

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



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Authors: **Louis Charpentier, Ted Freeman**

Designer: **Alberto Garcia**

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Any enquiries about this report should be addressed to:

Evaluation Office, United Nations Population Fund

E-mail: [evaluation.office@unfpa.org](mailto:evaluation.office@unfpa.org)

Phone number: +1 212 297 5218

The report is available on the evaluation office web page

[www.unfpa.org/evaluation](http://www.unfpa.org/evaluation)

## Foreword

The health of women, children and adolescents is essential to human development and progress. In 2000, reducing child mortality and improving maternal health became central components of the Millennium Development Goals (MDGs). By 2010, UNAIDS, UNFPA, UNICEF, UNWomen, WHO and the World Bank had forged the H4+ partnership to leverage their respective strengths and provide well-coordinated assistance in the development and implementation of MDG action plans. To accelerate the progress of the health-related MDGs, the H4+ partnership aligned with the Global Strategy for Women's and Children's Health (2010-2015) and the Every Woman Every Child movement. H4+ prioritizes low-income countries with high maternal and child mortality burdens and specific targets for improving, integrating and expanding access to reproductive, maternal, neonatal, child and adolescent health (RMNCAH).

From 2011 to 2016, Canada and Sweden provided significant funding to the H4+ partners to better collaborate and capitalize on each agency's distinct capacities in ten high burden African countries: Burkina Faso, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Guinea Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe. In 2013, the H4+ partners developed a joint results framework under one unified programme: the H4+ Joint Programme Canada and Sweden (H4+JPCS).

This evaluation concludes that H4+JPCS has contributed to strengthening health systems along the continuum of care in RMNCAH at both national and sub-national levels. It has also helped expand access to quality services in underserved and hard to reach areas by consistently targeting the populations most in need - youth, the poorest women and individuals living with HIV/AIDS. The H4+ partners consistently demonstrated their capacity to adjust to new priorities and challenges (such as the Ebola outbreak). The division of labour among partners drew on their comparative strengths and has helped them establish the groundwork for a deeper level of coordination and collaboration.

The H4+ partners could have had an even greater impact. They could have engaged systematically with national governments, to address broader impediments

(financial and human resources, infrastructure) to health sector effectiveness, as well as with communities to overcome socio-cultural barriers. While H4+JPCS encouraged innovations, limited information management systems hampered the testing and promotion of comprehensive approaches for youth and the programme's general ability to serve as an effective knowledge broker. As the Joint Programme concludes, the evaluation reveals the need for specific actions as well as new funding sources, especially in underserved areas, to ensure the sustainability of achieved results.

Just as H6 depends on collaboration, this evaluation relied on many exceptional partners. I am deeply appreciative of the considerable time and contributions of colleagues across United Nations agencies, their counterparts at national and sub-national levels, as well as implementing partners. Notably, this evaluation was jointly managed by the evaluation offices of UNFPA, UNICEF and Global Affairs Canada. It also benefitted from the invaluable insights of senior H6 representatives in the Evaluation Reference Group, who co-authored a set of recommendations based on the independent conclusions of the report. Furthermore, I am extremely grateful to the ten H4+JPCS country teams who generously shared their knowledge. They played a key role in facilitating the extensive evaluation data collection which involved interviews, site visits and focus group discussions to obtain the perspectives of all stakeholders, including programme beneficiaries.

The findings from the evaluation of the H4+ Joint Programme Canada and Sweden are especially relevant in the transition from the MDGs to the Sustainable Development Goals. The post-2015 global development agenda recognizes the health of women, children and adolescents as the cornerstone of public health and depends on unified efforts. I hope that this evaluation proves useful to the H6 partners as they continue their collaboration to support the renewed Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

**Louis Charpentier**  
Chair, Evaluation Management Group

# 1. Introduction

The H4+ (now “H6”) partnership pulls together the collective strengths and distinct capacities of the six UN agencies – UNFPA, UNICEF, WHO, UNAIDS, UN Women, and the World Bank – in maternal, newborn, child and adolescent health. The Joint Programme Canada and Sweden (JPCS) provided funding to the H4+ partners to reduce child mortality and improve maternal health (Millennium Development Goals 4 and 5). This evaluation examines how the H4+ partners used the programme to contribute to accelerating progress from 2011-2016. It offers valuable insights to inform future programmes and to support the H6 partners in their work as the technical arm of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

The evaluation focuses on the ten high burden African nations supported by the programme: **Burkina Faso, Cameroon, Côte d’Ivoire, the Democratic Republic of the Congo (DRC), Ethiopia, Guinea Bissau, Liberia, Sierra Leone, Zambia and Zimbabwe.** The Euro Health Group led the evaluation, guided by the UNFPA Evaluation Office in consultation with an Evaluation Reference Group composed of senior technical staff from all partner agencies.

The outputs include an overall programme evaluation report and country case studies for the **DRC, Liberia, Zambia and Zimbabwe.**

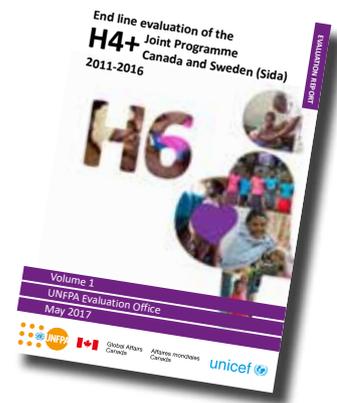
## The evaluation had six objectives

### To assess the:

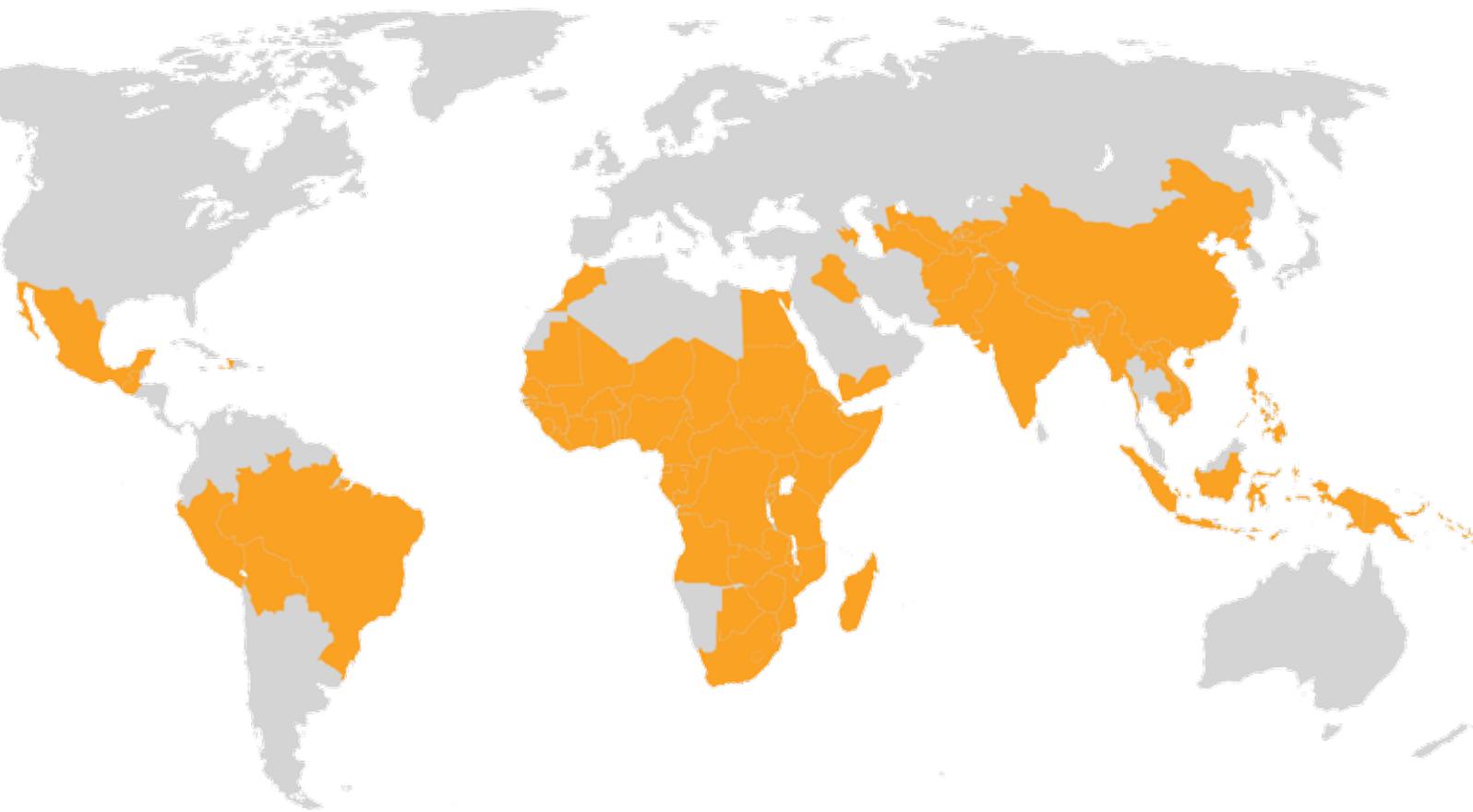
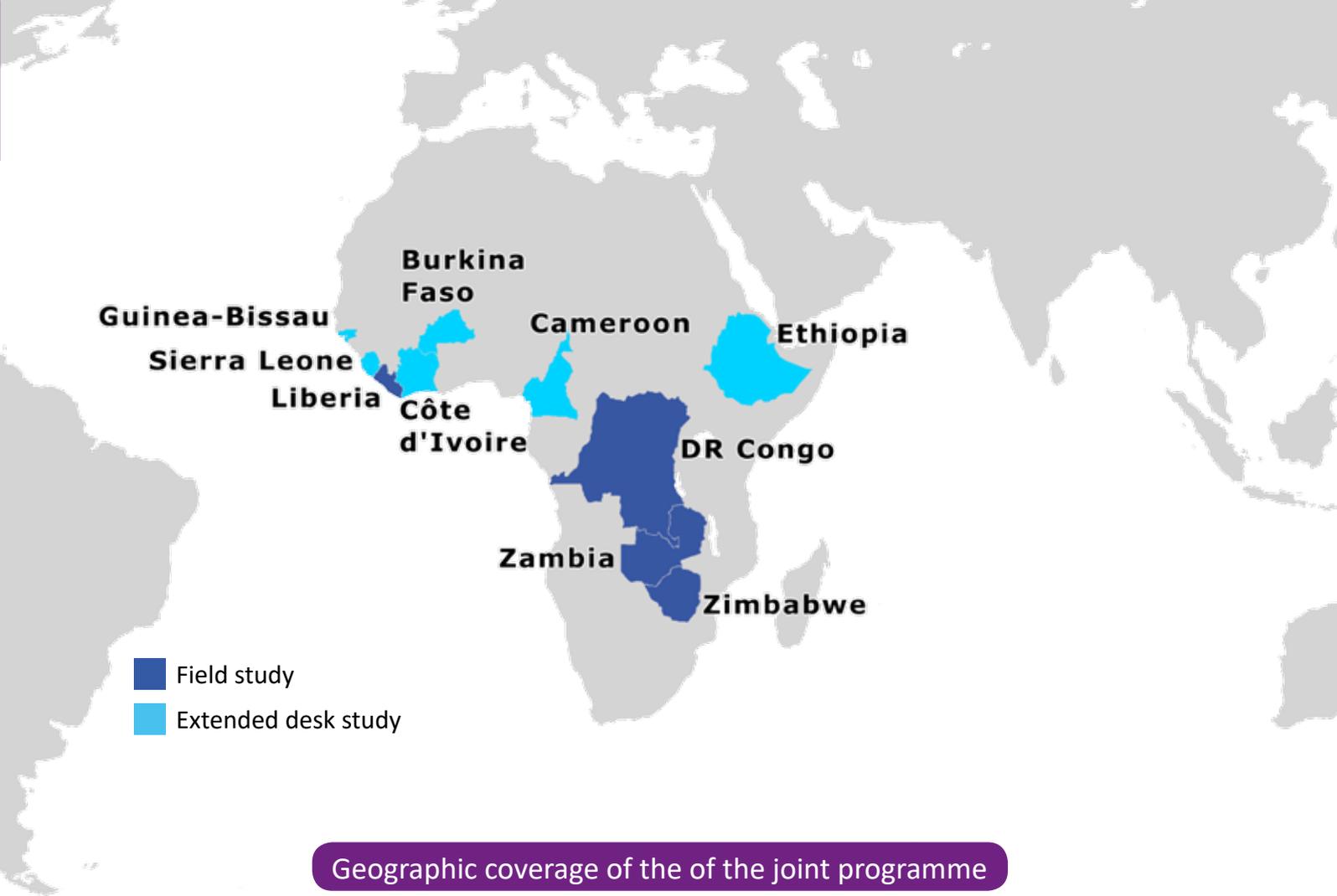
- 1** Relevance of the programme objectives and approach at global, regional, national and subnational levels.
- 2** Effectiveness and efficiency in strengthening national health systems and improving the delivery of comprehensive services in reproductive, maternal, newborn, child and adolescent health.
- 3** Sustainability of results.
- 4** Added value of the programme.
- 5** Extent to which gender equality, social inclusion and equity have been considered.

### To identify:

- 6** Lessons learned, good practices and opportunities to improve cooperation between the H6 partners.



H4+ members and Joint Programme Canada and Sweden (Sida)



75 countdown countries where more than 95% of all maternal and child deaths occur

# 2. The H4+ Joint Programme Canada and Sweden (Sida)

## How did the programme originate?

In 2008, UNFPA, UNICEF, WHO and the World Bank launched the H4 partnership as a joint initiative. It aimed to capitalize on the strengths of each partner to ensure the continuum of care for maternal, newborn, child and adolescent health.

In 2010, UN Secretary General Ban Ki-moon launched the Global Strategy for Women's, Children's and Adolescents' Health. H4+ became the technical arm of the Global Strategy and assumed the role of supporting the 75 high burden countries, where more than 85 percent of all maternal and child deaths occur. Also in 2010, the partnership was expanded to include UNAIDS, followed by UN Women in 2012. In 2016, it was renamed the H6 partnership. Canada (in 2011) and Sweden (in 2012) provided funding to the H4+ partners. The Joint Programme Canada and Sweden (Sida) (hereafter H4+ JPCS) requested that the H4+ partners develop a joint results framework, as a basis for coordinating programme implementation.

## H4+ JPCS Objectives

- 1** Support national efforts to implement and scale up integrated, equity-focused RMNCAH efforts in programme countries.
- 2** Support national health systems strengthening of RMNCAH interventions in partnership with other stakeholders and guided by national health plans.
- 3** Identify, support and document innovative approaches for high burden countries.
- 4** Support the strengthening of health information systems and national capacity to utilize data for planning and monitoring, with a focus on equity and human rights.

## H4+ JPCS Purpose

Accelerate progress toward meeting **Millennium Development Goals 4 and 5.**



## How did H4+JPCS operate?

The programme was designed to operate at three levels:

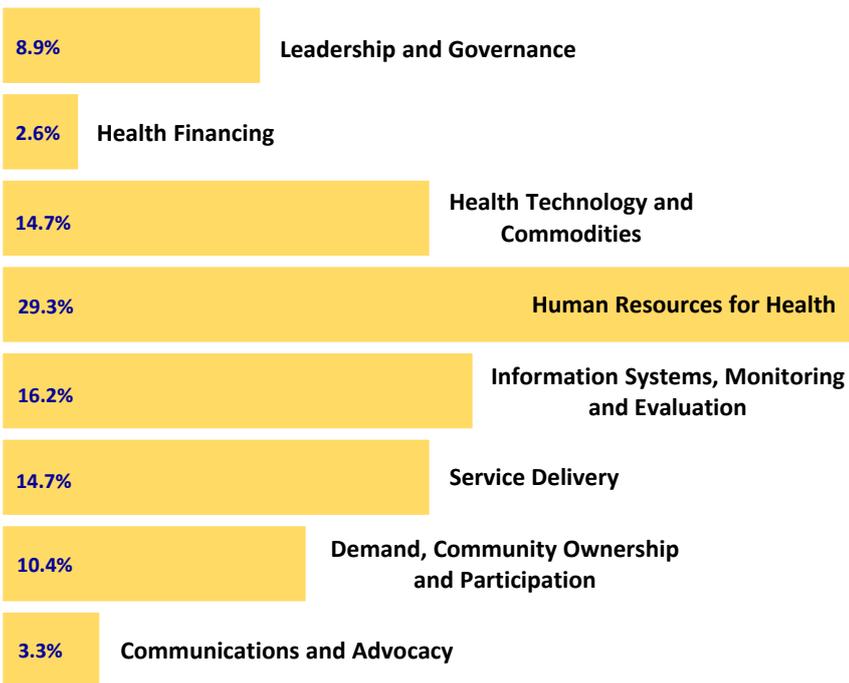
- 1** The **global and regional level**, where members of the global technical team worked to produce global knowledge products for advancing women's and children's health.
- 2** The **national level**, where programme resources were used to finance the H4+ country teams and their activities to strengthen national health systems.
- 3** The **local level**, where H4+JPCS supported integrated delivery of health services for reproductive, maternal, newborn, child and adolescent health. To generate demand for improved services, the programme also supported community level engagement.

The largest share of H4+JPCS expenditures occurred at national and local levels with a small portion spent on global and regional initiatives.

# What did H4+JPCS support?

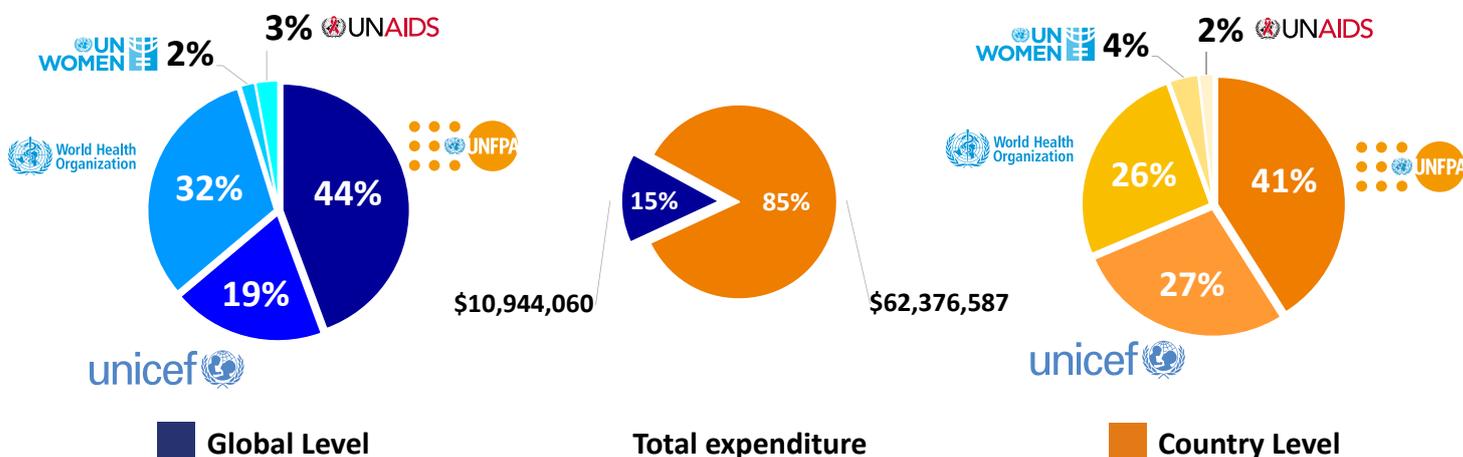
At the country level, the programme supported eight important building blocks for strengthening health systems to provide services in reproductive, maternal, newborn, adolescent and child health. From 2011 to 2015, H4+ JPCS invested \$62.4 million USD in supporting national health systems strengthening. The majority of country-level investments have been directed at improving the supply of health services and the performance of the formal health sector.

At the global level, the programme supported the collaborative development of valuable knowledge products across H4+ partner organizations, to support countries with a high burden of maternal and child mortality.



H4+JPCS Support to the Building Blocks of Health Systems Strengthening

Global Knowledge Products



H4+JPCS expenditures 2011 to 2015 by partner and programme level

# 3. Evaluation approach

The evaluation focuses on identifying the contribution of H4+JPCS to accelerating and improving results in RMNCAH in the ten programme countries and to supporting the implementation of the Global Strategy. In doing so, the evaluation assesses the effectiveness and efficiency of the programme in strengthening health systems and improving access to integrated RMNCAH services across the continuum of care. It also identifies the programme's promotion of innovative methods and assesses the sustainability of the results achieved. The evaluation also assesses the added value of H4+ JPCS. This approach was led by UNFPA, developed in coordination with the Evaluation Reference Group and jointly managed by the Evaluation Offices of UNFPA, UNICEF and Global Affairs Canada.

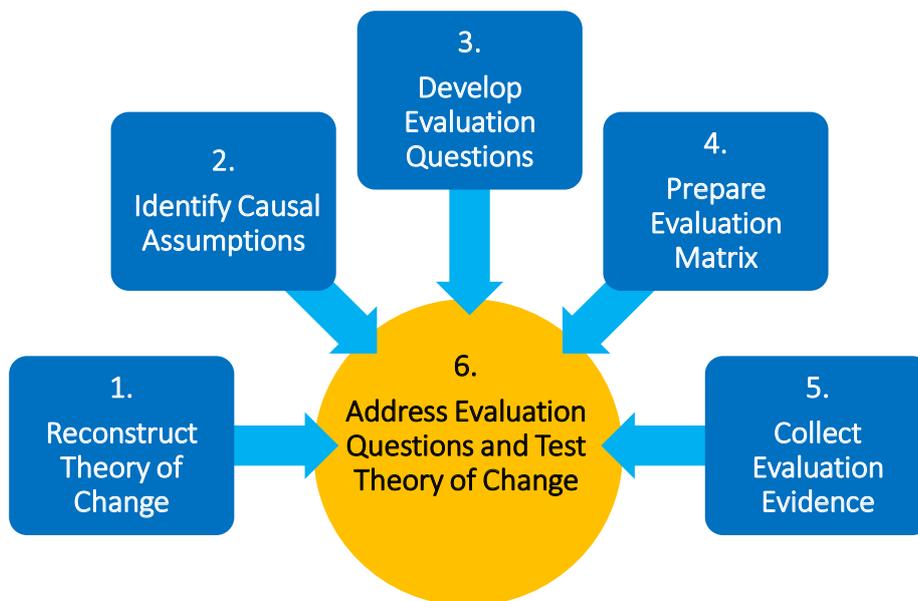
Based on a document review, interviews with members of the Global H4+ Steering Committee and an exploratory mission to Zimbabwe, the evaluation team reconstructed a theory of change for H4+ JPCS. This guided the development of key causal assumptions and related evaluation indicators, data sources and data collection methods (key informant interviews, four field-based and six desk-based case studies, document reviews and a survey of stakeholders in all H4+ countries). An evaluation matrix was prepared identifying the causal assumptions to be tested and the supporting evidence to be gathered and analysed for each of the six central evaluation questions, using *contribution analysis* as the central evaluation framework.

Geographically, the evaluation covers all ten countries receiving grant funding from H4+ JPCS. The assessment includes four field-based country case studies (the **Democratic Republic of the Congo, Liberia, Zambia and Zimbabwe**) and six desk-based country case studies (**Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea and Sierra Leone**). The evaluation also surveyed key informants in the remaining high burden countries, as identified by the Global Strategy for Women's, Children's and Adolescents' Health.

## The evaluation questions required an assessment of the extent to which H4+JPCS:

- 1** Strengthened health systems for delivering quality services in reproductive, maternal, newborn, child and adolescent health.
- 2** Expanded access across the continuum of care, including for marginalized groups and to promote gender equality.
- 3** Responded to evolving needs and priorities at national and local levels.
- 4** Identified, tested and scaled up innovations.
- 5** Enabled partners to develop an optimal division of labour.
- 6** Added value and contributed to the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).





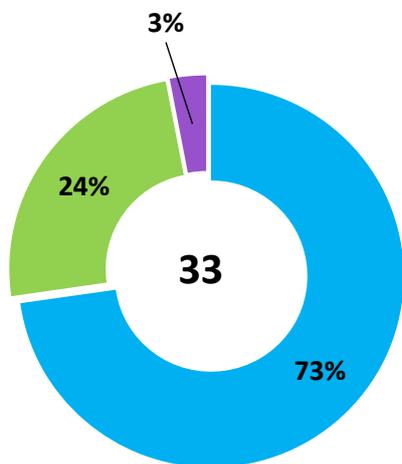
**Steps in the application of contribution analysis**

The evaluation was implemented in a highly interactive and consultative fashion. The team conducted structured interviews, group interviews and focus group discussions with over 800 key informants: 771 interviews at country level and 33 at global and regional levels. Those consulted included H4+ partner staff (global, regional and national), bilateral development partners, international non-government organizations, national health authorities, health services staff, community leaders, implementing partners, civil

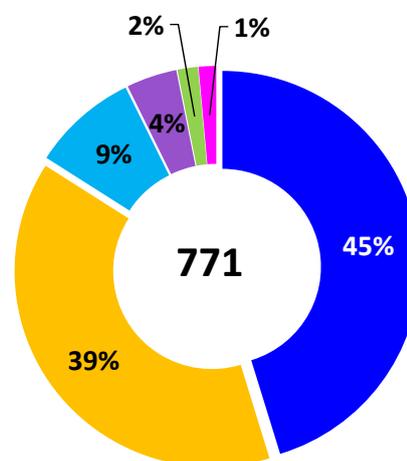
society organizations and community members receiving services or participating in community engagement activities.

An Evaluation Reference Group composed of representatives from all H4+JPCS partner agencies supported the evaluation throughout the process. The evaluation recommendations were developed jointly through an iterative process between the evaluation team and the reference group.

- Community members and service users (incl. community volunteers)
- National and Sub-national health authorities and service providers
- H4+ Members
- INGOs/NGOs/ CSOs
- Other International Partners
- Other Governmental Institutions



**Global and Regional Level Interviews**



**Country Level Interviews**

## 4. Overall assessment





H4+JPCS contributed to strengthening systems for delivering reproductive, maternal, newborn, child and adolescent health services in the all ten programme countries. In most cases, it provided flexible and responsive support at national and local levels of health systems. H4+JPCS support complemented the work of other, often larger programmes for health systems strengthening financed by national governments or other development partners. Programme support was also sometimes catalytic in improving the effectiveness of related programmes. In particular, H4+JPCS effectively supported efforts to strengthen national and local capacity for emergency obstetric and newborn care as well as maternal death surveillance and response.

Additionally, the programme helped improve the availability of quality RMNCAH services, especially by targeting hard-to-reach and underserved areas. This helped to strengthen trust between service providers and community members. However, these positive results could have been further strengthened had more resources been devoted to increasing demand through community engagement activities to challenge harmful socio-cultural norms, especially gender norms.

In each of the ten programme countries, H4+JPCS contributed to expanding access to quality integrated care by those most in need. As a result, the programme supported improved outcomes, such as reduced numbers of home deliveries, improved attendance at antenatal care visits and greater access to emergency obstetric and newborn care. Regarding the continuum of care, H4+JPCS was most effective in supporting the integration of HIV and AIDS programming into health services. It was not as effective in supporting the integration of family planning into RMNCAH services.

To respond to national and local needs, H4+JPCS relied on a combination of existing country-led mechanisms for coordinating actions in the health sector and separate, programme-specific working groups. The effectiveness of programme coordination depended on the extent to which planning, coordinating and review mechanisms extended from national to local levels and included all key stakeholders. Overall, the programme demonstrated a capacity to adjust and respond to changing needs and priorities at the country level. For example, the programme re-profiled support to countries affected by the Ebola virus disease.

H4+JPCS also supported a range of specific interventions aimed at meeting the needs of youth and adolescents, especially young women and girls. However, these interventions were often fragmented and of limited effectiveness in reaching the targeted groups. The programme missed an opportunity to develop, test, implement and promote comprehensive approaches to serve young people.

The gains in capacity and access to quality care supported by H4+JPCS are at risk. Effective exit strategies remain inadequate or missing, jeopardizing continued access to technical, financial and material support to services in reproductive, maternal, newborn and child health, especially at the local level.

# 5. Key results

## **H4+ JPCS applied a consistent approach to strengthening health systems in all ten programme countries. This approach focused on improving the quality of care in reproductive, maternal, newborn and adolescent health services**

The programme was characterised by: an alignment with national plans and priorities; the use of consultative planning and needs-identification processes; and engagement at both national and sub-national levels. It also included a strong geographic focus on under-served districts. Interventions were planned and implemented to complement existing support to the health sector and were sometimes catalytic. The fact that H4+JPCS supported national systems, such as maternal death surveillance and response, in addition to local capacities, has helped national health systems deliver RMNCAH services more effectively.

## **The ability of H4+JPCS to identify and systematically test and implement comprehensive policy and programming approaches to meeting the needs of adolescents and youth was uneven across countries**

As a whole, H4+JPCS did not contribute effectively or substantially to increasing knowledge on how to design and implement measures to meet the sexual and reproductive health needs and rights of, in particular, girls and young women.

## **H4+ JPCS made a significant contribution to expanding access to quality integrated care by those with the greatest need in all ten programme countries**

This success stems from targeting efforts to strengthen health systems and improve service quality to under-served populations including adolescent youth (especially young girls and women) and people living with HIV and AIDS.

As it improved the quality and availability of service supply, H4+JPCS faced the important challenge of also increasing the level of community engagement and demand. The role of UNAIDS and UN Women in supporting community activities to challenge harmful sociocultural norms was particularly notable and the programme demonstrated the feasibility of strengthening community demand for RMNCAH services within a restricted time frame.



**H4+ JPCS encouraged and supported innovation as part of its overall mandate to accelerate and catalyse action in support of improved outcomes in reproductive, maternal, newborn, child and adolescent health. However, the programme lacked systematic attention to documentation, which limited a shared understanding of lessons learned**

A practical definition of “innovation” gave wide latitude to country programmes to identify interventions that made sense within their respective contexts. In some countries, national authorities are in the process of adopting the supported innovations as national policy. Overall, however, the lack of evidence-based documentation has hampered the ability of H4+ JPCS to adequately serve as a knowledge broker for innovation.

**The H4+ JPCS partners were able to achieve an efficient division of labour at country and global levels, drawing on each partner’s mandate and comparative programming strengths**

The operation of the programme helped the H4+ partners working at the country level develop a new type of collaboration and joint programming. However, partly because of its different role in supporting national investments in health (and other sectors), the World Bank was not fully engaged in the H4+ JPCS at the country level.

At the global level, UN Women and UNAIDS have demonstrated the value of community engagement as a means to improving RMNCAH results and outcomes and the importance of women’s empowerment in order to secure their right to services.

**H4+ JPCS has contributed to the development of a significant body of global knowledge products which have been noted as useful and technically sound at both the global and country levels**

At the country level, H4+ JPCS enabled the partners to increase the volume and coherence of their policy engagement and advocacy activities. This more coherent and consistent approach to translating global guidance into national policy support has been recognised by health authorities in all programme countries. At the global level, H4+ JPCS has contributed to widening participation in the development and advancement of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030). It has also contributed to deepening the level of collaboration among H4+ partners and to encouraging the development of unified messages on key issues.



# 6. Summary of conclusions

**H4+ JPCS contributed to strengthening health systems for reproductive, newborn, child and adolescent health at both national and local levels. It improved the training and supervision of health care providers (especially for emergency obstetric and newborn care and for maternal death surveillance and response). This positively contributed to service quality and access, a contribution which could have been still greater had more programme resources been directed toward strengthening demand by engaging with communities to address socio-cultural barriers to access**

H4+JPCS support to health systems strengthening focused on critical needs as agreed between national and sub-national health authorities and H4+ partners. As a result, the funded initiatives aligned with national plans and priorities. Interventions also complemented existing and planned programmes of support to the health sector. However, demand generation and community participation activities were often too narrow in geographic reach and in duration and where further hindered by a relatively low level of investment. As a result, although these were often effective within a limited geographic area, they did not consistently demonstrate the same level of observed results as those supporting the supply of services.



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**The sustainability of improvements in service quality and availability achieved under the programme remains at risk, due to weak or undeveloped exit plans**

At the national level, important aspects of the programme's positive results are likely to be sustained after programme completion. These include improved and updated national policies, guidelines, and training curricula along with system-wide improvements, such as those in maternal death surveillance and response. However, in targeted, under-served and isolated areas, gains in the availability and quality of services are more at risk. In H4+JPCS countries, this risk arises partly because new and pre-existing programmes of health sector support are often not as flexible in identifying and responding to specific local needs. Local results are also more at risk because implementing partners often made significant gains during the later years of the programme. However, these same partners were often unable to find sources of support to maintain their presence and consolidate results achieved after the programme ended.

**H4+ partners effectively advocated for national action in reproductive, maternal, newborn, adolescent and child health. However, in implementing the programme at the country level, the partners missed an important opportunity to engage collectively with national governments to address broader impediments to health sector effectiveness**



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In all programme countries, efforts to strengthen health systems for RMNCAH were constrained by weaknesses in the overall enabling environment. Policy and resource constraints included human resources for health, health financing, transport infrastructure, electricity and lighting, and a lack of reliable clean water in health facilities. Although they improved the coherence of their advocacy efforts specific to RMNCAH policies, H4+ partners were not as effective in collectively advocating for intensified efforts to address these wider, cross-sectoral constraints to a strengthened health system. H4+JPCS did not take advantage of the World Bank's role in supporting national governments in health programmes and in other critical sectors.

**H4+JPCS contributed to expanding access to services in reproductive, maternal, newborn, child and adolescent health. It did so by consistently targeting the provision of services to underserved and remote areas and, within those areas, populations most in need of services (including adolescents and youth, the poorest women, and people living with HIV and AIDS). H4+JPCS investments and activities have addressed the capability, opportunity and motivation of health service staff to provide quality services while engaging in focused efforts at demand generation**



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The programme's support to community engagement (combined with improvements in service availability and quality) has contributed to increased levels of trust between community members and health care providers and, in turn, to increased demand for and use of services. In some countries, however, the programme did not adequately support the integration of family planning services in situations where it would have been appropriate.

## **In most countries, H4+JPCS missed an important opportunity to develop, test and promote new, comprehensive approaches to addressing the needs of youth and adolescents**

The programme supported a range of interventions to meet the needs of youth and adolescents, including young girls and women in and out of school, married and unmarried (as well as those of boys and young men). However, these interventions were often fragmented and of limited effectiveness in reaching the targeted groups. While H4+ JPCS supported efforts to directly address gender inequalities, these interventions, instead of being mainstreamed, were mainly limited to demand creation. As a result, gender equality initiatives had limited geographic reach, were under-resourced and were often implemented late in the programme.

## **H4+ JPCS demonstrated a capacity to adjust to changing needs and priorities at the country level and respond to specific national challenges. The programme effectively used participatory systems of planning and review, which sometimes extended from the national to the district and facility level**

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

## **H4+ JPCS encouraged and supported successful innovations to accelerate improved outcomes in reproductive, maternal, newborn, child and adolescent health. However, programme support to innovations seldom adhered to a systematic approach. It did not consistently support the shift from successfully testing an innovation to documenting the results necessary to develop national policy and scale up innovative practices across the health system**

H4+ JPCS identified and supported a number of successful innovations. However, the programme lacked adequate evidence-based documentation to support policy makers. This weakness in documentation hampered the programme's ability to serve as a knowledge broker, both nationally and across the participating countries. It also reflects the programme's general problem of underdeveloped systems and approaches to knowledge management.



**H4+ JPCS achieved an effective division of labour which drew on the mandate and comparative programming strengths of each partner agency. It also allowed the H4+ partners to avoid overlap and duplication. The experience of implementing the programme helped the H4+ partners develop a deeper coordination and collaboration at global and country levels. However, at the global level, this collaboration has been more notable in relation to technical and administrative matters than for strategic issues**

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



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**The primary added value of H4+ JPCS has been its positive contribution to improving the availability and quality of essential reproductive, maternal, newborn, child and adolescent health services in the ten programme countries. This contribution arises mainly from flexibility in jointly programming technical and financial support in a manner which complements other programmes. Additional value can be found in the broadened participation of the H4+ partners in the development of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)**

In addition to strengthening participation by, for example, UNAIDS and UN Women in the development of the Global Strategy (2016 - 2030), the programme contributed to the development of a significant body of useful and technically sound global knowledge products.



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# 7. Recommendations

**H6 country teams in the ten H4+ JPCS countries should undertake actions to make results sustainable.** H6 teams in each programme country should work with national authorities to ensure that a combination of national and external resources provides flexible, geographically-focused support to those provinces, districts and health facilities that have relied on the programme.

**H6 partners' efforts to strengthen national health systems should be designed to balance improving the supply of services and strengthening demand, by engaging with individuals and communities to address barriers to access, including sociocultural barriers.** Increased levels of investment in community engagement should focus on overcoming specific barriers for girls' and women's access to (and use of) services and to the knowledge necessary to securing their rights.





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The H6 partners should build on the experience of H4+ JPCS to engage with national governments using “one voice” and ensure that they can collectively influence broader impediments to the health sector and beyond (including weaknesses in human resources for health, health financing, and the general enabling environment), which originate outside the mandates of their traditional counterparts.

H6 partners supporting RMNCAH at the country level should ensure that programmes of support address key aspects of sexual and reproductive health and rights (including family planning) for those most left behind, especially for young women and girls. To this effect, H6 partners should invest in the promotion and dissemination of evidence-based, comprehensive approaches to meeting the needs of adolescents, including young women and girls. To this effect, H6 regional and country teams must have the required technical expertise and should engage with actors outside ministries of health (such as ministries of youth and sport, education, employment, gender and social development) and those outside the public sector.



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

**H6 partners should strengthen their learning and knowledge management strategy, including the generation and dissemination of evidence-based documentation. In supporting the innovation action area of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), H6 partners should support systematic approaches to linking evidence to policy and practice. This requires the development of new or strengthened learning networks as well as stronger linkages between the development and dissemination of global knowledge products and H6 country team experiences and needs.**

**H6 partners should ensure that the division of labour at both the country and global level allows for full participation by all partners to support the community engagement action area of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). H6 partners need to ensure that programme designs encourage full engagement of all partners, incorporating their different operational and normative strengths into work plans and funding allocations. It requires H6 country teams to seek funding opportunities and mobilise resources for collective action in support of RMNCAH.**

**Within the framework of their collaboration in support of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), H6 partners should develop a clear definition of the work to be done at the regional level. Regional H6 teams should provide more technical and operational support to country teams. This requires enhancing the roles and responsibilities (and corresponding funding) for regional teams to allow them to take advantage of opportunities for synergies and provide needed support to country teams.**





## Evaluation team

### *Evaluation Management Group*

<b>Louis Charpentier</b>	<i>UNFPA Evaluation Office (Chair)</i>
<b>Beth Ann Plowman</b>	<i>UNICEF Evaluation Office</i>
<b>Pierre J. Tremblay</b>	<i>Global Affairs Canada Evaluation Division</i>

### *Euro Health Group Core Evaluation Team*

<b>Ted Freeman</b>	<i>Team Leader</i>
<b>Lynn Bakamjian</b>	<i>Deputy Team Leader and Reproductive Health Expert</i>
<b>Dr. Allison Beattie</b>	<i>Health Systems Strengthening Expert</i>
<b>Camilla Buch von Schroeder</b>	<i>Adolescent Sexual and Reproductive Health Expert</i>
<b>Erling Høg</b>	<i>Data Analysis and Editorial Support</i>
<b>Jette Ramløse</b>	<i>EHG Coordination</i>

### *Field Country Experts*

<b>Deborah Haines</b>	<i>Liberia and Zambia</i>
<b>Beyant Kabwe</b>	<i>Zambia</i>
<b>Prince Kimpanga</b>	<i>Democratic Republic of the Congo</i>
<b>Minnie Sirtor</b>	<i>Liberia</i>
<b>Thenjiwe Sisimayi</b>	<i>Zimbabwe</i>
<b>Léon Tshiabuat</b>	<i>Democratic Republic of the Congo</i>

## Evaluation reference group

<b>Åsa Andersson</b>	<b>Sweden/ Sida</b>
<b>Camille Bouillon Bégin</b>	<b>Global Affairs Canada</b>
<b>Nazneen Damji</b>	<b>UN WOMEN</b>
<b>Hemant Dwivedi</b>	<b>UNFPA (H6 Global Coordinator)</b>
<b>Dirk van Hove</b>	<b>UNAIDS</b>
<b>Anneka Ternald Knutsson</b>	<b>UNFPA</b>
<b>Blerta Maliqi</b>	<b>WHO</b>
<b>Jeremy Veillard</b>	<b>World Bank</b>
<b>Willibald Zeck</b>	<b>UNICEF</b>



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**United Nations Population Fund**

**Evaluation Office**

605 Third Avenue

New York, NY 10158 U.S.A.

e-mail: [evaluation.office@unfpa.org](mailto:evaluation.office@unfpa.org)

[www.unfpa.org/evaluation](http://www.unfpa.org/evaluation)