968	25%
5. Information Systems, Monitoring and Evaluation	534,927	13%	1,332,235	25%	1,867,162	20%
6. Service Delivery	535,360	13%	755,214	14%	1,290,574	14%
7. Demand	496,510	12%	773,445	15%	1,269,955	14%
8. Communication and Advocacy	0	0%	85,289	2%	85,289	1%
TOTAL	4,093,060	100%	5,254,994	100%	9,348,054	100%

Over the life of the programme, the outputs related to human resources (including training) and technology and communications (including provision of equipment) accounted for almost half of total expenditures (44 percent). Also notable is the modest investment in promoting demand, which accounted for just 14 percent of expenditures during the period.

The Zimbabwe country level programme theory of change (ToC) (Figure 3) allocates the eight programme outputs into three streams: national leadership and management; local or district level supply of quality RMNCAH services (the supply side); and mobilising demand from users (the demand side).

¹⁹ A note on Sources: Data on the distribution of H4+ expenditures was coded by the H4+ coordinator in Zimbabwe based on guidelines provided by the global H4+ coordinator at UNFPA headquarters, using source data provided by UNFPA in final annual expenditure reports to Canada and Sweden (Sida).

Table 4 illustrates the H4+ JPCS Expenditures by Output Category (2012-2015). Outputs four, five and six (human resources, information systems and service delivery) are all situated within the central, supply side column of the ToC. Together, they account for 59 percent of the total expenditures. If investments in technology and communications are also considered supply side interventions, then the supply side share rises to 78 percent. In part, this reflects the late participation of UN Women and UNAIDS in H4+ in Zimbabwe as they have been the main (but not exclusive) supporters of demand side initiatives. The relatively small proportion of H4+ expenditures on activities aimed at engaging communities to increased demand raises the question of whether an appropriate balance has been found between improving the quality and availability of supply and encouraging increased demand for RMNCAH services.

2.5.2 Programme Outputs

An overview of some of the most important outputs of the H4+ programme in Zimbabwe can be gained from Table 5. The table presents output indicators as reported in the H4+ Zimbabwe results framework document of December 2015. Unless otherwise indicated, the targets and the reported values are cumulative over the 2012 to 2015 calendar years.

The data presented in Table 5, can be difficult to interpret, especially when comparing reported results to targets in output area four, health human resources (where reported results are cumulative and targets are given only for the year 2015). Interviews with H4+ country team members pointed out two factors which give rise to this difficulty.

The first is the late development (2014 and 2015) of quantitative targets for outputs in health human resources. The second is the broad definition of some of the indicators in human resources. For example, indicators of the number of health workers trained in EmONC, IMNCI, and Infant and Young Child Feeding (IYCF) did not specify which type or level of staff to be trained and did not capture the type of training provided. This meant, for example, the indicators give no distinction between training courses, workshops, training of trainers and provision of clinical mentoring which are all forms of training supported by H4+.

For these reasons, the output indicators for output area four on human resources for health should be used as a general indication of the overall scale of H4+ supported activities in training and skills development rather than for the purpose of directly comparing the volume of outputs achieved against targets. The same caveats apply to reported results on demand generation where numbers achieved greatly exceed targets but the nature of the contact with each participant was not defined in the indicator itself.

Table 5: Output Indicators Reported in the H4+ Zimbabwe Results Framework: December 2015

Output Area and Selected Indicators	Target to 2015	Reported Value Jan to Dec 2015
1. Leadership and Governance		
Proportion of facilities in targeted districts aware of new Pre-Natal Care guidelines	80 %	100%
Proportion of facilities in targeted districts aware of WHO HIV national guidelines (Option B+) ²⁰	80%	
National Emergency Obstetric and Neonatal Care (EmONC) improvement plan available	By programme end	In progress

²⁰ Option B+ refers to revised WHO guidelines for treatment of HIV positive pregnant and breastfeeding women (WHO 2016).

National Integrated Young Child Feeding (IYCF) strategy available	2014	Achieved in 2014
Emergency Triage Assessment and Treatment (ETAT) guidelines available	Guidelines available	Achieved in 2014
2: Finance		
No activity in Zimbabwe		
3. Health Technologies and commodities		
Proportion of facilities reporting no stock-outs of oxytocin and magnesium sulphate in previous three months	90%	100% Vital Medicines Availability Health Facility Survey (VMAHS) Round 22
Proportion of care givers of HIV positive infants receiving test results within two months of sample collection	70%	69% (VMAHS) Round 22
4. Health Human Resources		
Number of health workers trained in EmONC	252 (2015)	577 (Cumulative)
Number of health workers trained in IMNCI	250 (2015)	1118 (Cumulative)
Number of health workers trained in Infant and Young Child Feeding (IYCF)	300 (2015)	390 (Cumulative)
Number of health workers trained in Paediatric ART/Option B+/PMTCT/HIV Treatment and Care	180 (2015)	1154 (Cumulative)
Number of health workers trained in Growth Monitoring	400	482 (Cumulative)
5. Health Information Systems, Monitoring and Evaluation		
Proportion of targeted districts completing HMIS reports as per national guidelines in previous 3 months	100%	98.4%
Proportion of targeted districts/provinces which conducted Maternal Death Surveillance Reviews Quarterly	100%	83%
6. Health Services Delivery		
Number of health care facilities providing comprehensive EmONC services	6	11
Number of health care facilities providing basic EmONC	10 (2014)	14 (2014)
Number of health care facilities providing basic EmONC-2 (minus MVA and Assisted Vaginal Delivery)	21	138
Caesarean Section as percentage of deliveries	5-15%	4.3%
7. Demand Generation		
Number of active community groups	40	81 (31 adult groups + 50 young women forums)
Number of persons exposed to community dialogue that discusses RMNCAH/HIV issues in an integrated manner	1,500	12,414 (8095 young girls, 3295 older people, 1024 local leaders.

3 THEORY OF CHANGE FOR H4+ JPCS IN ZIMBABWE

A detailed overview of the country-level theory of change (ToC) for the H4+ JPCS programme in Zimbabwe is provided in Figure 3 (below). The ToC was tested and validated during the field missions and the analysis phase of the country case study.

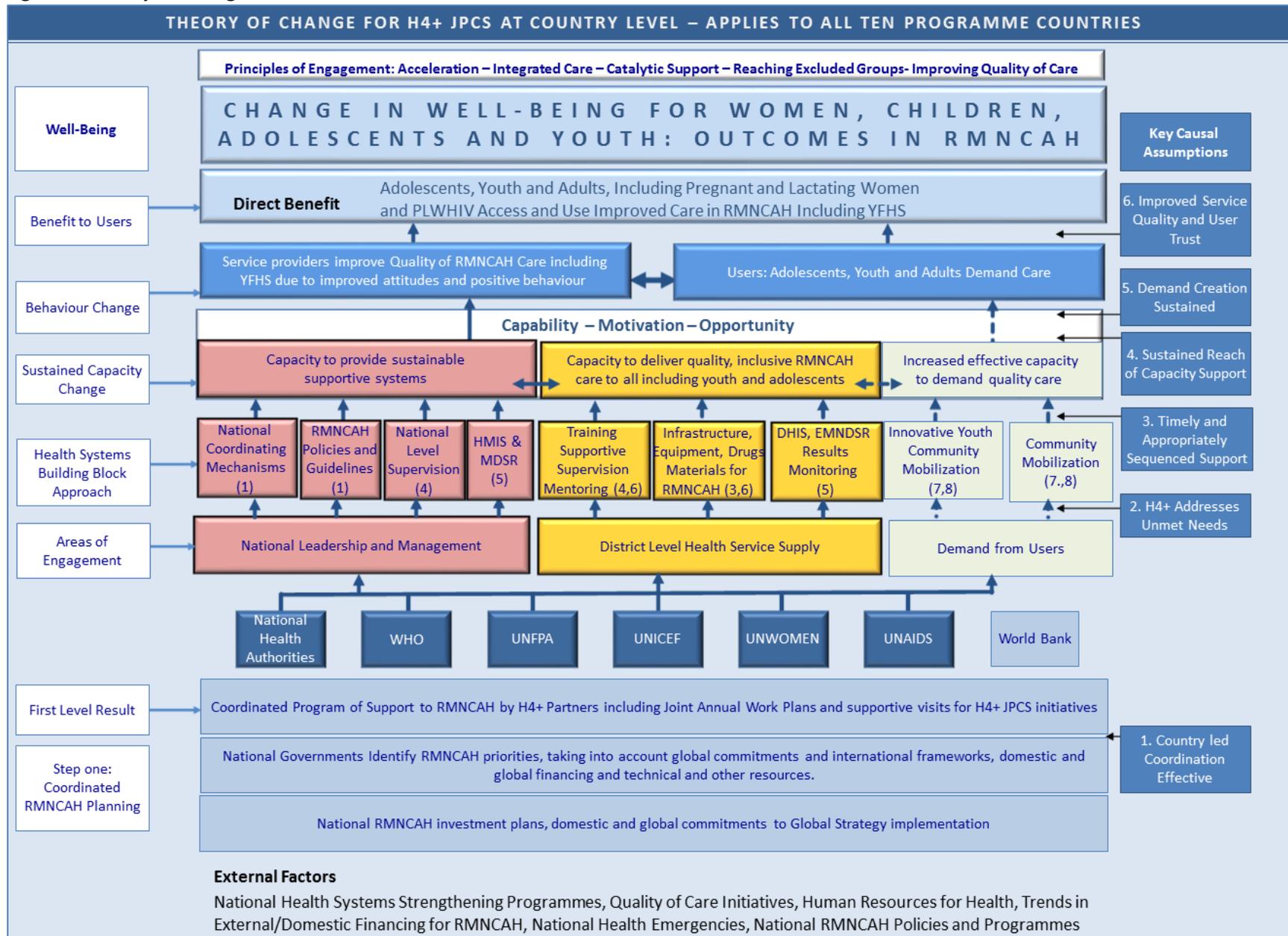
The analysis presented in Section four raises important concerns regarding the relative balance between the three main pillars of the ToC for H4+ in Zimbabwe: in particular the relative lack of emphasis placed on investments and supported activities intended to increase the capacity of communities to effectively demand quality care in RMNCAH.

This is represented graphically in Figure 3 in two different ways. First, the boxes representing H4+ JPCS investments in national leadership and management (filled in pink) and investments in district level health services supply (filled in yellow) have been shaded for increased emphasis. This has also been done for their contribution to immediate results (capacity strengthening at national and district level). In contrast, the borders of boxes representing investments in demand remain plain, reflecting the relative under-investment in these areas in terms of both financial investment and the reach and duration of the supported activities.

In addition, the arrows indicating the direction of causality use solid lines for linking investments in national leadership and district level health service delivery and are, in contrast, dashed for investments in generating demand and engaging communities. This is not a direct criticism of the value of the investments in engaging communities and stimulating demand. Rather, it attempts to illustrate the risk that gains in community engagement may be both limited in scope and fleeting in duration due to factors detailed in Sections 4.1 and 4.2.

Detailed descriptions of the key causal assumptions are provided in Annex 6.

Figure 3: Theory of Change for H4+ JPCS in Zimbabwe



4 EVALUATION QUESTIONS AND FINDINGS

This section presents the findings of the Zimbabwe 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 section follows the same structure throughout, beginning with a 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.²¹

Under each evaluation question, the analysis is organised in two parts. In the first part, evaluation data is used to test the validity of the assumption, by answering the question: does the assumption hold and is the theoretical causal link evident? The second part of the analysis builds on this testing of causal assumptions to directly address the evaluation question.

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 Zimbabwe.

Linking Evidence and Findings: The Evaluation Matrix

The data and information which support the evidence-based findings presented in this section are provided in detail in the evaluation matrix (Annex 1). The evaluation matrix is organised around the evaluation questions and assumptions. Unless otherwise noted, 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

1. H4+ supported interventions have addressed important unmet needs for health systems strengthening in RMNCAH through a consultative planning and review process led by the MoHCC.
2. H4+ supported interventions have been catalytic in the sense that the programme has complemented and influenced the content of investments and actions undertaken by other programmes and sources of support to RMNCAH, both within the six targeted districts and at a national level.
3. H4+ has contributed to improvements in the quality and availability of health services for RMNCAH, especially but not only, in the six targeted districts.
4. H4+ support to demand promotion and community mobilisation efforts was limited in its share of programme funding, and the supported activities were limited in geographic reach and duration. Nonetheless, they have been effective in building trust between communities and health facilities.

²¹ (UNFPA 2015c: 35-49)

5. There are important challenges to sustaining the positive contribution of H4+ in the six target districts – however, some H4+ approaches and methods have been taken to scale by the Ministry of Health and Child Care and may have a lasting effect on health systems for RMNCAH.

4.1.1 Testing causal assumptions for health systems strengthening

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 financing and support to accelerate action.*²²

In 2011, from the perspective of the Ministry of Health and Child Care (MoHCC), the point of departure for identifying needs for health systems strengthening in Zimbabwe and matching them with support from H4+ partners was “*the very low starting point in outcomes in MNCH which the Demographic and Health Survey of 2010 demonstrated were very, very poor*”. Senior officials at the Director and Deputy Director level also pointed out that they needed to take action to meet the national commitments to the Global Strategy (2010) and to the three core documents guiding their work in RMNCAH: the National Health Strategy, the Maternal and Neonatal Health (MNH) Road Map and the Child Survival Strategy.

The MoHCC also saw an opportunity to “*get behind a very focused effort aimed at improvements in MNCH outcomes, especially in the six worst districts and drawing on the collective strengths of the UN agencies, something they had not seen before*”.

The decision to focus the H4+ initiative on the six most difficult to reach, most underserved and most burdened districts in Zimbabwe clearly originated with the MoHCC and was readily accepted by the H4+ partners. From that point on, identifying critical needs and appropriate responses became a multi-dimensional question, involving needs at national, provincial and district levels. As noted by MoHCC staff, beyond district needs, they also recognised important issues that needed to be addressed at national level. These needs included: improving maternal and neonatal death surveillance and reporting (MNDSR)²³ systems; dealing with obstetric fistula; and the need for better clinical mentoring and supportive supervision throughout the health services.

Minutes of joint H4+ planning and review meetings and of the National H4+ Steering Committee (chaired by the Director of Family Health Directorate, MoHCC) make clear that the process of identifying health system needs in RMNCAH at the **district level**, and planning an appropriate response, was relatively weak up to the end of 2013. To that point, H4+ met with low levels of response from the six priority districts and poor understanding of potential support from the programme on the part of provincial health executives (PHEs) and district health executives (DHEs).²⁴

This situation greatly improved in late 2013 and early 2014 with much stronger direction and leadership provided by the Family Health Directorate, coupled with an interactive process of programme planning and review. The process of setting a new direction for H4+ began with the first quarterly joint planning and review meeting of all stakeholders (MoHCC, H4+ partners and provincial

²² Unless otherwise noted, for evidence cited in relation to assumption 1.1 see Annex 1, Assumption 1.1.

²³ Strictly speaking, these systems should be referred to as maternal and perinatal death surveillance and reporting systems since they include still births which are not normally included under the term neonatal. This report retains the use of the more common term MNDSR with the understanding that the system covers still births.

²⁴ (H4+ Zimbabwe 2014a: 2-3)

and district health facilities staff as well as participating NGOs) in September 2013.²⁵ This first step was followed up by the H4+ partners and the MoHCC during the global H4+ inter-country planning and review meeting held in Victoria Falls, Zimbabwe from May 26 to 30, 2014 (and subsequently referred to in key informant interviews as the Victoria Falls meeting). One outcome of this meeting was the establishment of the national H4+ steering committee under the chair of the Director of Family Planning of MoHCC, with its first meeting held in June 2014.

This combination of national leadership by the MoHCC and joint review and planning meetings served to consolidate views at the national, provincial and district levels. It involved all relevant stakeholders (national health authorities, PHEs, DHEs, H4+ partners and non-governmental organisations (NGOs) implementing activities funded by H4+) in quarterly planning and review meetings.²⁶ These, in turn, fed into H4+ annual workplans. The needs identified and the planned responses covered seven of the eight output areas of the H4+ programme (the exception being health financing).

The most critically important set of needs and responses mentioned repeatedly in interviews with stakeholders and noted in the minutes of planning and review meetings are:

- Improved national coordinating mechanisms
- Updated and improved RMNCAH policies and guidelines
- Improved MNDSR systems to strengthen accountability and identify solutions
- Improved training, supportive supervision and clinical mentoring for service providers in specific areas of RMNCAH, especially basic and comprehensive emergency obstetric and neonatal care (BEmONC and CEmONC), prevention of mother to child transmission (PMTCT), paediatric anti-retroviral therapy (ART), and youth friendly services
- Infrastructure and equipment for RMNCAH, including equipment for operating theatres to enable caesarean sections, provision of point of care (PoC) CD4 machines,²⁷ support to mother waiting homes
- Essential medicines and supplies for RMNCAH care, especially oxytocin and magnesium sulphate
- Demand creation through mobilisation and empowerment of key groups in the communities served by district hospitals, health centres and clinics.

This process of ongoing needs identification and adjustment of the H4+ programmatic response at national and sub-national levels was also supported by existing or newly commissioned research on barriers and needs in RMNCAH. These included the national integrated health facility assessment (NIHFA) and H4+ supported reviews and research. Specific examples include: a concept note on developing a national EmONC care plan undertaken by UNFPA (2014); an EmONC service needs assessments in the six H4+ districts prepared by MoHCC with support from H4+ (2014); and, a gender assessment of community structures that influence girls' sexual reproductive health (SRH) seeking behaviour in the six H4+ districts produced by UN Women (2014).

It is clear that the H4+ programme began with a common agreement among the H4+ partners and the MoHCC on the need for a priority focus on the six most underserved districts. There was also broad agreement on the specific need for strengthening the health sector in RMNCAH. However, this

²⁵ (H4+ Zimbabwe 2013b). While joint planning and review meetings were planned on a quarterly basis they sometimes occurred less frequently due to scheduling difficulties. At a minimum, they occur twice each calendar year.

²⁶ (H4+ Zimbabwe 2014c: 2-5)

²⁷ CD4 count is a laboratory test measuring the number of CD4 T lymphocytes [antibodies] in a patient's blood (AIDS.gov 2016)

national perspective was not well matched with a detailed understanding of needs at provincial and district levels in the beginning. That understanding became much clearer after changes in the coordination, planning and review processes and structures implemented in 2013 and 2014.

Assumption 1.2: H4+ JPCS support to sub-national level funded 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.*²⁸

There is a strong consensus among PHE and DHE staff, and staff of hospitals and health centres interviewed, that H4+ programme support to the provincial and district level is catalytic in that it supports and has influenced the content of other programmes. These key informants feel strongly that H4+ complements the programmes supporting health services for RMNCAH in its six operational districts (Table 5). These include, the Integrated Service Programme (ISP), the World Bank supported results-based financing (RBF) programme and the Health Transition Fund (HTF) managed by UNICEF (which also provides results-based financing to facilities in the supported districts). For example, H4+ support to clinical mentoring and supportive supervision complements staff retention bonuses paid by the HTF. In this way, the targeted support of H4+ to mentoring and supervision at district and provincial levels has the effect of increasing the effectiveness of the HTF retention bonuses to influence quality of care. Conversely, the retention bonuses of the HTF help to maintain a core of health professionals in place, a group that can be assisted by H4+.

Similarly, procurement of oxytocin and magnesium sulphate by H4+ can, in turn, be complemented by funds provided to facilities by the RBF programme (when used to purchase commodities in times of stock-outs).

H4+ planning documents and interviews with the MoHCC and the H4+ country team also indicate that the complementarity and fit between the interventions supported by H4+ and these large programmes was a priority in programme planning and implementing from the beginning of H4+. This complementarity was made stronger over time by the interlocking set of coordinating bodies overseen by the MoHCC including the Country Coordinating Mechanism (CCM), the HTF/ Health Development Fund (HDF) Steering Committee, the national RBF Steering Committee, and the national H4+ Steering Committee. These committees have overlapping membership structures; therefore, the key policy makers and partners meet regularly and have the ability to avoid significant programme duplication and maintain complementarity. Some consolidation of this committee structure can be expected under the HDF which will absorb the mandates of the HTF, the ISP and H4+.

As the programme comes to the end of its external funding by Canada and Sweden, senior MoHCC staff indicate that the new HDF will build on the approach and work of the H4+. MoHCC staff at national and provincial level commented that lessons learned in effectively supporting service delivery in RMNCAH during the implementation of H4+ had been picked up and incorporated into the design of the HDR. This was done, in part, by incorporating outcome indicators in RMNCAH and by supporting the same pillars as the H4+ of the building block approach. It also involves incorporating similar approaches to programme coordination into the HDF. In this way, the work of H4+ has been catalytic at the national level in the sense of influencing the content of the main, multi-donor funded programme of support to the health sector for the next five years.

What is not clear, however, is whether the new Health Development Fund will be able to provide tailored and flexible support to the six H4+ districts which has been noted by key informants as a key programme strength.

²⁸ Unless otherwise noted, for evidence cited in relation to assumption 1.2 see Annex 1, Assumption 1.2

Interviews and observations at facility level also point to important synergies and complementarities between H4+ investments and the HTF and RBF programmes in particular. The RBF programme, by providing incentives at the facilities level and incorporating maternal, neonatal and child health (MNCH) indicators as measures of performance (which are linked to incentives), has helped to improve quality of care in H4+ supported facilities. Similarly, H4+ supportive supervision at provincial and district level missions (and revitalised routine supportive supervision visits by the PHE and DHE) make use of RBF developed quality checklists. As already noted, the HTF programme, by providing retention bonuses for different categories of service providers, has helped retain the professionals supported by H4+ efforts in training and supportive supervision.

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.²⁹

The documents reviewed (including training workshop review reports, training needs assessments, and reports of post-training follow up and support missions carried out by MoHCC staff or H4+ partner staff) indicate that H4+ has supported frequent efforts to assess the effectiveness of training and supportive supervision. However, these reports are not uniformly positive. They often note both gains in skills and competence and some deficiencies, which are then the subject of further training and supervision efforts.³⁰ While the reported deficiencies are not insignificant, it is more important to note that the emphasis placed on follow up by H4+ is a positive sign that training efforts have shifted away from one-time skills upgrade efforts to a more continuous process.

The MoHCC senior staff at headquarters noted that H4+ has “*led the shift to more follow up and assessment of training initiatives*”. They also noted important gains in skills and competencies on the part of staff engaged in RMNCAH and integrated HIV services at all levels.

These perceptions were supported by interviews with MoHCC managers and staff at provincial, district and facilities level. Front line staff as well as managers confirmed the shift to in-service training coupled with supportive supervision and assessment. These staff, along with H4+ partner staff and staff of NGO implementing partners, pointed to what they saw as important gains in skills and competencies. Finally, focus group discussions with a variety of community groups pointed to increased trust and understanding between the communities and the staff of health centres that serve them.

Some of the most important areas where gains in skills and competencies were noted by key informants and participants in focus group discussions include:

- CEmONC and BEmONC, including competency in caesarean sections
- PMTCT and paediatric ART
- Option B+ management³¹
- Use of Point of Care (PoC) CD4 machines to assess viral load in HIV positive patients
- Integrated management of neonatal and child illnesses (IMNCI)
- Improved attitudes towards, in particular, youth and adolescents, especially pregnant girls
- Youth friendly services (YFS).

There is substantial evidence that H4+ support to training of staff is resulting in improved skills and competencies for RMNCAH and that these improvements are being tested and followed up (although

²⁹ Unless otherwise noted, for evidence cited in relation to assumption 1.3 see Annex 1, Assumption 1.3

³⁰ (Manicaland Provincial Health Executive 2014: 2-6)

³¹ Option B+ refers to revised WHO guidelines for treatment of HIV positive pregnant and breastfeeding women (WHO 2016).

some deficiencies in skill retention and supply availability are also noted). In 2015, the *Basic Emergency and Neonatal Care training assessment* in the six H4+ districts concluded that “*the findings of this assessment indicate that the capacity to manage obstetric emergencies has improved since the national health facilities assessment in 2012*”. The improvement noted in the training assessment is also indicated by the increase in the number of facilities providing CeMONC services in the six H4+ districts which increased from two in 2012 to 11 in 2015.³²

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.*³³

In order to make use of the skills acquired or revived during training or through clinical mentoring, health facility staff need proper equipment, reasonable infrastructure, adequate essential medical supplies and proper supervision. They also need an incentive structure that keeps them in place and motivated to provide quality care.

In the area of equipment, interviews and site visits confirm that facilities receive and make full use of PoC CD4 machines for management of HIV treatment and care (HTC) of HIV positive mothers; operating theatre equipment (including anaesthetic machines); communications equipment for electronic MNDSR; motorbikes for supportive supervision and for transporting dried blood spot (DBS) samples for HIV testing; bicycles for transport of CBAs; and manual vacuum aspirator (MVA) machines. The most critical medicines provided on a regular basis by H4+ were oxytocin and magnesium sulphate.

For the most part, machinery and supplies were provided by H4+ in the time frame planned, or close enough to not disrupt services. There were some exceptions reported in interviews and in the quarterly planning and review mission reports for the programme. For example, some stock-outs of oxytocin and/ or magnesium sulphate were reported. However, in World Bank RBF districts, health facilities reported they could use RBF funds to purchase needed essential medicines and reduce or eliminate the period of stock-outs.

There were also some issues of the sequencing of equipment. In one case in Chipinge, St. Peter’s Mission Hospital had received an anaesthetic machine and the full suite of theatre equipment to allow it to be certified for performing caesarean sections. However, the equipment could not be installed due to lack of funds to complete basic plumbing, paint and plaster work on the theatre and supporting preparation rooms.

In the area of incentives and motivation, health facility staff including doctors, midwives and staff of the PHE and DHE, receive retention bonuses under the HTF. These bonuses are based on a scale which takes into account both the level of salary needed to provide a sufficient incentive and other sources of funding for a given position. In World Bank RBF districts, these are augmented by performance bonuses at the facility level. From 2014 onward, the HTF districts have also had access to results based financing since 2014, but only at the health centre and clinic level. Up to now, the retention bonuses of the HTF and the performance based financing supported by the World Bank have been sufficient to retain well qualified staff in many health facilities. However, recent cuts in the level of HTF retention bonuses have raised issues regarding incentives in the future. As one young doctor at a district hospital remarked: “*Staff will be ‘flocking out’ of work in remote districts if retention bonuses are reduced.*” HTF has been an important complement to the work of H4+ at provincial and district level. The planned reductions in retention bonuses could have a negative

³² (H4+ Zimbabwe 2016a: 28)

³³ Unless otherwise noted, for evidence cited in relation to assumption 1.4 see Annex 1, Assumption 1.4

effect on the sustainability of HTF results, especially those relating to capacity development in RMNCAH.

Interviews with MoHCC staff at provincial, district and health facility levels indicate that H4+ support has been essential in facilitating supportive supervision in the six H4+ provinces and districts. However, shortages of funds for fuel and maintenance of equipment (including for H4+ provided motor bikes), represent a real challenge for continued, effective supportive supervision, at least in districts without access to other sources of funds (for example World Bank administered RBF).

The combination of skills, equipment, supplies and incentives which enables health facility staff to provide quality RMNCAH services is present in the H4+ districts, but it faces continuing challenges and constraints. The most frequently noted are often infrastructure or maintenance related and include lack of electricity and running water in the health facilities, and lack of fuel and adequate maintenance of transport equipment due to non-availability of funds.

Finally, there is evidence that the combination of training, mentoring, supervision and support to equipment, supplies and infrastructure has improved the quality of care in RMNCAH in the six districts, at least as perceived by users. Interviews and focus group discussions with PHE and DHE members, facilities staff, NGO staff, and members of a diverse set of community groups have all presented a strong and coherent picture of improved trust by the community in the quality of care and attitude of health centre staff. H4+ quarterly planning and review meetings have also reported both the perceived improvement in the quality of care and the challenges for maintaining quality going forward.

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.³⁴

There is a consensus among senior MoHCC staff, H4+ partner staff, and staff of NGO implementing partners, that improvements in service quality and efforts to raise demand and encourage community members, particularly pregnant women and girls, to access critical services in MNCH have contributed to increased access and use. This view is supported by facility staff at district and local level, who report reduced referrals to higher level care facilities and more use of district hospitals, rural mission hospitals and health centres and clinics. This view was put forward by a senior official of MoHCC: *“MoHCC can already see the evidence that the H4+ approach is working in the targeted districts. We don’t need another pilot study to justify taking elements of the H4+ approach to scale on a national level, for example in the HDF programme.”*

A review of usage data in the three H4+ districts covered during the case study (Chipinge, Mbire and Binga) supports the theory that access and usage of key MNCH services has improved over time. All three districts have seen some increase in the number of live births at facilities (most notably in Chipinge) since 2012. The data also show a notable decrease in the number of live births at home since 2013. Most striking perhaps, has been the large increase in the number of caesarean sections performed in the three districts since 2012. Finally, all three districts saw substantial increases in the number of repeat antenatal visits from 2012 to 2015.

³⁴ Unless otherwise noted, for evidence cited in relation to assumption 1.5 see Annex 1, Assumption 1.5

Table 6: Usage data on selected RMNCAH services in three Districts - 2012 to 2015

District	Chipinge		Mbire		Binga	
	2012	2015	2012	2015	2012	2015
Live births in health facility	7,909	11,456	2,026	2,265	3,707	4154
Live births at home	*1,199	813	**467	254	**413	272
Caesarean section deliveries	291	827	0	20	33	262
Repeat antenatal visits 2012	8,208	**17,330	2,487	**4,217	4,034	**7,908

* 2014 ** 2013. Source: (MoHCC 2015j)

It is also noteworthy that H4+ reports a significant increase in the number of facilities providing CEmONC services in the six H4+ districts in the same time frame. This increased from a baseline of two facilities providing CEmONC in 2012 to 11 in 2015, five more than the original target of six facilities.³⁵

This usage data needs to be viewed against the backdrop of general improvements in the overall health system since 2010. It is difficult to say if the gains in H4+ district are significantly larger than those in the rest of Zimbabwe. On the other hand, there is very strong agreement across all those interviewed that the six H4+ districts are no longer among the lowest performing in the country, despite their continued status as the most isolated and hard to reach.

However, there are important concerns which could challenge the current level of performance of the system for RMNCAH care in the H4+ districts as the programme comes to an end in 2016.

The concentration of H4+ spending into a very short time frame, with 70 percent of total funds expended in 2014 and 2015 means that the programme has been operating at full capacity for just over two years. This, combined with the concentration on hardest to reach districts (where the improvement in services has been substantial), means that the end of H4+ programme investments will have a sizeable impact. Managers at provincial and district level and health facility staff were not aware of any specific exit strategy on the part of H4+ as a programme. They also had no expectation that activities supported by H4+ would be able to access other sources of funding after programme completion.

Further, the relatively small share of funding devoted to promoting demand for services (14 percent as shown in Table 3) suggests that H4+ support to the demand side of health systems has been underfunded compared to supply side efforts promoting national leadership and strengthening service delivery at provincial and district level. PHE staff, DHE staff and managers of hospitals and health centres often noted that demand promotion and mobilisation efforts in the communities were very limited in reach. Many of the implementing partner NGOs working on demand promotion and mobilisation in the six H4+ districts operate in only a few wards and leave many more un-served, reportedly due to lack of funding for wider operations.

The material presented above serves to verify the most important causal assumptions underlying the contribution made by the Canada and Sida H4+ programme to health systems strengthening in RMNCAH, in Zimbabwe. However, it also identifies some issues of programme reach (especially for demand promotion activities in the communities in the six programme districts). Finally, it raises the question of whether the H4+ programme in Zimbabwe achieved an appropriate balance between H4+ investments to improve the quality and availability of services in RMNCAH on one hand, and efforts to promote demand and mobilise communities on the other.

³⁵ (H4+ Zimbabwe 2016a: 28)

4.1.2 Contributing to health systems strengthening for RMNCAH in Zimbabwe

It is clear from the close analysis of causal assumptions relating to evaluation question one that H4+ in Zimbabwe has been able to:

- Develop a common view, in consultation with key stakeholders, of the most critical needs for health systems support in RMNCAH
- Develop and support interventions which complement existing and planned interventions with their own, substantial, sources of funding
- Provide targeted support which may be sustained at national level but which faces important challenges in the six H4+ districts in the absence of an explicit exit strategy for the programme
- Demonstrate programming approaches which can be taken to scale at national level.

Developing a common view of critical needs for health systems support

From the beginning of the programme, H4+ partners and the MoHCC shared a common view that there were critical needs for health systems strengthening in RMNCAH at national, provincial and district levels, with priority emphasis given to the six districts which were the most underserved and reported the most negative outcomes. What was lacking was a detailed, common vision of how those needs could best be met at provincial and district levels. This was remedied with the establishment of the National H4+ Steering Committee in 2014 and the continued refinement of the system of quarterly planning and review meetings chaired by the Director of Family Health at MoHCC.

While this intervention came somewhat late in the programme life cycle, it led to a significant increase in the rate of programme implementation and expenditures of funds (from 35 percent of allocated funds in 2013 to 88 percent in 2015).³⁶ The result was a better fit between the needs of the districts (and by extension the provinces) and their understanding of the support that the H4+ programme could provide, which would be directly useful to them. This process was supplemented by H4+ supported joint review missions by the MoHCC, H4+ partners and NGO implementing partners.³⁷ The result of this process was a set of H4+ supported interventions, especially at district level, which focused on urgent and unmet needs.

Catalytic Interventions which build on existing or planned interventions and sources of funding

The diverse set of actions and interventions supported by H4+ in Zimbabwe have been designed and implemented to be catalytic and to build on the support provided by other programmes, particularly the ISP, HTF, and RBF programmes. This was the intention of both the MoHCC and the H4+ partners at programme start-up in 2011. An important factor in ensuring that H4+ supported catalytic interventions, was the programme flexibility, with workplans adjusted regularly in response to provincial and district level feedback, and its ability to support interventions that fill the gaps in larger programmes.³⁸ H4+ also helped improve the effectiveness of larger programmes by, for example, supporting skills improvements in RMNCAH for health staff supported by the HTF retention bonuses. By concentrating on filling gaps, H4+ has been able to leverage the larger investments made by the HTF, RBF and ISP programmes. This leverage has helped increase the effect of H4+ support while, at the same time, making it somewhat more difficult to isolate the specific contribution made by the programme to end results. This should not, however, be seen as a programme weakness.

³⁶ (H4+ Zimbabwe 2016a: 37)

³⁷ Annex 1, Assumption 1.1

³⁸ Annex 1, Assumption 1.2

Sufficient reach and duration to contribute to lasting change

The period of intensive programme implementation for H4+ JPCS in Zimbabwe was only slightly more than two full years (2014 and 2015) with some activities for both the Canada and Sida grants extended into 2016. This raises the question of whether interventions have been sufficient in duration to produce lasting changes.

Many of the changes brought about by the H4+ programme can be expected to have a lasting legacy. The MoHCC has already noted that it intends to model coordination mechanisms for the HDF programme on the experience gained in H4+. Improvements in national policies, guidelines and in national systems such as MNDSR and the District Health Information System 2 (DHIS2) (where H4+ advocated for age-disaggregated data on outcomes for girls and women) will also be continued. Similarly, technical and operational innovations supported by H4+ (described in section 4.4) have been accepted as national practice and should continue. Finally, improvements in the skills of staff should persist for some time, especially if supportive supervision is maintained.³⁹

On the other hand, in the six H4+ districts, where the most directly visible improvements in services for RMNCAH have been observed, there is real concern over the prospect of losing H4+ JPCS programme support. The end of the programme was referred to as H4+ “pulling out” by a number of interviewees. It is clear that the effect of loss of H4+ programme support will be most acutely felt at district level.

At a minimum, the districts will lose ongoing support to critical medicines and supplies. If funds are not available to maintain equipment and transport machinery, the ability of the PHEs and DHEs to provide supportive supervision will also deteriorate over time. Newly gained skills in, for example, CEmONC and BEmONC will be hard to maintain in smaller hospitals and clinics in the six districts if clinical mentoring and supportive supervision are not adequately funded. In summary, the six targeted districts will lose a more flexible, annually adjusted, programme of catalytic support which complements larger, less flexible programmes with national coverage. RMNCAH service providers in the six districts see considerable risk in this loss of flexibility.

Demonstrating approaches which can be taken to scale

It is clear that senior management in the MoHCC have viewed the H4+ JPCS programme as an opportunity for working with UN partners for outcomes in RMNCAH in a more coordinated manner. In interviews they have repeatedly emphasised that the approach to programme coordination, planning and review at national, provincial and district level demonstrated by H4+ is one they intend to follow in new national programmes.

It is noteworthy that UNICEF will act as fund holder and programme coordinator for HDF, and UNFPA will be responsible for financial management and oversight of the Sexual and Reproductive Health and Rights (SRHR) component of the new programme.⁴⁰ This will provide the two agencies, as partners in H6, the opportunity to support programme planning and review processes that are consistent with the H4+ experience.

At a more micro-level (discussed in detail in section 4.4 on innovation), they have tested specific innovations and modes of delivery in the H4+ target districts and taken those practices to scale on a national level. These include electronic MNDSR systems, using CD4 machines to test for HIV antibodies at the point of care for HIV positive pregnant women (to better manage their access to Anti-Retroviral Therapies (ART) and the re-vitalized practice of clinical mentoring for EmONC and MNCH. These are examined in more detail in section 4.4 on innovation.

³⁹ Annex 1, Assumption 1.5

⁴⁰ (MoHCC 2015c: 54, 55)

In summary, in combination with other programmes of support, the H4+ JPCS programme in Zimbabwe has made a significant contribution to health systems strengthening for RMNCAH, especially, but not exclusively, in the six target districts. It has done so by addressing needs which are not fully met, complementing the work of existing programmes and, building on the work of those programmes in a way which increases their effectiveness.

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

1. H4+ interventions have clearly contributed to strengthening quality of care in the facilities within the districts covered by the programme. The flexibility of addressing facility- and district-specific needs was instrumental in decentralizing emergency obstetric care closer to the community and reducing the need for referrals to higher-level facilities.
2. H4+ has expanded access to marginalised groups from six remote and hard-to-reach districts excluded from previous, widespread RMNCAH programme efforts. H4+ has contributed to strengthening integration of a package of RMNCAH service across a continuum of care. However, contraceptive services are not an explicit part of the H4+ programme, therefore there was less evidence that these services were integrated within the continuum of care.
3. H4+ JPCS investments have worked in concert with HTF/HDF and RBF to result in increased trust between service providers and users. H4+ provided much needed improvements in infrastructure, provider capacity and competence and an on-going supply of needed commodities and medicines to ensure communities that health services exist at the facility.
4. There is significant potential for loss of gains made by H4+, including breaking trust with the community in the six target districts. These districts have come so far with the relatively small inputs of H4+ and have a lot to lose if the gains cannot be sustained.

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).⁴¹*

Six districts in hard-to-reach geographic areas were targeted for programming on the basis of high maternal, neonatal and child mortality; weak community health programmes; and as areas endemic to malaria. These districts are all rural and notoriously difficult to access, particularly in the rainy season. In Mbire, some communities are further marginalised, as they are located on the grounds of former wildlife reserves which limits travel possibilities to health facilities, particularly at night, even for emergencies. Evidence from interviews and documents indicates the MoHCC was the main actor in prioritizing these districts to receive H4+ inputs in order to complement the activities of other, more widespread, efforts to rebuild the health system response to improve MNCAH, such as the HTF, the ISP, and RRBf. The targeting of the hardest to reach was also credited by some to the Canadian and Swedish donors and their commitment to rights-based approaches.

⁴¹ Unless otherwise noted, for evidence cited in relation to assumption 2.1 see Annex 1, Assumption 2.1

Within these geographically isolated districts, the main target group for H4+ was women, children, and adolescents (in-school and out-of-school youth), with additional focus on pregnant women and adolescents living with HIV. The interventions designed were geared towards meeting the needs of these groups through a package of integrated RMNCH services (especially EmONC, Ante Natal Care (ANC), Post Natal Care (PNC) and Prevention of Mother to Child Transmission (PMTCT)/ Paediatric ART). The main focus of this effort was placed on improving access by bringing services closer to communities and increasing trust by the community that quality services would be available.

Further, the development of maternity waiting homes (also called mother waiting homes and waiting shelters) attached to district hospitals and primary health facilities is credited with increasing access to facilities for pregnant mothers from rural and poor areas, thereby reducing time lost in reaching an appropriate health facility, one of the three major delays⁴² contributing to maternal mortality. The demand-side interventions undertaken by Women’s Action Group (WAG) in selected districts and wards to increase awareness of local leaders and men of the importance of facility-based births, is also seen as a contribution to improving access to pre-natal and BEmONC services by removing socio-cultural and gender barriers.

The establishment of services for adolescents, considered a vulnerable target group, follows the National Adolescent Sexual and Reproductive Health (ASRH) strategy with two main service components: community-based youth centres (counselling, recreational activities and condoms) and health facility based youth friendly corners (voluntary counselling and testing, condoms and other contraceptive methods). The approach was to train providers to be sensitive to and comfortable in dealing with the range of SRH issues experienced by youth, including coercion, date rape, and stigma. Observations and interviews at district and primary health facilities indicate that services are not accessed or well utilized, and that barriers exist more in the community than at the facility; findings that are consistent with a recent assessment of the national ASRH by Johns Hopkins.⁴³

When Sida grant funding through UN Women and UNAIDS became available in 2014 in support of demand-side activities, H4+ supported the establishment of peer support groups for in-school and out-of-school youth. These interventions began to improve access to vulnerable youth by promoting healthy behaviours and removing barriers to services, including the negative attitudes of service providers.

Table 7 provides an overview of H4+ partner support to community engagement for RMNCAH in Zimbabwe

Table 7: H4+ JPCS Partner Support to Community Engagement

UNAIDS	UNFPA	UNICEF	UN Women	WHO
- Engaged traditional leaders to address RMNCAH issues	- Supported adolescent engagement and trained youth peer educators	- Supported Mother Support Groups, PHLIV and Adolescents living with HIV Support Groups	- Supported the formation of community groups to discuss gender and RMNCAH issues including violence and HIV and AIDS	- Limited community engagement in Zimbabwe
- Promoted demand through print	- Trained midwives in youth-friendly talks and supported after school clubs	- Supported youth centre peer educators with	- Developed IEC materials for	

⁴² The Three Delay Model: Delay one: deciding to seek care. Delay two: reaching the health facility. Delay three: receiving adequate and appropriate care (Calvello, Skog et al. 2015).

⁴³ (John Hopkins University 2015)

and other materials.	- Supported village health workers	IEC materials, t-shirts and bags)	community engagement
- Supported NGOs to support community engagement and participation	- Supported ASRH social media use in Hurungwe	- Supported village health workers	- Revitalized community health centre committees

In two wards in each district of Mbire, Chipinge and Chiredzi, the Katswe Sista hood developed *Pachotos* (“safe spaces”) as entry points where young people can discuss their sexual experiences, learn about health and rights, and build confidence and skills. In Binga, Community Adolescent Treatment Support (CATS) groups were established by AFRICAID. In Mbire, the Organization for Public Health Interventions and Development (OPHID) supported groups to promote access to integrated HIV treatment within PMTCT and RMNCAH, especially for adolescents. Interviews with health facility staff, implementing NGOs and youth activities, credit these efforts with helping adolescents living with HIV overcome their fears of stigma and providing access to adolescent-friendly HIV treatment services.

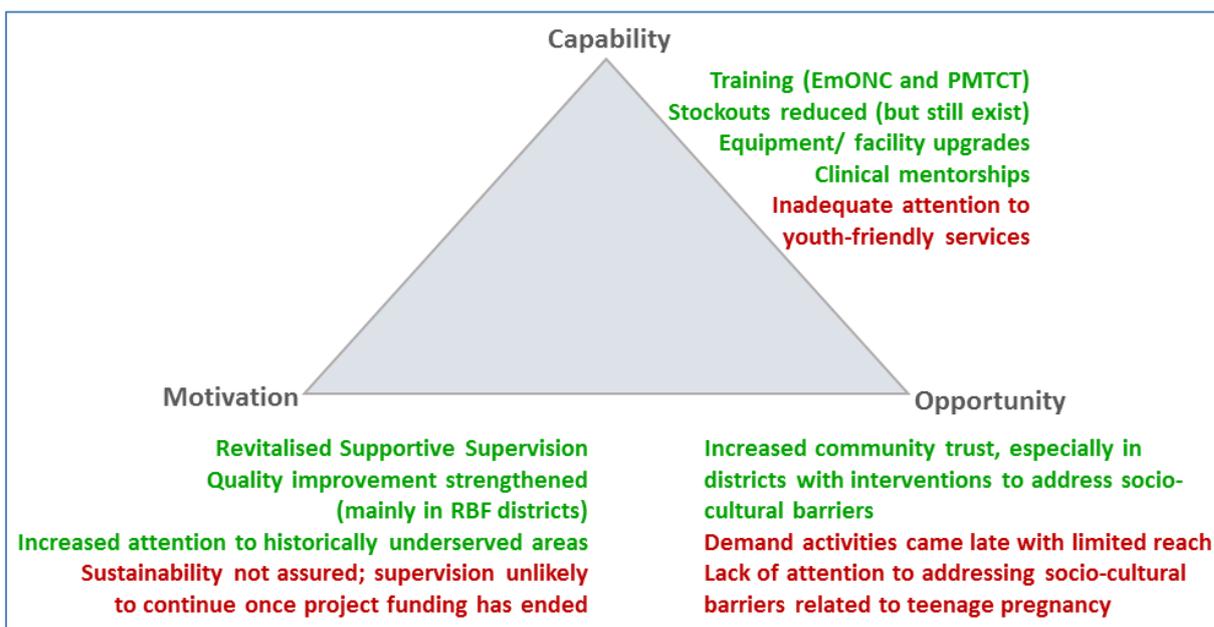
Nevertheless, every community visited expressed concern about the persistent high levels of teenage pregnancy. Unfortunately, improving access to contraception by youth (or in general) was not an explicit part of the H4+ package of RMNCAH services, and observations and interviews indicate this is a missed opportunity for addressing the needs of vulnerable girls.

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.*⁴⁴

Figure 4 provides an overview of the strengths and weaknesses of H4+ JPCS support to strengthening the capability, opportunity and motivation of health services in Zimbabwe.

⁴⁴ Unless otherwise noted, for evidence cited in relation to assumption 2.2 see Annex 1, Assumption 2.2

Figure 4: Addressing Capability, Motivation and Opportunity for Strengthened Services in RMNCAH



Overall, it is clear that the H4+ programme has a greater tilt towards the development of service delivery capacity, with the demand component coming mainly later in the programme cycle, when UN Women and UNAIDS received H4+ funding beginning in 2014. In terms of sequencing, some interviewed thought it was appropriate to postpone community-oriented demand activities until after service capability was well established; otherwise the community would lose faith as demand could not be met. However, many described the community component as “coming too late”. The reach of demand activities was also limited; for example, UN Women made the decision to “go deep” rather than “go wide,” and allocate the limited available funding to reach two wards within three of the six districts. Given the short time available for building trust “going wide” was not seen as a viable option. On balance, many key informants made a strong case for more widespread and more sustained investment in mobilizing demand during H4+ in Zimbabwe.

H4+ country team members acknowledged that it was not until “funds were on the table” that UN Women and UNAIDS were able to influence the programme, and the other agencies realised how much was missing without a stronger demand component. As a result, of the three dimensions of sustainable capacity development, there was greater emphasis in H4+ programming on capability and motivation, than on opportunity. (The dimension of opportunity, i.e., demand, will be covered under assumption 2.5.)

Interviews with health officials at national, provincial, district and primary levels consistently noted the importance of equipment and supplies provided (Box 4) and extensive training conducted across the continuum of care (Box 5). They were cited as major factors in the improvement of facility and provider readiness to offer services.

Box 2: Illustrative list of important equipment and supplies provided by H4+, as noted in interviews with health executives and providers

- Beds for facility and mother waiting shelters
- Anaesthesia machines and anaesthetics (such as, lidocaine, ketamine)
- Operating theatre equipment (tables, lights, resuscitators)
- Incubators
- Autoclaves and sterilizers

- Surgical instruments, including cannulas, MVA kit, laryngoscopes, endotracheal tubes, airways, ambubags
- Blood pressure monitors
- Essential medicines for RMNCAH, including oxytocin, misoprostol, magnesium sulphate
- Intravenous fluids/sets and blood giving sets
- CD-4 machines
- Motorbikes

The facilities observed for the country case study were clean, well maintained and organised, and providers pointed to the improvements in infrastructure and the provision of equipment made available under the H4+ programme. Stock-outs have been reduced, although staff report that they still occur. By 2015, however, 100 percent of health facilities in the six H4+ districts were able to report no stock-outs for a three-month period.⁴⁵

A major issue noted by providers in Binga concerns the blood supply and antibiotics, as these tend to be needed more generally and used up more quickly. However, the capacity to problem-solve was also evident, as managers noted how they would reach out to other facilities in the district to borrow or barter for necessities.

Box 3: Training provided by H4+, as noted in interviews with health executives and providers

- EmONC
- BEmONC
- IMNCI
- Infant and Young Child Feeding (IYCF)
- Youth-friendly service provision
- Paediatric ART
- MVA
- HIV Testing and Counselling, including for Option B+

As noted in Table 4, over 3,700 health care service providers were trained or received refresher training supported by H4+ from 2012 to 2015.

National, provincial, and district managers and health providers interviewed unanimously cited supportive supervision and clinical mentoring as the key ingredients for the positive results of H4+. Both provider capability and motivation were aided by H4+ inputs in supportive supervision and clinical mentoring. Although supportive supervision and clinical mentoring had been conducted previously in Zimbabwe to support the performance of providers, these approaches had fallen away in the face of economic challenges experienced by the health care system. The renewed availability of funding for travel via H4+ revived these approaches.

Supportive supervision and clinical mentoring were described as separate, but related, approaches which go hand-in-hand to improve and sustain health provider capacity to deliver quality services. District Health Executives conduct quarterly supportive supervision visits to rural hospitals and health centres. Interviews suggest that the approach to supervision has become much more “supportive”, partly as a result of checklists and processes introduced by RBF.

⁴⁵ (H4+ Zimbabwe 2016a: 12)

In Binga, one of the pilot RBF districts, provincial and district managers described supportive supervision as a day-long visit with a deep focus on RMNCAH. (Previously, supervision was characterised as a “fly-pass” which focused on all services, without enough time to address priorities). The RBF checklist includes sections on structure, process, drug availability, client exit interviews, and file and case management reviews. Since financing is dependent on the information provided and then verified in the checklist, the process is rigorously adhered to, leading to greater motivation for the act of supervision. In contrast, district managers in Mbire, which is not an RBF district, described a less detailed process of supportive supervision.

Clinical mentoring is provider- rather than facility-focused, and is considered by H4+ staff and health officials to be an effective approach for on-the-job coaching for providers who require additional post-training support to become confident in using their skills. Mentorship can take place at different organisational levels; for example, a provider from a lower level facility can be assigned for a two-week stint with a provincial or capital facility, depending on the availability of caseload in the procedure or service, which is the subject of mentoring. Alternatively, the mentor can spend several days at the provider’s home facility to work with him/ her to observe, assess skills and develop a plan for improvement/ closing the gaps. Mentorship has been credited with reducing the need for additional in-service training. More information on innovative aspects of clinical mentorship is found in section 4.4.

Regarding the sustainability of capacity, many of those interviewed expressed general concern about the end of H4+ and the prospects for maintaining the gains made and improvements in service capacity. Some were of the opinion that the upgrades in provider skills and infrastructure would be sustained over time; with the major concern about the continued supply of life-saving RMNCH commodities. MoHCC staff working in facilities supported by RBF were more optimistic that there would be options for financing supplies in a flexible and timely manner once H4+ funding ends.

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.⁴⁶*

As seen in planning documents and confirmed through interviews with H4+ country team and the MoHCC at all levels, H4+ is intended, by design, to be complementary by providing inputs that build on and help to accelerate the outcomes of other major initiatives addressing RMNCAH, namely, the HTF/ HDF, ISP and RBF.

Moreover, each participating UN partner is playing to its own strengths, with clear delineations of responsibility for programming as described in box 4. Where H4+ partners have similar technical capacities, team members indicated they plan and manage investments and activities to avoid overlap and duplication. For example, both UNFPA and UNICEF work in the area of BEmONC and CEmONC, with UNFPA focusing mainly on strengthening the curriculum in midwifery schools, and UNICEF handling the broader range of in-service and on-the-job training. The question of division of labour among H4+ partners is discussed in detail in section 4.5.

Box 4: Assigned Roles of H4+ Members

⁴⁶ Unless otherwise noted, for evidence cited in relation to assumption 2.3 see Annex 1, Assumption 2.3

- UNFPA: Midwifery (policy development and schools), strengthening BEmONC and CEmONC, strengthening MDSR, establishing obstetric fistula programme, cervical cancer screening, ARSH, FP
- UNICEF: Strengthening BEmONC and CEmONC services under the HTF, midwifery (schools and in-service/OJT), supporting VHWs, PMTCT
- WHO: Policy, Quality of Care guidelines, IMCI, strengthening RMNCH M&E framework, advocacy
- UN Women: community work in identified geographies, i.e., training CBAs, Pachoto sister clubs, revitalising community health centre committees, developing IEC materials, research on gender, working with WAG and Katswe Sistahood
- UNAIDS: Strengthening community networks with community leaders (WAG).

Ministry officials credit H4+ with bringing together the work of UN agencies, drawing on their collective strengths. The H4+ country team unanimously consider the united approach of the agencies as a major achievement of the programme. In addition, the advent of H4+ was described, by more than one H4+ country team member, as the first time that UN agencies worked in a holistic manner, with each one caring about issues that go beyond their particular expertise or interests.

Planning documents and interviews with the MoHCC and the H4+ team all point to the complementary nature of H4+ inputs and inputs from other programmes. For example, the H4+ country team and the MoHCC managers identified the HTF staff retention bonuses as critical to addressing HR capacity and providing the foundation for H4+ capacity development inputs. Likewise, the RBF quality of care checklists combined well with H4+ supportive supervision inputs to improve the content and the process of supervision.

Through the participatory annual planning process involving facilities and implementing partners, gaps that are not covered by the other programmes are identified for H4+ to address. Small amounts of flexible funding have been seen as making a major difference in complementing the other, larger programmes. The HTF offers a one-size-fits-all package of funding and that does not always meet the needs of individual facilities, especially in the hard to reach districts that are strapped for essential resources. RBF financing is dependent on fulfilling benchmarks of performance, which may be difficult for rural facilities to achieve, given the sparse populations they serve. In this way, H4+ has been described as a lifeline for facilities in these districts by providing flexible support for critical needs.

H4+ country team members and provincial and district health team staff concur that shortages of supplies were acute prior to H4+, especially in the six districts and that H4+ has improved procurement coordination.

The MoHCC leads the coordination for procurement of equipment and supplies, in cooperation with the HTF/ HDF team in UNICEF and the H4+ teams in both UNICEF and UNFPA. Together, UNFPA and UNICEF manage the procurement. Although district and primary health managers indicated that there continue to be shortages in H4+ districts, the supply situation has greatly improved due to the combined attention of H4+ and the HTF.

However, some challenges remain with timing and readiness of inputs. For example, the anaesthesia machines provided to Binga District Hospital were delivered but could not be installed. This occurred because a certified installation technician was not available at the time of their delivery and installation by any other person would void the warranty for this expensive equipment. Similarly, in Chipinge, renovations required to make the operating theatre functional to perform caesarean

sections had not happened because of delays in RBF disbursements, even though H4+ had already purchased and shipped the needed equipment.

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.⁴⁷*

Note: This assumption was also addressed as assumption 1.5 with regard to health systems strengthening. The focus here (in relation to evaluation question two) is on the resulting improvements in access for the marginalised and overcoming barriers to their participation.

Focus group discussions and interviews with community members, village health workers and health facilities staff indicate there has been a positive shift in the communications and trust between the health facilities and communities. Support from H4+ is seen as contributing to reductions in the number of home deliveries (confirmed by hospitals and clinics visited); an increased awareness at the community level and among health staff of RMNCAH issues and especially of child health, including nutrition; and a significant improvement in relations between the community and health facilities. In the districts visited, evidence from interviews and clinical registers supports the reported increases in institutional deliveries, skilled attendance at birth, post-natal checks, and PMTCT coverage. The decentralisation of capacity to perform caesarean sections and other minor surgeries (e.g., MVA) has resulted in increased access and utilisation of these services at district and rural hospitals, previously only available in provincial facilities or in Harare.

Key informants recounted the same narrative of a “before” and “after” H4+. Before, patients did not go to the health facility or accept services, and women delivered at home, in large part because they did not trust that the facility would have providers or the means to offer services, let alone quality services. After, there has been increased trust between facilities and communities because they have come to expect to receive quality care and attention.

H4+ country team members and staff of implementing partners describe this change in trust as the result of the capacity development efforts (described under Assumption 2.2), coupled with efforts to engage community members in a variety of ways. Community Based Advocates (CBAs) supported by WAG with UN Women funds (in Mbire, Chipinge and Chiredze) mobilise women and men’s consultative groups on the importance of booking early for antenatal care, delivering in facilities, and how to avoid “the three delays” which cause maternal mortality. WAG also works to increase engagement of traditional leaders in four districts with UNAIDS funding (Mbire, Hurungwe, Gokwe North and Chipinge) and has developed materials for use by community leaders to address issues related to HIV, gender based violence (GBV) and prevention of child marriages. CBAs spoke about having a good relationship with health facility staff and say that more people are accessing services because of this increased collaboration and trust.

Interviews with provincial and district health executives support the importance of working with local leaders, given the influence they have in their communities. For example, staff of the PHE in Bulawayo noted that in Binga, local leaders were said to have influenced an increase in male attendance at ANC visits to 60 percent as compared to 11 percent in other, non-H4+ districts. In addition, they are credited with encouraging women to deliver in facilities by levying the fine of a goat for a home-based birth. There is also evidence that communities are beginning to raise issues and complaints with health facility staff. They consider this a new and important development, signalling increased trust and a sense of partnership between communities and the health system.

⁴⁷ Unless otherwise noted, for evidence cited in relation to assumption 2.4 see Annex 1, Assumption 2.4

In RBF districts such as Binga, the increased engagement can also be attributed to the RBF, as one of the requirements for financing is the existence of an active Health Centre Committee (HCC). HCCs have wide representation; for example, in Binga, the HCC meets quarterly to review issues at the health centre, assess how the community interacts and to help disseminate information and education to the community. Examples of issues discussed include support to renovate the staff house destroyed by a storm and how to arrange training for Village Health Workers (VHW) from remote villages.

In Mbire, the HCC is very active with meetings every two weeks. In Mushumbi, the work of the HCC has contributed to strong community support to the Primary Health Centre (PHC). For example, community members have provided bricks and labour to help build the maternity waiting home attached to the clinic.

Due to the work of Katswe Sistahood and WAG, there was more evidence of efforts to address and social barriers in interviews regarding community engagement activities in Mbire than, for example, in Binga. There, key informants tended to focus more on a health care rationale for improvements in RMNCAH.

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.⁴⁸

There is a consensus among the H4+ country team, the MoHCC and Ministry of Women's Affairs, Gender and Community Development (MWAGCD) officials, and NGO implementing partners that community interventions have not received the same level of priority, resources and attention as health systems strengthening interventions. Until UNAIDS and UN Women were brought into the programme, there was inadequate attention to community engagement and especially mobilizing to engage men to support women's health-seeking behaviour and to address the needs of vulnerable youth. Even though services were improving in quality and quantity, there are still needs for some improvement to engage communities to demand services. The major challenge for community interventions noted by implementing partners and the H4+ country team was an inadequate level of resources which resulted in inadequate reach for the demand work.

Major socio-cultural and gender barriers were identified in a gender assessment of community structures that influence women's and girls' SRH and maternity health-seeking behaviours.⁴⁹ Interviews with facilities staff, community members and NGO implementing partners confirmed and expounded on similar issues during visits to Binga, Chipinge and Mbire. Issues often noted included: early marriage, school drop outs, teenage pregnancy, seasonal episodes of GBV related to harvest seasons for cotton and tobacco, negative views by men on their partners attending maternity homes, lack of value for education, and stigma about teenage sexuality (but not about early motherhood). The consensus was that there was not enough time available under H4+ support to make significant in-roads into the socio-cultural landscape that gives rise to these barriers.

Interventions to address these barriers are being undertaken in only two wards/district, and there is consensus that this has been both "too late" and "not enough". Staff from implementing partners indicate that there has been some success in increasing trust among community members in the health system and from efforts to increase SRHR literacy among youth. Regarding the latter, this

⁴⁸ Unless otherwise noted, for evidence cited in relation to assumption 2.5 see Annex 1, Assumption 2.5

⁴⁹ (UN Women 2014a)

includes improved confidence, knowledge and ability by those young people reached to communicate their needs and issues to health providers, coupled with an increased openness by service providers to engage and listen to young people. This is confirmed by focus group interviews with community members.

Participants in men's and women's forums noted that there has been more open discussion relating to the prevention of GBV and early marriage. They also pointed out that health centre staff are part of the forum and exhibit positive and helpful attitudes that assist in moving the discussions forward to engender trust. A mothers' support group spontaneously mentioned an array of health messages including: information about breastfeeding and balanced nutrition, child immunization, how to encourage partner HIV testing and counselling, adherence to medicines, use of contraception to space births, the importance of returning for PNC check-ups, and the dangers of early pregnancy (and importance of abstinence for young girls).

Discussions with a group of out-of-school youth supported by Katswe Sistahood (all young mothers) had a strong focus on HIV and GBV prevention, family planning and human rights. The members of the group defined human rights as the right to a choice about whether to use and what to use for contraception, the right to non-discrimination and the right to Sexual and Reproductive Health (SRH), including the right to ask for sex). The group indicated that the clinic has become "friendlier" towards women clients. Similar discussions with a group of in-school youth indicated that Katswe helps to teach them about hygiene, their rights, and how to prevent sexual abuse and rape.

For in-school youth, a major concern is avoiding early marriage and/or teenage pregnancy. The main method taught in schools for avoiding pregnancy is abstinence. In-school youth reported that it was difficult to remain enrolled in school because of high fees and their parents' preference that they marry. Both in-school and out-of-school youth remarked on difficulty in accessing SRH services including family planning. The nearest youth friendly corner (where contraceptives could be found) for both these groups was five kilometres distant and was unlikely to be used.

4.2.2 Contributing to expanded access to integrated care

H4+, working in complementary fashion with other programmes of support to RMCAH, has made identifiable contributions to expanded access to integrated care in Zimbabwe by:

- Strengthening the quality of care provided to under-served populations
- Expanding access for marginalized and excluded groups, especially adolescents, youth and poor women to services in MNCH but with less emphasis on sexual and reproductive health of adolescents
- Strengthening the integration of services across the RMNCAH continuum of care, with the exception of contraceptive services
- Helping to build trust between service providers and users.

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

H4+ interventions have clearly contributed to strengthening the quality of care in the facilities within the districts covered by the programme. The support of H4+ was instrumental in decentralizing emergency obstetric care closer to the community and reducing the need for referrals to higher-level facilities. Moreover, H4+ support expanded access by raising both the competence and confidence of health care providers across the continuum of care. Facilities have been upgraded so that they are welcoming, clean, and well appointed, leading the community to trust that quality services are available. While challenges continue to exist with stock-outs, transportation and other basics that are

hard to address in a somewhat fragile health system, there is also a culture of problem-solving and innovation which helps health facility staff to address these issues.

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

As the six districts were selected from among the poorest and most geographically remote, H4+ has expanded access to marginalised groups excluded from previous, widespread RMNCAH programme efforts. For adolescents and young girls, H4+ has contributed to expanding access to MNCH services more than SRH services.

The rising rates of teenage pregnancy cited by all categories of key informants have not been adequately addressed in service delivery, although the (somewhat limited) demand promotion activities are attempting to communicate the dangers of early pregnancy. The latest Zimbabwe Demographic and Health Survey (ZDHS) survey data indicates that the pregnancy rate among women aged 15 - 19 in rural areas remained the same in 2015 as in 2010 (28 percent). Further, the same data show that 38 percent of women aged 15 to 19 with only primary school education have begun child bearing.⁵⁰ Contraception appears to be an appropriate topic for out-of-school young mothers to prevent another pregnancy; however, it is reportedly too sensitive to raise with young, in-school girls who have never been pregnant.

Strengthening the integration of services across the RMNCAH continuum of care

H4+ has contributed to strengthening integration of a package of RMNCAH service across a continuum of care. Mothers receive integrated services from ANC to Post Natal Care (PNC), incorporating maternity, HIV testing and counselling, ART, PMTCT, and nutrition. GBV is addressed in community awareness activities. Contraceptive services are not an explicit part of the H4+ programme, so there was less evidence about the extent to which these services were integrated within the continuum of care.

Developing trust between service providers and users of RMNCAH services and sustainability of investments

H4+ JPCS investments have worked in concert with HTF/ HDF and RBF resulting in increased trust between service providers and users of RMNCAH services. H4+ provided much needed improvements in infrastructure, provider capacity and competence and an on-going supply of needed commodities and medicines to ensure communities have access to health services at the facility. Together, these inputs have made a significant difference in the quality of services. There is not a clear answer to the question of whether these improvements can be sustained. Given the reductions in retention bonuses envisioned under the new HDF and the planned ending of H4+ funding, there is significant potential for losing the gains and for breaking trust with the community. These districts have come so far with the relatively small inputs of H4+ and have a lot to lose if they cannot be sustained.

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

1. For a significant time after programme start-up, H4+ in Zimbabwe lacked an effective national coordinating mechanism and suffered from low visibility, especially at district level.

⁵⁰ (ZNSA 2016)

2. From 2014, the MoHCC assumed a stronger leadership role and established an effective H4+ national steering committee.
3. H4+ partners and the H4+ coordinator responded positively by supporting the MoHCC in its leadership role and by actively participating in coordination and planning mechanisms, including at provincial and district level.
4. H4+ has established an effective platform for coordination that extends all the way from offices in Harare to health facilities in the most remote and hard to reach districts.

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.*⁵¹

Interviews with MoHCC staff and H4+ country team members indicate that coordination of the H4+ programme, both internally within the partners group and externally with health authorities at national, provincial and district levels, was inadequate before 2014. It was only after the Victoria Falls meeting in April, 2014 and the subsequent establishment of the H4+ national steering committee in June the same year that an effective national coordinating body for the programme came into effect. In fact, the first meeting of the committee identified poor national coordination mechanisms as a key programme weakness. The establishment of the new committee also coincided with a shift within the MoHCC, with responsibility for the H4+ programme moving from the Reproductive Health Unit to the office of the Director of Family Health who reports to the Permanent Secretary through the Principal Director. This shift was interpreted by the H4+ country team as a sign of renewed commitment to leadership by the MoHCC.

During interviews, MoHCC staff, H4+ partners, and staff of NGO implementing partners all pointed to the establishment of the national steering committee and the leadership role of the Family Health Directorate of MoHCC as the most critical factor in the effective coordination of the programme. The new committee gave the H4+ partners and the MoHCC the chance to sit and plan together. This opportunity, combined with the quarterly provincial and district planning and review meetings (which also included health facility staff), meant that detailed discussions of programme progress, and the fit between needs and actions, could take place at the national, provincial and district levels for the first time.

For some members of the H4+ country team, the effects of the new coordinating committee went beyond improving the H4+ programme itself: *“improved coordination has been the major positive improvement due to the programme. Focusing on the real problems at district level helped to make each H4+ member organisation feel responsible for the work of the other agencies: especially since they all aim for the same results (while working at what they do best).”*

In addition to the national programme steering committee there are more informal structures for coordinating work across the different programme platforms supporting RMNCAH in Zimbabwe. One informal group also works under the coordination of the Director of Family Health and MoHCC and includes:

- The H4+ team at UNICEF
- The H4+ team at UNFPA
- The Health Transition Fund/ Health Development Fund team at UNICEF

⁵¹ Unless otherwise noted, for evidence cited in relation to assumption 3.1 see Annex 1, Assumption 3.1

- The chief accountant at MoHCC
- The Director of Pharmacy at UNFPA

This group works closely to coordinate procurement and distribution of essential medicines and supplies for RMNCAH so that the HTF programme and H4+ do not duplicate their efforts.

Senior managers at the MoHCC reported a significant change in the willingness of the H4+ partners to work together in a coordinated way with the advent of the national steering committee. They also acknowledged the role that the H4+ coordinator played in promoting the new mechanism in particular and coordination among the country team members in general. As one MoHCC manager remarked: *“Before the advent of the steering committee, one H4+ partner would come to us and say, let’s do X, then another would come and say let’s do Y. Even among the H4+ partners themselves, the visibility of H4+ was very low. This improved after the [April 2014] Victoria Falls meeting and the advent of the steering committee, in part because the district planning and review meetings encouraged the engagement of the district health executives.”*

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.*⁵²

As noted by the Manicaland Provincial Health Executive, responsible for Chipinge district, *“coordination works right down to the district level and involves all the partners in H4+”*. This was confirmed during interviews with key stakeholders in Harare, with the three PHEs visited, and with DHE and health facility staff. It was also reiterated by staff of NGO implementing partners.

The key to this system of joint coordination and planning for H4+ is the combination of three factors:

- The structure and operation of the H4+ national steering committee with clear leadership by the MoHCC – which includes representation of the MoHCC, the H4+ partners and at least one provincial medical director
- The existence of quarterly planning and review meetings (each three days in duration) bringing the coordinated planning and review of the programme directly to the district level
- Joint review and supervision missions undertaken by staff of the MoHCC and the H4+ partners.

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.*⁵³

The H4+ country team in Zimbabwe report that they took special note of the content and direction of national plans and priorities expressed in the following key documents:

- The National Health Strategy for Zimbabwe: 2009-2013
- The Zimbabwe National Maternal and Neonatal Road Map: 2007-2015
- The Final National Integrated Health Facility Assessment Report: 2013

⁵² Unless otherwise noted, for evidence cited in relation to assumption 3.2 see Annex 1, Assumption 3.2

⁵³ Unless otherwise noted, for evidence cited in relation to assumption 3.3 see Annex 1, Assumption 3.3

During early H4+ coordination meetings, the H4+ country team undertook to meet with the MoHCC staff at the national, provincial and district levels to inform them on the nature of the programme and develop an understanding of their specific needs for support. Since 2014, however, the main mechanism for ensuring that workplans respond effectively to changing national and, particularly, district level needs, has been the combined operation of the national H4+ steering committee and the quarterly provincial and district planning and review meetings.

Reports on the planning and review meetings provide examples of identified areas of need put forward by staff of PHE, DHE and health facilities staff. These needs are not always met due to resource constraints and issues of reach. For example, the call for more intensive work on demand promotion and community mobilisation on the part of DHEs may exceed both the funds allocated to demand-side activities and the capacities of NGO implementing partners.

Comparing the district report segments of the quarterly planning and review meeting minutes over time illustrates a strong shift from (in the 2013 report) a simple listing of deficiencies and challenges facing each district to (in the 2015 report) a reporting of achievements in each district including: health care providers trained, clinical mentoring carried out, installation of machines and equipment, and availability of medicines and supplies. It is clear from the 2015 report that actions have been taken by the H4+ programme to respond to the deficiencies identified in 2013. To provide one example, Mbire district identified the absence of a functioning operating theatre and an inability to perform caesarean sections as a major deficiency in 2013. During the June 2015 meeting it reported that the operating theatre was functional as a result of support by H4+.⁵⁴

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.*⁵⁵

There is certainly no apparent lack of coordinating bodies for health sector support in Zimbabwe. Nonetheless, the consensus among MoHCC staff and H4+ country team members is that the advent of the national H4+ steering committee improved the complementarity of programmes. The result is an interlocking set of coordinating mechanisms that can be viewed, in the words of one H4+ country team member as an “*integrated structure for coordinating across programmes of support to the health sector*”. These mechanisms include:

- The Country Coordinating Mechanism (Global Fund/ Gavi)
- The HTF/ HDF steering committee chaired by the Permanent Secretary of MoHCC
- The H4+ steering committee chaired by the Director of Family Health
- The Adolescent Sexual and Reproductive Health Forum
- The Ministry of Health and Donor Committee, which reviews all health programmes.

Senior managers at the MoHCC indicated that the main features of H4+, including its coordinating mechanisms, will be incorporated in the new HDF programme. However, they also fear that the focus on MNCH and on innovation that came with the national H4+ steering committee (and the funded initiatives it coordinated) may be lost. As one senior manager noted: “*There is a risk that HDF will provide funding at a big picture level and will not prioritise innovation in RMNCAH. The unique focus of H4+ could be lost.*”

⁵⁴ (MoHCC 2014b: 2-3, MoHCC 2015i: 7-9)

⁵⁵ Unless otherwise noted, for evidence cited in relation to assumption 3.4 see Annex 1, Assumption 3.4

4.3.2 Responding to national needs and priorities

H4+ in Zimbabwe has been able to establish planning, coordinating and review mechanisms and processes which are effective in responding to changing national and sub-national needs. Further, effective coordination mechanisms working at national, provincial and district levels under the leadership of the MoHCC have contributed to notable positive results.

Responding to change and placing countries at the centre of the programme

Experience in Zimbabwe indicates that the basic structures and processes of the H4+ JPCS programme are sufficiently flexible at country level to allow it to respond to the changing needs of the countries it serves. However, this flexibility was not effectively linked to national leadership for the first half of the programme period. After the advent of the national H4+ steering committee, there were three apparent factors that revitalised H4+ structures and processes so that national (and local) needs could drive programming:

- The willingness and ability of the MoHCC to assume a leadership role and to ensure coordinated programmatic action through the national H4+ committee
- The responsiveness of the H4+ country team (and active support of the H4+ coordinator) to ensure that the H4+ partners responded positively to national leadership
- A system of joint supervision and participatory planning and review at the provincial and district level that extended coordinated programme planning all the way to the level of individual facilities in the six H4+ districts.

The benefits of meaningful H4+ coordination under national leadership

As noted by managers and staff of H4+ partners, the MoHCC, and NGO implementing partners, the shift to an effective, nationally-led coordinating structure and process, with flexible funding for matching investments to needs on an annual basis, had notable positive results:

- Allowing the MoHCC and the H4+ partners to unite around a focused effort to improve outcomes in RMNCAH using first the Canada and then the Sida grant funds
- Contributing to a change in the nature of UN H4+ partner cooperation and collaboration based on shared responsibility for achieving results
- Allowing staff and managers at facility, district and provincial levels to have meaningful input to planning and review mechanisms which shaped work plans and investments in their jurisdictions and work sites.

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 mobilization and effective supervision, monitoring and accountability)?*

Summary

1. The programme has identified several effective practices that have the potential for significant effect in Zimbabwe. Two key innovations have contributed to health systems strengthening, i.e., the improved capacity of health staff to provide EmONC services (clinical mentorship) and manage the treatment of HIV+ individuals (POC CD4 machines).
2. The programme has produced limited documentation to systematically describe and assess the process, results and success achieved or failure from the testing and/or scale-up of innovative practices. Documentation has been done mainly in the form of public interest stories for communication purposes.

3. It is clear that there is a strong will within the programme and the Ministry to replicate and scale up practices deemed effective; however, determination regarding what is effective is not often based on a systematic review of evidence, but on opinion derived from practical experience. This informal attention to innovative practices leads to a missed opportunity to share knowledge and experience with the wider MNCAH community.

4.4.1 A theory of change for innovation in Zimbabwe

From the beginning, the H4+ initiative has emphasised the importance of innovation in country level efforts to catalyse and accelerate programming in RMNCAH. The H4+ working definition for innovation is *“any novel or newly packaged, scalable approach aimed at improving outcomes relevant to the continuum of maternal and newborn health care.”*⁵⁶ The working definition does not provide criteria or guidance for what constitutes a systematic and deliberate process for testing, evaluating and scaling an innovation. Ideally, this process would include the full cycle of innovation: from identification of an opportunity to experimentation, documentation and adaption of results.

The theory of change for innovation described in the inception report has been revised based on the Zimbabwe country case study using two examples:

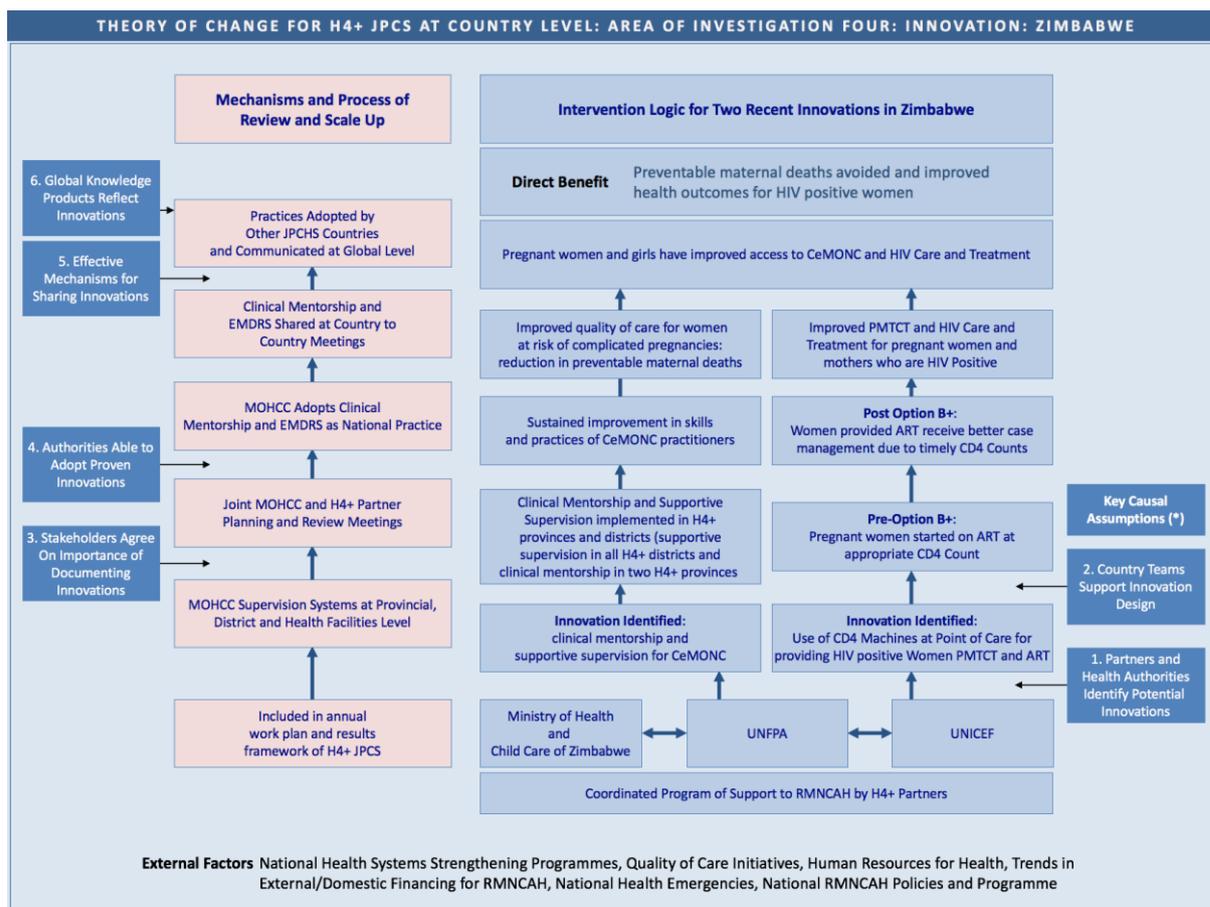
1. Clinical mentorship for CEmONC: Clinical mentorship is a process of professional capacity development that relies on practical training and consultation by an experienced mentor following the initial training of a provider. The practice of clinical mentorship had been in place in Zimbabwe, however, funding challenges led to its discontinuation. H4+ funding enabled it to be revitalized to support the MoHCC priority for accelerated capacity development in MNCAH.
2. Use of CD4 Machines at point of care for providing HIV positive women with PMTCT and ART services: CD4 count testing has been an important diagnostic tool to identify HIV positive patients eligible for ART and for monitoring patient responses to treatment. Access to CD4 testing was identified as a major barrier for increasing access to treatment and resulted in missed opportunities for early ART initiation among mothers and infants in PMTCT programmes. Provision of point of care (POC) machines and training in their use was introduced in Zimbabwe with H4+ funding as an innovation to improve access to reliable and immediate diagnosis of HIV.⁵⁷

The ToC is presented in Figure 4 below. The detailed causal assumptions for this ToC are stated and examined in detail in sub-section 4.4.3.

⁵⁶ H4+ Guidance for Documenting Innovative Approaches, November 2013

⁵⁷ Under option B+ which is now standard practice for ART therapy for pregnant women, CD4 testing is no longer needed as ARTs are now prescribed for life for any pregnant woman who is HIV positive regardless of the viral load. However, use of CD4 machines at PoC is still useful for case management

Figure 5: Theory of Change for Innovation in H4+: Zimbabwe



(*) Detailed descriptions of the key causal assumptions are provided in Annex 6

4.4.2 Testing causal assumptions for innovation

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.*⁵⁸

Throughout interviews with national, provincial and district health officials and health care providers, as well as H4+ country team members and other stakeholders, many activities were identified as H4+-supported innovations. In addition to the widely recognised clinical mentorship and provision of PoC CD4 machines (described in Section 4.4.1), other examples of innovation identified in interviews and documents included:

- Supportive supervision: a revitalisation of a proven practice during which health managers from province or district levels routinely visit facilities to assess quality and assist with problem identification and solving.
- Electronic maternal and neonatal death reporting system (EMNDRS): an on-line, web-based surveillance system to enable real-time reporting of maternal deaths from provincial to national level, being tested in Manicaland Province

⁵⁸ Unless otherwise noted, for evidence cited in relation to assumption 4.1 see Annex 1, Assumption 4.1

- Use of social media to address teenage pregnancy: an emerging strategy adopted from UNFPA and the National ASRH Network to exploit social media to empower adolescent girls to make healthy reproductive decisions and piloted in Hurungwe
- Piloting a “seal of quality” for BEmONC facilities⁵⁹
- Mobile technology for supporting referrals between facilities.⁶⁰

Many of these examples represent a new practice that has not been tried before, such as the EMDRS. Others, such as clinical mentorship and supportive supervision were practiced in different forms in the past in Zimbabwe, but had fallen into disuse because of the general decline of the health system. However, it was clear from interviews that the revitalisation of these practices constituted an innovation in the eyes of the vast majority of those interviewed.

The innovation of clinical mentorship is built upon a WHO global definition for the practice. Clinical mentorship emerged as a priority at a 2012 stakeholders meeting in keeping with the MoHCC prioritisation of building human resources capacity to achieve the national health and the Millennium Development Goals. The rationale for the prioritisation of clinical mentorship is highlighted within the guidelines developed for this intervention, which called for enhancing the skills of all cadres of health providers engaged in RMNCAH.⁶¹

In the case of PoC CD4 machines, the innovation was derived from a UNICEF pilot in October 2012, which supported the procurement of 45 machines and distributed them to 35 high volume clinics in seven districts in the country as part of a comprehensive scale up of PMTCT/ Paediatric HIV interventions integrated with RMNCAH services. The MoHCC commissioned an evaluation to generate evidence regarding the effectiveness of the PIMA POC CD4 count machines in MNCH settings. It concluded that patient management and retention had improved and most HIV+ pregnant women and their families were assessed for ART on time.⁶²

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.⁶³

Evidence from documents (meeting minutes, trip reports and H4+ interim reports) indicates that the H4+ team is making use of technical capacity within Zimbabwe (from the Government and H4+ team alike) and drawing on global knowledge products but is mainly driven by the leadership of the MoHCC in terms of identifying and prioritizing the intervention.⁶⁴ For example, key informants noted that clinical mentorship is built upon Zimbabwean technical experience and WHO global guidance, and its programming was done in Zimbabwe through a joint collaboration of H4+ partners and the MoHCC experts. Technical experts from Zimbabwe were instrumental in conducting the assessments and supported the use of these innovations.

Interviews with H4+ country team members indicate that each H4+ partner is tapping into its own regional/ global sources of expertise in RMNCAH, as needed. However, interviews have also indicated that there is no perceived need for more regular and systematic oversight or technical assistance from the regional offices for H4+ activities, and neither is there a need for a regional structure within the H4+ partnership. National level technical expertise is strong, and, where needed, it is supplemented by inter-country missions and planning meetings.

⁵⁹ Noted in H4+ Intermediate Report, 2013-2014; however, no details provided within the report

⁶⁰ Ibid

⁶¹ (H4+ Zimbabwe 2015b)

⁶² (UNICEF and MoHCC 2012)

⁶³ Unless otherwise noted, for evidence cited in relation to assumption 4.2 see Annex 1, Assumption 4.2

⁶⁴ (WHO 2013b, H4+ 2015b, AIDS.gov 2016)

Review missions by the global technical team to H4+ countries provide an opportunity for exchange and technical input. Documentation of such a mission to Zimbabwe in 2015, while it does not specifically focus on innovation, does cover the programme as whole. The report included recommendations for strengthening the level of documented evidence for the POC CD4 machines.⁶⁵

Inter-country programme planning meetings offer the opportunity for exchange and identification of issues. The Victoria Falls meeting of global H4+ partners in June 2014 included the issue of documentation of innovations as well as achievements, and suggested the use of strategies from other countries to address persistent challenges, for example, to address the lack of progress on ASRH programming. Exchanges between countries have also been useful. A trip by the H4+ country team and MoHCC staff to Ethiopia was conducted in 2013, the purpose of which was a planning workshop to support the finalisation of action plans, although there was no reference to discussions about specific innovations or technical exchanges. More, recently, staff of the UNFPA country office, the MoHCC and the University of Zimbabwe undertook a mission (supported by H4+) to Addis Ababa for the purpose of learning how to establish a successful obstetric fistula programme.⁶⁶

Technical expertise exists within the H4+ partnership to support monitoring and evaluation, especially for the routine monitoring of indicators, and for assessing progress of activities. The MoHCC, with support from UNFPA, assumed overall responsibility for the M&E system in H4+ in April 2014 (previously, it had been with UNICEF). The MoHCC and UNFPA have focused their efforts since then on ensuring that the results framework for H4+ in Zimbabwe was populated with the required data to inform the designated results indicators. What seems clear is that, other than approving the annual work plan, there was little effort made by H4+ regional and global teams to ensure adequate documentation of innovations supported by the programme in Zimbabwe.

And, while the partners have accessed experienced Zimbabwean evaluation consultants and firms to evaluate innovations on a limited basis, such as in the case of the PoC CD4 machines discussed in 4.1 above, this technical expertise has not been tapped to further the innovation agenda of H4+.

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.⁶⁷

There are H4+ guidelines for documenting innovation that offer a template that includes a description of the justification for the innovation, the background or problem it is intended to address, the strategy or intervention, the results (quantitative and qualitative) and the lessons learned.⁶⁸ The documentation of innovations and other best practices did not follow this guidance, but has been captured by H4+ in Zimbabwe as human-interest stories, shared with local audiences, ministry and development partners, H4+ donors and with other H4+ countries. Given the importance of communication and visibility for the Zimbabwe programme, the team produced documents, including a video documentary, mainly for that purpose. According to the H4+ country team, the global level did not place particular emphasis on documenting the process of innovation, and they were unaware of the 2013 guidance document developed for this purpose. The use of this guidance was not emphasised by the H4+ global team, nor was there any input received on what had been developed. The M&E framework included a benchmark for documenting two innovations, and human interest stories related to the innovative use of CD4 machines and the use of social media to promote youth engagement in Hurungwe District were written to satisfy this requirement. However,

⁶⁵ (H4+ 2015b)

⁶⁶ (UNFPA 2015b: 1)

⁶⁷ Unless otherwise noted, for evidence cited in relation to assumption 4.3 see Annex 1, Assumption 4.3

⁶⁸ (H4+ 2013a)

although H4+ staff did not identify it as a documentation of innovation, one example was found regarding the assessment of an innovative intervention prior to scaling up. The MoHCC commissioned an assessment of PoC CD4 machines, which reviewed the experience, feasibility and cost of this innovation in seven pilot districts.⁶⁹ This assessment was subsequently used to guide national replication, including scale up within PMTCT sites supported by USG PEPFAR funds.⁷⁰

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).*⁷¹

Interviews with MoHCC officials at the national and provincial levels indicate a commitment to finding effective and efficient solutions to the problems and challenges that they face. They attribute H4+ with providing the necessary resources and platforms for supporting innovations in RMNCAH and express concern that without H4+, the focus on innovation and the ability to flexibly try out solutions to problems will be lost. There is a consensus that the other major programmes are already fully designed and the room for flexibility and innovation is limited, in contrast to the case of H4+.

Given the impact that clinical mentorship has had on EmONC and provider capacity, there is a strong expectation that this will continue through the operations of the HDF, especially given that UNFPA and UNICEF play a key technical role in supporting clinical mentorship and the coordination of the HDF. Given that external donors finance large elements of the health system, Zimbabwe will rely on external sources of funding from the HDF and RBF to sustain the innovations.

4.4.3 Contributing to innovation for RMNCAH in Zimbabwe

Recognizing potentially effective innovations in RMNCAH

The programme has identified several effective practices that have the potential for significant effect in Zimbabwe. The MoHCC leadership is the driving force for innovation, with support from the H4+ country team. Despite the fact that innovation was an important feature of H4+ programming, there was limited attention regarding the genesis and rationale for considering innovative practices; innovation was a descriptor for certain activities that were being introduced or re-introduced via the H4+, and the identification and recognition was mainly done in an informal manner based on experience rather than evidence. Nevertheless, two key innovations have contributed to health system strengthening, i.e., the improved capacity of health staff to provide EmONC services (clinical mentorship) and manage the treatment of HIV+ individuals through the use of POC CD4 machines.

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

The programme has produced limited documentation to systematically describe and assess the process, results and success or failure achieved from the testing and/or scale-up of the practices identified as innovative. While innovation was highlighted as a priority aspect of the programme at its inception, it appears that the routine and intensive acts of programme coordination take precedence to investing in the implementation of the full cycle of programme innovation. Apart from exchanges at meeting, there is little evidence to support a strong effort at knowledge management within and across programmes. Despite having an M&E resources in place and access to technical expertise in country, the limited attention by H4+ to documenting the results of testing and scaling up of innovative practices is attributed to placing greater emphasis and importance on the communication of results to increase public awareness of H4+ activities.

Replication of innovations across districts and at national level

⁶⁹ (H4+ Zimbabwe 2014b, H4+ Zimbabwe 2014d)

⁷⁰ (PEPFAR 2010)

⁷¹ Unless otherwise noted, for evidence cited in relation to assumption 4.4 see Annex 1, Assumption 4.4

It is clear that there is a strong will within the programme and the MoHCC to replicate and scale up practices deemed effective, whether documented evidence exists or not. Mainly, decisions to adopt or scale up an innovation tended to be informal and based on practitioner experience rather than on a more strategic or analytical process. Consultations by national health and programme officials with provincial and district stakeholders have been an effective mechanism for rolling out innovative practices, such as clinical mentorship. However, without greater emphasis by the global and national teams on documenting both the content and process of innovation, H4+ misses an opportunity to influence other programmes with evidence and results of its experience.

4.5 Division of labour

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

1. The MoHCC led national H4+ steering committee and the system of provincial and district planning and review meetings, along with joint supervision missions, has allowed H4+ partners to arrive at an effective division of labour.
2. Starting from their own mandates and perceived comparative advantages, H4+ partners have been able to refine their support to match national, provincial and district needs.
3. There is evidence that H4+ partners have been able to be more effective in collaborative programming funded by H4+ than they would be in support of separate initiatives. This is illustrated by the common perception that H4+ support to RMNCAH is in fact a single, flexible programme of support.
4. Some problems in the disbursement and transfer of funds to the provincial and district level could have limited the effectiveness of H4+ support at sub-national level.

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.*⁷²

As noted in section 4.3 in relation to evaluation question three, and confirmed by interviews with a wide range of stakeholders in Zimbabwe, there was a considerable delay in establishing the national H4+ steering committee. As a result, the first part of the H4+ programme was characterized by “*poor national coordination*”.⁷³

This situation changed significantly in mid-2014 with the advent of the national H4+ steering committee with the Director of Family Health, MoHCC as the chair. The operation of the national steering committee, combined with the joint quarterly provincial and district review meetings provided the H4+ programme with an integrated system of oversight, coordination and review which extended from the national to the district level. This system became one of the most notable strengths of the programme in Zimbabwe.

⁷² Unless otherwise noted, for evidence cited in relation to assumption 5.1 see Annex 1, Assumption 5.1

⁷³ (MoHCC 2014d: 2)

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.⁷⁴

It is clear that each H4+ partner entered into the H4+ programme based on a clear perception of their pre-dominant roles in the programme, although they arrived at different times. UNFPA, UNICEF and WHO began participating in 2011, while UN Women and UNAIDS joined with the application of the Sida grant in 2013. The evolving roles of each H4+ partner in Zimbabwe are outlined here based on four different sources: interviews with H4+ country team members, the final H4+ workplan for 2015-16, reports of the quarterly provincial and district planning meetings which identify H4+ activities for the upcoming year, and the 2015 mapping of maternal health work by UN agencies.⁷⁵

Table 7 provides an overview of each partner’s role and their areas of work in 2015. It does not include assigned roles for the World Bank in Zimbabwe. This reflects that fact that the Bank was not assigned a specific role in annual H4+ work plans, was not a member of the national H4+ steering committee established in June 2014 after the Victoria Falls meeting, and did not participate in the quarterly H4+ provincial and district planning meetings.

Table 8: The Assigned Roles and Areas of Work (2015) of H4+ Partners in Zimbabwe

H4+ Agency	Programme Role	Areas of Work: 2015 With H4+ Support Indicated
UNFPA	<ul style="list-style-type: none"> • Current H4+ Coordinator • Policy, advocacy, human resources and commodities support for RMNCAH including the areas listed under areas of work • Strengthening BEmONC and CEmONC as well as MDSR 	<ul style="list-style-type: none"> • <i>Midwifery</i> policy and advocacy and support to midwifery schools • Strengthening BEmONC and CEmONC: national policies, training manuals and plans and training, clinical mentorship and supportive supervision, procurement of essential commodities (H4+) • Maternity waiting homes (H4+) • National obstetric fistula programme (H4+) • Cervical cancer screening: Visual Inspection with Acetic Acid (VIAC) • Adolescent reproductive sexual health programme • Piloting and establishing the electronic database on maternal and perinatal deaths (H4+)
UNICEF	<ul style="list-style-type: none"> • Original H4+ coordinator • Focus on PMTCT • Support to MCH under the HTF programme 	<ul style="list-style-type: none"> • PMTCT programme under H4+ with policy work contributing to adoption of WHO option B+, training, procurement of PoC PIMA machines, HIV testing and counselling (H4+) • Infant and young child feeding (H4+) • Strengthening CEmONC and BEmONC under the HTF with policy work, training, clinical mentorship, supportive supervision, results based financing and retention bonuses (not funded by H4+ but complementary to it) (HTF) • Midwifery work in support of training schools (HTF) • Community work in support of village health workers (H4+)
WHO	<ul style="list-style-type: none"> • Improving the policy environment for MNCH 	<ul style="list-style-type: none"> • Developing, updating, and revising guidelines, policies and strategies on MNCH (H4+)

⁷⁴ Unless otherwise noted, for evidence cited in relation to assumption 5.2 see Annex 1, Assumption 5.2

⁷⁵ (H4+ 2015c)

	<ul style="list-style-type: none"> • Capacity building especially for management of MNCH services 	<ul style="list-style-type: none"> • Conducting research and facilities assessments • Supporting improved Quality of Care (QoC) by adapting international guidelines (H4+) • Capacity building in Integrated Management of Childhood Illnesses (IMNCI), health care management and growth monitoring and assessment (H4+)
UNAIDS	<ul style="list-style-type: none"> • Ensuring HIV work is leveraged in support of integrated RMNCAH services 	<ul style="list-style-type: none"> • Policy work, leadership and coordination on integrating HIV and RMNCAH services • Support to monitoring and evaluation in HIV • Community work with traditional leaders (H4+)
UN Women	<ul style="list-style-type: none"> • Empowering youth and adults (esp. girls and women) to access RMNCH, HIV and GBV services 	<ul style="list-style-type: none"> • Training community based advocates (CBAs) (H4+) • Creating dialogue and awareness among girls and young women (H4+) • Establishing community forums for sharing on RMNCAH, HIV and GBV issues (H4+) • Creating and revitalizing community health centre committees (H4+) • Developing Information, Education and Communications (IEC) materials for community engagement (H4+) • Research on community structures that influence health seeking behaviours in MH of girls and women (H4+)

The programme roles and areas of work of the H4+ partners in Zimbabwe in 2015 address the elements of the continuum of care in RMNCAH with one important exception: services in family planning, especially promotion of contraceptives as a means of avoiding pregnancy for adolescent girls (and the associated early marriages). According to H4+ partners, the decision to not focus on contraceptive services was taken in order to avoid duplication with UN (particularly UNFPA) support provided through other programmes including the ISP. As noted in section 4.2, there is also a problem of community attitudes. There seems to be acceptance that family planning services are appropriate for very young pregnant and/or married women but not for single adolescent girls and boys.

For each H4+ partner, their role in the programme was first determined (as noted in interviews with H4+ country team members) by their *“mandates, capacities, historical roles, relationships with national authorities and implementing partners and their advantages”*.

The roles and areas of work assigned to each H4+ partner, as illustrated in Table 7, can be readily linked to the comparative advantages of each as described in interviews with the H4+ country team. These advantages include:

- UNFPA: a history of cooperation with MoHCC on RMNCAH and on Health Management Information Systems (HMIS) as well as resources to act as the coordinator and a willingness to share information fully
- UNICEF: a history of cooperation with MoHCC on PMTCT and HIV and AIDS as well as nutrition and the central role of UNICEF in the HTF, which allowed it to help integrate H4+ and HTF programming
- WHO: strong technical capacity in MNCH and HIV policy and guidelines development and in research and a history of supporting capacity building for management in RMNCAH
- UNAIDS: a history of focus on integrating HIV and MNCAH and community engagement for People Living with HIV and AIDS, especially adolescents as a target population

- UN Women: a mandate focused on girls and women and a history of support to communities to advocate and mobilize for empowerment of girls and women to access services.

Matching these advantages and roles with national, provincial and district needs became the primary focus of the MoHCC led national H4+ steering committee and the quarterly provincial and district planning and review meetings. A review of the needs identified during those meetings, and the subsequent support provided at district level by H4+, illustrates the programmes flexibility in meeting provincial and district needs by matching the identified needs with support from the H4+ partner with the mandate, capacity and history of engagement in meeting similar needs in Zimbabwe.⁷⁶ Similarly, there was no indication that H4+ partners lacked the technical or institutional capacity to carry out their designated roles.

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.*⁷⁷

Interviews with MoHCC staff at national, provincial and district 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 provide. In fact, senior staff of the MoHCC pointed to a more integrated and standardised approach by the H4+ partners as a form of increased efficiency. They noted:

- Generally, a more common approach to support by H4+ partners
- An agreed emphasis on less pre-service and more in-service and on-the-job training
- More consistent messages and common approaches to advocacy
- A standardised approach to providing support to clinical mentoring and supportive supervision
- An integrated monitoring and evaluation framework
- More emphasis in EmONC capacity building on follow up and supportive supervision by H4+ partners engaged in the area and less emphasis on traditional training methods.

The main effect of the integrated coordination, planning and review system and process for H4+ has been an improvement in effectiveness of support provided at provincial and district levels.

Joint planning also required H4+ partners and MoHCC at national, provincial and district levels to confront larger issues such as geographic isolation, poor transportation infrastructure, intermittent electrical supplies and generally poor infrastructure in the six targeted districts. In response, programme plans included efforts to support transport for volunteer health workers, selected improvements in health facility infrastructure and support to the construction and improvement of mother waiting homes.

Improvements in the effectiveness of H4+ work at provincial and district level has had at least one positive effect on efficiency for the health system in the targeted districts and provinces. This impact on efficiency was pointed out by staff of PHEs, DHEs, hospitals and health centres. Improvements in EmONC services at health centres and district hospitals (such as ability to perform caesarean sections in district hospitals) have helped those facilities reduce the number of referrals they make to higher levels in the system. This in turn, leads to savings (including transport costs for families) and allows

⁷⁶ (MoHCC 2015k: 7-9)

⁷⁷ Unless otherwise noted, for evidence cited in relation to assumption 5.3 see Annex 1, Assumption 5.3

for more appropriate referrals. As one Provincial Medical Director (PMD) noted “*there is now a decentralised system for dealing with emergencies in a competent way at district level*”.

There is one area of concern regarding the efficiency of the H4+ programme in Zimbabwe: problems in the disbursement of funds to the provincial and district levels. This is reportedly linked to national government procedures for disbursements of funds from the MoHCC headquarters level to the provinces and districts. PMD and DHE staff reported on several occasions that delays in funding flows caused inefficiencies in programming. In one province, funding for clinical mentoring for the fourth quarter reportedly arrived in December which meant all quarterly funds had to be expended in less than a month.

Lastly, there was a specific problem with funding used by UN Women to support Katswe Sistahood activities in 2015. Funding was suspended in November, apparently because UN Women in Zimbabwe did not receive the funds that were allocated in the workplan. This was apparently based on a problem with global disbursements by UN Women, not one specific to the Zimbabwe country office. Naturally this caused consternation for Katswe, and was damaging to its efforts to build confidence with the girls and young women it works with.

4.5.2 Achieving an effective division of labour

The H4+ country team and the MoHCC have collaborated to build an effective system of planning and coordination and used it to match H4+ partner strengths and experience to identified needs to strengthen RMNCAH services at national, provincial and district level. With the exception of supporting access to contraceptives for adolescents and youth, the support provided has addressed the continuum of care in RMNCAH by providing collaborative programming by H4+ partners.

A robust platform and system for coordinating support

As demonstrated in section 4.3, after a late start, H4+ was able to achieve an effective system and process for coordinated support to RMNCAH at national, provincial and district level. This system featured strong leadership by the MoHCC and the ability (through provincial and district planning and review meetings and joint supervision) to connect H4+ partner capacities directly to the demonstrated needs in the target districts and the provinces where they were located. There is no evidence that H4+ partners were duplicating or overlapping the services they provided. Where similar services were provided by two different H4+ partners, they occurred in different geographic locations (as when UNICEF supported BEmONC training in HTF districts, outside those supported by H4+).

Making best use of the strengths of H4+ partners

Starting from their history of support to RMNCAH in Zimbabwe, and their advantages in terms of mandate, experience and capabilities, H4+ agencies have been able to fit the activities they support to the needs of their partners and the communities they serve. This reflects the leadership role played by the Family Health Directorate at the MoHCC and the positive response and support from the H4+ team and, especially from the H4+ coordinator.

Collaborative programming

Perhaps the best test of collaborative programming in H4+ Zimbabwe is found in the way the programme is perceived at national, provincial and district levels. While key informants in PMDs, DHEs, hospitals, health centres and clinics generally knew which H4+ partner provided a specific element of support, they always referred to H4+ as a single programme. Unless prompted by the evaluators, they identified the support as H4+ support.

This was a view largely shared by MoHCC senior staff. As one senior manager noted:

“For H4+ we decided the UN programme should focus on the six hardest to reach districts but there were also issues that needed to be addressed nationally such as Maternal Death Surveillance and Response systems, dealing with obstetric fistula, and the need for better mentoring and supportive supervision throughout the health services. So we needed H4+ to intervene at both the national and district levels and do it in a collaborative way. They have done it well.”

Effective division of labour

Through effective national, provincial and local coordinating, planning and review systems, H4+ in Zimbabwe has been able to arrive at an effective division of labour. This has allowed the programme as a whole to provide effective support to systems strengthening for RMNCAH at national, provincial and district levels.

4.6 Value added for advancing the Global Strategy

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

1. The H4+ JPCS has allowed H4+ partners to increase the volume of their policy and advocacy work for RMNCAH in Zimbabwe and to better link it to priority needs at national, provincial and district level.
2. The policy and advocacy work of H4+ partners became more coherent and more integrated as programme coordination improved under the leadership of the MoHCC.
3. The main factor contributing to increased value added by the H4+ JPCS programme in Zimbabwe has been the level of coordination achieved among H4+ partners and the MoHCC and the reach of planning and review processes from national to provincial, district and facility level. This has, among other positive effects, strengthened the relevance and utility of the policy engagement and advocacy work carried out by the programme.

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.*⁷⁸

According to the senior staff of the MoHCC, H4+ partners have been able to do more work on policies, operational guidelines and on innovations since the beginning of H4+. In particular, they pointed to guidelines for clinical mentoring in EmONC and MNCH as policy products emerging from the H4+ programme after the Canada and Sida grants became available. Most importantly, they emphasised that the impact of H4+ supported policy work was felt at national and provincial levels, well beyond the borders of the six H4+ targeted districts. Senior MoHCC staff also noted that H4+ had helped to refine guidelines in PMTCT and ART as well as overall HIV Care and Treatment. Of equal importance, the programme backed up its policy work with support to the training of health care workers in HIV testing and the treatment of children and adolescents.

⁷⁸ Unless otherwise noted, for evidence cited in relation to assumption 6.1 see Annex 1, Assumption 6.1

This view was supported by staff of PMDs, and DHEs. They particularly noted the influence of H4+ (along with the RBF programme) in shifting quality checklists for supportive supervision from primarily quantitative to qualitative indicators. The shift to more qualitative indicators on supervision checklists was consistent with a change in approach and the use of more qualitative indicators in World Bank supported RBF programmes (so was not exclusively an H4+ matter). H4+ policy support to MNDSR systems and to maternal death audits (including guidelines for standardised definitions) was also identified as a key policy input at provincial and district levels. For PMDs, in particular, the support provided helps them to cover their entire province, not just the H4+ district.

The H4+ Zimbabwe *Monitoring and Evaluation Framework*, December 2015, identifies key outputs in leadership and governance, including policies and guidelines:

- Revised WHO national HIV guidelines (Option B+)
- National nutrition strategy available
- National EmONC improvement plan in development
- National Infant and Young Child Feeding Strategy (IYCF) available (2014)
- Emergency Triage and Assessment (ETAT) guidelines developed and distributed.

At a meeting in Harare in March 2016, the H4+ coordinator presented a more extensive list of the policies and guidelines produced with H4+ support from 2013 to 2015, adding to the list presented in the M&E framework report:⁷⁹ The policies and guidelines are published by the Government of Zimbabwe, but the primary supporting H4+ partner has been indicated for each.

- 2013-2014
 - Revised PNC guidelines adapted and rolled out (WHO)
 - National Integrated Young Child Feeding strategy adapted and rolled out (UNICEF)
 - Emergency Triage, Assessment and Treatment (ETAT) guidelines rolled out (WHO)
 - Computerized IMNCI training materials adapted (WHO)
 - MDNSR assessment (UNFPA)
- 2015
 - National child survival strategy developed (WHO)
 - Maternal health clinical mentorship guidelines (UNFPA)
 - EmONC training assessment (UNFPA)
 - Parent to child communication strategy developed (UNFPA)
 - National MDSR committee formed (UNFPA)
 - Draft National Health Strategy available (all H4+ partners)
 - MH division of labour based on MH mapping – better synergy on supporting national MH programme – reflected in the design of HDF (all H4+ partners but led and assembled by UNFPA).

The March 2016 presentation also reported that all of the targeted districts had upgraded RMNCAH and HIV standards and guidelines as well as the newly developed MCH curriculum by the end of 2015.

In summary, the H4+ JPCS programme was able to support a considerable body of policy work in RMNCAH and this work was refined in operational guidelines and procedures and supported by training and joint supervision (by H4+ country team and the MoHCC). While some of this work could presumably have been done without H4+ funding, there is consensus that H4+ as a funded programme, allowed the partners to do more policy work in RMNCAH and to link it more closely to national, provincial and district needs as described in section 4.1.

⁷⁹ (H4+ Zimbabwe 2016a)

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 RMNCAH by H4+ agencies which would not have otherwise been undertaken.*⁸⁰

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 Zimbabwe 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. More importantly, they are relevant to the policy inputs and guidelines which have been supported by H4+ in Zimbabwe as listed in relation to assumption 6.1 above.

On the other hand, H4+ partner staff did not identify a direct link from specific knowledge products supported by H4+ at a global level to the policies and guidelines produced or updated with H4+ support in Zimbabwe. They noted that there was little promotion of specific global knowledge products for use in policy engagement by H4+ at country level in Zimbabwe (other than regular interchanges on technical matters between H4+ country team members and their own global and regional offices).

⁸⁰ Unless otherwise noted, for evidence cited in relation to assumption 6.2 see Annex 1, Assumption 6.2

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.*⁸¹

At country level, the best test of assumption 6.3 is the extent the H4+ programme, through its coordinated, country-led (as described in section 4.3) approach to programming, resulted in more coherent, cohesive and effective policy engagement and advocacy by the partners.

MoHCC senior staff and H4+ partners agreed during interviews that policy coordination among H4+ partners was weak during the first half of the life of the programme in Zimbabwe. As the MoHCC staff remarked: *“There was confusion at the beginning of the programme, with H4+ partners still coming to the Ministry on an individual basis to promote policies, activities and projects. This took some time to alter, but it improved over time.”* By 2014, however, the MoHCC staff recognised a more coherent approach on the part of the H4+ agencies. During interviews they reported that the programme has made H4+ partner policy engagement more coherent and effective. They also indicated they will use the more integrated policy and advocacy work of H4+ as a model for use in the HDF which brings together a wider set of actors, including bilateral donors. As an example, the programme management system for the HDF programme uses the H4+ model of a national steering committee and joint review and planning missions as well as independent annual and mid-term reviews and a final evaluation.⁸² In particular, the functioning of the quarterly provincial and district level planning and review meetings with participation by all key stakeholders (national, provincial and district) has the potential to influence the approach to HDF.

MoHCC staff also emphasised areas where they reached agreement with H4+ partners based on their common understanding of needs and priorities gained through cooperating together under the programme:

- Targeting the hardest to reach districts and the under-served populations, particularly adolescents and youth
- The need to strengthen MNDSR systems (for example by establishing a national MNDSR committee) to improve accountability for results
- The need to deal effectively with obstetric fistula
- The need for improved clinical mentoring (now taken to scale as a national programme after trials in the H4+ district)
- The need for better supportive supervision and training follow up
- The emphasis on innovations to support RMNCAH programming.

Taken as a whole, there is reasonably clear evidence that participating collectively in the H4+ programme in Zimbabwe helped the partners to become more coherent and effective in their policy engagement and advocacy work.

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”.*⁸³

⁸¹ Unless otherwise noted, for evidence cited in relation to assumption 6.3 see Annex 1, Assumption 6.3

⁸² (MoHCC 2015c: 50)

⁸³ Unless otherwise noted, for evidence cited in relation to assumption 6.4 see Annex 1, Assumption 6.4

Section 4.3 above found that the H4+ programme has contributed to improvements in the quality and availability of health services for RMNCAH in Zimbabwe, especially in the six targeted districts. It also identified improvements in the level of use of key services (Table 6). This section has pointed out improvements in RMCAH policies and practices that extend beyond the six targeted districts to the provincial and national level. Without claiming that the programme was a decisive causal factor in outcomes at national level, it can be said in its favour that the conditions for H4+ to make a catalytic contribution to national, provincial and district level outcomes have been met (as described in the assumptions tested in this section). Trends in some outcomes in RMNCAH over the life of the programme are described in table 8.

Table 9: Trends in Selected Indicators in RMNCAH in Zimbabwe: 2010 to 2015⁸⁴

Indicator	2010/11 (ZDHS)	2014 (MICS)	2015 (ZDHS)
MMR	960	614	651
Under 5 MR	85	75	69
Skilled birth attendance	66%	80%	78%
Institutional Delivery	65%	80%	72%
PNC within 2 days of delivery	27%	77%	51.1%
Exclusive breastfeeding for first six months	31%	41%	48%
Unmet Need for FP	13%	10%	10.4%
Contraceptive Prevalence Ratio (modern methods)	57%	66%	67
HIV Prevalence	15%	14%	14.7
ART Coverage (Adults)	69%	77%	72%
ART Coverage (Children)	36%	41%	80%
PMTCT Coverage	55%	82%	84%

Sources: Zimbabwe National Statistical Agency, *Zimbabwe Demographic and Health Survey, 2015: Key Findings* and MoHCC, AIDS and TB Unit, *2015 National Estimates* (for HIV Data in 2015).

Note: Difference between the 2014 MICS estimate for PNC and the ZDHS estimate for 2015 may relate to indicator definitions in the two surveys.

The major improvement in coverage in paediatric ART reported in the 2015 national estimates relates to a very large increase in coverage by PMTCT and ART programming reported for 2014 and 2015.⁸⁵

4.6.2 The value added of H4+ JPCS

Sections 4.1 and 4.2 have detailed how the H4+ programme in Zimbabwe, under the leadership of the MoHCC, was able to develop and implement a coordinated and coherent programme of support to RMNCAH. Importantly, the programme was catalytic in support of other, larger sources of support and well matched to priority needs at national, provincial and district level. To some extent, this higher level of coordination and cohesion and its link to national and local needs represents the most important element of value added of the H4+ JPCS programme in Zimbabwe.

More extensive and coherent policy and advocacy engagement at country level

The availability of H4+ programme funding, combined with agreed priorities between the MoHCC and the H4+ partners for policy and advocacy work in RMNCAH, allowed the programme implementing partners to intensify their level of involvement in policy engagement and advocacy. This link between partner capacities and resources and the interest of the MoHCC, allowed key supported policies, guidelines and protocols to be immediately relevant to the needs of the policy makers and managers at national, provincial and district levels. Finally, the approach to policy work and advocacy used by H4+ partners was clearly more coherent and efficient during the last half of the programme (2014 to 2016). The resulting products were used well beyond the boundaries of the six targeted H4+ districts.

⁸⁴ (MoHCC 2014a, ZNSA 2016)

⁸⁵ (MoHCC 2014a: 19)

Contributing to outcomes in RMNCAH at national, provincial and district level

Sections 4.1 and 4.2 document the contribution that H4+ has made to strengthening health systems and improving access to integrated care, especially in the six target districts. This district level effect does not mark the limits of the H4+ contribution to results in RMNCAH. There is considerable evidence that H4+ has helped to improve policies and practices in RMNCAH at national and provincial levels. However, it is not possible, based on the methods used, to estimate the extent of the contribution made by H4+ to national, provincial and district level improvements in outcomes in RMNCAH. What can be said, is that the programme has met the conditions detailed in the key causal assumptions embedded in its overall theory of change in Zimbabwe. As a result, it appears that the H4+ programme has made a catalytic contribution to improving policies and practices in RMNCAH, especially but not only in the six target districts.

Informing H6 support to RMNCAH after the close of H4+

There is general agreement across all the key informants interviewed that the defining characteristic of H4+ as a programme in Zimbabwe has been the level of coordination and integrated planning, implementation and operational programme review at field level that was achieved. Virtually all the key informants agreed that H4+ partners worked more collaboratively after the April 2014 Victoria Falls meeting and the advent of the national H4+ steering committee; most significantly in the area of policy engagement and advocacy for RMNCAH.

The implications of all the findings in this section for the operation of H6+ are discussed more fully in Section five.

5 CONCLUSIONS

This section presents the conclusions and recommendations of the field country case study of Zimbabwe. The conclusions presented here are directly based on the findings provided in Section 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. While delays were noted in establishing **nationally led processes and structures for the coordination, planning and joint review of H4+**, they have been effective as the foundation for identifying and addressing critically important and unmet needs for support to health systems strengthening for Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) at national, provincial and district level.
2. By carefully identifying unmet needs down to the district level, and designing H4+ supported initiatives to complement the effect of larger programmes of support to RMNCAH, the H4+ partners and the Government of Zimbabwe (MoHCC) have been able build on the effect of those programmes and meet the conditions for providing **genuinely catalytic support**.
3. By providing **flexible support** to strengthen national and provincial health sector leadership and management balanced with direct support to district level capabilities, H4+ supported interventions have clearly contributed to **improving the quality of care and availability of services in RMNCAH**, especially but not only in the six targeted districts.
4. The programme has also contributed to **expanding access to services for marginalised groups** from six hard to reach districts normally excluded from previous efforts, and to increasing trust between communities and health facilities and staff.
5. Despite its success in contributing to expanded access, the H4+ programme has found it difficult to identify truly effective approaches to increasing access for **adolescents and youth**, especially girls and young women who are unmarried and not yet had their first pregnancy. In particular, “youth friendly corners” in, or near, health facilities have struggled to attract the participation of young women.
6. There is an ongoing serious challenge facing communities in the six H4+ targeted districts in Zimbabwe: how to reduce the frequency of **teenage pregnancies** and, especially, the practice of very early marriage. This was repeatedly emphasised in discussions with health system managers at provincial and district levels, with health service providers and with community groups of different kinds.
7. H4+ support to mobilising community groups, including adolescents and youth, has helped to **build trust and increase utilisation of services** in RMNCAH. However, this support has been limited in terms of funding and duration and has had limited geographic reach. This has led to some **imbalance between demand and supply side interventions**, particularly in the level of H4+ support provided to improve the quality and volume of health service supply at local level and the demand from the community.
8. While H4+ has made a significant contribution to improving quality and access to RMNCAH services in the six most under-served districts in the country, it has also made important contributions to health systems strengthening at national and provincial level through improved coordination mechanisms, enhanced policies and guidelines, better supervision and enhanced accountability, especially for Maternal and Neonatal Death Surveillance and Reporting (MNDSR).
9. Unfortunately, there is a **significant risk that many (although not all) of the gains** made with the support of H4+ in such a brief time frame (approximately two and one half years) **will be lost** as H4+ funding comes to an end, especially given the absence of an exit strategy for the programme in the six H4+ districts. The extent of these losses may depend most on whether or

not the Health Development Fund programme is able to provide flexible and dedicated support to the six districts.

10. **Innovations supported by H4+** in Zimbabwe have contributed to significant improvements in the capacity of health services staff to provide quality care in Emergency Obstetric and Neonatal Care (EmONC) and in the management and treatment of HIV positive individuals. Use of Point of Care CD4 machines in case management for HIV care and treatment was a genuine innovation in Zimbabwe. Support to clinical mentorship for EmONC involved the revitalization and redevelopment of a lapsed practice, but for most health service managers and staff it seemed truly innovative. Sometimes re-establishing a sound practice and doing it well can be innovative.
11. The single largest factor contributing to value added by the H4+ programme in Zimbabwe has been the eventual achievement of **truly country-led, collaborative programming** by the H4+ partners. The programme has been planned, implemented and reviewed in consultation with stakeholders at national, provincial and district level. For H4+ partners this has represented a very different working relationship, one that was grounded in the process of jointly programming and supervising (along with the MoHCC and non-governmental organisation (NGO) implementing partners) a programme of support to RMNCAH with dedicated funding accessible to all H4+ partners.

5.2 Lessons learned on the way forward for H4+ (H6)

As the H6 partners move forward with, or without, dedicated funds for programming at country level similar to those provided by Canada and Sida over the 2012-2016 period, the experience of H4+ JPCS in Zimbabwe suggests some lessons which can be incorporated into programming:

1. Whether dedicated and earmarked funds (as in the H4+ JPCS) are available or interventions are concentrated on advocacy with national governments on the use of other resources for RMNCAH, H6 should emphasise the urgent need for **country-led processes for coordination**.
2. H4+ has demonstrated the value of planning and reviewing processes which reach from the capital to the most remote districts, so that support can be matched to urgent needs. Where the support is provided through H6 members, these processes can ensure **support is catalytic and does not overlap, duplicate or conflict** with other initiatives.
3. While concentrating programme resources and initiatives in a small number of districts can lead to greater end results, the effect on the health system as a whole may be limited if the lessons are not applied at country level. Experience in Zimbabwe suggests that geographically concentrated programmes like H4+ can have a much wider impact, provided they capture the interest of national health authorities. This is especially true when **focused initiatives can be linked to a larger, continuing programme, which can benefit from lessons learned**, as with the new Health Development Fund (HDF). A broader, system-wide effect is dependent on the attention and interest of national health authorities in tracking and taking to scale the positive lessons learned. This should be a pre-requisite for focused programmes of support to RMNCAH.
4. Wherever initiatives like the H4+ JPCS are involved in funding and programming resources for RMNCAH in a defined time frame, it is critical to build links between ongoing programmes and larger, more durable initiatives to support the health sector as part of **a clear exit strategy**. Only then can the modest resources normally available to H6 partners can have a lasting impact on service quality, access and community mobilisation.
5. There is an urgent **need to develop more effective and practical ways to build trust between adolescents and youth, especially unmarried girls, and health service providers**. This is an area where H6 could take a lead in supporting research and spur innovation. With some exceptions, current practices, as supported by H4+ in Zimbabwe, are not capable of effectively

mobilising unmarried girls and young women to demand and access services in RMNCAH. There is also a need to re-think how these services are provided to young women.

6. Experience in Zimbabwe has shown the importance of arriving at **an appropriate balance** between funding to support improvements in the **supply of services** in RMNCAH and supporting interventions to mobilise **demand in the communities** being served.

6 ANNEXES

ANNEX 1 EVALUATION MATRIX

Area of Investigation 1: Strengthening Health Systems

<p>1. 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?⁸⁶</p> <p>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?</p> <p>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?</p> <p>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?</p> <p>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?</p>		
<p>Assumption 1.1</p> <p><i>H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unmet 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.</i></p>		
	<p>Information/data</p>	<p>Information sources</p>
1	<p>In planning the programme there were two sides to keep in balance while thinking of “every women, every child”:</p> <ul style="list-style-type: none"> • From the H4+ side the agencies looked to their mandates, capacities and historical roles and advantages (especially in Zimbabwe). From the government side, the MoHCC looked to the commitments made to the Global Strategy (2010) (advocated for by H4+) and to 	<ul style="list-style-type: none"> • Interviews with the H4+ country team, UNFPA staff • Confirmed in interviews with Ministry of Health and Child Care (MoHCC) staff at Director and Deputy Director level at headquarters.

⁸⁶ 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+JPCS 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.

	<p>the three core documents (The National Health Strategy; The MNCH Road Map; The Child Survival Strategy).</p> <ul style="list-style-type: none"> • The government (MoHCC) looked at low-performing Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) indicators on a national basis to help prioritize the implementation areas for H4+ to work in (the eight programme outputs). It also was the main actor in the choice of six hardest-to-reach, lowest performing districts in 2011. 	
2	<ul style="list-style-type: none"> • Even before 2011 MoHCC saw a need to bring together the UN agencies to work in a more coordinated way in RMNCAH. They (the UN) had shown an ability to work together on humanitarian work during the emergencies prior to that but they needed to be better organised in MNCH support. • MoHCC thought they could build on this and take advantage of the new (2011) H4+ Canada funded programme to get behind a very focused effort aimed at strengthening RMNCH. 	Interviews with MoHCC staff at Director and Deputy Director level at headquarters.
3	<i>“For H4+, the MoHCC decided that the UN programme should focus on the six hardest to reach districts, but there were also issues which needed to be addressed nationally, such as Maternal Death Surveillance and Response systems, dealing with obstetric fistula and the need for better mentoring and supportive supervision throughout the health services. So they needed H4+ to intervene and both the national and district levels. H4+ partners have responded well.”</i>	Interview with senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).
4	Procurement of selected EmONC commodities, equipment and sundries to support EmONC. <i>“Based on the gaps in commodities identified in the H4+ planning meeting and the preliminary results of the National Integrated Health Facility Assessment”.</i>	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration. August, 2012 (H4+ 2012a: 12)</i>
5	<i>“CIDA funding used to complement health systems strengthening initiatives, including the Health Transition Fund (HTF), the Global Fund and bilateral funding sources.”</i>	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration. August, 2012 (H4+ 2012a: 12)</i>
6	In response to government priority and urgent need for improved MDSR, <i>“UNFPA and UNICEF supported the development and finalization of maternal death audit guidelines and tools which are being pre-tested in the six districts and maternal death audit training will be integrated with planned Emergency Obstetric and Neonatal Care (EmONC) training.”</i>	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration. August, 2012 (H4+ 2012a: 16)</i>
7	Consultative meetings with young people from the six districts and representatives of the national Youth Network on Sexual and Reproductive Health solicited views from young people on how sexual and reproductive health services can be strengthened in their respective districts. Recommendations to be used to scale up the Adolescent Sexual and Reproductive Health (ASRH) component of the programme.	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration. August, 2012 (H4+ 2012a: 18)</i>
8	Assessment of community perceptions of maternal health problems and <i>barriers to access maternal and neonatal health (MNH) services</i> will be completed by end of August 2012.	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration. August, 2012 (H4+ 2012a: 18)</i>

	<p>UNICEF and UNFPA are supporting the MoHCC, ZNFPC and NAC to strengthen the community component of the programme.</p> <p>Bottleneck data was collected in the six districts to provide an overview of how problems and solutions in access to MNCH care were perceived at district level (p.19).</p>	
9	<ul style="list-style-type: none"> • By September, 2013 H4+ quarterly planning and review meetings were being chaired by The Director of Family Health, MoHCC with participation by representatives of provincial and district health authorities and the H4+ country team • The September meeting was used to allow the H4+ country team to introduce the programme and its potential benefits to representatives from the six H4+ districts. (p.1) • Meeting highlighted specific needs of the six chosen H4+ districts while it also highlighted achievements in 2013. (p.1) • Comments of the district staff highlighted in the report indicate that. <i>“...the H4+ initiative is not clear on how the districts are to benefit from the support. It was therefore recommended that the CIDA project be brought closer to the districts involving all the relevant stakeholders in order to get their buy in for the project”</i> (p.1). • That H4+ review and planning meeting also allowed each district to detail specific needs including lack of functional theatres and unreported home deliveries (Mbire), underutilisation of “youth friendly corners” and high perinatal mortality (Hurungwe), shortages of midwives (Chipinge) and problems with infrastructure and supplies medicines for MNCH (all districts). Each district presented its plans for the upcoming quarter and received advice from H4+ team members and MoHCC. Importantly, <i>“districts were to continue to work on plans for the fourth quarter (2013) and submit them to MoHCC with requests for support”</i> (p4). This shows MoHCC leadership in the programme planning process at district level. 	MoHCC, <i>Summary Report of the H4+ Review and Planning Meeting, 11-12 September 2013</i> (MoHCC 2013c)
10	<ul style="list-style-type: none"> • As with the September 2013 meeting, the purpose of the autumn 2014 meeting was to <i>“discuss implementation progress and come up with quarterly plans”</i>. (P.1) • The meeting highlighted <i>“the importance of on the job training in EmONC for newly qualified nurses during their induction and orientation”</i>. (p.1) • The meeting also identified specific district shortages and needs in the six H4+ districts which could be addressed by the programme. These were district specific and included as examples from different districts (p 2-5): <ul style="list-style-type: none"> ○ The need to improve utilization of youth friendly corners, especially by girls ○ Need to address increases in teenage pregnancy 	MoHCC, <i>H4+ Planning and Review Meeting, 23-24 September 2014</i> (H4+ Zimbabwe 2014c)

	<ul style="list-style-type: none"> ○ Need/opportunity to train registered general nurses in midwifery to cascade the cadre of midwives ○ The need to involve youth and adolescents more in planning/refurbishing youth friendly corners ○ A need to strengthen ASRH services across the districts ○ Need for improved training in maternal death audit. ● In planning activities with support from different H4+ agencies, strong emphasis was placed on the need for hands-on in service training and continued follow up on training in EmONC to address the <i>“challenge observed during assessment that there was a gap between knowledge and skills for those who were trained in EmONC”</i>. P.5 ● Participants included MoHCC senior management, provincial and district health executives for the six H4+ districts, H4+ country team staff and representatives of non-governmental organisation (NGO) implementing partners (WAG, Katswe Sistahood). 	
11	This meeting followed the format of the same meeting in the 2013 and 2014 and allowed for a detailed review of activities and outputs of H4+ in the six districts along with discussion of system support needs at district level in the coming quarter and year. It included a full slate of MoHCC staff from headquarters, provincial health executives (PHEs) and district health executives (DHE).	MoHCC, <i>H4+ Planning and Review Meeting Report, 01-03 June 2015</i> (MoHCC 2015i)
12	In individual interviews and group discussions, H4+ country team members from all five active partners (UNICEF, UNFPA, WHO, UNAIDS and UN Women) agreed that progress in coordinated planning was very slow up until 2014 when the MoHCC under the Director of Family Health took a major interest in leading a coordinated planning and review process at national, provincial and district level for the programme.	Interviews with H4 + Country team members.
13	Director and deputy director level interviews carried out with officials of the MoHCC in Harare confirmed and strengthened the perception that programme coordination and linkages to specific needs at national, provincial and district level were greatly strengthened after the third quarter of 2013 as a result of the September 2013 joint planning and review meeting, the April 2014 Victoria Falls meeting and the advent of the national H4+ steering committee in June 2014. They further noted a willingness on the part of the H4+ partners to engage in joint planning which helped the programme to better focus on needs for health systems strengthening at national, provincial and district levels.	Interviews with senior officials of the MoHCC in Harare.
14	Staff at provincial and district level medical directorates confirmed that the process of programme planning and review established in 2013 allowed them to participate in meaningful annual planning and quarterly review meetings of the H4+ steering committee and	Interviews with members of the provincial health directorates in three of six H4+ provinces (Manicaland, Matabeleland North and Mashonaland

	that those meetings allowed H4+ JPCS to identify critical system needs in their provinces and districts. Examples given included specific machinery (anaesthetic machines, MVA equipment, lighting for theatres, etc.) as well as medicines and supplies and vehicles (motorcycles) for supportive supervision and opportunities for clinical mentoring in Comprehensive Emergency Maternal, Obstetric and Neonatal Care (CEmONC).	Central) as well as district health executives in Chipinge, Mbire and Binga districts.
15	As with provincial and district level health service managers, staff of NGO implementing partners reported their full participation in the programme planning and review meetings. This assisted them in communicating demand side needs and specific interventions requiring support from H4+ although funding limitations and resource constraints limit the reach of the resulting interventions that are included in the agreed workplans.	Interviews with NGO implementing partners (AFRICAID, Kapneck Trust, WAG, Katswe).
16	<i>"H4+ [JPCS] support is complementary. The initiative should be viewed in the context of existing funding mechanisms."</i> This advice was provided by UNICEF colleagues from the headquarters and regional level (ESARO of UNICEF).	<i>Minutes of the H4+ coordinating committee</i> chaired by UNFPA in the absence of the UNICEF H4+ coordinator, March 13, 2012 (p.1) – UN agencies only present.
17	The March 2012 meeting of the H4+ coordinating committee included planned actions to consult with the provincial medical directors in the six provinces to brief them on the H4+ JPCS initiative as well as for an orientation meeting with district health executives in the six chosen H4+ districts. P.3	<i>Minutes of the H4+ coordinating committee</i> chaired by UNFPA in the absence of the UNICEF H4+ coordinator, March 13, 2012 – UN agencies only present (H4+ 2012b: 1)
18	This was the first meeting of the National H4+ Steering Committee set up after the meeting in Victoria Falls in April 2014. At this meeting the Director of Family Health and chair of the H4+ steering committee made it clear that: <i>"H4+ had poor recognition as an initiative in government circles, more specifically in the provinces and the districts, which was one of the reasons for provinces and districts to be not very responsive to H4+."</i> P.1 The meeting also highlighted: <ul style="list-style-type: none"> • The low implementation rate of H4+, 35% by May 1, 2014 (p.2) • Low awareness and visibility of H4+ (p.2) • Poor national coordination mechanisms (p.2) • Need for communication of guidelines and protocols to the districts (p.2) • The need to emphasise the catalytic nature of H4+. 	<i>Minutes of the National H4+ Steering Committee 18 June 2014</i> (H4+ Zimbabwe 2014a)
19	Interviews confirmed that the first meeting of the National H4+ Steering Committee in June 2014, following on the Victoria Falls country to country meeting in April the same year and the joint planning and review meeting of September, 2013, marks the advent of a much stronger coordination mechanism and process for H4+ JPCS in Zimbabwe. The first and subsequent national steering committee meetings, combined with the ongoing programme review and	Interviews with MoHCC staff at Director and Deputy Director level at headquarters.

	planning meetings show a commitment by MoHCC and the H4+ team to better align programme plans and actions to provincial and district priorities under the leadership of the MoHCC.	
20	Established national MDSR Committee as a technical working group on Maternal Death Surveillance and Reporting. Highlighted critical importance of improving MDSR.	<i>Minutes of the National H4+ Steering Committee 18 April 2015 (MoHCC 2015f)</i>
21	The September 2015 Steering Committee meeting identified a series of 19 different actions for addressing emerging and repeatedly emphasised needs at national, provincial and district levels that H4+ should address. Examples include: <ul style="list-style-type: none"> • Development of a national EmONC plan: concept note and terms of reference (prepared by UNFPA) approved by MoHCC and discussion ongoing with Liverpool School of Tropical Medicine to carry out the work. (p.3) • EmONC training assessment under way in the H4+ Districts. (p.3) • UNFPA developed guidelines for mentorship in maternal health [those for EmONC already in place] approved and signed by the Minister, UNFPA to print. (p.3.) 	<i>Minutes of the National H4+ Steering Committee, 3 September 2015 (MoHCC 2015e)</i>
22	<ul style="list-style-type: none"> • The concept paper, as noted above, served as the basis for developing at terms of reference to develop a national research plan. • It provides a survey (p.2) of quality of care in MNCH service delivery, especially EmONC (p.2-3) and establishes the need and rationale for a national EmONC Plan as a critical area. The subsequent development of a ToR was supported by H4+. 	<i>Concept note: Developing Zimbabwe National Emergency and Obstetric and Neonatal Care (EmONC) Plan. UNFPA for H4+, 2014 (UNFPA 2014)</i>
23	<i>“Overall, more than two thirds (69 percent) of all health workers working in the maternity units have not received in-service training in Emergency Obstetric and Neonatal Care (EmONC). This shows there is still a big gap in the number of staff trained in EmONC.”</i>	<i>Obstetric and neo-natal care service needs assessment for the H4+ supported Districts (MoHCC, Reproductive Health Unit, May 2014) (MoHCC 2014e)</i>
24	<ul style="list-style-type: none"> • Report on Hurungwe and Mbire districts assesses the roles and challenges for promoting maternal health faced by: (a) health delivery structures at community level, and (b) social structures including traditional leaders and structures, religious/faith based groups, family structures, schools etc. • <i>“UN Women Zimbabwe will design its interventions to address the strategic issues that emerge from this assessment and refine further the agency’s activities that have been broadly identified within the H4+ country programme. The overall focus of its interventions will be to enhance the link between gender equality, maternal health, and sexual and reproductive health in health service delivery and the demand for these services by women and girls in the six districts.”</i> 	<i>A Gender Assessment of the Community Structures that Influence Women’s and Girls’ maternal, Sexual and Reproductive Health Seeking Behaviour in Six Districts in Zimbabwe. UN Women, May 2014 (UN Women 2014a)</i>

25	Refer to evidence in line 3 on the need for H4+ to work at district and national level.	Interview with senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).
26	There is a near universal consensus that the choice of the six H4+ supported districts originated with the MoHCC and that these six districts are the hardest to reach and most under-served in the country. They also have high incidences of malaria and very high levels of poverty and illiteracy.	Interviews with MoHCC staff at national, provincial and district level and with H4+ partner staff and representatives of NGO implementing agencies.
<p>Assumption 1.2 <i>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.</i></p>		
Information/data		Information sources
27	In addressing the need to revitalize the health sector and address critical needs in RMNCAH the MoHCC received strong moral and financial support from DFID, Sweden and Irish Aid to help H4+ ensure it was integrated with the Health Transition Fund (HTF) which provided incentives to health workers and sustain infrastructure. The HTF helped stop health workers from leaving the country <i>en masse</i> and meant H4+ could have an impact in the six hardest to reach districts.	Interviews with H4+ country team: UNFPA
28	<ul style="list-style-type: none"> • H4+ and other programmes started from a very low point. The Demographic Health Survey 2010 showed that outcomes in MNCH were extremely poor. MoHCC responded by getting the donors (DFID, IRISH AID and others) to contribute to the Integrated Support Programme (ISP) and the Health Transition Fund. The H4+ programme provided a strong mechanism to allow the UN to take advantage of the Canada funded programme (2011) and get behind a very focused effort aimed at improvements in the six districts and drawing on the collective strengths of the UN agencies, something the MOHCC had not seen before. • The new Health Development Fund (HDF) which is coming out of the experience of the older HTF will build on the work of H4+. For example, it includes many outcome indicators in RMNCAH and supports all the pillars of the WHO health systems building blocks. • Alongside the HTF and its successor, the new HDF, the two large programmes of health sector support are the ISP which among other things deals with HIV and the World Bank 	Interview with senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).

	supported Results-Based Financing (RBF) programme. H4+ is more integrated with and complementary to the HTF/HDF and RBF.	
29	<ul style="list-style-type: none"> • HIV was receiving a lot of funding and attention through both the Global Fund and the President's Emergency Programme for AIDS Relief (PEPFAR). What H4+ brought to the table in a complementary way, was an integrated approach to HIV Care and Treatment Services and MNCH and a focus on rights and reaching the unreached. • Prior to H4+ UNFPA might have been doing MNCH in a given district but not dealing with HIV while in another district UNICEF might have been doing HIV but not addressing MNCH. Under H4+, UNFPA and UNICEF brought together MNCH and HIV in the same districts. • Complementarity is made stronger by the interlocking set of coordinating bodies. At the start, based on the original proposal, there was supposed to be a Steering Committee but it was not activated. • <i>"After the Vic Falls meeting in 2014, MoHCC really took the lead and got coordinated planning really moving. From that point on the Ministry took on the challenge of integrating the programme (including with other programmes supporting health care) by taking on ownership and accountability."</i> • Now there is an integrated structure for coordinating across programmes of support in the health sector including: <ul style="list-style-type: none"> ○ The country coordinating mechanism (Global Fund/Gavi) ○ The HTF/HDF steering committee chaired by the PS of MoHCC ○ The H4+ Steering Committee chaired by the Director of Family Health ○ The Adolescent Sexual and Reproductive Health Forum ○ The MODO, (Ministry of Health and Donor) Committee which reviews all health programmes. <p>Because the membership of these committees is often overlapping, it is easier for programmes, including H4+ to avoid overlap and to be complementary.</p>	Interviews with H4+ country team: UNICEF
30	<ul style="list-style-type: none"> • A big problem in all programmes was weaknesses in data coming from HMIS, including age and gender disaggregated data. • H4+ helped to get the District Health Information System 2 (DHIS2) in use at district level so that resulting data could help planning by District Health Executives. DHIS2 data can also be used (including under HTF/HDF and the RBF programmes) to advocate for more funding. H4+ plus also pushed to ensure that age and gender disaggregated data would be included. 	Interviews with H4+ country team: UNICEF and with MoHCC senior staff

31	<ul style="list-style-type: none"> • HTF was, in part, a recognition that resources were severely lacking in MNCH and needed partners to come together with pooled resources and fund high impact, low cost interventions. However, HTF had some gaps and provided a kind of one size fits all solution. • They needed a partner to address HIV activities in the most underserved areas and to complement the one size fits all blanket of the HTF. The answer was the responsiveness of H4+ to supplement the HTF. 	Interview with HTF/HDF Coordinator
32	<ul style="list-style-type: none"> • Coordinating and sequencing provision of equipment and supplies under HTF/HDF, RBF and H4+: <ul style="list-style-type: none"> ○ At the beginning of the HTF they did a national survey to identify which services were working and not working and why. The MoHCC then determined the equipment and supplies which needed to be provided to each district and facility. In order to avoid duplication and maintain complementarity of provision of equipment, medicines, and other supplies the different teams work under the overall coordination of the Director of Family Health in MoHCC. The different groups include: <ul style="list-style-type: none"> ▪ The H4+ team at UNICEF ▪ The H4+ team at UNFPA ▪ The HTF/HDF team at UNICEF ▪ The chief accountant at MoHCC ▪ The Director of Pharmacy. 	Interview with HTF/HDF Coordinator
33	Lessons in supporting integrated service delivery learned during the implementation of H4+ have been picked up and incorporated into the HDF programme as it succeeds HTF.	Interview with Provincial Health Directorate: Manicaland.
34	<ul style="list-style-type: none"> • When H4+ was being planned in Chipinge, they held a joint planning session with the DHE, the Provincial Health Directorate, the MoHCC headquarters, the Ministry of Education and active NGOs. UNFPA was involved for H4+ along with OPHID. These plans took account of other large programmes such as RBF and HTF. From 2014 on, plans were continuously refined through joint planning and review meetings. • Chipinge is a World Bank RBF district so that is their main source of support with H4+, and the US-AID Maternal and Child Health Integrated Programme (MChip) the other significant sources. H4+ has considerable impact and reach on training and plays a unique role in its support to mother waiting homes. 	Interviews with Chipinge District Health Executive members
35	<ul style="list-style-type: none"> • The H4+ planning committee met with the Hospital Board and community representatives to help identify needs which were not being met from other programmes and sources. They identified needs and H4+ provided support in these areas: 	Interviews at St Peter's Mission Hospital, Chipinge

	<ul style="list-style-type: none"> ○ Training nurses in BEmONC ○ Training in Integrated Management of Young Child Illnesses (IMNCI) ○ Improvements to the mother waiting home ○ An anaesthetic machine ○ Blood pressure monitors ○ Oxytocin and magnesium sulphate ○ Clinical mentoring for doctors (C Section) and nurses ○ Supportive supervision funded by H4+ helps them receive support from the PHE and DHE ○ Training in the electronic Maternal Death Reporting Systems <ul style="list-style-type: none"> ● Delay in Achieving Certification for CEmONC including C Sections <ul style="list-style-type: none"> ○ Chipinge expected to have a new operating theatre functional by March 2016 but, while H4+ has provided needed equipment, they are not able to get the operating theatre up and running. This is a big challenge. The district has the equipment and has started to repair the building but now lack the funds to complete the repairs. They have had to spend RBF funds on buying medicines to cover the stock-outs, as well as buying fuel for the ambulances and having them repaired (only one is functional of the two they have). They need plumbing, showers, air conditioning. The Provincial Medical Director is helping them to overcome these obstacles and find sources of funding to get the theatre operational later this year (2016). 	
36	<p>Health Transition Fund and H4+: The HTF is credited with ensuring HR capacity through the retention bonuses. This is a critical input that enables H4+ activities to be implemented. Doctors are bonded to a district for a year and then are free to go elsewhere. When the retention bonuses are reduced, people will be “flocking out” of remote districts. In addition, the HTF supported other costs of the primary health care, so that the facilities would not require/charge user fees. The DHE was not clear on an exit strategy for H4+. There is concern about sustainability and that the improvements gained will not last once H4+ ends.</p>	Chitsungo District Hospital, Mbire. Interview with the District Health Executive
37	<p>In almost every meeting and discussion outside Harare, the evaluation encountered the view that H4+ was genuinely catalytic in its support of other, more standardized, larger scale programmes of support to the health sector. This catalytic role and response of H4+ at a micro level was most often attributed to its flexibility and the continuous process of review and planning based on quarterly planning and review meetings. Examples varied but covered every different output area of the programme. See examples below.</p>	Interviews at Provincial Health Executives, District Health Executives, District Hospitals, Health Centres and Clinics and with implementing partner NGOs

38	Procurement of selected EmONC commodities, equipment and sundries to support EmONC. <i>“Based on the gaps in commodities identified in the H4+ planning meeting and the preliminary results of the National Integrated Health Facility Assessment.”</i> (2012). P.12	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration.</i> August, 2012 (H4+ 2012a: 12)
39	<i>“CIDA funding used to complement health systems strengthening initiatives, including the Health Transition Fund (HTF), the Global Fund and bilateral funding sources.”</i>	H4+, <i>Interim Progress Report on H4+/CIDA Collaboration.</i> August, 2012 (H4+ 2012a: 12)
40	<ul style="list-style-type: none"> • The Health Development Fund planning document summarizes the contributions made by four major externally funded programmes of support to the health sector. The four programmes noted were the HTF, the ISP, Maternity Waiting Homes and H4+. (p.2). • H4+ is noted (p.3 and p.4) for strengthening RMNCH-A programme delivery by strengthening health systems in the areas of: <ul style="list-style-type: none"> ○ Enhancing capacity ○ Ensuring availability of essential medicines and supplies ○ Providing infrastructural support ○ Reinforcing community demand and participation ○ Firming up monitoring and supervision mechanisms. 	MoHCC, <i>Health Development Fund: Programme Document for a Multi-donor Pooled Fund for Health in Zimbabwe. 2016-2020</i> (August, 2015) (MoHCC 2015c)
<p>Assumption 1.3 <i>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.</i></p>		
Information/data		Information sources
41	<ul style="list-style-type: none"> • Five-day workshop on BEmONC services provided to 30 health staff (midwives, registered general nurses, other nursing categories). • All candidates were pre and post-tested for gains in knowledge and skills. Skills were tested in Healthy Baby Breathing Station Partograph use and dealing with pre-eclampsia and postpartum haemorrhage (PPH). 	MoHCC, <i>Training Workshop Report: Basic Emergency and Obstetric Care (BEmONC): Manicaland.</i> (September 2013) (MoHCC 2013d)
42	<ul style="list-style-type: none"> • Report details a post-training follow up with supportive supervision for BEmONC training in Mbire district in 2014. Identified a considerable number of deficiencies. A day was spent by a three-person team of trainers in each facility checking on conditions, availability of needed supplies and assessing skills. They also assisted nurses in making emergency trays, delivery packs, PPH packs, eclampsia packs and other preparatory materials. • Frequent positive elements: <ul style="list-style-type: none"> ○ Partograph being used 	Manicaland Provincial Health Executive. <i>Provincial BEmONC Post-Training Follow-up for Mbire District.</i> November, 2014 (Manicaland Provincial Health Executive 2014)

	<ul style="list-style-type: none"> ○ Delivery packs available ○ Oxytocin and magnesium sulphate available ○ Nurses with knowledge on pre-eclampsia, eclampsia and HBB ○ Handbook and guidelines on Basic Emergency Maternal, Obstetric and Neonatal Care (BEmONC) available and in use ● Frequent negative elements <ul style="list-style-type: none"> ○ Lack of standard delivery packs ○ Dust and general conditions of the labour and delivery wards ○ Wrong documentation on the partograph ○ Lack of PPH packs ● Actions/Recommendations <ul style="list-style-type: none"> ○ Review team assisted nurses in preparing PPH packs and other materials and in cleaning labour and delivery wards ○ Refreshed nurses on practices such as HBB, including the use of the mannequin ○ Mentorship to be continued in the district ○ Encouraged nurses to read and practice recommended standards ○ One doctor sent for mentorship at provincial hospital ○ Further follow up/support meeting scheduled for December 2014 (one month later). 	
43	<ul style="list-style-type: none"> ● The review team visited seven sites in Binga including the district hospital, three health centres and three clinics: ● Frequent positive observations: <ul style="list-style-type: none"> ○ Retention of mothers on option B+ was good ○ HIV testing of pregnant mothers was high ○ Retention of care good through active tracking and tracing by village health workers ○ Male participation good (60%) because of active male mobilisers ○ Registers complete ● Frequent negative comments <ul style="list-style-type: none"> ○ Low male partner participation in some clinics ○ Problems with motorised (motorcycle) transport of samples due to maintenance issues and lack of fuel ○ Dried blood spot tests (DBS) turnaround time increased due to transport problems (especially when RBF funds are delayed). 	MoHCC PMTCT Programme: <i>Post Training Support for Binga District: Report of a Four Person Team. July, 2015 (MoHCC 2015h)</i>

44	<ul style="list-style-type: none"> • Assessment report of a course for doctors (1), nurses (16) and primary counsellors (13) held at Binga district hospital but with staff from the district hospital, rural hospitals, mission hospitals and rural health centres. • Trainers were from MoHCC and Africaid. • Skills building was done in: <ul style="list-style-type: none"> ○ Adolescent counselling ○ Pre-and post HIV-test counselling for positive results in adolescents ○ Disclosure ○ Adherence ○ Legal and ethical issues • Results <ul style="list-style-type: none"> ○ Pre and post-training tests of knowledge and skills report significant gains, usually more than doubling the pre-test scores (p.7). 	MoHCC: <i>Prevention, Treatment and Care and Support for Adolescents Living with HIV: Training Health Care Workers: Binga District</i> . December 2014 (MoHCC 2014f)
45	<ul style="list-style-type: none"> • <i>“Trainee interviews focused on knowledge and skills, especially with regard to life threatening events during and after child birth.” P.2</i> • Results: <ul style="list-style-type: none"> ○ Management of postpartum haemorrhage – 80 percent trainees with acceptable knowledge/skills ○ Pre-eclampsia – 75 percent with knowledge of main elements of treatment ○ Knowledge of neonatal resuscitation – 68 percent with satisfactory knowledge • Availability of supplies <ul style="list-style-type: none"> ○ Magnesium sulphate and oxytocin available everywhere ○ Other supplies often lacking, including in the provincial hospital • User satisfaction <ul style="list-style-type: none"> ○ <i>“Users reported improved satisfaction with services at district hospitals, but staff attitudes at health centres raised concerns. Users were well aware of the existence and importance of antenatal and post-natal care.” P.3</i> • Conclusion <ul style="list-style-type: none"> ○ <i>“The findings of this assessment indicate that the capacity to manage obstetric emergencies has improved since the national health facility assessment in 2012 (NIHFA).” P.3</i> 	MoHCC. <i>H4+ Basic Emergency Obstetric and Neonatal Care (BEmONC) training assessment: Binga, Cihpinge, Chiredzi, Gokwe North, Hurungwe, and Mbire</i> . September, 2015 (MoHCC 2015b)
46	<ul style="list-style-type: none"> • During the joint review missions, the MoHCC has noted positive results in the six H4+ districts with much less emphasis on pre-service and more on in-service training and supervision 	Interview with senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).

	<ul style="list-style-type: none"> • H4+ has led the shift to more follow-up and assessment for training. • Mentorship had a big impact on improving skill in EmONC. 	
47	<ul style="list-style-type: none"> • <i>“With H4+ training health care workers are more vigilant and confident regarding testing and prescribing ART for infants diagnosed with HIV, it’s a big improvement.”</i> • <i>“In particular, counselling for children and adolescents on HIV treatment has really improved as practitioners have been trained and gained experience.”</i> 	Interview with the MoHCC PMTCT and ART team.
48	<ul style="list-style-type: none"> • Staff of the NGO implementing partners engaged in community advocacy, awareness raising and rights based empowerment of diverse community groups (in and out of school youth, married and unmarried girls, adolescents and youth living with HIV, VHWs and CBAs and traditional leaders) were virtually unanimous in indicating an improvement in skills and attitudes of health care providers. They also noted an improvement in communication and trust between the health care providers working in health facilities and the communities they serve. 	Interviews with NGOs working as implementing partners of H4+ engaging in demand side activities with community groups in the H4+ districts (J.F Kapneck Trust, Africaid, Organization for Public Health Intervention and Development (OPHID), Women’s Action Group (WAG); Katswe Sistahood.
49	<ul style="list-style-type: none"> • Improvements in skills and attitudes of facility staff, especially in EmONC but also in RMNCAH due to clinical mentoring and improved, supportive supervision (with ongoing challenges for transport and fuel in support of supervision) • Increased trust on the part of the community that they will receive quality health services with improved supplies and better trained staff. 	Interviews with staff of Provincial Health Executives in Manicaland (Chipinge), Mashonaland Central (Mbire) and Matabeleland North (Binga)
50	<ul style="list-style-type: none"> • Training and mentoring supported by H4+ improved skills in: <ul style="list-style-type: none"> ○ BEmONC ○ Infant and child feeding practices ○ Option B+ management ○ ART, especially paediatric ART ○ Integrated management of childhood illnesses (IMCI) ○ Infant/child feeding ○ Manually vacuum assisted (MVA) • Staff also report improved trust between the community and the health facility staff. • <i>“BEmONC training has resulted in fewer maternal complications and infant deaths. High risk cases are referred to the district hospital, while others can be managed by the health centre.”</i> Kariangwe Mission Hospital, Binga • <i>“Skills have greatly improved through one to one mentorship and provision of supportive supervision which works better than regular supervision. All of this is more effective than sending staff away to workshops.”</i> Siabuwa Primary Health Centre, Binga. 	Interviews with staff of district health executives, district hospitals, mission hospitals, rural hospitals, and health centres in Chipinge, Mbire and Binga

	<ul style="list-style-type: none"> • “There is a clear link between the training of nurses in Youth Friendly Services (YFS) and the work done by Katswe Sisterhood to engage young married and unmarried girls and the recognizable improvement in attitudes by nurses and trust by young people.” Chipinge District Health Executive. 	
51	<ul style="list-style-type: none"> • “The rural health centre is providing improved services” (Women’s support group, Mushumbi, Mbire) • “Great improvements in trust between community and health workers” (village health workers (VHWs), Mushumbi, Mbire) • “More people are accessing services at the health centre due to increased trust between staff and the community”. (Community-Based Advocates (CBAs), Karai, Mbire) • “The clinic offers better services and the staff have become more friendly towards young women clients.” (Out of school youth group, Karai, Mbire). 	Focus group discussions with community members including: in and out of school youth, married and unmarried girls, women’s and men’s consultative forums, adolescents and youth living with HIV, VHWs and CBAs and traditional leaders.
Assumption 1.4 <i>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.</i>		
	Information/data	Information sources
52	<ul style="list-style-type: none"> • Availability of supplies <ul style="list-style-type: none"> ○ Magnesium sulphate and oxytocin available everywhere ○ Other supplies often lacking, including in the provincial hospital • Conclusion <i>“The findings of this assessment indicate that the capacity to manage obstetric emergencies has improved since the national health facility assessment in 2012 (NIHFA).” P.3</i> 	MoHCC. <i>H4+ Basic Emergency Obstetric and Neonatal Care (BEmONC) training assessment: Binga, Chipinge, Chiredzi, Gokwe North, Hurungwe, and Mbire.</i> September, 2015 (MoHCC 2015b)
53	<ul style="list-style-type: none"> • Mission participants were MoHCC, WHO, UN Women and UNFPA • “Supervision is being done regularly, though not necessarily jointly. Monthly reports are being done regularly to higher authorities by each level. There were no major stock outs of essential drugs that are necessary to provide CEmONC and no acute shortage of essential equipment necessary to provide CEmONC.” 	UN Women, Harare. <i>Report of a Joint Supervision Mission to Mutare and Masvingo for H4+.</i> 2014 (UN Women 2014b)
54	<ul style="list-style-type: none"> • Received adequate supply of oxytocin and magnesium sulphate with no stock outs. (Gokwe North) • No stock-outs of rapid diagnostic tests (RDT), HIV Kits or of blood products (Gokwe North) 	MoHCC, <i>Minutes of H4+ Planning and Review Meeting 23-25 September, 2014</i> (MoHCC 2014c)

	<ul style="list-style-type: none"> • Refurbished and expanded mother waiting homes are an important improvement in ensuring delivery at facilities (supported by H4+ and RBF in different locations) • UNFPA to support another round of monitoring and supportive supervision by the Provincial teams to each H4+ district in the coming quarter. • Non-availability of MHW (Chiredzi) • IEC materials do not portray daily life in the district, they will develop their own IEC materials in the local language (Binga and Gokwe North). 	
55	<p>On follow up and supervision of trainees</p> <ul style="list-style-type: none"> • <i>“Training of health workers on BEmONC and of two to three health workers per facility on care during delivery, HBB and PNC was done along with training for Option B+ and use of PoC machines done for all 51 health facilities. Health workers are being supervised with follow up on the job.”</i> (Chipinge) p.3 • <i>“Thirty five nurses were mentored during BEmNOC post-training follow up and supportive supervision was provided.”</i> (Mbire district) p.5 • <i>BEmONC training was conducted for the whole district and follow up supervision was done for all facilities.</i> (Binga District). p.6 	MoHCC, <i>H4+ Programme Review and Planning Meeting Report, 01-03 June 2015</i> (MoHCC 2015i)
56	<p>On Materials, Equipment and Medicines, and funds</p> <ul style="list-style-type: none"> • Gokwe reported on unavailability of funds to undertake some planned H4+ activities p.5 • <i>“The DHE conducted regular quarterly site support visits to all health visits and ART initiating sites.”</i> (Binga district) p.6 • <i>“Did not conduct district based maternal death and perinatal death audits because of lack of funds.”</i> (Binga district) p.6 • Almost all the districts present reported problems of shortages of water, some due to the continuing drought. 	MoHCC, <i>H4+ Programme Review and Planning Meeting Report, 01-03 June 2015</i> (MoHCC 2015i)
57	<ul style="list-style-type: none"> • All three reports indicate there are some persistent issues of supply and some which become more positive over time: • Persistent Issues <ul style="list-style-type: none"> ○ Transport, especially lack of funds for maintenance of vehicles and motorbikes and purchase of fuel (with a negative effect on both transport of DBS samples for HIV testing and the ability of Provincial Health Executives and District Health Executives/District Hospitals to carry out supportive supervision ○ Problems with lack of reliable electrical supply and, especially, water shortages ○ Difficulties with the transfer of funds from Harare to provinces and districts. • Improving Issues (2014 and 2015) 	MoHCC, <i>Minutes and Reports on Joint Review and Planning Meetings, 2013, 2014, 2015</i>

	<ul style="list-style-type: none"> ○ Availability of PoC CD4 machines for PMTCT (Option B+) and equipment for theatres to support CS and CEmONC ○ Availability of Oxytocin and Magnesium Sulphate ○ Improvements in infrastructure, especially mother waiting homes with support from the community and sometimes other funding sources, particularly RBF. 	
58	<ul style="list-style-type: none"> ● They do see real improvements in quality of care in the H4+ districts: <ul style="list-style-type: none"> ○ Three of the six districts had no capacity for Caesarean Sections but now they are carrying out the procedure. ○ Outcome data is improving in the six H4+ districts and they are doing relatively better than other districts. For example, Mbire and Chipinge were the worst for outcomes and now are doing better than many districts. Year on year, the absolute numbers of maternal deaths in the H4+ districts are declining. ○ Nationally, in 2011, there were 1,300 maternal deaths in institutions. This has since declined to 660 in 2014. ○ At national level, caesarean sections have risen from just 3 percent of those needed in 2011 to 77 per cent in 2014. ○ Neonatal deaths have come down, however for both maternal and neo-natal deaths there is still room for improvement. They still see avoidable deaths reported in the DHIS. 	Interview with senior MoHCC staff (Permanent Secretary, Director of Family Health, Director of Preventive Services).
59	Mentorship for caesarean sections and for anaesthetics technicians is being done inexpensively and is helping to improve quality of care.	Interview with H4+ country team (UNICEF)
60	<ul style="list-style-type: none"> ● Incentives <ul style="list-style-type: none"> ○ Under the HTF, retention allowances go to MoHCC staff, doctors at district level, midwives, tutors for midwives, PMD staff, DHE staff. This policy is nation-wide. In 2016, allowances were adjusted downward with variations by category, some as little as 15 percent and some by 85 percent. Decisions on adjustments are made by the MoHCC and the Health Services Board. The HTF retention bonus is used to supplement all other sources of funding for a position. ● Equipment and supplies <ul style="list-style-type: none"> ○ Shortages of equipment and supplies were very acute in 2010/11, especially in the H4+ districts which were the weakest. 	Interview with HTF team (UNICEF)
61	<i>"Incentives available from the World Bank RBF programme had a very positive impact on institutions they worked with under H4+ to promote PoC use of CD4 machines."</i>	Interview with J.F. Kapneck Trust
62	<i>"Having the capacity to do Caesarean Sections in Mbire is a major, major achievement."</i>	Interview with Women's Action Group

63	<ul style="list-style-type: none"> • <i>“Chipinge has been performing better than other districts in the province partly due to H4+. In particular, Chipinge is able to perform caesarean sections and is doing more than other districts in the province.”</i> • <i>“Motor bikes provided by H4+ have been important in helping the PM Directorate to cover all aspects of RMNCH with supportive supervision. Has an effect across the province, not only in H4+ districts.”</i> • <i>“By providing small amounts of funds for infrastructure in Chipinge, H4+ was really useful in overcoming some infrastructure challenges but others remain.”</i> 	Interview with Provincial Health Executive, Manicaland Province (oversees Chipinge district)
64	<ul style="list-style-type: none"> • <i>“Equipment supplied to the district has come on time. It includes anaesthesia machines, hospital beds, operating theatre beds, lighting for theatres, and MVA machines among others.”</i> • <i>“H4+ helps with the procurement of essential medicines for RMNCH. They have not experience stock outs since support was started by H4+ with some brief exceptions. When short term stock-outs in some facilities occur, they can use RBF funds for replenishment.”</i> • <i>“Without H4+ these improvements would not be there. Chipinge would disappear from the radar.”</i> 	Interview with District Health Executive, Chipinge district
65	The PMD team discussed the issue of reductions or cutbacks in the level of retention bonuses from HTF/HDF. In combination with the end of H4+ which provides funding for materials and supplies (alongside RBF) these reductions could seriously hamper motivation and incentives.	Interview with Provincial Health Executive, Mashonaland Central Province (oversees Mbire district)
66	<ul style="list-style-type: none"> • Infrastructure, equipment and supplies arrived on time and were essential in the following ways: <ul style="list-style-type: none"> ○ Provision of four motorbikes to transfer samples from clinics to hospital then to Harare via FedEx ○ Establishing a new operating theatre, including the provision of equipment (laryngoscopes, vaporizers, etc.) and consumables - used to refer cases to Harare, now can perform C-sections (2-3 per week). May still end up referring if a nurse anaesthetist is not available. ○ Consumables: oxytocin, IV fluids, anaesthesia medicines (lidocaine, ketamine), misoprostol ○ MVA kits (3 MDs are trained in MVA) ○ Establishment of maternity waiting homes by UNFPA, including cooking facilities for mothers who live far from the facility. • Health Transition Fund: The HTF is credited with ensuring HR capacity through the retention bonuses. This is a critical input that enables H4+ activities to be implemented. 	Interviews, Chitsungo District Hospital, Mbire district.

67	H4+ resources supported: waiting mother shelters, delivery beds, resuscitators, and medicines (oxytocin- although didn't receive adequate amounts). A CD4 machine was provided, but is not functional. While it is being serviced, they were able to use one from another centre.	Interviews at Mushumbi Health Centre, Mbire District.
68	<i>"H4+ disbursement of funds to provinces is a challenge – very difficult to plan activities because of unpredictable nature. At the end of last year, funding was received for clinical mentorship, which was supposed to be for the last quarter; therefore, they had a month to spend a quarter's worth of funds. Money flows from UNFPA-NY to UNICEF to Ministry, to Province, to District."</i>	Interview with Provincial Health Executive, Matabeleland North (oversees Binga District)
69	<ul style="list-style-type: none"> • H4+ provides: <ul style="list-style-type: none"> • Medicines and supplies: Oxytocin, IV fluids, cannulas, ambubags, endotracheal tubes, airways • Equipment: delivery beds, incubators, anaesthesia machines. The anaesthesia machines are still boxed up and not yet installed as there is a need for a qualified technician to install them otherwise the warranty will be void • Renovations of maternity homes, including beds and linens, ablution and kitchen facilities • Motor bikes for transferring samples. 	Interview with District Health Executive at Binga District Hospital.
70	<ul style="list-style-type: none"> • Point of Care CD4 machines were provided and are functional • H4+ supported a Waiting Mother Home, including a cooking facility. 	Interviews at Karyangwe Mission Hospital, Binga district.
71	<ul style="list-style-type: none"> • H4+ provided: <ul style="list-style-type: none"> • Medicines, e.g., oxytocin, IV fluids for maternity; have experienced some stock-outs but are able to get supplies from the district hospital when needed • Equipment: beds and CD4 machine • Mothers waiting home with a kitchen • RBF helps maintain value of these investments by providing funds to the facility which can be used for maintenance of equipment like the CD4 machines. 	Interviews at Siabuwa Primary Health Centre, Binga district.
72	<ul style="list-style-type: none"> • Training and mentoring supported by H4+ improved skills in: <ul style="list-style-type: none"> • BEmONC • Infant and child feeding practices • Option B+ management • ART, especially paediatric ART • IMCI • Infant/Child feeding 	Interviews with staff of District Health Executives, District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres in Chipinge, Mbire and Binga

	<ul style="list-style-type: none"> • MVA • Staff also report improved trust between the community and the health facilities based in improved services and skills. • “BEmONC training has resulted in fewer maternal complications and infant deaths. High risk cases are referred to the district hospital, while others can be managed by the health centre.” Kariangwe Mission Hospital, Binga • “Skills have greatly improved through one to one mentorship and provision of supportive supervision which works better than regular supervision. All of this is more effective than sending staff away to workshops.” Siabuwa Primary Health Centre, Binga. • “There is a clear link between the training of nurses in Youth Friendly Services (YFS) and the work done by Katswe Sistahood to engage young married and unmarried girls and the recognizable improvement in attitudes by nurses and trust by young people.” Chipinge District Health Executive 	
<p>Assumption 1.5 <i>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.</i></p>		
	Information/data	Information sources
73	<ul style="list-style-type: none"> • Significant increase in number of live births at hospitals from 7,909 in 2012 to 11,456 in 2015 • Live births at home peaked at 1,199 in 2014 and declined to 813 in 2015 • All maternal deaths at home and in facilities peaked in 2013 at 16 and declined to 8 in 2015⁸⁷ • Caesarean sections increased from 291 in 2012 to 827 in 2015 • Repeat antenatal visits increased from 8208 in 2012 to 17,330 in 2015. 	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Chipinge District .
74	<ul style="list-style-type: none"> • Slight increase in live births at hospitals/clinics from 2,026 in 2012 to 2,265 in 2015 • Decrease in live births at home from 467 recorded in 2013 (no data for 2012) to 254 in 2015 	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health

⁸⁷ Maternal deaths reported at the district level are difficult to interpret because complicated deliveries are often referred to the Provincial hospitals after significant delays; as a result many mothers from the districts will have their deaths recorded at the provincial hospitals.

	<ul style="list-style-type: none"> • Caesarean sections increase from 0 in 2012 to 20 in 2015 • Repeat antenatal visit (all ages) increased from 2,487 in 2012 to 4,217 in 2015. 	Information and Disease Surveillance for Mbire District.
75	<ul style="list-style-type: none"> • Slight increase in reported live births at hospitals and clinics from 3,707 in 2012 to 4154 in 2015 • Live births at home peaked in 2013 at 413 and declined to 272 in 2015 (no data for 2012) • All maternal deaths: no pattern year by year • Caesarean Sections increased from 33 in 2012 to 262 in 2015 • Repeat Antenatal Visits (all ages) increased from 4,034 in 2012 to 7,908 in 2015. 	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Binga District.
76	<ul style="list-style-type: none"> • By comparison in the non-H4+ Province of Mashonaland East: <ul style="list-style-type: none"> • Live births at hospitals declined from 36,972 in 2012 to 35,794 in 2015 • Live births at home peaked at 5667 in 2013 and declined to 550 in 2015 • All maternal deaths peaked at 181 in 2013 and declined to 31 in 2015 • Caesarean Sections rose only slightly from 1,272 in 2014 to 1,527 in 2015 • Repeat antenatal visits rose from 24,923 in 2012 to 57,111 in 2015. 	District Health Information System 2 (DHIS2) Data 2012 to 2015 provided by MoHCC office of Health Information and Disease Surveillance for Mashonaland East Province (non-H4+ Province with nine districts).
77	Managers and health facilities staff at PHE, DHE and health facility levels are unaware of any specific exit strategies for H4+ in their districts. They had no expectation that activities supported by H4+ would be able to access other sources of funds.	Interviews with staff of district health executives, district hospitals, mission hospitals, rural hospitals, and health centres in Chipinge, Mbire and Binga
78	Concentration of H4+ JPCS activities and expenditures is overwhelmingly in latest two years of the programme (2014 and 2015) which accounted for over 69 percent of programme expenditures, as a result any improvements in service delivery and access in the six H4+ districts must have occurred subsequent to the ramping up of investments and activities in early 2014. Effects on both the supply and demand side of RMNCAH services have thus been concentrated in the latter part of the programme. This has implications for the expected rise in utilization.	H4+ JPCS Expenditure Data (See section 2.5).
79	Noted: <ul style="list-style-type: none"> • Low implementation rate of Zimbabwe H4+ at only about 35 percent by May 2014 • Poor national coordination mechanisms as one of the reasons for a low implementation rate. 	MoHCC, <i>Minutes of the First H4+ Steering Committee Meeting</i> . June, 2014 (H4+ Zimbabwe 2014a)
80	Funds received versus funds expended, 2015: Sida grant = 78 percent, Canada grant = 88 percent. Illustrates accelerated implementation rate and concentration of investments and activities in the latter part of H4+ in Zimbabwe (2014 and 2015).	H4+ Country Team: <i>Financial Progress 2015</i> . In presentation: <i>H4+ Zimbabwe: Catalytic Support of RMNCH-A Programme of the Government of Zimbabwe</i> . 7-14 March 2016 (H4+ Zimbabwe 2016b)

81	<i>“Chipinge has been performing better than other districts in the province partly due to H4+. In particular, Chipinge is able to perform caesarean sections and is doing more than other districts in the province.”</i>	Interview with Provincial Health Executive, Manicaland Province (oversees Chipinge District)
82	<ul style="list-style-type: none"> • <i>“MoHCC can already see the evidence that the H4+ approach is working in the targeted districts and they don’t need another pilot study to take elements of the H4+ approach to scale on a national level, for example in the HDF programme.”</i> • <i>“It is important to note that H4+ support to areas such as policy, operational guidelines, and innovation have effects way beyond the borders of the six selected districts.”</i> 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
83	<ul style="list-style-type: none"> • <i>“Access to PMTCT and ART services did improve as services improved and they were able to clear the backlog of unserved cases by early 2015.”</i> • <i>“RBF helped to improve delivery issues and attendance because it encouraged facilities staff to help motivate men and women to register for ANC.”</i> 	Interview with J. F. Kapneck Trust.
84	<ul style="list-style-type: none"> • <i>“With H4+ support community based advocates (CBAs) got training, materials and bicycles for travelling throughout the two wards in each district and got a positive response to messages on the importance of delivering in facilities. Also noted higher levels of trust between health facility staff and community members.”</i> • <i>“They have seen great reductions in the number of home deliveries and increased use of facilities for deliveries in the wards and districts they work in.”</i> 	Interview with Women’s Action Group.
85	<i>“Service providers are much more open to have young people engage with them and more willing to listen to their concerns. This builds confidence and allows young people to access health facilities but there is still a problem of young girls in particular not using the Youth Friendly Corners”</i>	Interview with Katswe Sistahood.
86	H4+ supported training of Primary Health Care (PHC) Counsellors in the supervision of youth friendly corners but there are problems of getting attendance and use, especially by girls.	Interview with Provincial Health Executive, Manicaland (oversees Chipinge).
87	<ul style="list-style-type: none"> • They definitely see the demand side increasing and facilities being accessed and used more. In fact, <i>“as demand increases, there is now a risk that the supply side will be overwhelmed. Since they have a common border with Mozambique, people from there are willing to travel to Chipinge to deliver their babies.”</i> • <i>“The relatively small scale and narrow reach of the demand side work is an issue, however. Chipinge has 38 wards and only three or four get support on the demand side to increase community access and involvement with funding from UNAIDS and UN Women.”</i> 	Interview with Chipinge District Health Executive.
88	All in all, because of increased trust between the health facilities and the community, the district has had good success in discussing how to avoid preventable deaths and getting	Focus Group Discussion with members of a Women’s Consultative Forum supported by Women’s Action Group in Chipinge.

	women to go to the health facilities for deliveries. This is most effective where there are functioning mother waiting homes.	
89	<ul style="list-style-type: none"> • The establishment of mother waiting homes with UNFPA support has helped to encourage use of the facilities by mothers who live far away. At the district hospital they have seen an increase in use of the facility for deliveries as a result of improved staff attitudes and the improvements in the mother waiting homes. • <i>“Huge improvement in relationships between the hospital and the surrounding community. There is increased trust that the community will receive quality health services as a result of the inputs from H4+. Increased male engagement has resulted in more men accompanying women for ANC.”</i> 	Interviews at Chitsungo District Hospital with the members of the District Health Executive.
90	<ul style="list-style-type: none"> • Institutional deliveries have increased from 68 percent of live births in the catchment area to 98 percent in the period of H4+. • Numbers coming to the youth friendly corners (YFC) are low and conditions not so good because of inadequate space. The numbers coming to the YFCs are particularly low for girls. 	Interviews at Mushumbi Health Centre, Mbire district
91	<i>“Before, patients did not go to the health facility or accept services; women delivered at home and women with HIV did not know their status. Now partners are being tested and there are great improvements in the clinic’s services and in trust between health workers and community members.”</i>	Group discussion with Mushumbi Village Health Workers Group.
92	<i>“There is a good relationship between the advocates and the PHC. The PHC keeps advocates informed on any changes in services and more people are accessing those services because of increased trust.”</i>	Group discussion with CBAs in Karai (Mbire).
93	<i>“Traditional leaders have worked hard [after training supported by H4+] to explain and promote use of health facilities, particularly for deliveries. The response has been positive because community members can see the improvement in services.</i>	Group discussion with traditional leaders in Karai (Mbire).
94	<i>“Local leaders have great influence. Giving health messages to local leaders and having them engage in advocacy is critical. Working with local leaders has helped increase male attendance at ANC appointments with their partners to 60 percent in Binga as opposed to 11 per cent in other districts.”</i>	Provincial Health Executive, Matabeleland North (oversees Binga district).
95	<ul style="list-style-type: none"> • <i>“There is an active hospital health committee with representation from different groups in the community which meets monthly to discuss issues in service. This has helped reduce home deliveries and head off rumours about the hospital. Usage has increased.”</i> • <i>“H4+ has helped improve the hospital’s relationship with the community through engagement with community leaders with positive effects on attendance and access.”</i> 	Interviews with staff of the Karinyangwe Mission Hospital, Binga district.

96	<ul style="list-style-type: none"> • In 2011, 53 percent of births in the catchment area of the health centre occurred at home; now 95 percent of live births are delivered at the health centre. • Prior to work by male mobilizers supported by H4+, only three percent of mothers were accompanied by a partner, as compared with 80 percent now. 	Interviews at Siabuwa Primary Health Centre, Binga district.
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Area of Investigation 2: Expanded Access

2. 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?
- 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)?
 - To what extent have H4+ JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women?
 - How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care?
 - 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	The six districts were chosen and were the ones with the worst outcomes in RMNCAH and the hardest to reach. The Government of Zimbabwe was the main actor in selecting the districts and looked at low-performing RMNCAH indicators on a national basis to help prioritize the implementation areas for H4+ (i.e. the eight programme outputs).	<ul style="list-style-type: none"> Senior officials in the MoHCC in Harare H4+ country team members.
2	<i>“The proposed programme will target the same 6 districts where the H4+ CIDA project (2011-2015) is currently being implemented. The 6 districts selected are in 6 different provinces with a population of 1,367,267 (11% of the total population, 2012 Population Census): Chipinge in Manicaland (300,792), Gokwe North in Midlands (244,976), Hurungwe in Mashonaland West (324,675), Mbire in Mashonaland Central (81,908), Chiredzi in Masvingo (276,842) and Binga in Matebeleland North (138,074). These districts were selected on the basis of high maternal, neonatal and child mortality; weak community health programs; hard-to-reach; inclusion of areas prone to malaria and areas that have not benefited from the initial phase of Results Based Financing funding or current CIDA funded PMTCT programmes.” (p. 21)</i>	H4+ Zimbabwe, <i>Final Proposal Sida Grant</i> , July 2013 (H4+ Zimbabwe 2013a)
3	The six districts were selected on the basis of their high maternal, neonatal and child mortality and morbidity, and because they are notoriously difficult to access, particularly	CCORE, <i>CIDA H4+ Baseline Assessment Report</i> , 2013 (CCORE 2013)

	<p>in the rainy season. At the time of the baseline, none of the districts was benefiting from other initiatives to improve maternal and child health.</p> <p><i>“Some communities are marginalised. They stay far away from health facilities and there are challenges with wild animals.”</i> (p. 30)</p>	
4	<p>Trends in RMNCH-A between the 2010/11 ZDHS and the 2013/14 MICS show improvement in key indicators at the national level:</p> <ul style="list-style-type: none"> • Maternal Mortality Ratio: decrease from 960 deaths to 614 deaths per 100,000 live births • Under 5 Mortality Ratio: decrease from 85 deaths to 75 deaths per 1,000 live births • Skilled attendance at birth: increased to 80% from 66% • Institutional Delivery: increased to 80% from 65% • Post-natal check within 2 days of delivery: increased to 77% from 27% • Exclusive breastfeeding in first six months of life: increased to 41% from 31% • Unmet need for family planning decreased to 10% from 13% • Contraceptive prevalence rate: increased to 66% from 57% • ART coverage (adults): increased to 77% from 69% • ART coverage (children): increased to 41% from 36% • PMTCT coverage: Increased to 82% from 55%. 	<p>Presentation made by H4+ country team members during pre-evaluation mission to Zimbabwe on 7 March 2016</p>
5	<p>Among UN H4+ officials, there is coherence that activities of H4+ are aligned with national priorities and needs of the population, including the most vulnerable and hard-to-reach, and with international maternal and newborn mortality reduction strategies. (p.8)</p>	<p>H4+, <i>Mid-term Review Country Report, Zimbabwe, 2013</i> (H4+ 2013b)</p>
6	<p>Establishment of maternity waiting homes by UNFPA, including cooking facilities for mothers who live far from the facility. At the district hospital in Mbire (Chitsungo Hospital), there were 52 mothers in the waiting home, and it can accommodate up to 70. (Families accompanied mothers and there was a camp atmosphere outside the several buildings in the complex housing the mothers.) Women’s vitals are checked daily, and every week they are giving a full exam. High risk mothers are examined daily. If there is a problem noted, the woman is referred to a doctor. Women receive information on immunization, nutrition, PMTCT (FP not mentioned here). 3 out of 20 are young mothers.</p>	<p>District health executives, including District Medical Officer.</p>
7	<p>Attention to adolescent issues in RMNCH-A have come late in the program, mainly through the advocacy of UNAIDS and often around HIV issues:</p>	<p>Senior officials in the MoHCC in Harare.</p>

	<ul style="list-style-type: none"> • Counselling for children and adolescents has improved as practitioners have been trained and gained experience. H4+ has developed counselling tools and providers have been trained in testing and rapid treatment of children and adolescents. • H4+ has supported youth friendly services; however, there is no evidence yet that they are effective. 	
8	<p>The National ASRH strategy defined an essential set of adolescent sexual and reproductive health services to be delivered through three programming venues:</p> <ol style="list-style-type: none"> 1. Community-based (<i>youth centers</i> offering counseling, recreational activities and condoms); 2. Health facility-based (onsite <i>youth-friendly corners</i> which were planned to offer voluntary counseling and testing as well as condoms and other family planning methods); 3. School-based (life skills training and counseling). <p><i>The presence of older males at youth centres acts as a deterrent to younger adolescent females using the family planning services that may be provided there.</i></p> <p>Training providers in youth friendly approaches alone does not appear to increase adolescent utilization. <i>It appears that the central problem is not youth-friendliness, but rather the opposite – barriers to youth services.</i> If adolescents are to utilize such services, the focus of service delivery programs should not only focus on making the centre or clinic “youth friendly” but also on the identification and elimination of barriers (human and structural) that impede adolescent utilization of services. For youth-friendly health services to be effective they must, from the beginning, have strong community support.</p>	Johns Hopkins University: <i>ASRH Strategic Plan Review</i> , 3 November 2015) (John Hopkins University 2015)
9	<p>Adolescents need and are receiving more attention, starting at the 2014 Global AIDS conference. UNAIDS works with AFRICAID to support its peer educator model. UNICEF supports AFRICAID to extend the CATS (Community Adolescent Treatment Supporters) programme in Binga and Gokwe South.</p> <ul style="list-style-type: none"> • This model was first piloted by the MoHCC in 2009 and is intended to assist youth to overcome their fears of stigma and ease their access to adolescent-friendly HIV treatment Services (HTS). 	H4+ country team members.

	<ul style="list-style-type: none"> • CATS are supervised by the DHE's primary health care coordinators and are stationed in some health centers with funding from UNICEF. The work is not very widespread; it started in Harare and is working in four of the six H4+ districts. • CATS are able to reach youth and provide young people who have not revealed their status and help connect them with health services. 	
10	H4+ funding to OPHID in Mbire supported integrated HIV treatment within PMTCT and RMNCH, especially for adolescents. They were effective in supporting Mberika Groups (Mberika is the local word for the cloth used by mothers to carry their babies). H4+ emphasised integration of PMTCT and HCT into MNCAH.	H4+ country team members.
11	What H4+ brought to the table was an integrated approach and a stronger focus on rights and the need to reach the unreached – this was reinforced by Canada and Sweden and their track record on rights.	H4+ country team members.
12	Prior to H4+, Mbire experienced severe problems with PPH, HIV and malnutrition. Major changes have been made, such as the reduction in maternal deaths and reduction in HIV infections. This has been accomplished through the establishment of functional operating theatres, speedier transport of specimens by motorbikes, improved capacity through training and mentorship, and decentralization of ART.	Provincial Health Executives, Mashonaland Central Province including Provincial Medical Officer
13	In Chipinge, H4+ supported training through Katswe and the "Sista 2 Sista" approach, which incorporated and integrated gender issues including coercion, early marriage, date rape, into the mobilisation and training of young women. It also involved training male mobilizers to work with young men.	District Health Executives, including District Medical Officer.
14	In Mbire, there are fewer maternal deaths because of the decentralised capacity to address emergencies at the district level and bring mothers closer to the facility prior to delivery. Fistula cases can now be referred to Harare as there is money for transport. However, there is no clear answer regarding the low number of reported deaths as compared to the maternal mortality rate reported in the recent DHS (600 per 100,000 live births).	District Health Executives, including District Medical Officer.
<p>Assumption 2.2 <i>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.</i></p>		
Information/data		Information sources

15	<p>There have been tangible improvements in quality of care in the H4+ districts:</p> <ul style="list-style-type: none"> • Three of the six districts had no capacity for C-sections but now are doing them. [Mentorship has had its biggest impact on EmONC and the availability of skilled anaesthetists and technicians] • Outcome data is improving in the six H4+ districts and they are doing relatively better than other districts, e.g., Mbire and Chipinge were the worst for outcomes and now are doing better than many districts • Nationally, the number of maternal deaths reported in institutions declined from 1,300 in 2011 to 660 in 2014 • At national level, C-sections have risen from just three percent of those needed in 2011 to 77 percent in 2014. 	<ul style="list-style-type: none"> • Senior officials in MoHCC in the capital (Harare) • District Health Executives • Health facility staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.
16	<p>As of July 2014, implementation of H4+ had not yet occurred, given delays in getting started (owing to absorptive capacity of the MoHCC). However, general service readiness was deemed good, with the procurement of supply and equipment, improvements in physical structure and environment, and partial availability of protocols, guidelines, training manuals and IEC materials to participating facilities. Challenges noted at this point in the program included, fund disbursement delays, inadequate coordination support from the ministry, lack of capacity for M&E, and staff shortages within UN agencies. (p. 9-11)</p>	<p>H4+, <i>Mid-term Review Country Report, Zimbabwe, 2013</i> (H4+ 2013b)</p>
17	<p>Community activities came too late within the programme, and there is a need to better balance supply and demand, as supply side (HSS) activities outweighed the demand side activities.</p> <p>UN Women is in only three of the six districts, and in only two wards per district. In those districts there have been significant changes in behaviour, but there is no opportunity with the programme ending for taking this work to other wards within the district.</p>	<p>H4+ country team members.</p>
18	<p>Country team members noted that at the time when UNAIDS and UN Women began to participate in H4+, services were improving in quality and quantity, the communities were inadequately engaged, the demand side was missing and <i>“women were dying and the level of trust by the community was nil”</i>. UN Women and UNAIDS were unable to influence the program until there was <i>“money on the table”</i> that enabled them to showcase their capabilities. The other groups realised their importance, but too late within the programme.</p>	<p>H4+ country team members.</p>
19	<p>H4+-supported capacity development activities in Mutare:</p>	<p>Provincial Health Executives, Manicaland Province.</p>

	<ul style="list-style-type: none"> • H4+ assisted the PHE to cover all aspects of MHCAH in supportive supervision and provided transport (motorbikes). In addition, there is now a national committee on MDSR to assure accountability and consistency in maternal death surveillance. Training was provided to doctors and other staff to better classify maternal deaths, but some may be missed. • Clinical mentoring for EmONC, including C-Sections was supported (under the Road Map for Accelerating progress on Maternal, Newborn and Child Health). All district hospitals (9) as well as some Mission hospitals are able to do C-sections. Doctors were supported to attend the Mutare Provincial Hospital for clinical mentoring in C-Sections and MVAs. They also trained five nurse anaesthetists for work in the districts. 	
20	<p>In Mashonaland Province, the Provincial Health Team conducted a client satisfaction study covering all districts within the province, the “first of its kind” according to officials. Issues that surfaced included: long patient waiting times, stock-outs of supplies/medicines, health worker attitudes, and privacy. “Mbire wasn’t the worst,” inferring that quality has improved in this heretofore-marginalised area.</p> <p>Regarding maternal death outcomes:</p> <ul style="list-style-type: none"> • There were two deaths reported last month in the province. Reports are sent to the DMO then forwarded to the PMD by paper. When a death is reported, the PMO conducts the maternal death audit in collaboration with the DMO. Maternal death surveillance is conducted via a weekly review meeting. • Regarding the discrepancy of maternal death rates between DHS and DHIS2, it was noted that there is limited follow-up of women who come for ANC but do not deliver. VHWs can follow-up women who live nearby, but it is more difficult to follow-up in cases where the mothers come from far away. 	Provincial Health Executives, Mashonaland Central Province, including Provincial Medical Officer.
21	<p>Mentorship is deemed a key approach for improving the capacity of providers. Mentorship is done by a person deemed skilled in an area and is matched to a mentee who needs improvement in the skill area. The mentor spends a whole day with the mentee, walking through the steps of a procedure, helping the mentee conduct a self-assessment, and then coaching and monitoring for improvement.</p>	Provincial Health Executives and District Health Executives, including District Medical Officers.
22	<p>H4+ forced the UN agencies to bring vertical platforms together and strengthen attention to all components of the program in a holistic manner.</p>	H4+ country team members.
23	<p>OPHID: H4+ funding in Mbire supported integrated HIV treatment within PMTCT and RMNCH, especially for adolescents. They were effective in supporting Mberika Groups</p>	H4+ country team members.

	(Mberika is the local word for the cloth used by mothers to carry their babies). H4+ emphasised integration of PMTCT and HCT into MNCH-A.	
24	<p>Chipinge District received major inputs from H4 + including:</p> <ul style="list-style-type: none"> • Equipment including anaesthesia machines • Beds • Other operating theatre equipment • MVA machines • Support to training, esp. for BEmONC an CEmONC • Clinical mentorship for nurses from rural health centres who come to the district • Training for PMTCT for option B • Training in MVA • Training in providing care for adolescents, including Youth Friendly Services. • Almost all training is on the job. • Procurement of essential medicines for RMNCH. They have not experienced stock-outs since support from H4+ and when short-term stock outs in some facilities occur, they can use RBF funds for replenishment <p>As a result of training in ANC/PNC when mothers come for their first booking they are taken through a comprehensive interview/examination encompassing:</p> <ul style="list-style-type: none"> • HIV information • Testing for HIV • Starting on ART if HIV positive • Family Planning with an emphasis on long term methods • Safe delivery • Baby feeding and mother and child nutrition • After Delivery they get continuous care and babies are tested for HIV at six weeks (aided by the provision of motor bikes for rapid delivery of Dried Blood Spot test specimens to laboratories) <p>These input helped to build trust between the community and health workers.</p>	District Health Executives.
25	<p>At St. Peters Mission Hospital (Chipinge), a Catholic mission hospital with 84 beds and a catchment area of 14,000, H4+ provided support in the following areas:</p> <ul style="list-style-type: none"> • Training nurses in BEmONC • Training in IMNCI 	Health facility staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres.

	<ul style="list-style-type: none"> • Improvements to the mother waiting home • An anaesthetic machine • Blood pressure monitors • Cannulae • Oxytocin and magnesium sulphate (not a continuous supply but is provided on a push system and RBF helps to cover stock-outs) • Clinical mentoring for doctors (C Section) and nurses • Supportive supervision funded by H4+ helps them receive support from the PHE and DHE • Training in the electronic Maternal Death Reporting Systems <p>There was a delay in achieving certification for CEmONC including C-Sections. They expected to be up and running with the new theatre by March 1 but, while H4+ has provided needed equipment, they are not able to get the operating theatre up and running yet. This is a big challenge. They have the equipment and have started to repair it but now have a lack of funds to complete the repairs. They have had to spend RBF funds on buying drugs to cover the stock outs, as well as buying fuel for the ambulances and having them repaired, only one is functional of the two they have. The need plumbing, showers, air conditioning. The Provincial Medical Director is helping them to overcome these obstacles and find sources of funding to get the theatre operational later this year. This is a major bottleneck as the achievement of a new theatre with capacity to do CEmONC including C Sections would really improve their ability to provide quality services.</p>	
26	<p>Chitsungo District Hospital in Mbire received major inputs from H4+ including:</p> <ul style="list-style-type: none"> • Training <ul style="list-style-type: none"> • BEMONC for all nurses in district (emergency OBS, resuscitation of newborns) in 2013-2014 • Infant and child feeding practices in 2015 • Option B+ • ART • Provision of four motorbikes to transfer samples from clinics to hospital then to Harare via FedEx • Establishing a new operating theatre, including the provision of equipment (laryngoscopes, vaporizers, etc.) and consumables - used to refer cases to Harare, now 	District Health Executives, including District Medical Officer

<p>can perform C-sections (2-3 per week). May still end up referring if a nurse anaesthetist is not available.</p> <ul style="list-style-type: none"> • Consumables: oxytocin, IV fluids, anaesthesia medicines (lidocaine, ketamine), misoprostol • MVA kits (three MDs are trained in MVA) • Establishment of maternity waiting homes by UNFPA, including cooking facilities for mothers who live far from the facility. At the district hospital there were 52 mothers in the waiting home, and it can accommodate up to 70. (Families accompanied mothers and there was a camp atmosphere outside the several buildings in the complex housing the mothers.) Women’s vitals are checked daily, and every week they are giving a full exam. High risk mothers are examined daily. If there is a problem noted, the woman is referred to a doctor. Women receive information on immunization, nutrition, PMTCT (FP not mentioned here). 3 out of 20 are young mothers. • Resources to enable the DHT to conduct supportive supervision for the 13 health facilities within the district. • Support for partners for demand side activities: <ul style="list-style-type: none"> • Katswe works with youth under 24 years to address teenage pregnancy and improve health-seeking behaviour, and empower girls to realize their sexual and reproductive rights. In Mbire, Katswe established a youth friendly center near the secondary school. • WAG works on improving MCH (i.e., early bookings for hospital deliveries, HIV testing, engaging men as partners) by mobilizing community and religious leaders to support messages related to safe MCH practices. • OPHID (funded by UNICEF) to support community development, revolving funds • Comparing now to 2012 (the start of H4+ activities in Mbire): <ul style="list-style-type: none"> • Huge improvements - fewer fistula and maternal deaths because of decentralized capacity to address emergencies at the district level and bringing mothers closer to the facility (waiting homes) prior to delivery, thereby reducing one of the major delays. • Fistula cases can now be referred to Harare as there are funds available for transport • Stronger relationships have been built between the hospital and the surrounding community. There is increased trust that the community will receive quality health services as a result of the inputs from H4+ 	
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	<ul style="list-style-type: none"> • Increase male engagement has resulted in more men accompanying women for ANC. • District personnel say that they have seen fewer deaths in the district. When asked about how this tracks with the latest DHS data showing a maternal death rate (approximately 600 deaths per 100,000 live births), there wasn't a clear answer. The VHWs are the "eyes in the community" and they are supposed to let the matron know of any deaths. They do not have any reason not to report this information Also the local leaders also know they should report a maternal death. • Family planning is not provided at the District Hospital as it is owned by the Catholic Mission. Although H4+ has supported integration among the various service delivery components, FP is excluded. Challenges noted: <ul style="list-style-type: none"> • There has not been a reduction of teenage pregnancies. • There is more reporting of GBV as a result of increased community awareness, which is a first step in addressing the issues. (However, there was no mention of services for GBV survivors). • Many pregnancies are unplanned. Contraceptive failure was given as a reason, i.e., women take OCs when the husband is home from working in the field. • The Health Transition Fund (HTF) is credited with ensuring HR capacity through the retention bonuses and is an important complement to H4+ activities (or the other way around). There is concern that when the retention bonuses for staff are reduced, people will be flocking out of remote districts. 	
27	<p>Key activities supported by H4+ in Mbire:</p> <ul style="list-style-type: none"> • A major contribution was the resuscitation of the OR (provision of an anaesthesia machine at the Mbire District Hospital so that it could perform C-sections). Prior to H4+, difficult cases were referred to the provincial capital. The mentorship programme was key in capacity development as <i>"training is not enough"</i>. • H4+ supported training was conducted in the following: <ul style="list-style-type: none"> • Early infant diagnosis • Rapid HIV testing • Option B+ for mothers • ART • Infant and child feeding • ASRH - counselling for nurses 	Provincial Health Executives, Mashonaland Central Province.

	<ul style="list-style-type: none"> • For family planning, nurses have been trained in Jadelle to increase choice. Family planning is discussed during ANC. • Training of nurses in youth friendly services (YFS), including the set-up of youth-friendly corners in some facilities, including the creation of support groups in some schools. Mbire has two centres. This component needs strengthening; in particular, there isn't a clear policy on provision of contraceptive services (pills, condoms) in schools. • Mentorship is done by persons skilled in a particular topic area. The mentor spends a whole day walking through steps in the procedure, helping the mentee conduct a self-assessment, and then coaching and monitoring for improvement. H4+ supported the practice of supportive supervision, with a change from a focus on quantitative indicators to qualitative indicators. The PHE just conducted a supportive supervision to Mbire, and they consider the district their "baby" that they want to catch up with the rest of the districts in the province. The PHE plans to integrate supportive supervision for the many different programs that are being implemented in the province. <p>Regarding the delivery of information and services:</p> <ul style="list-style-type: none"> • VHWs are the main source of information for the community; VHW training is supported mainly by UNICEF with resources from the Global Fund. District has monthly meetings with VHWs to discuss issues and services, e.g., Mazowe District is piloting self-testing for HIV; VHWs testing for malaria, indoor spraying, use of nets. • Adolescent pregnancy is a major challenge. • Unsafe abortion is a problem. • A mother receives the following continuum of care (from antenatal to delivery to postnatal): <ul style="list-style-type: none"> • 1st ANC visit: Education on nutrition and PMTCT, individual counselling and testing, medical history, exam, anaemia, blood grouping, syphilis screening, blood pressure, package for ANC (antimalarial, ITPT), schedule subsequent ANC visits; VHW encourages mother to delivery at facility • Labor and delivery: oxytocin for PPH, mother stays for 3 days - discharge depends on whether baby is HIV+ • Mother returns 7 days postpartum, VHW monitors at home; FP info is provided 	
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	<ul style="list-style-type: none"> In Mbire, community leaders are supporting male involvement and facility deliveries (if delivery takes place at home, the woman is fined a goat). WAG organizing traditional leaders to provide information about the importance of delivering in facilities. 	
28	<p>Key activities supported at Mushimbi Health Centre (Mbire), serving a population of 11,500:</p> <ul style="list-style-type: none"> Maternity waiting home was built in 2011 and opened in 2012, and is credited with an increase in the number of births at the facility. The waiting home was built for 8 mothers, but they accommodate up to 20 with 596 births in 2015. Institutional deliveries have increased and staff believe that women come from outside the catchment area because of the quality at the facility. Only 12 home deliveries were reported by VHWs. Only 16 cases were referred to the District Hospital for complications as they are now able (as a result of H4+ support) to manage PPH and eclampsia, do manual delivery of the placenta, manage breach births, and support healthy baby breathing. No maternal deaths have occurred in the facility since 2014. H4+ supported training was conducted in the following topics mainly in 2014-2015: <ul style="list-style-type: none"> BEmONC IMCI Infant/child feeding ASRH Male mobilizers (2 trained in 2014; need 5) - increased the number of men supporting wives from 20% to 50%, including for PMTCT. The head nurse was trained as a trainer in MVA H4+ resources supported: waiting mother shelters, delivery beds, resuscitators, and medicines (oxytocin- although didn't receive adequate amounts). A CD4 machine was provided, but isn't working. While it is being served, they were able to use one from another centre. Contraceptive services offered include OCs, injectables, and implants (Jadelle and implanon). There is not a demand for IUCD. Forty to fifty percent of births are to married, mainly out of school, teens age 15-19. Mushumbi PHC is a HTF/HDF facility. 	Health facilities staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres.
29	<p>Key activities supported by H4+ at the provincial level:</p> <ul style="list-style-type: none"> Maternal death audits and quarterly review meetings Clinical mentorship program where a doctor spends 2 weeks with obstetrician/gynaecologist consultant on lifesaving procedures, C-sections 	Provincial health executives, including Provincial Medical Officer, Matabele North.

	<ul style="list-style-type: none"> • Started in the most remote districts (Binga and Wanye) as want them to be able to manage complications. The intent is to cover the whole province • Received feedback from midwives that they are not gaining skills at the central level because doctors are available and they are the ones that perform the procedures; therefore, decentralized the mentorship to the district level. • Only the new doctors haven't done attachments • Specific support for Binga - nurses at the PHC level are attached to the District level for management of complications • Training (EMONC) at provincial and district level – 95 percent of nurses have been trained although they still have challenges after training (fixed with clinical mentoring) • Mentoring is not new, but has been revitalized • Supportive supervision is separate from mentoring. It consists of managers going to the facility from the provincial or district level to look at how things are being done. <ul style="list-style-type: none"> • Provincial level receives reports from the district and data from HMIS • Supervisors work with facilities to address the “know-do” gap; mentorship came in to address this • There is a checklist used (“know book”) • Supervisor spend the whole day observing procedures; diagnostic process whereas mentoring is intended to solve the problem • Transport and fuel is a major challenge given the vastly populated district with difficult roads • Binga is supported by RBF; difficult to attribute changes to one particular project. • Approach: Supportive supervision was always there but not enough vehicles to do it. A prior weakness was the amount of time the team spent at the facility. Before, it was a “flypass” but now supervisors spend the whole day. Feedback is provided on the same day • Supervision is integrated -- HIV and maternal health addressed at the same time • RBF supplied the quality checklist which includes sections on structure, process, drug availability, client exit interviews, file and case reviews (to see whether cases were properly diagnosed and managed) • Province conducted a mystery client study (27 women) in 5 districts including Binga. Findings included: 	
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	<ul style="list-style-type: none"> • Reception areas are tidy and clean • Male nurses treat clients better than female nurses; some nurses were abusive and slapped women in labour • Only 40% would refer their daughters to the facility; 7% would never refer their daughters • Very low percentage of women receive the package of ANC services that should be done, e.g., BP monitoring. According to MICS and DHS, 90% of women receive ANC and 70% deliver in facilities; however, given the high MMR, this tells us that coverage is good, but quality is low. (“Coverage has improved, but outcomes have not.”) • The PHT looks at the data for each district and does a root cause analysis of the problems. For example, in Binga the issue is high fertility. • HR capacity: The number of doctors increased from 1 to 3 in Binga. HTF retention allowances have been instrumental in supporting the increases in coverage. H4+ has contributed to the improvement in the C-section rate because of the OR and commodities. 	
30	<p>H4+ inputs (Binga)</p> <ul style="list-style-type: none"> • Medicines and supplies: Oxytocin, IV fluids, cannulas, ambubags, endotracheal tubes, airways • Equipment: delivery beds, incubators, anaesthesia machines. Re the anaesthesia machines, these are still boxed up and not yet installed as there is a need for a qualified technician to install them otherwise the warranty will be voided. • Renovations of maternity homes, including beds and linens, ablution and kitchen facilities • Trainings in BEMONC for all health workers; HIV counselling and testing, MVA training • Supportive supervision on a quarterly basis - greater focus on RH/BEmONC and on reinforcing skills and confidence and problem-solving. • Mentorship: Nurses come to district hospital for 2 weeks (district hospital is a “centre of excellence”). Doctors and midwives also go to the central hospital to gain skills and on-the-job (OJT) coaching. • Motor bikes for transferring samples. <p>Changes seen as a result of H4+:</p> <ul style="list-style-type: none"> • Increased rate of C-sections because staff are more confident and readily able to identify complications and deal with issues on-site. (They perform approx. 20 	Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.

	<p>caesarean-sections, 20 minor surgeries, including MVA monthly.) The facility used to send patients away, because we did not have consumables. During mentorships in Bulawayo, the DMO learned to manage complications (i.e., ectopic pregnancies)</p> <ul style="list-style-type: none"> • Stock-outs have been reduced, although they still occur. Major issue is with blood supplies and antibiotics (as these are used more widely and run out more quickly). 	
31	<p>H4+ inputs at Karinyangwe Mission Hospital (owned by Catholic Mission and staffed by the MoHCC):</p> <ul style="list-style-type: none"> • Waiting mother shelter, including a cooking area • Training in breastfeeding support • Supportive supervision - doctors come from Binga hospital to “see the registers, verify the numbers” as part of the RBF scheme. Karinyangwe is “losing a lot of money” because it does not provide family planning, which is incentivised under the RBF. The process of supervision includes the review of partographs, complications and case management. QA includes internal audits. Supervisors sit down with staff to rectify problems. • Point of care CD4 machines are functional. <p>Most important changes since H4+:</p> <ul style="list-style-type: none"> • Integrated services across the continuum of care (with the exception of FP for religious reasons). The facility receives several requests a month for implant removals (as PSZ is active and offers services via outreach). • Hospital relationship with community has been strengthened through the engagement of local leaders. Teenage pregnancy remains a major challenge and it is perceived to have gotten worse in the past two years. • BEmONC training as resulted in fewer maternal complications and infant deaths. High-risk cases are referred to the district hospital, while others can now be managed by the health centre. • There are no reported maternal deaths (definition of maternal death is a death during pregnancy or within 6 weeks of birth). VHWs are supposed to report deaths to health centre or to chief. Health centre will notify the police, as the community is afraid of doing so. <p>Staff indicate they will be able to sustain improvements because of the RBF and because they might be able to obtain additional support from the Catholic Mission. The major</p>	<p>Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres</p>

	<p>issue is that the catchment area is so spread out, as more than ¾ of the population is far away.</p>	
32	<p>H4+ Inputs (Siabuwa):</p> <ul style="list-style-type: none"> • Received medicines, e.g., oxytocin, IV fluids for maternity; have experienced some stock-outs but are able to get supplies from the District Hospital when needed • Equipment: beds and mattresses; CD4 machine • Training in young child feeding, paediatric ARTs, BEMONC, MVA • Maternal waiting home with a kitchen. • Supportive supervision from the DHE is conducted quarterly and includes checking registers, review using the RBF quality checklist, verification of data for RBF. RBF includes different teams that focus on everything, whereas the H4+ focuses mainly on MNCH. • Mentoring in maternity services, including obstetric care, opportunistic infections and ART • Participation in district-level maternal review meetings (each staff member rotates attendance) • Youth centre peer educators - receive some materials (IEC materials, DVDs, tees and bags) from IPPF affiliate based in Harare and UNICEF; also receive allowances for travel. Peer educators are between 10-24 years; 1 in 8 has been trained. <p>Changes seen as result of H4+:</p> <ul style="list-style-type: none"> • In 2011, 53% home deliveries; now 95% deliveries are at the facility. No reported cases of fistula or maternal deaths since 2008. • Prior to work by male mobilizers, only 3% of mothers were accompanied by partner, as compared to 80% now. • Skills have improved through 1:1 mentorship rather than sending staff to workshops at a district hospital. • Supportive supervision has worked better than regular supervision. It is more focused on MNCH, problems are reviewed and solved in real time, solutions are brought from other places, and materials and support are provided on the spot. • HCC meets quarterly to review issues at the health centre, how the community interacts, to help disseminate information and education to the community. Examples of issues discussed include support to renovate the staff house destroyed by a storm and how to arrange for training for VHWs from remote villages 	<p>Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.</p>

	<ul style="list-style-type: none"> • HCC supported increase in early booking for delivery at the facility (to prevent home delivery) Hospital is the secretariat for the Health Centre Committee (instituted under the RBF). Representation includes VHWs, youth representatives, business leaders, local leaders, traditional healers, church representatives, PLHIV and NGO representatives. (There is one active NGO working on environmental issues and deforestation.) • Major challenge remains with teen pregnancy. It has gotten worse in the past two years (20% of girls have dropped out of school). Because of drought, parents are marrying off their children, rather than pregnancy resulting in early marriage. Early marriages tend not to last; teenage mothers can go back to school if the family takes them back and supports them. Poverty and distances from school are the main reason for dropping out. 	
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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
33	Shortages of equipment and supplies were very acute, especially in the H4+ districts, which were the weakest. Equipment and supplies are coordinated under the general direction of the MoHCC, and includes the H4+ team in UNICEF, the H4+ team in UNFPA, the HTF/HDF team in UNICEF, the Chief Accountant at the MoHCC and the Directory of Pharmacy. All work to coordinate the procurement, which is managed by UNFPA and UNICEF.	H4+ country team members.
34	Even before H4+ the Ministry saw the need to bring the UN agencies together in a more coordinated way and the MoHCC took advantage of the H4+ Canada programme to get behind a very focused effort aimed at the six poorest districts and drawing on the collective strengths of the UN agencies, something that had not happened before. It took time to get organised, but things have improved and the H4+ approach is working.	Senior officials in the Ministry of Health.
35	In Chipinge, providing small amounts of H4+ funds to support infrastructure was very useful although some issues remain. For example, complicated deliveries are now being handled with confidence in the District Hospitals but problems persist:	Provincial Health Executives, Manicaland.

	<ul style="list-style-type: none"> • Supply disruptions • Disruptions in the flow of funds • Machine breakdowns <p>All of these problems, when they happen at the district hospital level, result in referrals to the Provincial Hospital (with attendant costs and delays due to transport issues which place the mother and baby at risk). It is also inefficient to refer cases which should be dealt with at the district hospital to the provincial level.</p>	
36	<p>Complementary Zimbabwe initiatives and strategies/policies (current)</p> <ul style="list-style-type: none"> • Reproductive Health Policy and Guidelines • MoHCW comprehensive MNH assessment (2004) and the Maternal and Newborn Health Road Map (2007-2015) • 2011 National Integrated Health Facility Assessment (NIHFA) providing updated and specific information on the gaps and needs (including for EmONC services) – providing a baseline for this proposed programme • Child Survival Strategy 2010-2015. • RHCS situational analysis and related strategy • Community Based Distribution programme including improvements to family planning services and re-orientation of traditional birth attendants (TBA) • Kangaroo Mother Care promotion • Expansion of comprehensive PMTCT and MER ART regimen • Promotion of Baby Friendly Hospital Initiative • Adoption of Integrated Management of Newborn and Childhood Illness (IMNCI) approach • Expanded Programme on Immunisations (EPI) including Vitamin A supplementation • Adoption of Integrated Infant and Young Child Feeding and Counselling (IYCF) • Introduction of new cadre called Primary Care Nurses (PCN) as well as task shifting (empowering midwives and VHW to perform key procedures). 	H4+-Zimbabwe, <i>Revised Canada Proposal</i> , November 2012 (H4+ Zimbabwe 2012: 12)
37	<p>The UN agencies are playing to their different strengths in ways that do not overlap and are mapped as follows:</p> <ul style="list-style-type: none"> • <u>UNFPA</u>: midwifery (policy development and schools), strengthening BEmONC and CEmONC, strengthening MDSR, establishing Obstetric Fistula programme, cervical cancer screening, ARSH, FP 	H4+ country team members.

	<ul style="list-style-type: none"> • UNICEF: Strengthening BEmONC and CEmONC services under the HTF, midwifery (schools and in-service/OJT), supporting VHWs, PMTCT • WHO: Policy, Quality of Care guidelines, IMCI, strengthening RMNCH M&E framework, advocacy • UN Women: community work in identified geographies, i.e., training CBAs, Pachoto sister clubs, revitalising community health center, developing IEC materials, research on gender, working with WAG and Katswe • UNAIDS: Strengthening community networks with community leaders (WAG). 	
38	H4+ and other programs (RBF and HTF): The programmes complement each other, but there are still gaps where support is needed and where H4+ has made a big difference in access to MCH services and quality of services.	Staff of District Health Executives, including District Medical Officer (Binga)
<p>Assumption 2.4 <i>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.</i></p>		
Information/data		Information sources
39	Mushimbi PHC (Mbire): There is an active Health Centre Committee (HCC) which holds regular meetings every two weeks. The HCC is composed of the head nurse, the ward councillor, business and other leaders in the community, as well as VHW, male mobilizers, care givers and others. The community has been supportive, including helping to build the maternity waiting home by procuring bricks. The HCC shares community input on programs and progress, including complaints such as long distances, concerns about stock-outs and drug shortages, and the on-going need for an ambulance. For example, the MoHCC policy is to refer all first births to the district; however, since there is no transport, the HC manages at its level. This strengthened link has resulted in both increased trust as well as increased complaints.	District Health Executives, including District Medical Officer (Mbire).
40	Binga District Hospital is the secretariat for the Health Centre Committee (instituted under the RBF). Representation includes VHWs, youth representatives, business leaders, local leaders, traditional healers, church representatives, PLWHIV and NGO representatives. (There is one active NGO working on environmental issues and deforestation).	District Health Executives, including District Medical Officer (Binga).

	<ul style="list-style-type: none"> • HCC meets quarterly to review issues at the health centre, how the community interacts, to help disseminate information and education to the community. Examples of issues discussed include support to renovate the staff house destroyed by a storm and how to arrange for training for VHWs from remote villages • HCC supported increase in early booking for delivery at the facility (to prevent home delivery) • Major challenge remains with teen pregnancy. It has gotten worse in the past two years (20% of girls have dropped out of school.) Because of drought, parents are marrying off their children. Poverty and distances from school are the main reasons for dropping out, rather than pregnancy. 	
41	<p>The changes in capacity and quality of services over the past few years was noted as follows:</p> <ul style="list-style-type: none"> • <i>Before</i>, the patients didn't go to the health facility or accept services; women delivered at home, there were many child deaths before immunization; women with HIV didn't know their status; women were using traditional FP methods; most children were born HIV+. Immunization programs at school were ineffective because parents were telling children not to participate. Notably, community advocates were not concerned about the lack of integration of family planning as they said that commodities are "always available" and referrals are made to community based distributors for access to contraceptives. The advocates were taught by WAG to counsel abstinence for unmarried youth. If the youth ask for contraception they teach them the importance of abstaining. They will not provide contraceptives to youth under 18 because of cultural sensitivities.] • <i>Now</i>, partners are being tested, homes are sprayed with insecticide, male partners are being circumcised; "great improvements" in clinic; trust has increased between health workers and community members. <p>There were also some challenges and complaints:</p> <ul style="list-style-type: none"> • Mothers waiting shelter is too small; there is no linen at the shelter and there are not enough beds • There are stock-outs of medicines at the clinic; not enough beds • Patients treat the clinic as a hospital and prolong their stay, leading to overcrowding • Need to address staff shortages 	Village Health Workers and Community Based Advocates, Mushimbi and Chiruya (Mbire District).

	<ul style="list-style-type: none"> • Facility should be upgraded to a hospital status; provide more accommodations for staff • Address drug shortages • Procure an ambulance • Procure IEC materials for VHWs • No incentives for VHWs - they get some incentives “here and there” but it has been a long time since there were any t-shirts, promotional materials (bags, etc.) • PLHIV caregivers are not giving transport; they use their own personal funds. <p>There is a good relationship between the advocates and the PHC. Advocates have a phone number to use in case there are problems experienced by a community member. Most people are accessing services because there is an increase in trust between the community and the PHC.</p>	
42	<p>In Binga, the RBF has a strong component related to demand-side activities, i.e., the revitalization of Health Centre Committees. It also supports quarterly client satisfaction surveys by community-based organizations. This will be expanded to other districts within the Province (WAG and Katswe are not active in Binga through H4+).</p> <ul style="list-style-type: none"> • Local leaders have great influence. Giving health messages to local leaders is critical. Working with them has increased male attendance at ANC with partners to 60 percent in Binga as opposed to 11 percent in other districts • A major success of H4+ (along with other programs) has been the increased trust between facilities and communities. PMO receives regular calls from MP who is quite alert to complaints. One example shared was a complaint from a community about how RBF funds are being spent, indicating that there is increased transparency and communities are holding facilities accountable. Other community issues include increased coverage and staffing by doctors, more say in how RBF resources are used (bottom up versus top down). 	<ul style="list-style-type: none"> • Provincial Health Executives, including the Provincial Medical Officer • Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.
43	<p>Regarding quality of care, the Province Health Team conducted a mystery client (with study participants posing as clients for MNCH services) study in five districts including Binga. Findings included:</p> <ul style="list-style-type: none"> • Reception areas are tidy and clean • Male nurses treat clients better than female nurses; some nurses were abusive and slapped women in labour 	<p>Provincial health executives, including the provincial medical officer.</p>

	<ul style="list-style-type: none"> • Only 40 percent would refer their daughters to the facility; 7 percent would never refer their daughters. 	
<p>Assumption 2.5 <i>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.</i></p>		
<p>Information/data</p>		<p>Information sources</p>
<p>44</p>	<p>Selected findings from a UN Women-sponsored study on gender assessment of the Community structures that influence women's and girls' maternal, sexual and reproductive health-seeking behaviour in Six districts in Zimbabwe, 20-25, May 2014 <u>Hurungwe</u>:</p> <ul style="list-style-type: none"> • Few health centres in the district are servicing mothers • maternity waiting home – men are suspicious of women cheating if they go and sit at waiting home, especially if there are male nurses at the clinic • Men do not trust their women at MWH alone because of the risk of cheating • Referrals are difficult because the transport system is bad – there is no fuel for caterpillars • Early marriages at 12 years are common and considered a way out of poverty. Due to economic hardships in the areas and also because of high numbers of school dropouts – boys get preference to stay in school and girls are forced to drop out • Need to sensitise the local leadership to get through to the community and relate that women are not minors- can do the sensitisation with the leaders; with the chiefs and village heads • Need to empower women to go and report to the Chief or village head • CAMFED is in the wards but a number of girls supported are also dropping out of school due to pregnancy 	<p>UN Women, Report on Gokwe North and Binga Mission, 2014 and <i>Report on Hurungwe and Mbire Mission, 2014</i> (UN Women 2014c, UN Women 2014d)</p>

<ul style="list-style-type: none"> • As council, need to change people’s attitudes and habits. Need to keep hammering information the message; on and on • GBV is seasonal in Hurungwe; tobacco season statistics increase because men abuse women/their wives during this season; this is because men often misuse the money or buy things without discussing with the wife and thus resulting in misunderstandings • Emotional abuse – may involve refusal of permission to go to MWH <p><u>Mbire:</u></p> <ul style="list-style-type: none"> • Early marriages rampant (as early as 12 years old) • School dropouts are common with about 19 girls dropping out of Mushumbi Pools Secondary school in 2013 • Due to poverty; parents resort to selling off their daughters whilst still too young • SRH education is very limited • Proceeding with school is easier for boys than girls • In the district; the practice of male nurses attending to female patients, especially pregnant patients, is taboo and thus not acceptable. • Not enough health centres in the district • Not enough waiting homes resulting in those who live far away delivering at home. • Pay after delivery (US\$10) • Lots of teenage pregnancies • GBV common during the cotton selling season (May-July) • Pregnant women experience GBV especially when they ask for money for baby clothes <p><u>Gokwe North:</u></p> <ul style="list-style-type: none"> • Poverty levels are quite high with most people not able to pay the required user fees to utilise hospital services • SRH education is not common, resulting in very high levels of teenage pregnancy. The communities are, however, more open and will accept sexuality education • Young people interviewed were concerned that their parents did not value education as much as they should. This resulted in a lot of girls dropping out of school. Due to poverty, a lot of parents cannot afford to pay school fees and parents find that giving 	
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their sons a piece of land to grow cotton is a good solution. This, however, brings with it other social problems as the young men then start drinking and disrespecting their parents once they start earning more money from cotton more than their parents.

Binga:

- Marriage is considered the ultimate achievement
- Most girls do not have any other alternative after dropping out of school except getting married
- Early marriages – 15 years onwards
- On average, many are married by 18 and in most cases in polygamous unions.
- The women/girls do attend ANC on time
- Due to polygamous unions, fertility rates are very high – competition amongst wives.
- The women know about ANC bookings and usually deliver at health institutions. There are very few home deliveries as the clinics are working with traditional leaders – village heads to ensure that all women deliver in health facilities. The Maternal Health Committee at village level charges the fine for home birth, which currently stands at US\$25. That US\$25 is then given to the clinic to buy mealie-meal and beans for the maternity waiting home.
- All high risk pregnancies are supposed to be referred from the clinics to the hospital; these include: all first pregnancies; previous operations; those with underlying health issues (heart conditions, diabetes) are all referred to Binga District Hospital, which, as a result, reports with up to 150 deliveries per month
- The customary marriage can be the exchange of a chicken or a goat for a bride
- ASRH information is not readily available to those young people who do not visit the clinic.
- Girls as young as 13 are getting pregnant.
- Culture is a big barrier in the community and creates huge gender disparities and inequalities. GBV goes unreported and behind closed doors; the younger wives cannot negotiate for safer sex with their older husbands due to their age difference. HIV infections are rising among the young girls.

45	<p>The approach used by Katswe is to develop safe spaces as entry points where young people can discuss their sexual experiences. They work on health and rights, literacy and confidence, skills building and identifying factors that limit their rights. They also support access to ARTs for ALHIV (adolescents living with HIV). They work with both youth (in-school and out of school) and with key stakeholders in the community (parents, teachers, health care providers and police) where youth present their issues in drama, poetry, song and poster formats. They also have district-level “be heard” festivals in which adolescent girls can share their experience with matrons, police, counsellors and educators.</p> <ul style="list-style-type: none"> • Katswe works in Mbire, Chipinge and Chiredze, always in selected wards. In Chiredze, the population is truly hard to reach, with a game reserve at one end and people resettled from Masvingo District • In every ward and district they work, traditional leaders want them to extend the work to additional wards • Successes include: <ul style="list-style-type: none"> ○ Improved confidence, knowledge and ability by young people to communicate their issues and needs ○ Increased openness by service providers to engage and listen to young people ○ Educators are working to reduce the number of dropouts in primary school ○ Increased attention to working with young men. At the Chipinge Rural Hospital, after a few <i>Pachoto</i> (safe space) meetings, the girls said they need to bring in boys to hear their concerns on coercion, date rape and contraception. In Mbire, men were included in the adult groups which were formed. 	Staff of implementing partners, especially NGOs.
46	<p>With UN Women funding, WAG supports work in Mbire, Chipinge and Chiredze to mobilise women and men’s consultative groups in two wards in each district. They also supported Community-Based Advocates (CBAs) with training in:</p> <ul style="list-style-type: none"> • ANC and PNC • Importance of booking early for antenatal care • Family planning • PAC • Importance of delivering in facilities • Option B+⁸⁸ 	Staff of implementing partners, especially NGOs.

⁸⁸ Option B+ refers to revised WHO guidelines for treatment of HIV positive pregnant and breastfeeding women (WHO 2016).

	<ul style="list-style-type: none"> • How to avoid the three delays which cause maternal mortality (delays in seeking care, delays in transport and delays in treatment/referral at the facility) <p>With UNAIDS funding, WAG targets traditional leaders in Mbire, Hurungwe, Gokwe North, and Chipinge (five wards). They increased awareness on the issues reducing demand for MNCH services and gained commitment to support and advocate for ANC, PNC and birth in facilities. Traditional leaders would fine families a goat for home births. They developed a package of materials for community leaders to use in their advocacy allowing them to discuss HIV, GBV, prevention of child marriages and linking with development concern in the communities. WAG appreciates that UNFPA has taken up the issue of child marriage at the national level, which supports the work they are doing with traditional leaders in the districts/wards.</p> <p>WAG worked in five of the six districts with either UN Women or UNAIDS funding, but in Chipinge, WAG received funding from both.</p>	
47	<p>H4+ support is seen as contributing to real reductions in the number of home deliveries (confirmed by hospitals and clinics visited); an increased awareness at the community level, and among health staff of MNCAH, around issues such as child health, including nutrition (although the work in this area was from another programme); and a significant improvement in relations between the community and health facilities. As an example of coordination and collaboration, WAG supported the development of a maternity waiting home at the Chiryuwa Clinic (Mbire) by providing funding for cement and roofing; the community will provide bricks and a contractor and RBF will support window frames.</p>	Staff of implementing partners, especially NGOs.
48	<p>Major challenges have to do with adequate funding and reach. There are communities where there are no health facilities to mobilise. One community in Chiredze identified a house and refurbished it for a clinic, only to find out that it did not meet the necessary standards (width of hallways, doors, lights, water, etc.) and there are not enough maternity waiting shelters.</p>	Staff of implementing partners, especially NGOs.
49	<p>In Chipinge, there is a need for more investment in community involvement, now that clinical services are better. Male involvement also needs to improve, in order to remove barriers for women to go to facilities. In addition:</p> <ul style="list-style-type: none"> • Transport is a major challenge, it may be less than 20 km to a health centre or clinic but the terrain in Chipinge is very rough and transport is expensive 	District health executives.

	<ul style="list-style-type: none"> • There are still huge human resources issues, they need more skilled nurses and some posts need to be confirmed such as that of the District Nursing Officer • They don't have enough trained and motivated village health workers who can stimulate demand. They have 89 VHWs and calculate that they need 289 • As demand increases there is now a risk that the supply side will be overwhelmed, they have a common border with Mozambique and people from there have begun travelling to Chipinge to, for example, deliver babies. • The scale of the demand side work and its narrow reach is an issue. They have 38 wards and three or four get support on demand side work from agencies funded by UNAIDS and UN Women. 	
50	Mushumbi HC is working with WAG on offering services, family planning with STI/ HIV testing and counselling. They formed "Mberico" groups in the villages to promote PMTCT and breastfeeding. VHWs work with groups and they have achieved 100 percent HIV testing in ANC and 95 percent in EPI. A youth friendly corner was established to offer information on SRH, family planning, STI/ HIV by peer educators on Mon-Wed-Fridays, but there is challenge with having adequate space, so that sometimes the peer educators work out in the community. The numbers coming to the YFC are low.	Health facilities staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres.
51	In Chipinge, for in-school youth, there is a link through the Katswe Sista hood work and training in Youth-friendly Services for 56 nurses (supported by H4+) and engagement by young girls promoted by Katswe led to improved attitudes on the part of nurses and trust by young people. The girls forums promoted by Katswe which bring together girls with an audience of teachers, counsellors, and police have helped to improve trust and change attitudes of services provides (not just in health).	Health facilities staff, including staff of district hospitals, mission hospitals, rural hospitals, and health centres.
52	Key messages recalled from WAG awareness-raising included: <ul style="list-style-type: none"> • Breastfeeding for two years • Balanced nutrition especially for HIV+ babies • Child immunization • Encouragement of partner HIV testing and counselling • Adherence - take medicines as instructed • How to bathe kids • Return for PNC check-ups • Learned about importance of abstinence and dangers of early pregnancy and HIV infection • Taught about contraceptive methods (pills, Depo, Jadelle, condom, loop) 	Mothers Support Group, Mushimbi (Mbire)

	<ul style="list-style-type: none"> ○ Re. Depo, concerns about long time for menstruation (and fertility) to return <p>Mothers indicated that the PHC is providing good services, and did not mention any specific challenges when asked.</p>	
53	<p>First community programme in Karai was started by WAG in 2014. Activities conducted by advocates include:</p> <ul style="list-style-type: none"> ● In-home counselling with couples to address GBV and report cases of abuse to the police. GBV is generally caused by money problems after the cash crop. ● Social games in the community to support behaviour change communication and build good relationships ● Encouragement of ANC visits with husband, to promote opportunity for HIV counselling and testing of both partners. (When asked about FP, the response was “<i>not much is done</i>”). ● WAG assisted with raising money for the maternity waiting home given the increase of facility-based births. 	Community-based advocates, Karai (Mbire).
54	<p>Katswe helps to teach children their rights, about sexual abuse and rape, and hygiene.</p> <ul style="list-style-type: none"> ● They provide a place to go where the girls can recite poems or perform dramas Parents have been invited, however, they are against the activity “<i>perhaps because the parents didn’t go to school</i>” ● Parents do not want girls to go to school; school fees are too high; “<i>they prefer us to be married off and forgotten (making the in-laws rich)</i>” ● Family planning is not discussed. Mentor group discuss how to protect against pregnancy by practicing abstinence ● The Youth Friendly Corner at Chiruwya PHC is 5km away. <p>The girls need sanitary pads. These are expense and girls lose 3 days/month as they are too embarrassed to attend school while menstruating without protection.</p>	In-school youth, Karai (Mbire).
55	<ul style="list-style-type: none"> ● The support group, established in 2014, assists with the following topics: HIV, GBV, rights, cervical cancer, family planning and fistula ● Major challenges to address include male resistance to family planning and the need for transport given the remoteness of the villages within the community ● When asked what about their human rights, they mentioned the following: <ul style="list-style-type: none"> ○ The right to a choice about whether to use family planning and what method to use ○ The right to non-discrimination 	Out-of-school youth, Karai (Mbire).

	<ul style="list-style-type: none"> ○ The right to SRH - they have the right to make decisions on sex and on their own reproductive health ○ The group agreed that the clinic offers quality services and the staff have become more friendly towards women clients. They wore t-shirts with the slogan, “Child marriage destroys dreams”. 	
56	There is only one male mobilizer for three wards covering a total of 12,000 (Karinyangwe).	Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals, and Health Centres.
57	The Siabuwa “youth centre” is in an out-building on the RHC premises, with a desk and a few chairs, and a bookcase filled with a somewhat random collection of books and educational materials. The five “peer educators” were hanging out, and it did not seem that this would be a welcoming environment for secondary school girls. There are meetings once per week and there are four male and four female peer educators who have not yet been trained and are using the peer education handbook to educate and counsel their peers on stress, alcohol abuse, family planning (mainly abstinence), STI prevention (male and female condoms). In cases of GBV, they refer to adults (at the health centre or church). Although they say they do condom demonstrations for both boys and girls, it is unlikely that girls would welcome this instruction.	<ul style="list-style-type: none"> ● Health facilities staff, including staff of District Hospitals, Mission Hospitals, Rural Hospitals and Health Centres ● Out-of-school youth, ages 19-24 (male).
58	In Chipinge, there has been more open discussion of issues relating to the prevention of pregnancy, GBV, prevention of early marriage. The men forum reported overcoming early resistance by men to the notion that their wives should gain knowledge on the use of contraception and their right to a choice of methods; however, there was improved community support for action to prevent GBV and a change in community attitudes towards GBV.	Men’s Forums.
59	<p>In Chipinge:</p> <ul style="list-style-type: none"> ● They focus on encouraging and helping women to avoid GBV and, most importantly, not to marry their young girls off at an early age ● They also discuss and air general family and community problems ● They openly discuss sexual rights of women in the relationship between husbands and wives ● They discuss issues relating to preventable deaths of mothers and newborns during delivery and encourage young mothers to go the maternity waiting homes and to go early. However, some health facilities have no MWHs – <i>“there is no working Mothers Waiting Home in this community which has its own Health Centre.”</i> 	Women’s Forum.

	<ul style="list-style-type: none"> • Health centre staff are part of the forum and have a good attitude to the discourse in the forum. The programme has helped to build trust between the community and the health centre staff. 	
60	<p>The role of WAG-supported CBAs in Chipinge:</p> <ul style="list-style-type: none"> • They meet once a month in meetings led by the Community Based Distributors (family planning) • The messages communicated by the CBAS: <ul style="list-style-type: none"> ○ Do ANC booking early ○ Get tested and get appropriate care for HIV ○ Messages on preventing domestic violence ○ Encourage male involvement and male support for MNCH, in particular access to ANC/PNC and safe delivery and to family planning ○ The community has taken these messages well and, in particular, the process has helped address domestic violence issues ○ There are now frank discussions on use of condoms and protected sex in the community and with adolescents, subjects that were taboo before ○ They are focusing hard on the prevention of early marriage and getting the community to discourage it, especially for girls under 18 years – many of the girls interviewed were married ○ They find no objection to their health messages from the community, partly because they involve community leaders. 	Community based advocates.

Area of Investigation 3: Responsiveness to National Needs

- 3. 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?**
- 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?
 - 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:

<p><i>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.</i></p>		
	Information/data	Information sources
1	<ul style="list-style-type: none"> Refer to evidence in question one, line one of the matrix The different programme objectives, activities and outputs across the members were not unified into a single M&E framework until late 2014 (after the Victoria Falls meeting). This reflects the slow start up to the coordination processes and structures. 	Interviews with H4+ country team (UNFPA).
2	This early coordinating committee meeting (2012) included the H4+ country team plus one member of the H4+ team at global level (UNICEF) and from the UNICEF Southern Africa Regional Office. They committed to meet with Provincial Medical Directors to orient them on H4+ and to undertake a gap assessment and a district level orientation and planning meeting. (p.2)	UNFPA, <i>Minutes of the H4+ Coordinating Committee</i> , 13 March, 2012. (UNFPA 2012)
3	This meeting consisted of the members of the H4+ country team and focused on preparing the first proposal for the Sida funding grant. One key point states: <i>“There is a general consensus that the team needs to improve on meeting and engaging the districts so that implementation can be planned and monitored closely.”</i>	UNFPA, <i>Minutes of the H4+ Planning Meeting</i> . 27 August 2013 (UNFPA 2013)
4	<ul style="list-style-type: none"> The main feature is a national steering committee for H4+ with the UN agencies, the Ministry and the NGOs. There are regular (biannual) provincial and district planning and review missions. H4+ JPCS is dealt with at a higher level in the Ministry (since beginning of 2014) where it is linked to the Director of Family Health (one level down from the Permanent Secretary), instead of the Reproductive Health unit. 	Interviews with H4+ country team (UNFPA).
5	Refer to evidence in question one, line two	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
6	<ul style="list-style-type: none"> The H4+ Steering Committee (national) gave the UN and the MoHCC the opportunity to sit down and plan together. This is followed up by the quarterly District Review meetings where they can have the same kind of interaction with the District Health Executives, the facilities and the communities Coordination was weak and the H4+ agencies did not really act in a joined up way until the national Steering Committee was established at the 2013 Victoria Falls meeting. 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters

7	<i>“Before the SC: WHO would come and say let’s do X, then UNFPA would come and say let’s do Y. The visibility of H4+ was very low. This improved after the Victoria Falls meeting and the advent of the national Steering Committee in part because of the provincial and district review Meetings and the engagement of the District Health Executives.”</i>	Interviews with MoHCC staff at director and deputy director level at Headquarters
8	<ul style="list-style-type: none"> • This was the first meeting of the National H4+ Steering Committee set up after the planning and review meeting in Victoria Falls in September 2013 and the Victoria Falls country to country meeting in April 2014. At this meeting the Director of Family Health at MoHCC and chair of the H4+ steering committee made it clear that: <i>“H4+ had poor recognition as an initiative in government circles, more specifically in the provinces and the districts, which was one of the reasons for provinces and districts to be not very responsive to H4+.”</i> P.1 • The meeting also highlighted poor coordination (p.2). 	<i>Minutes of the 1st National H4+ Steering Committee 18th June 2014 (H4+ Zimbabwe 2014a)</i>
9	As in Assumption 1.1, interviews confirmed advent of a strong coordinating system in 2014.	Interviews with MoHCC staff at director and deputy director level at headquarters.
10	Established national MDSR Committee as a technical working group on Maternal Death Surveillance and reporting. Highlighted critical importance of improving MDSR.	<i>Minutes of the National H4+ Steering Committee 18th April 2015 (MoHCC 2015f)</i>
11	There is a near universal consensus that the choice of the six H4+ supported districts originated with the MoHCC and that these six districts are the hardest to reach and most under-served in the country. They also have high incidences of malaria and very high levels of poverty and illiteracy.	Interviews with MoHCC staff at national, provincial and district level and with H4+ partner staff and representatives of NGO implementing agencies.
12	<ul style="list-style-type: none"> • Complementarity is made stronger by the interlocking set of coordinating bodies. At the start, based on the original proposal, there was supposed to be an H4+ Steering Committee but it was not activated. • <i>“After the Vic Falls meeting in 2013, MoHCC really took the lead and got coordinated planning really moving. From that point on the Ministry took on the challenge of integrating the programme (including with other programmes supporting health care) by taking on ownership and accountability”.</i> • Now there is an integrated structure for coordinating across programmes of support in the health sector including: <ul style="list-style-type: none"> ○ The country coordinating mechanism (Global Fund/Gavi) ○ The HTF/HDF steering committee chaired by the PS of MoHCC ○ The H4+ Steering Committee chaired by the Director of Family Health ○ The Adolescent Sexual and Reproductive Health Forum 	Interviews with H4+ country team: UNICEF.

	<ul style="list-style-type: none"> ○ The MODO, (Ministry of Health and Donor) Committee which reviews all health programmes. ● Because the membership of these committees is often overlapping, it is easier for programmes, including H4+ to avoid overlap and to be complementary. 	
13	They all work and coordinate around the UN Country Team structure where a lot of conversation takes place; a lot of coordination and discussion also takes place at the technical level.	H4+ country team (UN Women).
14	<ul style="list-style-type: none"> ● Improved coordination has been the major positive improvement due to H4+ JPCS. With the advent of the funds needing to be programmed they collaborated first on the needs assessment to underpin a coordinated response. ● They focused on the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best). 	H4+ country team (WHO)
15	<ul style="list-style-type: none"> ● The Child Survival Technical Working Group is chaired by the Family Health Directorate and focuses on improving child survival and development ● There is also a National Reproductive Health Steering Committee focusing on SRHR/HIV integration and an HIV Partners Forum. 	Interviews with MoHCC staff at Director and Deputy Director level at headquarters.
16	<ul style="list-style-type: none"> ● On coordination there are still some important questions: <ul style="list-style-type: none"> ○ How can the Country Coordination Mechanism (CCM) really function as it deals with almost half a billion dollars of Global Fund money? ○ The Steering Committee for the ISP never really worked in a coordinated way with the one for the Health Transition Fund so will it work better under the (combined) Health Development Fund)? 	Interview with H4+ country team (UNAIDS)
17	<ul style="list-style-type: none"> ● Coordinating and sequencing provision of equipment and supplies under HTF/HDF, RBF and H4+: <ul style="list-style-type: none"> ○ The different teams work under the overall coordination of the Director of Family Health at MoHCC. The different groups include: <ul style="list-style-type: none"> ▪ The H4+ team at UNICEF ▪ The H4+ team at UNFPA ▪ The HTF/HDF team at UNICEF ▪ The chief accountant at MoHCC ▪ The Director of Pharmacy 	Interview with HTF/HDF Coordinator.

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
<p>18</p> <ul style="list-style-type: none"> • This was the first meeting of the national H4+ Steering Committee set up after the review meeting in Victoria Falls in late 2013. At this meeting the Director of Family Health MoHCC and chair of the H4+ steering committee made it clear that: “H4+ had poor recognition as an initiative in government circles, more specifically in the provinces and the districts, which was one of the reasons for provinces and districts to be not very responsive to H4+.” P.1 • The meeting also highlighted: Poor national coordination mechanisms (p.2) 	<p>Minutes of the 1st National H4+ Steering Committee 18th June 2014 (H4+ Zimbabwe 2014a)</p>
<p>19</p> <p>Refer to evidence in question one, line 13 and 19</p>	<p>Interviews with MoHCC staff at Director and Deputy Director level at headquarters.</p>
<p>20</p> <p>AFRICAID are invited to, and take full part in, H4+ quarterly planning, review and coordination meetings and do joint supervision visits to the field.</p>	<p>NGO Interview (AFRICAID).</p>
<p>21</p> <p><i>“WAG take extensive part in the H4+ JPCS review and coordination meetings. There was a three-day review meeting in Harare in February. All implementing partners take part in the quarterly review meetings and their advice is given directly to the MoHCC and the H4+ partners.”</i></p>	<p>NGO Interview (Women’s Action Group).</p>
<p>22</p> <p><i>“For Katswe Sistahood, being invited into the H4+ programme and its quarterly review and planning meetings was a big step in their organizational recognition and development.”</i></p>	<p>NGO Interview (Katswe Sistahood).</p>
<p>23</p> <p><i>“The PMD takes a full part in the quarterly planning and review meetings of the H4+ at the national level.”</i></p>	<p>Interviews at Provincial Health Executive: Mashonaland Central Province.</p>
<p>24</p> <p><i>“The District Medical Officer participates in the annual planning meeting and in quarterly review and planning meetings of H4+. They identify needs, assist with preparing proposals and propose training. NGO partners (WAG, Katswe Sistahood) also participate.”</i></p>	<p>Interviews with District Health Executive at Chitsungo District Hospital, Mbire District.</p>
<p>25</p> <p><i>“The rural health centre takes part in district level planning: every facility provides inputs to the process of planning the H4+ proposals in the district. H4+ support is helpful in filling gaps in a flexible manner.”</i></p>	<p>Interviews: Siabuwa Primary Health Centre.</p>
<p>26</p> <ul style="list-style-type: none"> • <i>“Coordination works right down to the district level and involves all partners in H4+”</i> 	<p>Interviews at Provincial Health Executive: Manicaland.</p>

	<ul style="list-style-type: none"> All the districts take part a quarterly partner coordination forum which is chaired by the Provincial Medical Director. All the partners have to fit their work into the Provincial Work Plan. Discussions on how to match H4+ activities to needs take place at H4+ planning meetings which are joint with the MoHCC, the provincial team, district teams and implementing partners as well as H4+ agencies. It is important to recognise that all of this was done under the “Road Map for Accelerating Progress on Maternal, Newborn and Child Health” “The annual planning meetings for H4+ are/were used to establish quarterly implementation targets and these were followed up in quarterly planning and review meetings.” 	
27	The DHE met to develop plans and identify needs then did a joint planning session with the DHE, PHE, MoHCC, MoGWCD, Education, Plan International, World Vision etc. to develop their overall plan before integrating H4+. In 2011, OPHID joined in this process and a representative of H4+ became involved in the planning (UNFPA). Plans were refined through later joint planning and review meetings, especially from 2014 onwards.	Interviews with District Health Executive: Chipinge District.
28	<i>“From the beginning, hospital staff were involved in planning how H4+ as a programme could support them. The H4+ planning committee met with the Hospital Board and Community Representatives to identify their needs and how the programme could best support them.”</i>	Interviews at St. Peter’s Mission Hospital: Chipinge.
29	Membership in the national H4+ Steering Committee, since its beginning in June 2014, has included MoHCC (as the chair), representatives of the H4+ partners (not the World Bank, however) and the Provincial Medical Director from one Provincial Health Executive.	<ul style="list-style-type: none"> MoHCC, <i>Minutes of the First National H4+ Steering Committee</i>, 18 June, 2014 (H4+ Zimbabwe 2014a) MoHCC, <i>Minutes of the National H4+ Steering Committee</i>, 29 April, 2015 (MoHCC 2015g) MoHCC, <i>Minutes of the National H4+ Steering Committee</i>, 3 September, 2015 (MoHCC 2015e)
30	This was an internal coordinating committee of the UN country team in Zimbabwe. It also included (in the February 2012 meeting) representation from UNICEF HQ in and from the Eastern and Southern Africa Regional Office of UNICEF. At first meeting the decision was taken to meet with Provincial Medical Directors to orient them on the H4+ initiative.	<ul style="list-style-type: none"> <i>Minutes of the H4+ Coordinating Committee</i>, 13 February 2012 (H4+ 2012c) <i>Minutes of the H4+ Coordinating Committee</i>, 27 August, 2013 (H4+ 2013c)
31	The quarterly H4+ planning and review meetings include representation from MoHCC headquarters at the Director, Deputy Director and Programme Officer level as well as technical staff. They also include members of the H4+ country team (all partners). Most importantly they include Provincial Medical Directors and members of the District Health Executive and facilities staff from all six H4+ districts. Finally, implementing partner NGOs	<ul style="list-style-type: none"> MoHCC, <i>Report on Quarterly Provinces and Districts Review and Planning Meeting</i>, 11-12 September 2013 (MoHCC 2013a) MoHCC, <i>Report on H4+ Planning and Review Meeting</i>, 23-25 September 2014 (the Victoria Falls Meeting) (MoHCC 2014b)

	take part in these meetings with Katswe Sistahood and WAG taking part in the June 2015 meeting.	<ul style="list-style-type: none"> MoHCC, <i>Report in H4+ Planning and Review Meeting</i>, 01-03 June 2015 (MoHCC 2015i)
Assumption 3.3 <i>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.</i>		
Information/data		Information sources
32	<ul style="list-style-type: none"> During original programme planning, and in the first years of the programme, the H4+ members (with inputs from the MoHCC) had to be responsive to the plans and priorities expressed in key national documents: <ul style="list-style-type: none"> The National Health Strategy for Zimbabwe: 2009-2013 by MoHCC The Zimbabwe National Maternal and Neonatal Road Map: 2007-2015 Final National Integrated Health Facility Assessment Report (FNIHFA): 2013 MoHCC Service Guidelines on SRHR and HIV Linkages: 2013. 	Interviews with H4+ country team (UNFPA, UNICEF, WHO, UN Women, UNAIDS).
33	<ul style="list-style-type: none"> As the final workplan for the H4+ in Zimbabwe, the document outlined actions taken over the period prior to 2014 and in 2014 to respond to the changing environment, including priorities and needs at national and district level. Examples in include: <ul style="list-style-type: none"> Ongoing work on identified needed policy documents including: <ul style="list-style-type: none"> National Food and Security Strategy Adaptation of computerized Integrated Management of Newborn and Child Illness (IMNCI) training materials Draft Clinical Mentorship guidelines Supporting review and revision of the National Maternal and Neonatal Road Map Supporting Review and Revision of the National Child Survival Strategy Strengthening national coordination mechanisms, including creation of the H4+ Steering Committee National Maternal and Neonatal Death Surveillance and Reporting (MNDSR) Committee Formed National sub-committees on PoC, EID, Paediatric ART and MNCH formed and conducting regular meetings Support to development of the National EmONC Plan 	H4+ Zimbabwe, <i>H4+ Workplan 2015-2016</i> (H4+ Zimbabwe 2015a)

	<ul style="list-style-type: none"> ○ Continued procurement of essential reproductive health drugs and commodities and equipment ○ Continued support to clinical mentorship and training in the six H4+ districts ○ Joint quarterly supportive supervision ongoing ○ Supporting improved MND Review Meetings ○ Replenishing EmONC protocols and forms in H4+ districts ○ Strengthening support to ASRHR ○ Support outreach and community mobilization, especially with community leaders. 	
34	<ul style="list-style-type: none"> ● Reports on the planning and review meetings provide examples of identified areas of need put forward by staff of provincial health executives, district health executives and health facilities staff. These needs are not always met due to resource constraints and issues of reach. For example, the call for more intensive work on demand promotion and community mobilization on the part of district health executives may exceed both the capacity of NGO implementing partners and the funds allocated to demand-side activities, especially by UN Women and UNAIDS ● After each quarterly planning and review meeting, as reported in the minutes for the 2015 meeting (P.8) staff of each District Health Executive work together to prepare their workplan for H4+ for the coming quarter. ● Comparing the district report segments of the reports over time illustrates a strong shift from (in the 2013 report) a simple listing of deficiencies and challenges facing each district, to (in the 2015 report) a reporting of achievements in each district including health care providers trained, clinical mentoring carried out, installation of machines and equipment, and availability or occasional stock outs of medicines and supplies. ● In the 2013 report examples of deficiencies reported include: <ul style="list-style-type: none"> ○ Need for funds for the refurbishment of youth friendly service corners (Binga, p.2) ○ Challenges in securing fuel and transport for supportive supervision (Binga, p.2) ○ Lack of electricity for lighting in the delivery rooms (Chiredzi, p.2) ○ Shortages of midwives (Chiredzi, p.2) ○ No functional theatre at the hospital (Mbire, p.3) ○ Underutilization of youth friendly corners and a shortage of health care providers trained in YFS (Hurungwe, p.3) ○ Human resource shortages generally (Hurungwe, p.3) ○ Shortages of midwives for quality maternal health services (Chipinge, p.4) 	<ul style="list-style-type: none"> ● MoHCC, <i>Report on Quarterly Provinces and Districts Review and Planning Meeting</i>, 11-12 September 2013 (MoHCC 2013a) ● MoHCC, <i>Report on H4+ Planning and Review Meeting</i>, 23-25 September 2014 (the Victoria Falls Meeting) (MoHCC 2014b) ● MoHCC, <i>Report in H4+ Planning and Review Meeting</i>, 01-03 June, 2015 (MoHCC 2015i)

	<ul style="list-style-type: none"> • By the 2015 report, the Chitsungo District Hospital in Mbire reported (p.5) that it had a functional operating theatre commissioned in 2015 after receiving support by H4+ and was performing caesarean sections at the time of the review. • The 2015 report (p.7-9) includes a report by the H4+ partners on the activities funded for 2015 in response to earlier planning and review meetings. These included specific initiatives to address deficiencies raised in early planning meeting reports. For example: <ul style="list-style-type: none"> ○ Training of doctors and nurses in treatment of obstetric fistula at Mutare hospital in response to districts identifying the lack of capacity as an issue (UNFPA) ○ Training of Trainers in MVA (UNFPA) ○ Training health workers on how to deal with young people living with HIV (UNICEF) ○ Improved reporting on male mobilizer activities (UNICEF) ○ Focus on improved support to peer mother support groups (UNICEF) ○ Training on IMNCI and training of managers of MNCH programmes (WHO) ○ Training of more facilitators to respond to success of community dialogue forums facilitated by Katswe Sistahood (UN Women) 	
35	Refer for evidence to question three, lines 19 to 26	<ul style="list-style-type: none"> • NGO Interviews (AFRICAID, Women’s Action Group, Katswe Sistahood) • Interviews with provincial health executives for Mashonaland Central and Manicaland • Interviews with District Health Executive in Binga, Chipinge and Mbire Districts
36	<ul style="list-style-type: none"> • Refer for evidence to line 29 	<ul style="list-style-type: none"> • MoHCC, Minutes of the First National H4+ Steering Committee, 18 June, 2014 (H4+ Zimbabwe 2014a) • MoHCC, Minutes of the National H4+ Steering Committee, 29 April, 2015 (MoHCC 2015g) • MoHCC, Minutes of the National H4+ Steering Committee, 3 September, 2015 (MoHCC 2015e)
Assumption 3.4		

<p><i>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.</i></p>		
	Information/data	Information sources
37	<p>Interviews with members of the H4+ country team did point to the interlocking set of coordinating and planning committees and technical working groups involved in coordination of the health sector in Zimbabwe but they did not note significant levels of duplication or overlap. Specifically, they agreed that the establishment of an effective National H4+ Steering Committee in 2014 was necessary to achieve coherence in UN support to RMNCAH. They also pointed to the expressed intention of the MoHCC to continue some form of national coordinating committee for MNCH within the structure of the HDF.</p>	<p>Interviews with H4+ country team (UNFPA, UNICEF, WHO, UN Women, UNAIDS).</p>
38	<ul style="list-style-type: none"> • <i>“The H4+ Steering Committee (national) gave the UN and MoHCC the opportunity to sit down and plan together. This is followed up by the quarterly Provincial and District Planning and Review meetings where they can have the same kind of interaction with the District Health Executives, the facilities and the communities.”</i> • <i>“Coordination was weak and the H4+ agencies did not really act in a joined up way until the national Steering Committee was established and got really going at the 2013 Victoria Falls meeting.”</i> 	<p>Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.</p>
39	<ul style="list-style-type: none"> • Complementarity is made stronger by the interlocking set of coordinating bodies. At the start, based on the original proposal, there was supposed to be a Steering Committee but it was not activated. • <i>“After the Vic Falls meeting in 2013, MoHCC really took the lead and got coordinated planning really moving. From that point on the Ministry took on the challenge of integrating the programme (including with other programmes supporting health care) by taking on ownership and accountability”.</i> • Now there is an integrated structure for coordinating across programmes of support in the health sector including: <ul style="list-style-type: none"> ○ The country coordinating mechanism (Global Fund/Gavi) ○ The HTF/HDF steering committee chaired by the PS of MoHCC ○ The H4+ Steering Committee chaired by the Director of Family Health ○ The Adolescent Sexual and Reproductive Health Forum ○ The MODO, (Ministry of Health and Donor) Committee which reviews all health programmes. 	<p>Interview with H4+ country team (UNICEF).</p>

	<ul style="list-style-type: none"> • Because the membership of these committees often includes the same people, it is easier for staff of supporting organisations, including H4+ to avoid programme overlap and to ensure complementarity. 	
40	<p><i>“What H4+ has brought to the situation that is new is a new era of coordination. The government (MoHCC) has recognised how effective the H4+ coordination has been and wants to use the model in the coordination of the new Health Development Fund.”</i></p>	Interview with H4+ country team (UNICEF).
41	<p><i>“In the transition to the Health Development Fund MoHCC expect the World Bank to get more involved in the joined up partnership and to bring new perspectives and dynamics not there at the present time.”</i></p>	Interviews with MoHCC staff at Director and Deputy Director level at headquarters.
42	<ul style="list-style-type: none"> • <i>The new Health Development Fund which is coming out of the experience of the older Health Transition Fund will build on the work of H4+. For example, it includes many outcome indicators in RMNCAH and supports all the pillars of the WHO health systems building blocks.</i> • <i>However, H4+ targets innovation in MNCAH and the Permanent Secretary is worried that, in the absence of dedicated funding for MNCAH innovation will this dimension be lost. There is a risk that the HDF will provide funding at a big picture level and will not prioritize innovation in MNCAH. The unique focus of H4+ could be lost.</i> 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
43	<ul style="list-style-type: none"> • On coordination there are still some important questions: <ul style="list-style-type: none"> ○ How can the Country Coordination Mechanism (CCM) really function as it deals with almost half a billion dollars of GFATM money? ○ The Steering Committee for the ISP never really worked in a coordinated way with the one for the Health Transition Fund so will it work better under the (combined) Health Development Fund)? 	Interview with H4+ country team (UNAIDS).

Area of Investigation 4: Innovation

4. 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)?
- How do H4+ JPCS partners and health authorities and other stakeholders at national and sub-national level recognised potentially effective innovations in RMNCAH?
 - 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?
 - 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	<p>For the evaluation, 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 Zimbabwe include:</p> <ul style="list-style-type: none"> • 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) 	Interviews with H4+ global and country team

	<ul style="list-style-type: none"> • 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). <p>However, the team in Zimbabwe was unaware that these existed or that they could be useful for advocacy or policy work, or that there was an expectation that they should be used.</p>	
2	<p>In the most recent annual reports available, the following innovations were noted:</p> <ol style="list-style-type: none"> 1. Use of social media to reach young people with education and information on SRH: This initiative was jointly undertaken by H4+ and Integrated Support Programme (ISP) in six districts of Masvingo and Mashonaland West provinces. (H4+ funding supported the training of 100 youth peer educators in Hurungwe.) As part of the Peer Educator training supported by H4+, young people were trained in the use of social media, especially Facebook Club, for increasing their knowledge on sexual and reproductive health, including HIV and AIDS and for sharing knowledge with their peers. This collaborative effort was undertaken in association with Young People’s Network – Get Engaged, the Ministry of Health and Child Care, National AIDS Council, Zimbabwe National Family Planning Council and SAY – WHAT, a youth NGO. H4+ together with ISP procured 64 tablets for the Peer Educators, of which 40 were procured through H4+ funding. This work was featured in an article for the ‘UN in Zimbabwe’ Newsletter, Issue 10, June – September 2014. 2. Use of PoC PIMA CD4 Count Machines: The PoC PIMA machines have led to faster results on assessment of eligibility for ART. These CD4 count machines are portable and can be used in rural health centres after basic training. These machines have 	H4+ Zimbabwe, <i>SIDA H4+ 2014 Final Report</i> , March 2015 (H4+ Zimbabwe 2015c)

	significantly reduced the time between testing and knowing the results and hence significantly contributed to increase in number of eligible HIV positive cases accessing and continuing ART without undue delay and break. It is playing an important role in achieving the goal of virtual elimination of mother to child transmission of HIV and hence has an important role to play in the delivery of quality-integrated mother, newborn and child health services. This innovation was featured in a story, ‘Same-day CD4 testing improves uptake of HIV care and treatment in rural Zimbabwe’	
3	<p>Innovations in Zimbabwe</p> <ul style="list-style-type: none"> • Use of social media to reach young people with information and education on SRH. • Mobile technology for facilitating referral linkage between facilities and communities • Use of PoC PIMA CD4 Count machines • Plans to pilot seal of quality for BEmONC facilities • Socialising health messages in health campaign 	H4+ <i>Intermediate Report, 2013-2014 (H4+ 2014b)</i>
4	At UN H4+ review meetings, agenda item on “sharing the progress” allows the different UN agencies to showcase what is working – e.g. UNFPA identified its “Parent to Child Communication” as a potential strategy to reduce teenage pregnancy, although there is no evidence of how it was received/used.	Minutes_IIIQ_UN-Meeting_20 th August2015
5	H4+ participated in, and supported, the mid-term review of the ASRH strategy (although there is no mention of which UN or other agency organised the review). This resulted in an age-appropriate breakdown of interventions as well as the introduction of innovations using new technologies to reach out to larger numbers of young people. In addition, it resulted in advocacy to ensure that interventions are evidence-based and should draw on documented on good practices good practices from within the region.	H4+, <i>2013 Annual Narrative Progress Report, Final, 2014 (H4+ 2014a)</i>
6	UNFPA supported a study on the determinants of teenage pregnancy in Hurungwe. The study was commissioned by the MoHCC and conducted in partnership with ZNFPC, Zimbabwe Youth Council, UNFPA and H4+.	
7	<ul style="list-style-type: none"> • The World Health Organization defines clinical mentorship as a <i>system of practical training and consultation that fosters ongoing professional development to yield sustainable, high quality clinical care outcomes. Mentorship should be seen as part of the continuum of education required to create competent health – care providers. Mentorship should therefore be integrated with and immediately follow initial pre-</i> 	<ul style="list-style-type: none"> • WHO, <i>Agenda for Clinical Mentorship</i>, September 2013 (WHO 2013a) • (Sibanda 2014)

	<p><i>and in- service training. The MOHCW also acknowledges that appropriately trained and skilled and well-motivated workforce is a critical component required for the efficient delivery of health services.</i></p> <ul style="list-style-type: none"> • Zimbabwe’s health delivery system has been affected by a massive loss of experienced qualified health professionals from the public health sector. The exodus has also reduced capacity to train and mentor additional health professionals. In view of this, the Ministry of Health and Child Welfare, has prioritized human resources in order to increase access to trained human resources as well as achieve both national health and millennium development goals (MDGs). • In November 2012 a stakeholders’ meeting was held to discuss the need to develop clinical mentorship tools for MNCH programme. Recommendations from this meeting indicated the need to come up with a task force to spearhead the development process. It is against this background the MOHCW with financial support from UNFPA has organised a follow up meeting with obstetricians and midwives to initiate and mobilize their support for the development of the clinical mentorship tools. 	
8	<ul style="list-style-type: none"> • Rationale for RMNCH Clinical Mentorship Programme <ul style="list-style-type: none"> ○ <i>While maternal health situation in Zimbabwe has significantly improved over the years yet it is still high. Though improved from 960 (ZDHS 2010-11) to 614 (MICS – 2014) yet the MMR for the country still is far below the MGD goal of 174. Post-partum haemorrhage continues to be the major cause of maternal mortality. The burden of maternal mortality is borne most by the young girls and women. Teenage pregnancy continues to be high at 20% and adolescent fertility high at 120. Contraceptive prevalence Rate though high yet is skewed towards short term measures. Family planning unmet need is still high at 10%.</i> ○ <i>Primary Health Care delivered through approximately 1100 Rural Health Centres (RHC) is the first port of call for maternity services for all mothers in Zimbabwe, regardless of age, parity and background. These RHCs are mostly managed by Nurses, most of them Primary Care Nurses (PCN). Not all but some also have midwives. As mentioned above, most of these are not adequately trained due to constraints faced during the economic crises of 2000s. The situation in terms of availability of skilled RMNCH staff is more or less similar at secondary level health care system. Recent National Integrated Health Facility Assessment (NIHFA) held in 2012 also pointed out knowledge and skills gaps on mother and newborn care among different cadres of health service providers. The assessment also found</i> 	(H4+ Zimbabwe 2015b)

	<p><i>that nationally 53% midwives, 67% Registered General Nurses (RGN) and 70% Primary Care Nurses (PCN) were not trained on EmONC. The situation was worse in RHCs. Thus there definitely is a need for enhancing the skills of all cadres of health care providers engaged in RMNCH service delivery at primary and secondary health care system as they handle the bulk of maternity services and it is here that most of the maternal health complications and thus maternal deaths can be averted.</i></p> <ul style="list-style-type: none"> ○ <i>In response to the findings of NIHFA, a 5-day EmONC training was prioritized that enhanced the knowledge base of health providers on EmONC services. However, in three years of focus on EmONC what also has emerged is the need for continued support to this trained cadre of health providers to perfect and sustain their clinical skills. This finding has brought to centre stage the need for the clinical mentorship for all cadre of health providers on RMNCH and especially, maternal health.</i> 	
9	<p>Rollout of Clinical Mentorship was done through stakeholder sensitization and consultation meetings at the national level and then again in the provinces:</p> <ul style="list-style-type: none"> • To introduce the concept of clinical mentorship in MNH • To consult provincial/district managers on the specific areas which need prioritisation in the clinical mentorship programme • To consult provincial/district managers on how best to implement the programme <p>Areas identified included</p> <ul style="list-style-type: none"> • Anaesthesia for those doctors in the province who did not do a rotation in anaesthetics, mentorship in emergency surgical procedures such as ectopic pregnancies, ruptured uterus and subtotal abdominal hysterectomies for uncontrollable PPH. DNOs (representing the nurses at the peripheral health facilities) • EmONC signal functions for the nurses at the rural health facilities. This includes management of PPH, manual removal of the placenta and resuscitation of the newborn among other areas. 	<ul style="list-style-type: none"> • (MoHCC 2015d) • (MoHCC 2013b)
10	<p>The findings of this assessment indicate that the capacity to manage obstetric emergencies has improved since the national health facility assessment in 2012 (NIHFA). Continuous access to emergency drugs and supplies remains a challenge, and the need to constantly refresh and update the knowledge and skills of service providers</p>	<p><i>EmONC Assessment Report Sept 2015 (MoHCC 2015a)</i></p>

	<p>is apparent. The latter is especially important for health workers in first-line primary care facilities, who are seldom exposed to obstetric emergencies and have limited means to deal with them. Recommendations include to increase in the number of supportive supervision visits to revise and refresh knowledge and investigating the feasibility of arranging hospital attachments for health centre staff as well as the development of other mentoring systems to enhance knowledge and skills transfer between trainers and trainees, i.e., distant learning and feedback via email or skype. could be an option.</p>	
11	<ul style="list-style-type: none"> • In each country, H4+ contracted with a national institute selected to coordinate and provide technical support for country-based M&E activities during the life of the programme. Responsibilities included conducting baseline surveys; collection and analysis of routine data; assistance in identifying and documenting innovative approaches or interventions; and support for mid-term and final programme evaluations. In Zimbabwe, the Collaborating Centre of Operational Research (CCORE) was selected to serve this role. The H4+ partners assigned M&E staff from UNFPA and MOHCC to work closely with CCORE and the national level Steering Committee served as the consultative group for M&E, with CCORE mandated to report to the SC every two months. Each of the H4+ countries, including Zimbabwe, are reported to have made progress in the area of monitoring and evaluation in 2013, including laying a foundation for expanding and improving M&E at the national level. • CCORE implemented a baseline survey. In addition three assessments were conducted to understand the perception of communities regarding key SRH issues, on 1) maternal health problems and access barriers, 2) on approaches for reaching adolescents and young people, and 3) on the awareness and attitudes of community and religious leaders, health providers, parents and young people. These assessments were reported to identify several gaps related to service accessibility, availability and quality. 	<p>H4+, <i>2013 Annual Narrative Progress Report, Final, 2014.</i> (H4+ 2014a)</p>
12	<p>UNICEF and MoHCW commissioned an evaluation to generate evidence in order to improve understanding of the effectiveness of the PIMA POC CD4 count machines in maternal and new-born child health (MNCH) settings in country; document best practices, lessons learnt, challenges and recommendations related to scale up of this new technology. It was largely acknowledged that patient management had improved due to reliable clinical assessments, and also patient retention had improved due to</p>	<p>(Mtapuri-Zinyowera and Chiyaka 2012)</p>

	less referrals. There was a general consensus that most HIV positive pregnant women and their families were now able to be assessed for ART eligibility on time.	
13	Pepfar supported the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) to support the introduction of point of care CD4 testing in PMTCT sites, starting with an initial 25 PMTCT sites. Clinton HIV/AIDS Initiative (CHAI) and UNICEF procured the machines for use at medium/low volume PMTCT sites to support ART initiation for eligible pregnant women. The Pepfar plan also noted, <i>“In FY2010 USG PMTCT partners will lead scale-up of early infant diagnosis and pediatric ART, and point of care CD4 testing in a PMTCT setting.”</i> (p. 31)	<i>Zimbabwe Operational Plan Report, Pepfar, 2010</i> (PEPFAR 2010)
14	<ul style="list-style-type: none"> • A major objective of the meeting was to discuss strengthening of the processes towards capturing progress on the agreed indicators of M&E framework and documentation of the innovations as well as achievements. In addition, there was an agenda item on communications to discuss plans to design and strengthen communication and documentation of H4+ achievements and innovation for enhanced visibility of efforts to accelerate progress to achieve MDG 4 and 5. • Each of the six H4+ countries presented their activities and progress to date. One of the major issues raised was the lack of progress on ASRH programming. Suggestions discussed during the meeting (from experiences in other countries) included: <ul style="list-style-type: none"> ○ <i>“Use different strategies (e.g. Colombia used state money, and the Swiss were giving money for ASRH programming so countries could apply it). The trick he indicated was to ‘show results’ in order to justify asking for money.</i> ○ <i>Communicate clear messages from the beginning in order not to scare parents such as; ‘Delay in sexual debut of young people.’</i> ○ <i>Use emotional blackmail if need be to get high level people at policy level interested and engaged</i> ○ <i>Make Youth Friendly Centres (YFC) physically and emotionally safe for girls</i> ○ <i>Make YFCs friendly and welcoming to boys in order to draw them in.”</i> (p.5) 	(MoHCC 2014b)
Assumption 4.2 <i>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.</i>		
Information/data		Information sources

15	<ul style="list-style-type: none"> • Each H4+ partner draws on the regional technical focal points in MNCAH in its own agency and they see little or no need for duplicating technical expertise at regional level since they already have it. Each agency reports to its own agency and there was no felt need to duplicate a major regional role for H4+ beyond the on-going technical support that each partner already gets. With regard to the expertise needed to support the design, implementation and monitoring of interventions, H4+ agencies have relied on internal expertise within their organisations and the MoHCC for M&E activities, plus they have access to, and have used, consultants and national institutions to supplement expertise. • H4+ agencies have a reasonable level of technical capacity in-house with experienced advisers with a long history of involvement with H4+, especially in the case of UNFPA, UNICEF and WHO. There are highly competent senior and middle managers in MoHCC who are solid technical counterparts for the UN agencies in the area of RMNCAH as well as in the routine aspects of M&E. However, there is less evidence of expertise in the specific area of building a case to more systematically manage the process of innovation, including the capacity to document a practice or tool as an innovative approach worthy of scaling up. 	<ul style="list-style-type: none"> • Interviews with H4+ Country Team. • Interviews with MoHCC staff at Director and Deputy Director level at headquarters.
16	<p>A H4+ Joint Mission trip to Zimbabwe in September 2015 was undertaken to observe progress in intervention areas and provide feedback and recommendations. There wasn't a specific mention of innovation in the report, although there was a note that there wasn't documented evidence to back up the reports of reduced lag time to inform results of DBS samples of infants with use of the POC CD4 machines.</p>	<p>H4+ Global Team, <i>H4+ joint mission report: Zimbabwe</i>, September 2015 (H4+ 2015b)</p>
17	<p>HQ-produced guidelines are used in the development of national level guidelines, for example WHO-produced guidance was the basis for clinical mentoring guidelines produced in 2015. These guidelines are an important tool for the on-the-job mentoring for practicing health professionals in reproductive, maternal, neonatal, child and adolescent health. The purpose of the guidelines is to provide guidance at all levels of care, national, provincial, district health management teams and central hospitals in developing and/or integrating a clinical mentorship programme, to ensure quality healthcare service delivery in all health facilities.</p>	<p>(H4+ Zimbabwe 2015b)</p>
18	<p>Zimbabwe MoHCC and H4+ country team members travelled to Ethiopia in June 2013 to develop country action plans for H4+ activities. Country teams were oriented to the SIDA H4+ proposal and areas for financial and technical assistance were identified. (No specific mention of innovation; but is a good example of country exchange.)</p>	<p>WHO, <i>Report on H4+ Addis 2013</i> (WHO 2013b)</p>

Assumption 4.3		
<i>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.</i>		
	Information/data	Information sources
19	There is mention within this report of a compendium of case studies on innovative approaches to MNH. It was finalised and published in print and electronically. Copies were also provided to all H4+ countries at the annual Canada H4+ meeting. The ultimate purpose of the compendium is to inform countries about existing innovative approaches to MNH and highlight some key considerations for bringing MNH innovations to scale. In addition, a guidance note for documenting innovative approaches to MNH was developed and shared with H4+ countries to enhance active documentation of best practices. (Refer to evidence in Line 20).	H4+, <i>Annual Narrative Progress Report for 2013 (Canada) Final</i> . May 2014. (H4+ 2014a)
20	<ul style="list-style-type: none"> • The H4+ working definition for innovation is “any novel or newly packaged, scalable approach aimed at improving outcomes relevant to the continuum of maternal and newborn health care” (p. 3). It should be innovative in the country context and can be identified at any one of the planning, implementation or evaluation/programme stages. Practical guidance was offered for documenting as a description summary (using case study format), as a report or working paper, or as an academic/peer review journal article. A template was offered for documentation of innovations, with key sections noted below: <ul style="list-style-type: none"> ○ Justification of innovation (why is the intervention considered innovative; what is new about this approach compared to previous approach) ○ Strategy (a description of the strategy used, where it came from how is it implemented, at what scale) ○ Results (including progress, coverage and verified results and whether it is being replicated elsewhere) • Lessons learned (including enabling and constraining factors, and how these were respectively leveraged or overcome) 	H4+, <i>Guidance for Documenting Innovative Approaches</i> . November 2013 (H4+ 2013a)
21	<ul style="list-style-type: none"> • The key indicator on innovation is under Output 8: Communication and H4+ visibility: Number of documentations produced (human interest stories and innovations). Two documents have been produced: 	<ul style="list-style-type: none"> • H4+Zimbabwe, <i>H4+ M&E Logframe revised May 2014</i> (H4+ 2014c)

	<ul style="list-style-type: none"> ○ The POC PIMA CD4 story summarises the assessment noted in Assumption 4.1 of the POC machines in 7 districts, but does not discuss the process of scaling this up through H4+ ○ The document describing the use of social media in addressing teenage pregnancy in Hurungwe is a human-interest story. It indicates that UNFPA and its partners in the National ASRH Network identified this “emerging strategy”. It is intended to “exploit social media to empower adolescent girls to make healthy reproductive health choices and act on them”. The document briefly describes the inputs, but does not present outputs. ● The documents appear to have been written to satisfy the requirement of reporting on two innovations. The POC CD4 document includes information on scalability; however, neither follows the guidance on documentation (refer to evidence in Line 20), nor includes information on the results of testing or scaling them up within H4+. 	<ul style="list-style-type: none"> ● H4+ Zimbabwe, <i>The use of Point of Care PIMA CD4 Cell Count Machines for HIV Positive Women and their Families in Maternal Newborn and Child Health Settings in Seven Districts in Zimbabwe</i> (H4+ Zimbabwe 2014d) ● Hurungwe Youth User of Social Media to Fight Teenage Pregnancies ● Interviews with H4+ Country Team.
22	<p>This report contains documentation about the results of clinical mentorship, even though it was not written for the purpose of documenting an innovation. Doctors and nurses were mentored on surgical and aesthetic management of PPH, ruptured uterus, eclampsia, and ectopic pregnancy and the report included feedback from mentees:</p> <ul style="list-style-type: none"> ● According to all the doctors and nurses who have gone through the mentorship “attachments”, the programme is very useful for their professional development with respect to management of obstetric emergencies as they are now able to perform complicated C-Sections. The doctors are also now able to perform MVAs, which they were not able to do before the programme. ● However, there are some procedures that the mentees were not able to do, because caseload was inadequate. 	
<p>Assumption 4.4 <i>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).</i></p>		
Information/data		Information sources
23	<p>H4+ is recognised as a vehicle for programme innovation. During the Victoria Falls review meeting in 2013, innovation was introduced as an important topic and area of focus. Prior to this, the individual agencies did not have a common view or vision of</p>	<p>Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.</p>

	innovation within the programme. Before the Steering Committee became operational, most programme activities were focused on training and the supply of commodities.	
24	There are major concerns that resources for innovation will be limited after H4+ ends and this will translate to less interest and focus on innovation in RMNCAH. The HDF is the main resource vehicle for RMNCAH going forward, and there is a risk it will not prioritize innovation and the unique focus within H4+ could be lost.	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
25	The Global Fund and PEPFAR are scaling up the use of CD4 machines at point of care nationally, based on the approach developed by H4+. Documentary evidence indicates that EGPAF was the initial driver of introducing and testing this innovative approach in Zimbabwe, which was not mentioned or acknowledged in interviews with H4+ team members.	Interviews with H4+ country team members Zimbabwe PEPFAR Operational Plan Report, 2010.
26	The coordinators of the new HDF programme (UNFPA and UNICEF) intend to carry forward some of the innovations “introduced” by H4+, including clinical mentorship and supportive supervision. However, funds pledged for this programme are well below the needs identified, so it is not clear whether and how these innovations will be prioritised within HDF. The GoZ resources for health are allocated mainly for personnel costs, therefore, unless additional donors funding is identified, the future is not clear for scale up of these (and other aspects) of the H4+ programme.	<ul style="list-style-type: none"> • Interviews with H4+ country team members • Interviews with donor representatives

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

<p>5. 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?</p> <p>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?</p> <p>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?</p> <p>c. Do efforts at coordination result in collaborative programming which is more effective than separate initiatives?</p>		
<p>Assumption 5.1 <i>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.</i></p>		
	Information/data	Information sources
1	<p>The process of setting a new direction for H4+ began with the first quarterly joint planning and review meeting of all stakeholders (MoHCC, H4+ partners and provincial and district health facilities staff as well as participating NGOs) in September 2013.⁸⁹ This first step was followed up by the H4+ partners and the MoHCC during the global H4+ inter-country planning and review meeting held in Victoria Falls, Zimbabwe from May 26 to 30, 2014 (and subsequently referred to in key informant interviews as the Victoria Falls meeting). One outcome of this meeting was the establishment of the national H4+ steering committee under the chair of the Director of Family Planning of MoHCC, with its first meeting held in June 2014.</p>	<ul style="list-style-type: none"> • Interviews with H4+ country team • Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters
2	Refer for evidence to question three, line five.	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
3	Refer for evidence to question three, line six.	Interviews with MoHCC staff at director and deputy director level at Headquarters.
4	Refer for evidence to question three, line eight.	<i>Minutes of the 1st National H4+ Steering Committee 18th June 2014 (H4+ Zimbabwe 2014a)</i>

⁸⁹ (H4+ Zimbabwe 2013b). While joint planning and review meetings were planned on a quarterly basis they sometimes occurred less frequently due to scheduling difficulties. At a minimum, they occur twice each calendar year.

5	Interviews confirmed that the first meeting of the National H4+ Steering Committee, following on the September 2013 provincial and district planning and review meeting and the April 2014 Victoria Falls meeting, marks the advent of a much stronger coordination mechanism and process for H4+ JPCS in Zimbabwe. It and subsequent National Steering Committee Meetings, combined with the ongoing programme review and planning meetings show a commitment by MoHCC and the H4+ team to better align programme plans and actions with provincial and district priorities under the leadership of the MoHCC.	Interviews with MoHCC staff at Director and Deputy Director level at headquarters.
6	Refer for evidence to question three, line seven.	<ul style="list-style-type: none"> • Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters • Interviews with H4+ country team members • Interviews with staff of NGO implementing partners.
7	Refer for evidence to question three, line 17	Interviews with H4+ country team: UNICEF.
8	<ul style="list-style-type: none"> • Enhanced coordination has been the major positive improvement due to H4+ JPCS. The programme collaborated first on the needs assessment to underpin a coordinated response • They focused on the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best). 	H4+ country team (WHO).
Assumption 5.2 <i>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.</i>		
Information/data		Information sources
9	<ul style="list-style-type: none"> • UN Women became part of the programme in 2013 when Swedish (Sida) funding was provide for Zimbabwe. It concentrated on efforts to engage and empower girls and boys, men and women to effectively demand access to services in SRH, MNCH and HIV. • WHO is part of the original H4+ team and Zimbabwe was one of the original countries with an H4+ country team. The H4+ team (and especially WHO) worked with the MoHCC to develop a set of priorities and prepare the original proposal for Canada funding 	Joint interview with H4+ country team (WHO, UNICEF, UNFPA, UNAIDS, UN Women).

	<ul style="list-style-type: none"> • UNICEF was part of the original H4+ Canada programme way back in 2011 and acted as the coordinator then. Priority in the early days was to ensure HIV was integrated into MNCH. H4+ worked with MoHCC on HIV integration. • UNAIDS began to receive funding under the programme in 2012 (Sida) but only became operational in 2013. Their focus (within H4+) was having HIV services leveraged out to other MNCH services. They integrated their work into the harmonized H4+ JCPS work plan of 2013 and their mandate (within the programme) was to mobilize support at the community level. • In particular, UNAIDS focused on stimulating demand for, and access to, contraceptives and to demonstrate need and value to traditional community leaders. Their NGO implementing partner developed a tool kit for traditional leaders. 	
10	<p><i>“The role of UNAIDS in H4+ is to see how the HIV response can be leveraged in support of MNCH. They focus on innovative forms of community engagement and participation, always through partner NGOs such as Women’s Action Group (WAG) who focused on increasing the knowledge level of traditional leaders so that community members could become engaged and demand services.”</i></p>	Interview with H4+ country team (UNAIDS).
11	<ul style="list-style-type: none"> • Historically, HIV and AIDS was receiving the bulk of funding and attention. Millennium Development Goals (MDG) 4 and 5 (maternal and child health) did not receive comparable resources and they all sat down to see what was needed to trigger meaningful change. • <i>“WHO pushed the ideal of improving skilled birth attendance but skills were lacking when you looked at field level, especially when you look at EmONC.”</i> 	Interview with H4+ country team (WHO).
12	<ul style="list-style-type: none"> • <i>“The question of who should house the H4+ coordination role in Zimbabwe was essentially one of burden sharing and who has the resources. When it became clear in 2012 that UNICEF would house the HTF, it seemed clear that UNFPA could look at HIV issues and the coordination of H4+ in their house. UNFPA was also committed to sharing information with all the H4+ members.”</i> 	Interview with H4+ country team (UNICEF).
13	<ol style="list-style-type: none"> 1. UN Women bring to the table their strong understanding of women’s rights and of gender equality issues. Their technical advantage is that they understand women’s rights. 2. Sida has a long dedication to gender so when they got behind H4+ it was natural that UN Women was a focus of attention. 	Interview with H4+ country team (UN Women).

	<p>3. "In H4+, UN Women focuses on a right to access and on ensuring that when providers meet their obligations to address demand for access, once the right to service is recognised by providers and users alike, demand is there. The key is raising people's awareness so that they can make their demands effective but you also need to contribute to the government and others thinking about supply."</p> <p>4. "When the H4+ programme started in Zimbabwe UN Women were not part of it. Their HQ in 2013 or so said you have to become engaged. They looked at UNPFA and WHO and how they were involved in policy development and strengthening services but the demand side was missing, women were dying and the level of trust by the community was nil."</p> <p>5. In their work with Katswe SistaHood and WAG, they liaise with the Ministry of Women's Affairs, Gender and Community Development (MWAGCD).</p>	
14	<p>UNFPA Key activities for 2015 (p.7)</p> <ul style="list-style-type: none"> ○ Support and supervision for clinics ○ Maternal death review meetings once a quarter by provinces and districts ○ Training of trainers and direct training in MVA ○ EmONC mop-up training ○ MDSR ○ EmONC Assessment ○ Obstetric Fistula <p>UNICEF Key activities for 2015 (p.8)</p> <ul style="list-style-type: none"> ○ HIV and PMTCT ○ Infant and Young Child Feeding (IYCF) ○ Coordination of PoC, Early Infant Diagnosis (EID) and Paediatric ART ○ Mentorship in Paediatric ART ○ Training of health workers on how to deal with adolescents living with HIV ○ Improved reporting on male mobilizers activities ○ Supporting community peer mother support groups ○ End use monitoring, especially on commodities and equipment (e.g. PoC machines and motorcycles) <p>WHO Key activities and areas supported in 2015 (p.8)</p> <ul style="list-style-type: none"> ○ Review and development of policies and strategies ○ Human resources – training on IMNCI, growth monitoring, quality of care and management training of managers of MNCH programmes 	MoHCC, <i>Summary Report of the H4+ Provincial and District Planning and Review Meeting</i> . June, 2015 (MoHCC 2015k)

	<ul style="list-style-type: none"> ○ Capacity building for Emergency Triage Assessment and Treatment (ETAT) ○ Nutrition – nutrition surveillance guidance ○ Growth standards ○ Capacity building in EmNOC, MHIS, MDSR, RMNCH generally ○ Data quality and joint monitoring visits <p>UN Women Key priorities and activities for 2015 (p.8-9)</p> <ul style="list-style-type: none"> ○ Covering three of six districts (Chiredzi, Mbire and Chipinge) ○ Advocacy to mitigate socio-cultural and religious barriers to access of essential services in MNCH, SRHR, GBV and HIV by boys, girls, women and men ○ Train facilitators to continue the work of dialogue forums between young people and health service providers, educators, police, community leaders ○ Conduct Pachoto (safe spaces) forums. 	
15	<p>Areas of Work by Agency in 2015 (with and without H4+ funding): UNFPA (p.1-4)</p> <ol style="list-style-type: none"> 1. Work on midwifery including: policy and advocacy, curriculum development, regulatory development, strengthening the national midwifery association, HR assessments, and advocacy for increased assessments as well as support to midwifery schools 2. Strengthening BEmONC and CEmONC services including: policy work (national documents on MH, training manuals, mentorship guidelines, operational plans), training of trainers, direct EmONC training, clinical mentorship, MVA training, post-training follow up and supportive supervision, procurement of essential commodities (medicines, surgical sundries, medical supplies and equipment), infrastructure support to health facilities and maternity waiting homes, advocacy and communications, and strengthening health management information system (HMIS) to capture MH services 3. Strengthening MDSR including: policy work (finalising national maternal and perinatal death review and reporting guidelines, including revising the national reporting formats), developing the electronic MNDSR data base – eMNDSR, regularising provincial and district level maternal death review meetings, and training on MDSR 4. Establishing the national obstetric fistula programme including: policy and advocacy, needs assessment, establishing an obstetric fistula repair centre in Mutare 5. Cervical cancer screening: Visual Inspection with Acetic Acid (VIAC) including policy work, support to coordination and monitoring, establishing VIAC screening and pre- 	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)

	<p>cancerous treatment sites, capacity building of health workers, developing IEC materials</p> <p>6. Adolescent reproductive sexual health programme including: policy work (the Hurungwe Determinants of Adolescent Fertility Study and National Teenage Fertility Study, support to existing youth friendly corners to bring them to internationally accepted YFC standards, empowering young people with information on SRHR, developing a cadre of peer educators and developing Information, Education and Communications (IEC) materials on ARSH issues.</p> <p>7. Family planning programme (Outside H4+).</p>	
16	<p>Areas of Work by Agency in 2015 (with and without H4+ funding): UNICEF (p. 5-6)</p> <p>1. Strengthening CEmONC and BEmONC services under the Health Transition Fund: including policy work, support to BEmONC training of midwives Primary Care Nurses (PCNs), clinical mentorship on MH, post training follow up and supportive supervision, results-based financing to health facilities to provide basic maternal and neonatal health services, human resource support through retention bonuses, facilitating blood availability, procurement of essential MH drugs and supplies, supporting quality of care initiatives, strengthening referral and communications and advocacy</p> <p>2. Midwifery work: supporting all 22 midwifery schools in the country with basic teaching aids, training of midwives, on the job training for midwives, and providing retention bonuses for midwives under the HTF</p> <p>3. Community work in support of village health workers: policy work including situation analysis of the geographic distribution of VHWs and standardising training materials, training VHWs on MNCH activities and revitalization of health centre committees</p> <p>4. PMTCT programme (Under H4+): policy work contributing to adoption of WHO guidelines on option B+, training on option B+ of health workers, nurses and PCNs, procurement of PoC PIMA machines, and HIV testing and counselling campaigns in communities.</p>	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)
17	<p>Areas of Work by Agency in 2015 (with and without H4+ funding): WHO: (p.6-7)</p> <p>1. Improving the policy environment for MNCH: developing, updating and revising guidelines, policies and strategies on MNCH</p> <p>2. Conducting research and assessments including the national facilities assessment</p>	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)

	<p>3. Supporting improved Quality of Care (QoC): adapting international guidelines on QoC to Zimbabwe's needs and contributing to development of tools</p> <p>4. Capacity building, particularly in Integrated Management of Neonatal and Childhood Illnesses (IMNCI), strengthening health worker management skills, and skills in growth monitoring and assessment</p> <p>5. Strengthening the RMNCH M&E Framework through consolidation and revision</p> <p>6. Advocacy on key national MNCH policy issues and interventions including failure of contraceptives as a means of reducing illegal abortions and their consequences.</p>	
18	<p>Areas of Work by Agency in 2015: UN Women: (p.6-7)</p> <p>The maternal health work of UN Women is fully supported by H4+ and aims to empower women and girls to access RMNCAH, HIV and GBV services through</p> <ol style="list-style-type: none"> 1. Training of community based advocates (CBA): to conduct community awareness programmes and dialogues on RMNCHA, HIV and GBV issues 2. Creating dialogue and awareness among adolescent girls and young women through the Pachoto Sista to Sista clubs 3. Establishing community forums for women, men and adolescent girls: to discuss, share and learn on various aspects of RMNCHA, HIV and GBV 4. Creating and revitalising community health centre committees through facilitating advocacy platforms between CBAs and health centre personnel in the selected wards. 5. Developing IEC materials for engaging community and encouraging discussion and information sharing 6. Research and Studies to undertake gender assessments of the community structures that influence women and girls' MH health seeking behaviour. 	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)
19	<p>Areas of Work by Agency in 2015: UN Women: (p.8-9)</p> <ol style="list-style-type: none"> 1. Policy work, leadership and coordination, including: advocacy for integrating SRH and HIV programmes using UNAIDS global plan on PMTCT and the UNAIDS global Strategy and Investment Case study 2. Monitoring and evaluation and strategic information support, including the investment case, HIV estimates, global progress reporting, hotspots mapping, strengthening M&E systems for integrated SRH and HIV M&E (along with UNFPA and WHO) 3. Community work with traditional leaders through community dialogues and sensitizing traditional and religious leaders on RMNCAH, including gender and 	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)

	<p>human rights, and the use of an innovative model for mobilizing and capacitating community leaders to reach out to most vulnerable groups and fine solutions in relevant areas of service provision, including MNCH so “no one is left behind”</p> <p>4. Documentation of the community model engaging traditional leaders including human interest stories, small videos and photography</p> <p>5. Prioritising youth and women by advancing communities and their leaders’ engagement in solving SRH and broader rights and access related problems.</p>	
20	As the final workplan for the H4+ in Zimbabwe, the document outlined actions taken over the period prior to 2014 and in 2014 to respond to the changing environment, including priorities and needs at national and district level. (For a detailed listing see Assumption 3.3).	H4+ Zimbabwe, <i>H4+ Workplan 2015-2016</i> (H4+ Zimbabwe 2015a)
21	<ul style="list-style-type: none"> • For the H4+ partners, they started to plan their role in the programme based on their “<i>mandates, capacities, historical roles, relationships with national authorities and implementing partners and their advantages</i>” • “<i>The overall planning framework was the global response by the H4+ team to the 2010 Global Strategy and EWEC, there was a sense that each H4+ member would respond in accordance to its mandate.</i>” 	Interviews with H4+ Country Team (UNFPA, UNICEF).
22	“ <i>After the Victoria Falls meeting (in 2014) the national H4+ steering committee and the quarterly provincial and district planning and review meetings served to make sure that provincial and district needs were fully reflected in H4+ plans and that H4+ partners were able to contribute the needed support at provincial and district level, not just at national level.</i> ”	Interviews with MoHCC staff at director and deputy director level at headquarters.
23	Refer for evidence to question five, line five.	<ul style="list-style-type: none"> • Interviews with MoHCC staff at director and deputy director level at headquarters • Interviews with H4+ country team members • Interviews with NGO implementing partners.
24	The partners focused on where is the real problem at district level. This helped to make each H4+ member organization feel responsible for the work of the other agencies especially since they all aim for the same results (while working at what they do best).	H4+ country team (WHO).
25	Refer for evidence to question three, line 34.	• MoHCC, <i>Report on Quarterly Provinces and Districts Review and Planning Meeting, 11-12 September 2013</i> (MoHCC 2013a)

		<ul style="list-style-type: none"> • MoHCC, <i>Report on H4+ Planning and Review Meeting</i>, 23-25 September 2014 (the Victoria Falls Meeting) (MoHCC 2014c) • MoHCC, <i>Report in H4+ Planning and Review Meeting</i>, 01-03 June, 2015 (MoHCC 2015i)
<p>Assumption 5.3 <i>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.</i></p>		
	Information/data	Information sources
26	Refer for evidence to question five, lines 14 to 18.	H4+, <i>Mapping of Maternal Health Work of H4 + and UN Agencies</i> , March 2015 (H4+ 2015c)
27	Refer for evidence to question five, line 19	H4+ Zimbabwe, <i>H4+ Workplan 2015-2016</i> (H4+ Zimbabwe 2015a)
28	<ul style="list-style-type: none"> • During the Review Missions MoHCC have noted different positive results linked to more common approaches to support by H4+ partners: <ul style="list-style-type: none"> ○ There is less emphasis on pre-service and more emphasis on on-the-job training ○ While there is more follow up and assessment required for training H4+ partners are providing support for it ○ They have standardized their approach to mentorship and supportive supervision ○ EmONC training is now scaled down with more emphasis on support and supervision. ○ IMNCI training is mainly now done through on-line distance training and needs to be supported by better supervision. 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
29	<ul style="list-style-type: none"> • H4+ is one of many interventions being done jointly to support RMNCAH so H4+ partners had to acknowledge what was being done already when they set up the programme. They needed to do something differently • The partners noticed that some things were being done reasonably well nationally by the MoHCC and external partners but some things were being left behind 	Interviews with H4+ country team (UNICEF).

	<ul style="list-style-type: none"> • In the six districts, H4+ and MoHCC were looking at the largest challenges (isolation, infrastructure, travel times, poverty etc.). This meant addressing issues of transport for health facilities staff and volunteer health workers and some infrastructure issues if not the larger issues of transport for patients. It is one of the factors which made support to mother waiting homes so important. • HIV was receiving a lot of funding and attention through the Global Fund and PEPFAR • What H4+ brought to the table was an integrated approach and a stronger focus on rights and the need to reach the unreached – this was reinforced by both Canada and Sweden with their track record on rights • UNFPA might have been doing MNCH in a given district but not dealing with HIV while UNICEF was doing HIV one district over but not addressing MNCH. In H4+, they brought together RMNCH and HIV. 	
30	H4+ and other programs (RBF and HTF): The programs complement each other, but there are still gaps where support is needed and where H4+ has made a big difference in MCH service access and quality.	Interviews with District Health Executive, Binga.
31	Improvements in EmONC service capacity at health centre and district, rural and mission hospital levels have helped those facilities reduce the number of referrals from health centres to district hospitals and from district to provincial hospitals. This saves funds (including transport costs for families) and allows for more appropriate referrals. There is now a decentralized system for dealing with emergencies in a competent way at district level.	<ul style="list-style-type: none"> • Interviews at Karinyangwe Mission Hospital, Binga District • Interviews at Provincial Health Executive for Manicaland (oversees Chipinge District) • Interviews at Provincial Health Executive for Matabeleland North (oversees Binga District) • Interviews with the District Health Executive for Mbire District and the Chitsungo District Hospital • Interviews with the Chipinge District Health Executive.
32	<i>“H4+ disbursement of funds to provinces is a challenge. It is very difficult to plan activities because of the unpredictable nature of funding flows. At the end of last year (December), funding was received for clinical mentorship, which was supposed to be for the last quarter; therefore, they had a month to spend a quarter’s worth of funds. The money flows from UNFPA HQ to UNICEF HQ in NY to UNICEF Zimbabwe and then from Ministry to Province to District. Delays become a big problem.”</i>	Interviews with the Provincial Health Executive, Matabeleland North.

33	<p><i>“H4+ funding ended abruptly in November 2015 when planned disbursements were not allocated to UN Women in Zimbabwe. The young women in their groups wanted to know why planned funding was not forthcoming and they (Katswe) had no reasonable answer. It seemed strange to them that some H4+ members (UNAIDS, UNICEF) had funding for activities but another (UN Women) did not. They were told that it had something to do with UN Women globally not disbursing the available funds though it had done so in Zimbabwe. The abrupt ending to planned funding was very damaging to young women’s confidence.”</i></p>	<p>Interview with implementing partner NGO: Katswe Sistahood and with H4+ country team member: UN Women.</p>
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Area of Investigation 6: Value Added in Support of the Global Strategy

6. 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?”
- 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?
 - 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?
 - As programme funding ends, to what extent can the lessons learned in implementing H4+ JPCS inform the work of the H6 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 sources
1	The establishment of H4+ in Zimbabwe meant UNFPA/UNICEF/WHO could seek and receive strong financial and moral support from DFID, Sida and Irish Aid to help with the integration of H4+ support with the much larger HTF.	Interview with H4+ country team (UNFPA).
2	Funds available under H4+ also meant that the H4+ partners were able to do more work on policies, operational guidelines (for example guidelines for clinical mentoring in EmONC and MNH) and on innovations such as eMNSDR and use of PoC CD4 machines. This support has effects well beyond the borders of the six H4+ districts.	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
3	In the application of clinical mentoring and supportive supervision, H4+ supported the practices directly by for example, financing travel costs for mentors, but also with policies and guidelines, for example, H4+ helped change the emphasis of supportive supervision from quantitative to qualitative indicators on the check list. The shift to more qualitative indicators on supervision checklists was consistent with a change in approach and the use of more qualitative indicators in World Bank supported RBF programmes (so was not exclusively an H4+ matter).	Interviews with Provincial Health Executive Staff in Mashonaland Central Province (oversees Mbire district).
4	Using H4+ (and RBF) guidelines and checklists for clinical mentoring and supportive supervision	Interviews with Provincial Health Executive Staff in Matabeleland North (oversees Binga district).

5	Prior to H4+, the supportive supervision teams from the province to the district level looked at everything, now these visits are much more focused on reproductive health and EmONC, including maternal death surveillance. There is also a shift to qualitative versus quantitative indicators using checklists supported by both H4+ and RBF.	Interviews with the District Health Executive, Binga District.
6	<ul style="list-style-type: none"> • H4+ direct support (for transport) and policy support (guidelines and checklists) for clinical mentoring and supportive supervision help the Provincial Medical Director (PMD) cover all aspects of EmONC and MNCH throughout the whole province, not just in Chipinge which is an H4+ district. • The support provided by H4+ to the national committee on MDSR also helps by ensuring consistency and accountability in maternal death surveillance 	Interviews with provincial health executive staff in Manicaland (oversees Chipinge District).
7	<ul style="list-style-type: none"> • In PMTCT and ART, as well as general HIV Care and Treatment (HCT), H4+ has helped with refining guidelines. In particular, H4+ helped in the development of counselling tools for HIV positive children and backed it up with support to training of health care workers in testing and HIV treatment of children and adolescents. • This support also helped them build the skills and the confidence of MCH nurses in diagnosing HIV in children and in intervening with paediatric ART. 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.
8	<ul style="list-style-type: none"> • Outputs in leadership and governance including policies and guidelines. <ul style="list-style-type: none"> ○ Revised WHO national HIV guidelines (Option B+) ○ National nutrition strategy available ○ National EmONC improvement plan in development ○ National Infant and Young Child Feeding Strategy (IYCF) available (2014) ○ Emergency Triage and Assessment (ETAT) guidelines developed and distributed 	H4+ Zimbabwe, <i>Completed Monitoring and Evaluation Framework</i> . December 2015 (H4+ 2015a)
9	<ul style="list-style-type: none"> • Policies and Guidelines Supported by H4+ 2013-2015 (p.3) • 2013-2014 <ul style="list-style-type: none"> ○ Revised WHO National HIV Guidelines (Option B+) ○ Revised PNC guidelines adapted and rolled out ○ National IYCF strategy adapted and rolled out ○ Emergency Triage and Assessment (ETAT) guidelines developed and rolled out ○ Computerized IMNCI training materials adapted ○ EmONC needs assessment ○ MDSR assessment • 2015 	H4+ Zimbabwe, <i>Catalytic Support to RMNCH-A Programme of the Government of Zimbabwe</i> , 7 March, 2016 (H4+ Zimbabwe 2016a)

	<ul style="list-style-type: none"> ○ National child survival strategy developed ○ Maternal Health clinical mentorship guidelines ○ EmONC training assessment ○ Parent to child communication strategy developed ○ National MDSR committee formed ○ Draft National Health Strategy available ○ MH division of labor based on MH mapping – better synergy on supporting national MH programme – reflected in HDF. 	
10	100% of targeted districts use updated RMNH and HIV standards and guidelines as well as MCH worker curriculum and recent recommendation in MNCH	H4+ Zimbabwe, <i>Catalytic Support to RMNCH-A Programme of the Government of Zimbabwe</i> , 7 March, 2016 (H4+ Zimbabwe 2016a)
<p>Assumption 6.2: <i>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.</i></p>		
Information/data		Information sources
11	<p>Global knowledge products identified which can be linked to policy and advocacy outputs described under assumption 6.1:</p> <ul style="list-style-type: none"> ● 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/family planning by the UN Commission on Life Saving Commodities with H4+ input (UNICEF 2013) ● MDSR sub-regional workshops (WHO 2014) ● 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) ● RMNH training guidelines developed. A mapping of existing training tools for CHWs in SRH/MNH (UNFPA 2013) 	H4+ Global Coordinator, <i>RMNCH Global Knowledge Products and Global Public Goods (2011-2015)</i> , June, 2016 (H4+ 2016)

	<ul style="list-style-type: none"> • 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) 	
12	H4+ partners did not identify direct links from specific global knowledge products to policy development work undertaken in Zimbabwe. They indicated that little had been done at the global or regional level to promote the use of global knowledge products in H4+ programming in Zimbabwe other than the regular technical interchanges on RMNCAH matters which occur between country offices and headquarters on an ongoing basis.	
Assumption 6.3 <i>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.</i>		
Information/data		Information source
13	<ul style="list-style-type: none"> • Key Elements of the Global Strategy (p.7-8) <ul style="list-style-type: none"> ○ Country-led, costed health plans supported by all partners ○ Comprehensive, integrated package of essential interventions and services (FP, 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 	United Nations Secretary General, <i>Global Strategy for Women's and Children's Health</i> , September 2010 (UN 2010)
14	MoHCC has recognised how improved coordination has made H4+ partner policy engagement and advocacy more coherent and effective and wants to use this as a model for coordinating the new Health Development Fund.	Interviews with H4+ country team (UNFPA).
15	<ul style="list-style-type: none"> • There was confusion at the beginning of the H4+ programme, with partners communicating with the Ministry on an individual basis to promote policies, activities and projects. This took some time to alter but eventually did improve 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.

	<ul style="list-style-type: none"> • Coordination was weak and the H4+ agencies did not really act in a joined-up way until the national H4+ steering committee was formed. 	
16	<ul style="list-style-type: none"> • Examples of areas where strong common agreement was reached and supported by H4+ at national level based on their (MoHCC and H4+) joint recognition of the problem and need for action): (not a comprehensive list but indicative of priorities) <ul style="list-style-type: none"> ○ Targeting the hardest to reach districts and the under-served populations, particularly adolescents and youth ○ The need to strengthen MDSR systems (for example by establishing a national MDSR committee) to improve accountability for results ○ The need to deal effectively with obstetric fistula ○ The need for improved clinical mentoring (now taken to scale as a national programme after trials in the H4+ district) ○ The need for better supportive supervision and training follow up ○ The emphasis on innovations in how to support MNCAH programming including: eMNSDR, PoC use of CD4 machines in PMTCT and the revitalization of clinical mentoring. 	Interviews with MoHCC staff at director and deputy director level at Headquarters.

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																																						
17	RMNCAH Indicators 2010 (ZDHS), 2014 and 2015) <table border="1" data-bbox="257 1069 1534 1412"> <thead> <tr> <th>Indicator</th> <th>2010/11 (ZDHS)</th> <th>2014 (MICS)</th> <th>2015 (ZDHS)</th> </tr> </thead> <tbody> <tr> <td>MMR</td> <td>960</td> <td>614</td> <td>651</td> </tr> <tr> <td>Under 5 MR</td> <td>85</td> <td>75</td> <td>69</td> </tr> <tr> <td>Skilled birth attendance</td> <td>66%</td> <td>80%</td> <td>78%</td> </tr> <tr> <td>Institutional Delivery</td> <td>65%</td> <td>80%</td> <td>72%</td> </tr> <tr> <td>PNC with 2 days of delivery</td> <td>27%</td> <td>77%</td> <td>51.1%</td> </tr> <tr> <td>Exclusive breastfeeding for first six months</td> <td>31%</td> <td>41%</td> <td>48%</td> </tr> <tr> <td>Unmet Need for FP</td> <td>13%</td> <td>10%</td> <td>10.4%</td> </tr> <tr> <td>Contraceptive Prevalence Ratio (modern methods)</td> <td>57%</td> <td>66%</td> <td>67</td> </tr> </tbody> </table>	Indicator	2010/11 (ZDHS)	2014 (MICS)	2015 (ZDHS)	MMR	960	614	651	Under 5 MR	85	75	69	Skilled birth attendance	66%	80%	78%	Institutional Delivery	65%	80%	72%	PNC with 2 days of delivery	27%	77%	51.1%	Exclusive breastfeeding for first six months	31%	41%	48%	Unmet Need for FP	13%	10%	10.4%	Contraceptive Prevalence Ratio (modern methods)	57%	66%	67	<ul style="list-style-type: none"> • H4+ Zimbabwe, <i>Catalytic Support to RMNCH-A Programme of the Government of Zimbabwe</i>, 7 March, 2016 (H4+ Zimbabwe 2016a: 43) • Zimbabwe National Statistics Agency, <i>Zimbabwe Demographic and Health Survey 2015: Key Indicators</i>, May 2016 (ZNSA 2016) 		
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18	Refer for evidence to question one, lines 73, 74, and 75	District Health Information System 2 (DHIS2) Data 2012 to 2015 Provided by MoHCC office of Health Information and Disease Surveillance for Chipinge, Mbire and Binga Districts												
19	Refer for evidence to question one, line 76	District Health Information System 2 (DHIS2) Data 2012 to 2015 Provided by MoHCC office of Health Information and Disease Surveillance for Mashonaland East Province (non-H4+ Province with nine districts).												
20	<ul style="list-style-type: none"> • <i>“MoHCC can already see the evidence that the H4+ approach is working in the targeted districts and they don’t need another pilot study to take elements of the H4+ approach to scale on a national level, for example in the HDF programme.”</i> • <i>“It is important to note that H4+ support to areas such as policy, operational guidelines, and innovation have effects way beyond the borders of the six selected districts.”</i> 	Interviews with MoHCC staff at Director and Deputy Director Level at Headquarters.												

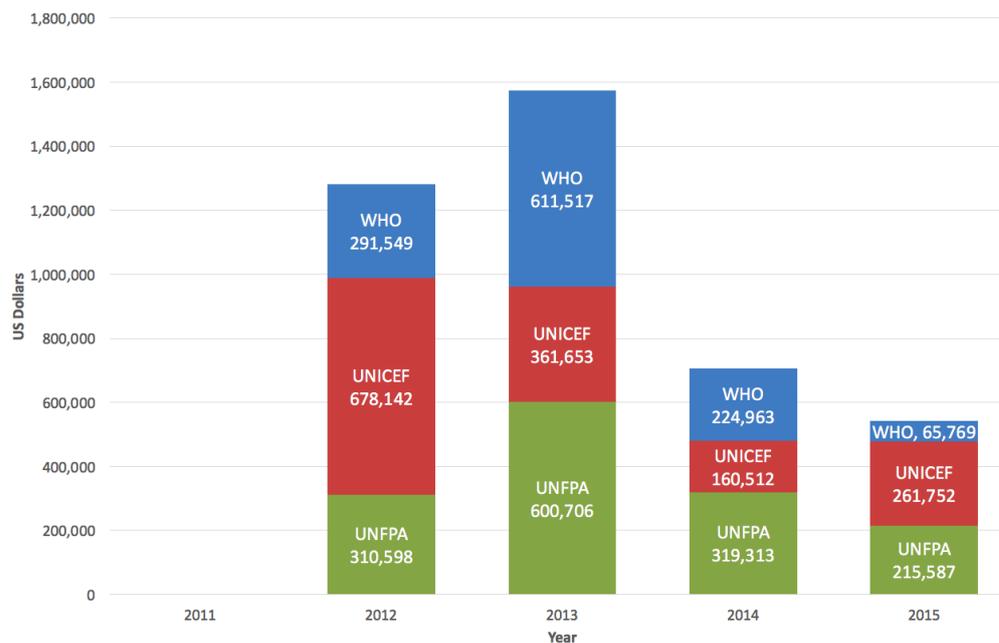
ANNEX 2 FINANCIAL PROFILE OF H4+ JPCS IN ZIMBABWE

Table 10: H4+ JPCS Expenditures in Zimbabwe, Canada

US\$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	310,598	600,706	319,313	215,587	1,446,204	35%
UNICEF	0	678,142	361,653	160,512	261,752	1,462,059	36%
WHO	0	291,549	611,517	224,963	65,769	1,193,798	29%
TOTAL US\$	0	1,280,288	1,573,876	704,788	543,108	4,102,061	100%

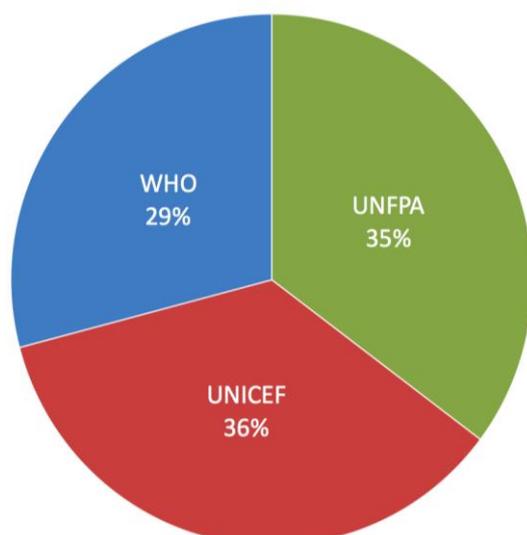
Source: (UNFPA 2015a)

Figure 6: H4+ JPCS Expenditures by Year and Agency in Zimbabwe, Canada



Source: (UNFPA 2015a)

Figure 7: H4+ JPCS Expenditures in Zimbabwe: 2011-2015, Canada



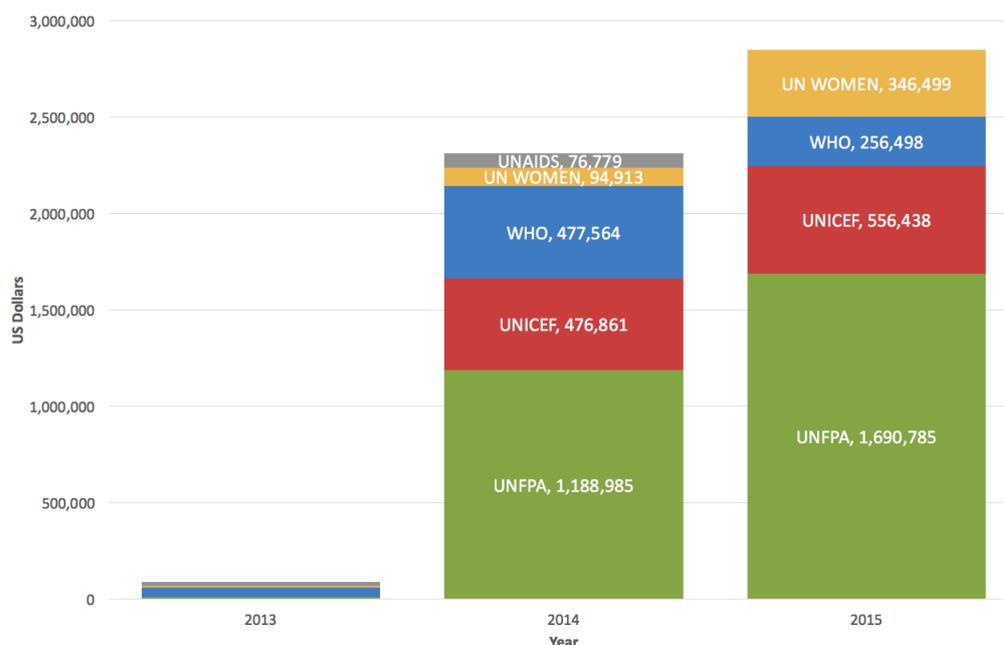
Source: (UNFPA 2015a)

Table 11: H4+ JPCS Expenditures in Zimbabwe, SIDA

US\$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	0	9,055	1,188,985	1,690,785	2,888,825	55%
UNICEF	0	0	1,364	476,861	556,438	1,034,663	20%
WHO	0	0	47,499	477,564	256,498	781,561	15%
UN Women	0	0	11,754	94,913	346,499	453,166	8%
UNAIDS	0	0	0	20,000	76,779	96,779	2%
TOTAL US\$	0	0	69,672	2,258,323	2,926,999	5,254,994	100%

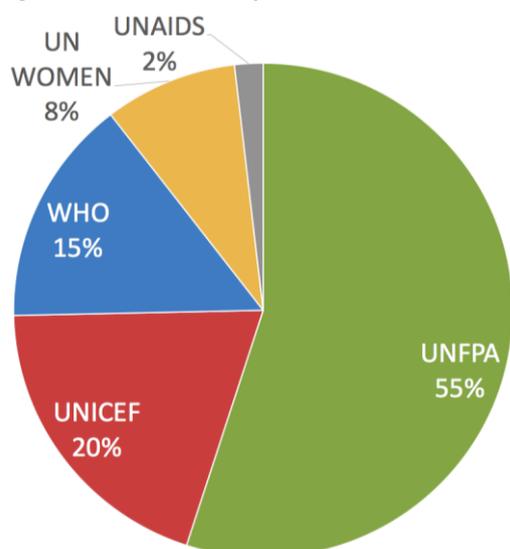
Source: (UNFPA 2015a)

Figure 8: H4+ JPCS Expenditures by Year and Agency in Zimbabwe, SIDA



Source: (UNFPA 2015a)

Figure 9: H4+ JPCS Expenditures in Zimbabwe: 2011-2015, SIDA



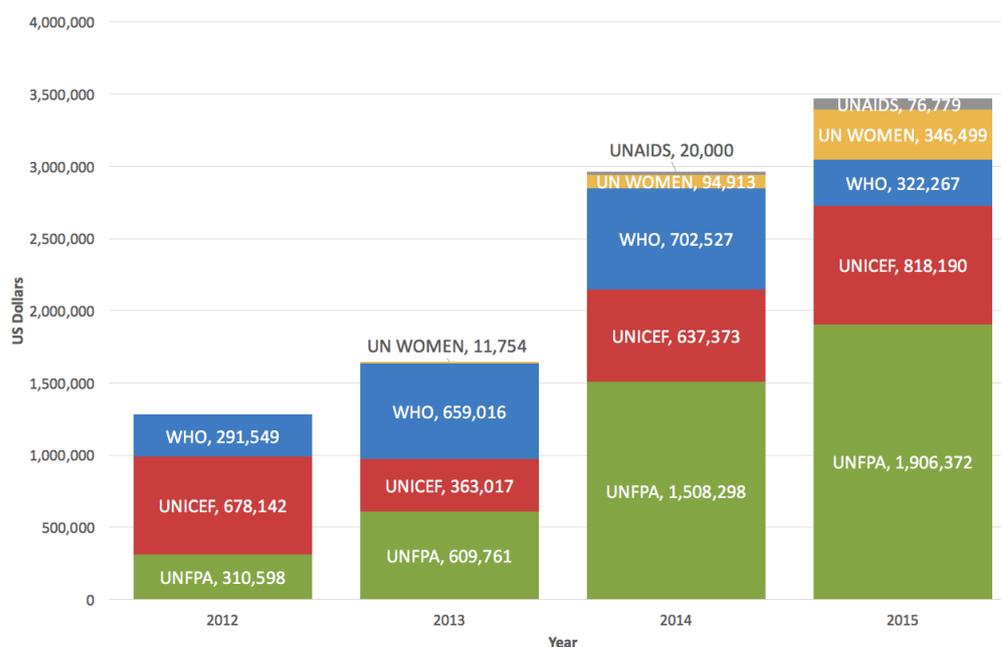
Source: (UNFPA 2015a)

Table 12: H4+ JPCS Expenditures in Zimbabwe, Canada and SIDA

US\$	2011	2012	2013	2014	2015	Total	%
UNFPA	0	310,598	609,761	1,508,298	1,906,372	4,335,029	46%
UNICEF	0	678,142	363,017	637,373	818,190	2,496,722	27%
WHO	0	291,549	659,016	702,527	322,267	1,975,359	21%
UN Women	0		11,754	94,913	346,499	453,166	5%
UNAIDS	0			20,000	76,779	96,779	1%
TOTAL US\$	0	1,280,288	1,643,548	2,963,111	3,470,107	9,357,055	100%

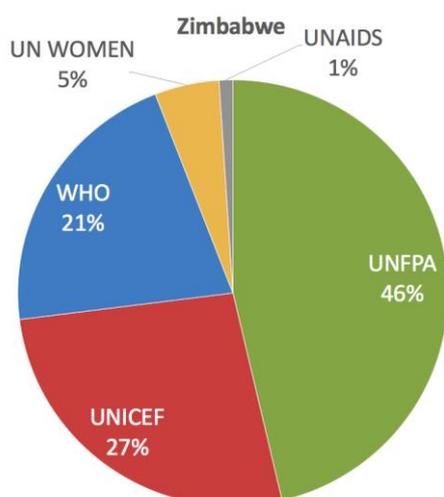
Source: (UNFPA 2015a)

Figure 10: H4+ JPCS Expenditures by Year and Agency in Zimbabwe, Canada and SIDA



Source: (UNFPA 2015a)

Figure 11: H4+ JPCS Expenditures in Zimbabwe: 2011-2015, Canada and SIDA



Source: (UNFPA 2015a)

ANNEX 3 OUTCOMES IN RMNCAH

Zimbabwe

Table 13: Basic information

Country income level	Low-income	
Population 2014	15.2 million	(World Bank 2016j)
Literacy rate 2011	83.6%	(World Bank 2016a)
Political/administrative system	8 provinces, 59 districts	

Table 14: Health expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2014	4.0%	(World Bank 2016e)
Total expenditure on health	Public	% of GDP, 2014	2.5%	(World Bank 2016f)
Out-of-pocket health expenditure	Public	% of THE, 2014	35.9%	(World Bank 2016i)
Out-of-pocket health expenditure	Private	% of PHE, 2014	58.3%	(World Bank 2016h)

Table 15: H4+ JPCS profiling indicators 1990-2015

Indicator	1994	1999	2006	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	72%	76%	80%	80%	87%	(Countdown 2015a)
Indicator	1997	2002	2003	2008	2013	Source
Adolescent Fertility Rate, per 1,000, women age 15-19	108	103	101	112	120	(Countdown 2015a)
Indicator	1994	1999	2006	2011	2013	Source
Teenage mothers, % women age 15-19	19.7%	20.5%	21.2%	23.5%	-	(World Bank 2016k)
Indicator	1995	2000	2005	2010	2015	Source
Maternal Mortality Ratio, per 100,000	449	590	629	446	443	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000	-	-	-	-	24	(Countdown 2015b)
Infant Mortality, per 1,000	-	-	-	-	47	(Countdown 2015b)
Under Five Mortality, per 1,000	95.5	105.8	101.9	89.5	70.7	
Indicator	1994	1999	2005	2011	2015	Source
Contraceptive Prevalence Rate, % aged 15-49	48.1%	53.5%	60.2%	58.5%	-	(World Bank 2016c)
Indicator	1994	1999	2006	2011	2015	Source
Unmet need for contraception, % aged 15-49	19.1%	16.7%	15.5%	14.6%	-	(World Bank 2016l)
Indicator	1994	1999	2006	2011	2014	Source
Antenatal care, rural, ≥ 4 visits, %	74%	64%	71%	65%	70%	(Countdown 2015a)
Indicator	2006	2009	2010	2011	2014	Source
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	9.4%	31.0%	50.1%	78.2%	(Countdown 2015a)
<i>Lower bound</i>	<1%	8.7%	28.7%	46.2%	72.4%	
<i>Upper bound</i>	<1%	10.2%	33.5%	54.1%	84.6%	
Indicator	1994	1999	2006	2011	2014	Source
Skilled attendant at delivery, %	69%	73%	69%	66%	80%	(Countdown 2015a)
Postnatal care for baby, %	-	-	-	-	85%	(Countdown 2015a)
Postnatal care for mother, %	-	-	-	-	77%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	11.2%	31.7%	22.2%	31.4%	41%	(Countdown 2015a)
Facilities providing BEmONC, number	-	-	-	-	-	
Facilities providing CEmONC, number	-	-	-	-	-	
C Section Rate, % of live births, women age 15-49	6%	7%	5%	5%	6%	(Countdown 2015a)
Indicator	1994	1999	2004	2011	2014	Source
Community Health Workers, per 1,000 people	-	-	0.04	-	-	(World Bank 2016b)
Indicator	1994	2004	2009	2011	2014	Source
Nurses and/or midwives, per 1,000 people	-	1,485	1,251	1,335	-	(World Bank 2016g)

ANNEX 4 PERSONS MET

Persons Interviewed during the Main Evaluation Mission: June 6-22, 2016

	Organisation	Designation	
HARARE			
1	Bartos, Michael, Dr	UNAIDS	Country Director
2	Chidawanyika, Henry, Mr	RTI	Director RTI
3	Chigumira, Ancikaria Mrs	MoHCC	Deputy Director- Nutrition Services
4	Cisse, Cheikh Tidiane, Mr	UNFPA	Country Representative
5	Darikwa, Patricia	UNICEF	HDF Coordinator
6	Gerede, Regina, Ms	MoHCC	Deputy Director- Community Nursing
7	Jumo, Talent	KATSWE	Director
8	Kanyowa, Trevor, Dr	WHO	FRH Programme Officer
9	Karonga, Wisdom, Mr	MWAGCD	Deputy Director- Women Affairs
10	Katiyo, Joshua, Mr	MoHCC	Health Information & Disease Surveillance
11	Madzima, Bernard, Dr	MoHCC	Director - Family Health Programme Specialist Gender & HIV
12	Marume, Moline, Ms	UN Women	
13	Masiyiwa, Edna, Mrs	WAG	Director
14	Mbinda, Absolom, Mr	MoHCC	M&E Officer
15	Mpaya, Joyce, Ms	UNICEF	Chief HIV and AIDS
16	Msemburi, Abbigail, Mrs	UNFPA	Assistant Country Representative
17	Mushavi, Angela, Dr	MoHCC	PMTCT & Paediatric Care and Treatment Coordinator
18	Raghuvanshi, Vibhavendra, Dr	UNFPA	Technical Specialist MH& FP
19	Senzanje, Beaula, Mrs	UNICEF	HIV/AIDS Specialist
20	Sisimayi, Chenjerai, Mr	WorldBank	Health Specialist
21	Yu-Yu, Mr	UNFPA	Assistant Country Representative
PROVINCIAL HEALTH EXECUTIVE - MATABELELAND NORTH			
22	Goverwa Sibanda, Dr	MoHCC	MCH/TB/HIV Officer
23	Maphosa Seretse	MoHCC	HIV/STI Focal Person
24	Masuka Nyasha, Dr	MoHCC	Provincial Medical Director
25	Sibanda Freeman	MoHCC	Reproductive Health Officer
PROVINCIAL HEALTH EXECUTIVE - MASHONALAND CENTRAL			
26	Andifasi, Precious	MoHCC	HIV/STI Focal Person
27	Gabaza, Malvern	MoHCC	Provincial Pharmacist
28	Manjonjori, Elizabeth, Mrs	MoHCC	Provincial Nursing Officer
29	Moyo, Grace	MoHCC	Accountant

30	Muchembere, Marvelous	MoHCC	Administrator
31	Mzezewa, Nyaradzo	MoHCC	Accountant
32	Ngandu, Lillian, Ms	MoHCC	Reproductive Health Officer
33	Ngandu, Renwick, Mr	MoHCC	Provincial Environmental Health Officer

DISTRICT MEDICAL DIRECTORATE - MBIRE

34	Chidzwa Edwicks, Dr	MoHCC	District Medical Officer
35	Dandajena Godfrey, Mr	MoHCC	District Environmental Health Officer
36	Katikiti Edmore, Mr	MoHCC	Acting District Nursing Officer
37	Matape Walter, Mr	MoHCC	Pharmacy Technician
38	Mubambo Joel, Mr	MoHCC	Accountant
39	Mukokokveka Spencer, Mr	MoHCC	Acting Matron

DISTRICT MEDICAL DIRECTORATE - BINGA

40	Majaya	MoHCC	Community Nurse
41	Mlilo, Dr	MoHCC	District Medical Officer
42	Mudimba S	MoHCC	Matron
43	Munsanka V, Mrs	MoHCC	Sister in Charge
44	Mushangwe E	MoHCC	Assistant Sister in Charge
45	Muzopa S, Mrs	MoHCC	Sister in Charge
46	Ncube B, Mrs	MoHCC	Administrator

MUSHUMBI CLINIC

47	Chibira Victoria	MoHCC	Registered General Nurse
48	Mazikana Mirriam	MoHCC	Primary Counsellor
49	Mutenderedzi Taona	MoHCC	Environmental Health Technician
50	Nyakazieni Aaron	MoHCC	Registered General Nurse
51	Takawira Zorodzai	MoHCC	Primary Care Nurse

SIYABUWA RURAL HEALTH CENTRE

52	Chitungwa T,	MoHCC	Primary Care Nurse
53	Dube N, Mr	MoHCC	Primary Care Nurse
54	Nyaguse Shepherd	MoHCC	Youth Facilitator

KARIANGWE MISSION HOSPITAL

55	Mbwinda, Mr	MoHCC	Registered General Nurse
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Persons Interviewed During the Exploratory Mission: March 7-15, 2016

	Name	Organisation	Designation
HARARE			
1	Bartos Michael	UNAIDS	Country Director
2	Chidawanyika Henry	RTI	Director RTI
3	Chinhengo, Tamisayi	UNFPA	Programme Specialist - ASRH
4	Cisse, Cheikh Tidiane	UNFPA	Country Representative
5	Damiso, Choice	UNFPA	Gender Programme Specialist
6	Eaglesmann, Barbara	OPHID	Director
7	Gwashure, Susan	MoHCC	HIV Testing Services Coordinator
8	Gwinji, G Dr	MoHCC	Permanent Secretary, MoHCC
9	Harnish, Dagmar	UNFPA	Technical Specialist SRH and HIV
10	Hore, Diana	UNFPA	Programme Analyst - RHCS
11	Jembere Margaret	Kapnek Trust	Programme Coordinator
12	Kanyowa, Trevor	WHO	FRH Programme Officer
13	Karonga, W. Mr	MWAGCD	Deputy Director- Women Affairs
14	Katiyo, J Mr	MoHCC	Health Information & Disease Surveillance
15	Madzima, B Dr	MoHCC	Driector - Family Health
16	Makoni, Agness	UNFPA	Programme Analyst - Maternal Health
17	Manyenya, Sunday	UNFPA	M&E Analyst
18	Marangwanda Caroline	Kapnek Trust	Deputy Director
19	Marume, Molline	UN Women	Programme Specialist Gender & HIV
20	Masanga, Margret	UNFPA	Communications Officer
21	Maudzeke Martha	AFRICAID	Programmes Manager
22	Mbinda, Absolom	MoHCC	M&E Officer
23	Mhlanga, G Dr	MoHCC	Principal Director - Preventive Services
24	Mhonde, Rudo	UNFPA	M & E Analyst
25	Mpaya, Joyce	UNICEF	Chief HIV/AIDS
26	Mpeta, Edwin	UNFPA	Programme Specialist - RH
27	Msemburi, Abigail	UNFPA	Assistant Country Representative
28	Muita, Jane Dr	UNICEF	Country Representative
29	Murungu Dr.	MoHCC	Deputy National ART Coordinator
30	Mushavi Dr.	MoHCC	PMTCT & Peadiatric Care and Treatment Coordinator
31	Nyamukapa, Daisy	UNFPA	Programme Analyst - SRH & HIV
32	Okello, David Dr	WHO	WHO Resident Representative
33	Patel, Diana	OPHID	Deputy Director
34	Raghuvanshi, VS	UNFPA	Technical Specialist MH& FP
35	Senzanje, Beula	UNICEF	HIV/AIDS Specialist
36	Shoko, Bertha	UNFPA	Communications Analyst
37	Tavadze, Lia	UNAIDS	Advisor Gender, HIV Integration

38	Yu-Yu MR	UNFPA	Assistant Country Representative
PROVINCIAL HEALTH EXECUTIVE - MUTARE			
39	Kanyunyunda, Clifford	MoHCC	Provincial Accaountant
40	Mahati, Venus	MoHCC	Provincial Nursing Officer
41	Mandimutsira, Jane	MoHCC	RH Focal Person
42	Mufambanhondo, Emmanuel	MoHCC	Provincial Environmental Health Officer
43	Tsangamidzi, Charles	MoHCC	Acting Prov. Health Services Administrator
DISTRICT HEALTH EXECUTIVE			
44	Dube, Frank	MoHCC	CHW
45	Gurai, Godhelp	MoHCC	Senior Nursing Officer
46	Guveya, Kudzanai	MoHCC	Acting District Medical Officer - Chipinge
47	Mahlathini, Honest	MoHCC	Nutritionist
48	Makundayika	MoHCC	DEHO
49	Mandevhana, Plaxedes	MoHCC	Acting District Nursing Officer
50	Mukandi, Bright	MoHCC	ADHSA
51	Mutimurefu, Elijah	MoHCC	DPM
52	Nyamaende, Lyoyd	MoHCC	A/ACC Chipinge
St PETERS MISION HOSPITAL			
53	Chapoterera Rosemary	MoHCC	Sister in Charge
54	Davison, Taremba Dr	MoHCC	Government Medical Officer
55	Mbiri, Stephen Dr	MoHCC	Government Medical Officer
56	Mugarisi, Sibongile	MoHCC	Registered General Nurse

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ANNEX 6 KEY CAUSAL ASSUMPTIONS FOR THE ZIMBABWE THEORY OF CHANGE

1. Key Causal Assumptions for the Theory of Change of H4+JPCS in Zimbabwe

1. H4+ partners, in a process led by national authorities and encompassing key stakeholders, are able to develop and operationalize a coordinated process and platform for planning their joint support to RMNCAH while taking full account of the role of other relevant initiatives. The process is able, over time, to overcome barriers to integrated and coordinated planning which may have obstructed joint support in the past. Complementarity and synergy in efforts by H4+ enabled joint support to be more integrated and coherent, which provided more added value than the independent support (without complementarity & synergy with others) by H4+ members.
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. 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.
3. H4+ JPCS support at national and sub-national levels can be sequenced appropriately⁹⁰ with support to RMNCAH from other sources. (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 has adequate reach and is sustained enough over time so that it can effect access to quality services for marginalized groups. In combination with contributions from other programmes and sources of investment, H4+ JPCS support addresses the three dimensions of sustainable capacity improvement: capability in terms of skills and supportive supervision; opportunity in terms of the availability of adequate facilities, equipment and supplies; and 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.
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. This further implies that improvements in service quality and access are not disrupted by failure to provide adequate facilities, equipment and supplies of crucial commodities.
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. *(Relates to areas of investigation one: strengthening health systems for RMNCAH; two: expanded access to integrated services along the continuum of care; and three: responsiveness to national needs and priorities).*

⁹⁰ Because H4+ JPCS support is meant to be catalytic and operates in conjunction with other programmes and investments in health systems support, it must provide resources in a timely way and take into account the planned and actual delivery of support from other sources. For example, support to training of clinicians by H4+ JPCS can have little effect if infrastructure support or commodities provided by other programmes is delayed.

2. Key Causal Assumptions for the Theory of Change for Innovation in H4+ in Zimbabwe

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.
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.