FINAL INCEPTION REPORT

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

Evaluation Office

New York
May 2016

Affaires mondiales Canada
Global Affairs Canada

unicef

UNFPA

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

Evaluation Management Group:

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

Evaluation Reference Group:

Kim Dickson	UNICEF
Hemant Dwivedi	UNFPA
Ulrika Hertel	Sweden / SIDA
Dirk van Hove	UNAIDS
Katja Isaksen	UNWOMEN
Laura Laski	UNFPA
Blerta Maliqi	WHO
Jeremy Veillard	World Bank

Evaluation Team:

Lynn Bakamjian	Euro Health Group
Dr. Allison Beattie	Euro Health Group
Dr. Jacques Emina	Euro Health Group
Ted Freeman	Euro Health Group (Team Leader)
Camilla Buch von Schroeder	Euro Health Group

Any enquiries about this Report should be addressed to:
Evaluation Office, United national Population Fund
Email: evaluation.office@unfpa.org – Phone number: +1 212 297 2620

TABLE OF CONTENTS

List of Tables:

List of Figures:

ABBREVIATIONS AND ACRONYMS

A4	Addis Ababa Action Agenda
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
COIA	Commission on Information and Accountability
DHIS	District Health Information System
EMG	Joint Evaluation Management Group
EmONC	Emergency Obstetric and Newborn Care
ERG	Evaluation Reference Group
EWEC	Every Woman Every Child
G8	Group of Eight Highly Industrialized Countries
GFF	Global Financing Facility
H4+JPCS	H4+ Joint Programme Canada Sweden (Sida)
HRITF	Health Resources Innovation Trust Fund
iERG	Independent Expert Review Group
MDG	Millennium Development Goals
MNCH	Maternal Newborn and Child Health
NGO	Non-government Organisation
PMNCH	Partnership for Maternal Newborn and Child Health
PR	External Peer Reviewer
QM	Quality Manager
RBF	Results Based Financing
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Care
RMNCH	Reproductive Maternal Newborn and Child Health
SDG	Sustainable Development Goal
TB	Tuberculosis
ToC	Theory of Change
ToR	Terms of Reference
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children Fund
UNSG	United Nations Secretary General
WHO	World Health Organisation

1 INTRODUCTION

In 2008, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the World Bank launched the H4 partnership as a joint effort for capitalising on the core competencies of each partner along the continuum of care for maternal, newborn and child health. In 2010, United Nations Secretary General, Ban Ki-moon, launched the Global Strategy for Women's and Children's Health ("the Global Strategy") to accelerate progress to meet Millennium Development Goals (MDGs) four (a two thirds reduction in under-five mortality) and five (a three-quarters reduction in maternal mortality and universal access to reproductive health). This initiated the Every Woman Every Child movement (EWEC) to put the Global Strategy into action (UN 2016a). In the same year, the partnership was expanded to also include UN Women and UNAIDS and the H4+ partnership was fully constituted. At the same time, the focus of H4+ was broadened to include reproductive health and child health in order to help countries put into action their commitments under the Global Strategy for implementing the integrated package of reproductive, newborn and child health (RMNCH) services. H4+ became the technical arm of the EWEC strategy and assumed the role of supporting the 75 high burden countries where more than 85 percent of all maternal and child deaths occur, including the 49 lowest income countries.

In an effort to accelerate progress toward meeting MDGs four and five, Canada (in 2011) and Sweden (in 2012) provided significant grant funding to the H4+ partners. In 2013, at the request of both Canada and Sweden, the H4+ partners developed a joint results framework, intended as a basis for jointly closely coordinated implementation under one H4+ Joint Programme Canada and Sweden (hereafter: H4+JPCS) (UNFPA 2015b: 5).

The Canada and Sweden (Sida) grant funding was designated for expenditures in 10 high burden countries in Africa.

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

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

In 2015, in anticipation of the programme closing the following year, the UNFPA Evaluation Office began the preparatory phase for an end line evaluation of the programme. Euro Health Group was commissioned in January 2016 to carry out the evaluation under the direction of the Evaluation Management Group (EMG) of the Evaluation Division at Global Affairs Canada and the Evaluation Offices at UNICEF and UNFPA (Chair).

1.1 Objectives of the Evaluation

The ***purpose*** of the evaluation is to (UNFPA 2015b: 5):

- Support ***learning*** among key stakeholders from the experience of implementing the H4+JPCS at global, regional, national and sub-national levels, with a view to: (i) informing similar initiatives for the delivery of the comprehensive package of services and support in the field of RMNCH; (ii) supporting the H4+ partners review of the partnership mandate in the post-2015 context
- Support ***accountability*** of the H4+ partners for the achieved results under the programme.

The ***objectives*** of the evaluation are to:

- Assess the relevance of the objectives and the approach of the H4+JPCS at global, regional, national and subnational levels, including its role and positioning within the context of other partnerships and platforms
- Assess the effectiveness and efficiency of the implementation of the H4+JPCS at global, regional, national and sub-national levels with regard to:
    - Achievements of the programme regarding the strengthening of national health systems at policy and programme level in the ten H4+JPCS countries
    - Improvements in the delivery of a comprehensive package of RMNCH services to the population in intervention areas in H4+JPCS countries
- Assess the sustainability of the results achieved by the programme at global, regional, national and sub-national levels
- Assess the added value of the H4+JPCS approach and actions for the development of tools and guidelines for RMNCH programming, awareness raising and technical guidance
- Assess to what extent issues of gender equality, social inclusion and equity have been taken into consideration
- Identify lessons learned and good practices from the implementation of the H4+JPCS, and opportunities to improve both the cooperation between the six agencies and their support, aimed at the improved delivery of the comprehensive package of services and support in RMNCH, in a set of concrete and actionable recommendations.

1.2 Scope of the Evaluation

The evaluation will cover the period from March 2011 to April 2016 (the end of the inception phase of the evaluation). It will thus cover the actions financed by Canada and Sweden both before and after their integration into the joint programme in 2013.

The evaluation will cover all 10 countries that are part of the H4+JPCS with four countries (DRC, Liberia, Zambia and Zimbabwe) addressed by field-based country case studies. The remaining six programme countries (Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau and Sierra Leone) will be the subject of desk-based country case studies.

In addition, the evaluation will cover the contribution made by the H4+JPCS at global and regional level, including the contribution made by global knowledge products to the Global Strategy and the role of H4+ global technical support in strengthening action on RMCH in the wider group of 75 countdown countries.

Thematically, the evaluation will cover two major areas:

- The actions carried out with H4+JPCS support in the output areas of RMNCH and health systems strengthening which are the focus of programme operations:
    1. Leadership and governance
    2. Financing
    3. Health technologies and commodities
    4. Human resources
    5. Health information systems, monitoring and evaluation
    6. Health service delivery
    7. Demand, including community ownership and participation
    8. Communications and advocacy

- The contribution made by the H4+JPCS to the delivery of the Global Strategy and to the EWEC movement.

1.3 Overview

The evaluation has five phases:

Phase 1: The preparatory phase encompasses work carried out by the members of the joint Evaluation Management Group (EMG) under the leadership of the UNFPA Evaluation Office and includes consultation and documentary research to prepare the terms of reference (ToR), management of the tendering process, and collecting and organising programme documentation for use by the selected evaluation team.

Phase 2: The inception phase, described in this report, includes fielding of the external consultant team, development of methodological and research instruments, refinement of the intervention logic and theory of change (ToC) for the evaluation, and development of a work plan for carrying out the evaluation.

Phase 3: The data collection phase includes completing the review of relevant H4+JPCS documents and knowledge products, accessing and profiling data on results in RMNCH, key informant interviews and group discussions at global, regional, national and sub-national level, completion of draft field and desk country case study notes, and completion and analysis of online surveys. Finally, this phase includes consolidation of the collected data into the evaluation matrix and preliminary analysis.

Phase 4: The data analysis and reporting phase culminates with the preparation of a draft final report.

Phase 5: The management response will be coordinated by the joint EMG in collaboration with the ERG.

Phase 6: The dissemination phase involves development of evaluation briefs in English, French and Spanish and presentation of the results of the evaluation at a stakeholder workshop by the team leader and the EMG.

1.4 Purpose and structure of the Inception Report

The purpose of the inception report is to:

- Review the global context for the H4+JPCS programme in the evolving architecture of international support to the Global Strategy and the EWEC movement
- Reconstruct and refine the intervention strategy and theory of change for H4+JPCS, especially as they relate to the six main areas of investigation of the evaluation
- Develop the evaluation questions addressing the main topics and issues identified in the ToR
- Identify the indicators and data sources to be used to address all the evaluation questions
- Describe the methodology and research instruments to be used
- Discuss challenges, limitations and risks which could affect implementation
- Present a detailed work plan.

The chapters of the inception report focus on:

- Chapter 2 describes the global context of H4+JPCS.
- Chapter 3 identifies the intervention logic of H4+JPCS and its changes during the evaluation period, and reconstructs the theory of change and its evolution during that time.

- Chapter 4 covers details of the methodology and analysis to be used.
- Chapter 5 presents the evaluation matrix with details of the questions to be answered in each of the areas of investigation highlighted in the ToR, including the rationale for those questions, the assumptions to be verified, and the indicators and data sources to be used.
- Chapter 6 describes the next steps in the work with a detailed plan and timetable. The annexes present information on the instruments and protocols to be used for data collection and other pertinent information.
- Chapter 7 presents a preliminary reading of observations from the inception phase.

2 THE GLOBAL CONTEXT

2.1 Addressing preventable maternal and child deaths

Despite the significant change in global health policy as a result of the launch of the Millennium Development Goals (MDGs) in 2000, progress on reducing maternal mortality in the first half of the decade continued to be slow (WHO 2007). The **Partnership for Maternal, Newborn and Child Health (PMNCH)** was established in 2005, housed at WHO in Geneva, to galvanize, coordinate and focus the efforts of partners to advance the achievement of MDGs 4 and 5.[1] **Countdown to 2015**, an initiative aimed at building more robust data for decision-making and tracking around maternal and child health, was also launched in 2005, housed within the Partnership (Countdown 2015b). A family planning target was added to MDG Five in 2008 (becoming MDG 5b).

The 75 highest burden countries accounted for 95 percent of the maternal and child mortality burden globally and included many countries experiencing conflict, complex humanitarian emergencies and protracted crises. In many of these, HIV and AIDS, tuberculosis (TB) and malaria underpinned a large share of maternal and child morbidity.[2] Nutritional insufficiencies, incomplete vaccinations and harmful cultural practices further exacerbated poor health outcomes in many communities (Say, Chou et al. 2014). In these countries, there was agreement that sustained partnership, technical assistance, financial aid, and health systems strengthening focused on reaching the most vulnerable and marginalized were needed to make progress especially on maternal mortality reduction and newborn survival.

In this context, the **H4 partnership was formed in 2008** with the aim of better combining and uniting UNICEF, UNFPA, WHO and the World Bank in their work at national, regional and global levels to support countries to achieve the MDGs. Focusing on the needs of the 75 highest burden countries, the H4 partnership aimed to optimise partner capacity and knowledge while minimising duplication and competition at country level (WHO 2014a). The H4 aimed to ensure that countries were able to take full advantage of partner skills and capacity in their efforts to achieve MDGs 4 and 5.

The UN Secretary General (UNSG), recognizing that many high burden countries were struggling to make progress on the health MDGs, developed **the Global Strategy for Women's and Children's Health (Global Strategy 2010) in 2010** (UN 2010). The Global Strategy set out a clear agenda for action and attracted a wide range of policy and programme commitments including from 58 of the 75 high burden countries.[3] The UN launched the "**Every Woman Every Child**" (EWEC) movement to lead, engage with and integrate a wide range of actors beyond national governments and donors, in taking forward the Global Strategy 2010 including civil society, non-governmental organisations (NGOs), academics, health professionals, multilaterals and the private sector.

[1] For the early history of the Partnership see (WHO 2016a)
[2] See, for example, (MHTF 2010) and (WHO 2013c)
[3] Commitments are shown here: (WHO 2016c)

The H4+ (with the **addition of UNWomen and UNAIDS in 2010**) further aligned its efforts to support the mobilisation and implementation of commitments made by countries and their partners to the Global Strategy 2010. Working with the H4+ partners, PMNCH produced an agreed summary of essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health (PMNCH 2011). This was followed in 2013 with the "Success Factors Study" showing what worked in maternal and child health implementation (WHO 2014c). Together, these guidelines helped identify how the H4+ could achieve the greatest impact in the highest burden countries.

In the wake of UN leadership around accelerating progress, the Group of Eight highly industrialised countries (G8)[4] met at Muskoka, Canada, and through the ***Muskoka Initiative*** committed to a combined financing package of an additional USD 10 billion over five years to support the implementation of the Global Strategy and achieve the health MDGs, including additional support to nutrition.[5]

Following Muskoka, the Director General of WHO (Dr Margaret Chan) set out her plan for the **2011 Commission on Information and Accountability (COIA)** to improve transparency by holding partners accountable for all their commitments made to the Global Strategy (WHO 2014b). The commission was co-chaired by President Kikwete of Tanzania and Prime Minister Harper of Canada. COIA recommendations included the establishment of an annual, independent review process to focus on accountability. From 2012, the newly **formed independent Expert Review Group (iERG)** published annual reports which included an assessment of partners' commitments, including financial tracking information (produced by the PMNCH) and making recommendations to the extended global maternal and child health community regarding priority actions. The iERG reports were widely read and helped shape global priorities in the run-up to 2015 (WHO 2015a).

2.2 Accelerated support and the Sustainable Development Goals

The year 2012 marked the initiation of activity implementation in five countries under **the Canadian five-year grant** to the H4+ (committed in 2011).[6] **Sweden contributed to H4+ targeting an additional five countries in 2012**, and with activity implementation starting in 2013.[7] Together, these grants formed the H4+ Joint Programme Canada and Sweden (H4+JPCS) (WHO 2015b).

As a result of better data and improved evidence about lagging indicators and barriers to progress, three separate but related initiatives were also launched in 2012**. These were the UN Commission on Life-Saving Commodities for Women and Children (UN 2016d)**; the launch of **Family Planning 2020** (by the government of the United Kingdom and the Bill and Melinda Gates Foundation and with support from UNFPA) (FP 2020 2015); and the creation of the initiative for child survival "**A Promise Renewed**" (led by USAID and UNICEF) (APR 2015). The 2014 "**Every Newborn call to action and global plan**" also provides a significant example of H4+ leadership in its development and launch (WHO 2016b).

Global funding for MNCH increased significantly from 2010, and efforts were made to improve coordination of major funding streams. However, there continues to be concern, especially in the post-MDG era, that insufficient funding may threaten to undo recent gains. In 2013, the Lancet Commission on Global Health produced an update to the landmark 1993 WHO Report on Investing in Health. The update, Global Health 2035, sets out the economic case for investing in health. The key messages focused on the necessity and feasibility of eliminating preventable maternal and child death. The update outlined how global health could achieve a "grand convergence" by 2035 such

[4] France, Germany, Italy, the United Kingdom, Japan, the United States, Canada, and Russia
[5] The full text of the communique is here: (CTV News 2010)
[6] Burkina Faso, Democratic Republic of the Congo (DRC), Sierra Leone, Zambia, Zimbabwe
[7] Cameroon, Cote D'Ivoire, Ethiopia, Guinea Bissau, Liberia

that all nations achieve minimum levels of health outcomes and life expectancy (Lancet Commission 2013).

Building the investment case for health for women and children has been an important factor in reinforcing momentum and commitment to addressing maternal and child health. The PMNCH, working with WHO and others, produced an investment case for women's and children's health that identified critical investments towards MDGs 4 and 5, investments which provided the most value for money (WHO 2013a, WHO 2013b). The World Bank, working with many partners and building on the UK-Norway funded Health Resources Innovation Trust Fund (HRITF) experience of results-based financing, **announced the Global Financing Facility (GFF) in 2014, launched in 2015** (World Bank Group 2015). Still in early days, the GFF aims to strengthen domestic as well as global commitments to reproductive, maternal, newborn, child and adolescent health (RMNCAH) using performance-based financing modalities to leverage World Bank credits.

By focusing on new financing modalities and a role for the private sector, the GFF anticipated the main aims of the ground breaking Addis Ababa Action Agenda (the A4), signed at the global meeting in Addis Ababa in July 2015.[8] The A4 calls for, and sets out, plans to achieve a much stronger role for private sector engagement in developing countries, more sustained and targeted domestic commitment, innovative financing modalities, and approaches that address the reality of the declining importance of traditional aid in most countries.

As the MDGs neared conclusion, the H4+ network again supported the office of the UNSG in the challenging process of negotiating the post-2015 agenda. With only one overt health goal among the 17 Sustainable Development Goals (SDG), the challenge for the maternal and child health community was to sustain focus and build new partnerships to not lose momentum and to work with, and through, others to deliver "health in all we do". After a global process of negotiation, consultation and discussion, the UNSG launched *Survive, Thrive and Transform: The Global Strategy for Women's, Children's and Adolescents' Health 2015 -2030* **(Global Strategy 2015)** at the United Nations General Assembly in September 2015 (UN 2016c). The launch took place immediately after the announcement of the agreed SDGs.

The **new Global Strategy 2015** aimed to set out an agenda for action that would eliminate preventable deaths in women and children (Survive), improve health outcomes and access to services (Thrive), and remove the barriers to leading a long, healthy and fulfilling life (Transform). The Global Strategy 2015 focuses on equity, leaving no one behind, ensuring particular attention to the most vulnerable in conflict and humanitarian settings, and building health systems. The governance arrangements for the new Global Strategy 2015 foresee the **H4+ (announced as the newly launched H6 on March 18, 2016)** (UN 2016b) taking on a leading technical assistance role in the implementation of the Global Strategy 2015, always in response to country-determined needs (UN 2015b: 76-78). The GFF will lead on financing support to high burden countries to map out investment plans while the PMNCH will support accountability. H6 partners are thus engaged in all aspects of the Global Strategy 2015 implementation, both individually and together as a group. As the H4+JPCS comes to an end (2016), there is an opportunity for the H6 to learn from and build on the H4+JPCS experience.

Table 2: A Timeline of Developments in RMNCAH

Year	Key Developments in Maternal, Newborn, Child and Adolescent Health
2005	Partnership for Maternal Newborn and Child Health (PMNCH) established
2005	Countdown to 2015 Initiative launched
2008	H4 Partnership formed (UNICEF, UNFPA, WHO, World Bank)

[8] The A4 outcome document is here: (UN 2015a)

2010	Global Strategy for Women's and Children's Health (Global Strategy 2010) launched by the Secretary General
2010	Every Women, Every Child Movement launched by the United Nations
2010	H4 becomes H4+ with addition of UNWomen and UNAIDS
2010	Muskoka Initiative launched by G8 member nations
2011	WHO forms the Commission on Information and Accountability
2011	H4+ funded programme established with grant from Canada
2012	H4+JPCS programme becomes operational with additional grant from Sweden
2012	Independent Expert Review Group (iERG) begins annual reporting
2012	UN Commission on Life-Saving Commodities for Women and Children established
2012	Family Planning 2020 Initiative launched with support from the government of the United Kingdom, the Bill and Melinda Gates Foundation and UNFPA
2012	A Promise Renewed child survival strategy initiative led by USAID and UNICEF
2014	Every Newborn call to action and global plan developed with support from H4+
2015	Global Financing Facility launched (announced in 2014)
2015	New Global Strategy for Women's and Children's Health (Global Strategy 2015) announced coincidentally with the Sustainable Development Goals
2016	H4+ announced as the new H6
2016	Current phase of programming under H4+ JPCS to be completed

3 INTERVENTION LOGIC AND THEORY OF CHANGE

3.1 Logical reconstruction of the Theory of Change

This Chapter begins by presenting a reconstruction and refinement of the intervention logic and Theory of Change (ToC) for the H4+JPCS programme. In doing so, it does not attempt to replace or in any way diminish the importance of the results framework already developed by the programme. As made clear in section 4.1, as the evaluation examines the causal links in the ToC for the programme, these will be related directly to the observed outputs and outcomes of the results framework.

As noted in the Terms of Reference (ToR) for the evaluation, the implementation of the H4+ Joint Programme Canada and Sweden 2011-2016 (H4+JPCS) has implicitly been guided by a ToC since its beginning in 2011. However, this ToC has not been explicitly stated in programme documents. This means that developing a proper, theory based design for the evaluation requires the evaluation team to develop an explicit ToC for the programme which illustrates the intervention logic of the H4+JPCS.

An explicit theory of change and intervention logic for the programme is also necessary to allow the evaluation to apply contribution analysis as its central analytical approach. The ToC and intervention logic will guide the evaluation team in the design of data collection methods, the analysis of data collected, the reporting of findings, and the development of conclusions and recommendations.

Successful application of contribution analysis begins with the development of a credible theory of change for the H4+JPCS, capable of illustrating the causal links and related assumptions which inform it. The ToC, with its depiction of causal links from the H4+JPCS programme to changes in well-being for women, children and adolescents (and the assumptions which inform those links), becomes the basis for specifying data collection and analysis tools and instruments as detailed in Chapter 4.

3.1.1 Intervention logic and theories of change

A theory of change is a representation of the underlying concept of how a programme contributes to desired changes. The process of developing a theory of change for a given intervention begins with the depiction of the causal links explaining how the activities of the intervention are expected to lead to desired results. The depiction of these links and pathways from activities to results is described in the literature under different terms including results chains, logic models, and impact pathways (Mayne 2015). For the purposes of this evaluation, the term *intervention logic* is used to describe the depiction of causal links from activities to results for the H4+JPCS. In effect, this work builds on the existing results framework for the H4+JPCS. It is those results which will be analysed in relation to the credible contribution of the programme.

The main difference between a causal model or intervention logic diagram and a more complete ToC is the additional step of identifying the causal assumptions behind the links from activities to results – what has to happen for the causal assumptions to be realised (Mayne 2015: 121). It is in fact the combination of a well-constructed intervention logic and the identification of key causal assumptions which characterises a useful theory of change.

The theories of change developed by the evaluation for H4+JPCS do not classify results levels as immediate, intermediate and final outcomes or impacts. Because these commonly used terms often generate debate about classification of results, the evaluation has used the approach suggested in (Mayne 2015: 125): concentrating on how activities contribute first to capacity change, subsequently to changes in behaviour, and (through them) to direct benefits for the target group and, ultimately, to changes in well-being. Causal assumptions can be identified at each of these levels of results. Each of the ToCs for the H4+JPCS takes as its starting point the development of a coordinated set of H4+JPCS interventions at either global or country level. These are then linked to activities and higher level results in the eight output areas of the programme:

1. Leadership and governance
2. Financing
3. Health technologies and commodities
4. Human resources
5. Health information systems, monitoring and evaluation
6. Health service delivery
7. Demand, including community ownership and participation
8. Communications and advocacy.

3.1.2 Types of theories of change and their purpose

In the evaluation of the H4+JPCS, the reconstruction of the programme ToC serves a number of purposes:

- Providing a graphic depiction of how the programme operates at country and global level which is recognisable to key stakeholders, and can be used to organise data collection tools such as key informant interview guides, focus group discussion guides and online survey questionnaires
- Identifying the evaluation questions which can be used to investigate and report findings and conclusions on the indicative areas of investigation identified in the ToR for the evaluation
- Identifying the explicit causal assumptions linking support from H4+JPCS to an identifiable contribution to changes in capacities, behaviour, benefits and well-being which are depicted in the theory of change and which relate directly to the outputs and outcomes of H4+JPCS as identified in the results framework for the programme

- Allowing the evaluation design, as depicted in the evaluation matrix, to test the causal assumptions associated with each area of investigation.

In essence, the evaluation relies on the use of *nested* ToCs to provide the appropriate level of detail for identifying the causal links and associated assumptions underlying the design of the H4+JPCS in relation to the areas of investigation identified in the ToR. "Nested ToCs" refers to the fact that three overall types of theories of change were developed to provide the level of detail necessary for the identification of pathways from activities to results in the six areas of investigation.

The first type of ToC is an overall, two-part, model of the theory of change for H4+JPCS at programme country and global levels. It is the foundation for all of the work that follows. In fact, ToC types two and three (described below) should not be seen in any way as independent ToCs. Rather, they illustrate the causal pathways (and associated assumptions) to different types of results (health systems strengthening, equity of access) and different evaluation criteria and investigations areas (responsiveness, innovation, social inclusion, efficiency, value added) embedded in the overall ToC.

The second type of ToC uses either the global or country focussed parts of the overall theory of change (with links between the two) to zoom in to a tighter focus and explore the causal pathways and assumptions associated with the six areas of investigation. It unpacks specific areas of the overall ToC, and helps trace and substantiate results at different levels. As a result, there is a distinct ToC relating to each area of investigation of the evaluation. They are presented in this section and in Annex 1.

The third and final type of ToC explores a single, more specific, pathway, depicting the process of innovation in the H4+JPCS. The pathway ToC for innovation has been built using two example innovations reported by the programme in Zimbabwe. A separate and distinct pathway ToC was developed for the innovation element of the programme because it represents a cross-cutting element in programming which can be present in other results pathways. For example, innovations can be found in all eight output areas of health systems support at country level.

As each field country team examines the H4+JPCS during field country case study missions, they will make any necessary adjustments to the country level segment of the overall ToC as it applies in the relevant country. This will not undermine the overall ToC, but it will assist the field country case study team in reflecting the differences among the programme countries, especially in terms of activities in support of the eight output areas.

Table 3: Theories of change in relation to areas of investigation

Areas of Investigation	Theory of Change type		
	Overall country and global	Country and global pathways	Innovation pathway
1. Strengthening health systems for RMNCAH	Yes	Yes	Yes
2. Expanded access to integrated care	Yes	Yes	Yes
3. Responsiveness to national needs and priorities	Yes	Yes	Yes
4. Innovation and scale up			Yes
5. Division of labour	Yes		
6. Value added for the Global Strategy (2010)	Yes	Yes	Yes

3.1.3 Sources used to develop the theories of change

In developing the three different types of theories of change, the evaluation team relied on a variety of sources of information, including:

- Descriptions of the structure and operation of H4+JPCS provided in the ToR, including the original and merged results frameworks
- Annual work plans and results reporting frameworks for the global programme and in selected programme countries
- Annual and other periodic reports of results at global and country levels
- Joint review mission reports at global level
- Minutes of the H4+ Joint Steering Committee at global level and of H4+ coordinating committees at country level
- Interviews with members of the H4+ Joint Steering Committee representing the partners (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank)
- Interviews with current and past representatives of Global Affairs Canada and Sida engaged with H4+JPCS
- Interviews with the H4+ global coordinator based in UNFPA
- Interviews with the H4+JPCS country team in Zimbabwe, UN representatives, and appropriate government officials and other key stakeholders at national, provincial and district levels during the exploratory mission
- Site visits to health facilities and communities in the Chipinge District of Zimbabwe.

Information from these sources was analysed and served as the basis for developing the three different types of theories of change for H4+JPCS.

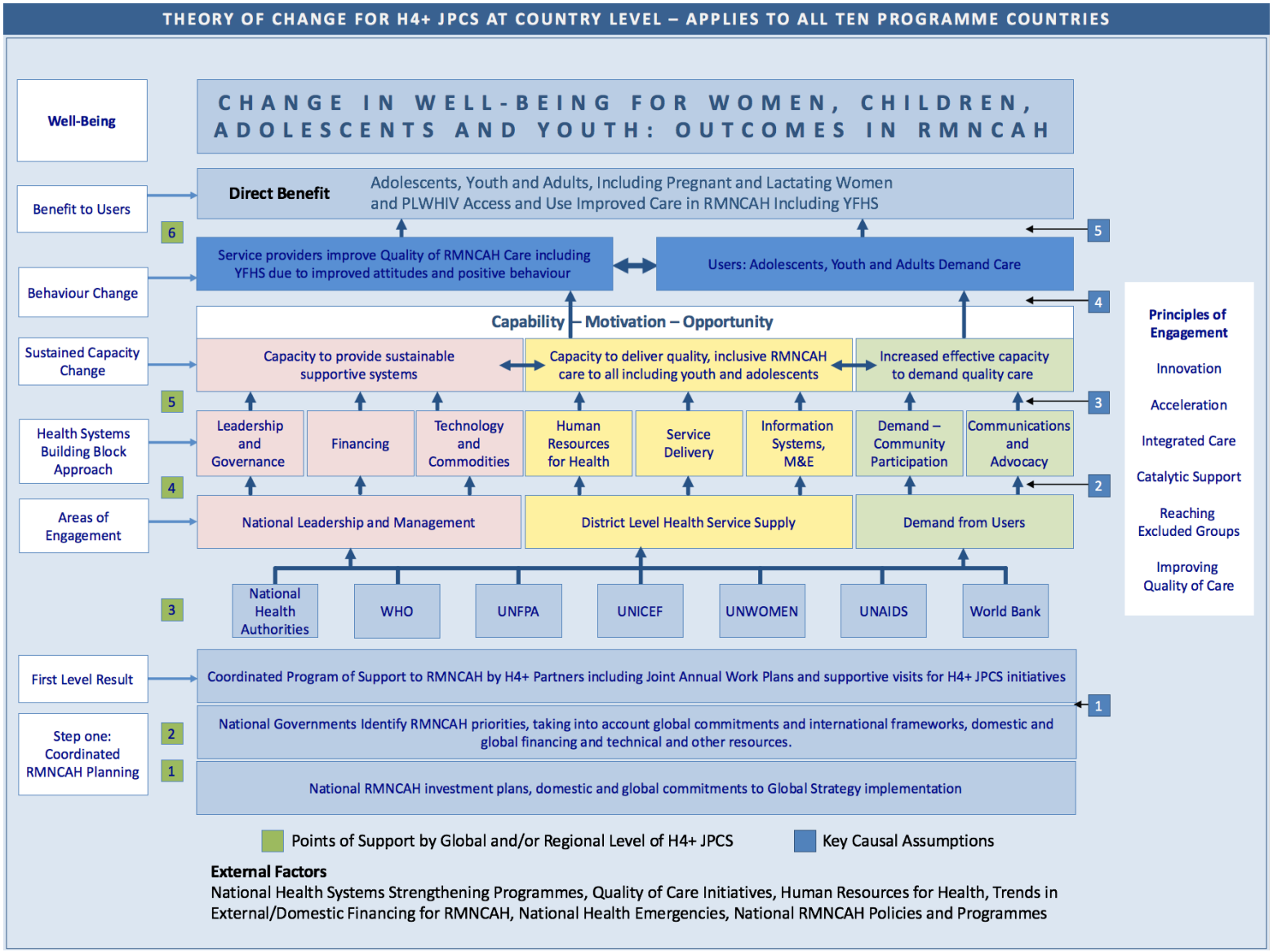
It is important to note that the evaluation team will update and improve all three types of theories of change during the evaluation process. This will ensure that the draft and final synthesis report provides a re-assessment of the strengths and weaknesses of the theory of change which drives the contribution made by H4+JPCS to results in RMNCAH.

3.2 Overall theory of change and illustrative pathways

3.2.1 The overall theory of change – country level

As already noted, the overall theory of change for the H4+JPCS has been developed in two parts – at country and global levels. The ToC should be seen as a single theoretical model of the programme which is provided in two parts for ease of presentation only. To that end, part one – the country level – identifies the most important points where the global/regional activities of H4+JPCS have an effect at country level. The country level is presented first because it represents the bulk of H4+JPCS investments, and it is where the H4+JPCS results are ultimately attained.

Figure 1: Theory of Change for H4+JPCS at Country Level (*Global and Regional Level in Figure 2)*



The key feature to note for the overall ToC for the programme at country level is the way that H4+JPCS support is organised, at least in theory, into **a coordinated programme of support** to RMNCAH. This programme is structured around joint annual work plans and results reporting, and with participation in planning and review by all partners and the national health authorities.

Similarly, the support to RMNCAH provided by H4+JPCS activities and investments is organised under a modified health systems building blocks approach which includes eight outputs (see listing in section 3.1.1). This is consistent with the decisions and discussions of the H4+ Joint Steering Committee from early in the programme and with the organisation of annual work plans and results reporting for H4+JPCS, including the joint results framework (UNFPA 2015b: 52-56). In programme terminology, these eight areas of support are called output areas with annual work plans and budgets and results reports organised under the eight headings (WHO 2015b: 39-48).

There are **three main pathways** through which H4+JPCS support to improved access to quality care in RMNCAH flows at country level: support to improved national leadership and management; support to improvements in the sub-national supply of health services in RMNCAH; and improvements in the capacity for and exercise of effective demand by community members, especially marginalised group members including adolescents and youth.

Sustained improvements in capacity are not achieved by the upgrading of skills alone. The literature on capacity development points to three important dimensions which must be satisfied for sustained improvements in capacity leading to changes in behaviour: capability (skills and knowledge); motivation (incentives and commitment); and opportunity (access to facilities, equipment, essential supplies) (Darnton 2008).

This link between capacity improvement and change in behaviour illustrates the importance for H4+JPCS initiatives at country level to be properly sequenced with programmes which may address other parts of the capability-motivation-opportunity triad, so that positive behaviour change can be achieved.

The opportunity leg of the triad applies to both the demand and supply side for services in RMNCAH. Service providers will not have the opportunity to practice newly established skills if they do not have adequate and reliable infrastructure, equipment and supplies of essential drugs and commodities. Bottlenecks and interruptions have the potential to derail the aimed-for changes in behaviour. Similarly, service users need transport, financial capacity, and cultural acceptability to access services, even free services. This suggests that in many cases it will be beyond the scope of H4+JPCS interventions alone to address all three dimensions of behaviour change. The key question then becomes how does the programme engage with other initiatives which it complements so that, together, they can effectively contribute to behaviour change in the supply of (and demand for) services in RMNCAH.

Key points of support from global and regional to country level of H4+JPCS
The country level component of the overall theory of change for H4+JPCS also identifies the points where the global and/or regional levels of the programme are intended to support operations at country level.

1. Global knowledge products produced by H4+JPCS partners and global/regional advocacy assist national governments in identifying RMNCAH priorities and making commitments in line with international frameworks and national and global resources for RMNCAH.
2. The global/regional team (the global technical team and regional coordinators) and global coordinator (under the guidance of the Joint Steering Committee) develop and provide

country teams with guidelines and ongoing technical support for the joint development of integrated annual work plans, and associated results reporting frameworks.

3. The Joint Steering Committee reviews and approves integrated annual work plans and budgets. This allows the administrative agent (UNFPA) to release funds to the headquarters level of H4+ partners, for onward transfer to investments and activities at country level, in conformity with work plans. The administrative agent tracks expenditures against budgets and execution rates to facilitate any necessary reprogramming across investments within the work plans.
4. The global/regional team supported by the global and regional coordinators facilitates annual country to country meetings to allow for inter-country communications on successful innovations and on achievements and challenges, including strengthening results monitoring and reporting. The global/regional team provides technical support to the H4+ country teams on an as needed basis to review and strengthen interventions in the eight areas of health systems strengthening for RMNCAH. The global/regional team, assisted by the global coordinator, also provides technical assistance to H4+ Country Teams in gathering, analysing and reporting information on the results of work plans as they are implemented.
5. Global knowledge products developed by H4+ partners provide H4+ country teams, and their counterparts in government, with tools for incorporating agreed international standards of care in RMNCAH into efforts to build capacity and promote behaviour change.
6. The global/regional team and the global coordinator prepare and summarize results information, and assist in processes of monitoring and evaluation to allow for accountability to donor partners.

Key causal assumptions: country level

For use in evaluations, the identification of causal assumptions is perhaps the most important result of developing a fairly complete theory of change. It is these causal assumptions which can be tested to determine the credibility of programme claims to contribution toward results.

1. H4+ partners, in a process led by national authorities and encompassing key stakeholders, are able to develop and implement a coordinated process and platform 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 and enable joint support which is more integrated and coherent and provides more added value than the support normally provided by H4+ members. (*Relates to area of investigation three: responsiveness to national needs and priorities and area of investigation five: division of labour and coordination*).
2. H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unserved needs in the eight areas of health systems support. These include needs which are not fully met by other sources of support and, importantly, where programme support can build on investments and activities already underway. *(Relates to area of investigation one: strengthening health systems for RMNCAH)*.
3. H4+JPCS support at national and sub-national level can be sequenced appropriately[9] 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

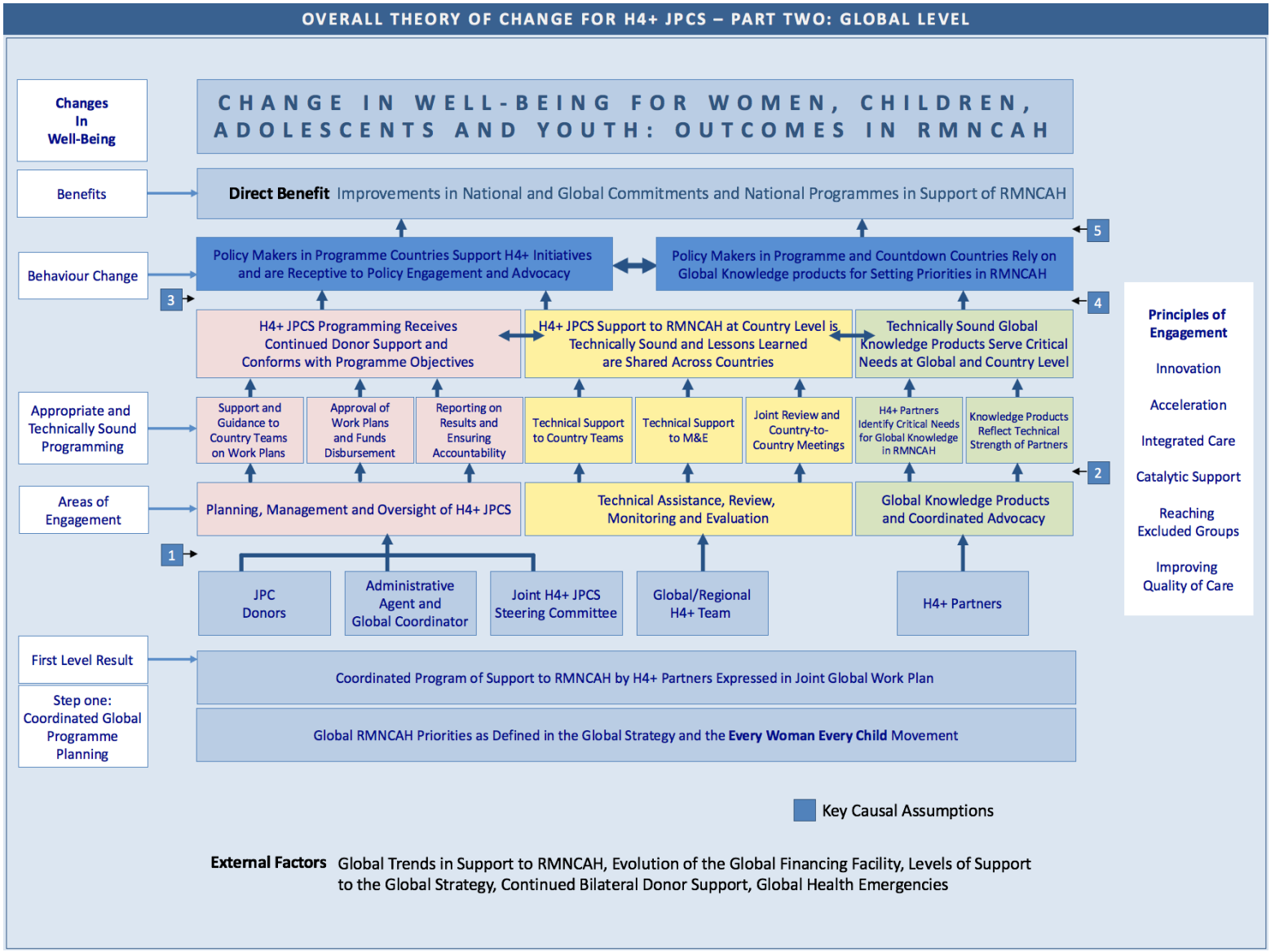
[9] Because H4+ JPCS support is meant to be catalytic and operates in conjunction with other programmes and investments in health systems support, it must provide resources in a timely way and take into account the planned and actual delivery of support from other sources. For example, support to training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

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

5. Demand creation activities and investments have sufficient resources, and are sustained enough over time, to make enduring positive changes in the level of trust between service users (especially including youth and adolescents and other members of marginalised groups in the community) and service providers. These investments and activities are not limited to demand side interventions, but also aim to change the attitude and behaviour of service providers toward users in an effort to build mutual trust. 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. *(Relates to area of investigation two: expanded access to integrated services along the continuum of care).*
6. The combination of improved quality of services in RMNCAH, increased trust and understanding between service providers and users, and increased capability and opportunity for service users to effectively demand care is sufficient to produce a notable increase in the use of services, and to overcome barriers to access which existed in the past. *(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).*

3.2.2 The overall theory of change – global level

Figure 2: Theory of Change for H4+JPCS at Global Level



The second part of the overall theory of change for the programme details three main pathways through which the global level of H4+JPCS seeks to contribute to results at both the country and global levels.

The first pathway involves support to the ongoing planning and management of the H4+JPCS programme. These functions are carried out by the administrative agent and global coordinator (UNFPA) working with the Joint H4+JPCS Steering Committee and supported in that work by the representatives of the two donors.

The second pathway involves the global/regional H4+ team providing ongoing technical support to H4+ country teams, and to national health authorities on the technical requirements of programme interventions, and on the requirements of systems for monitoring and evaluating the programme. It also involves the global/regional team in facilitating joint country to country planning and review meetings.

The third pathway at global level requires the H4+ partners to first identify critical needs for new or updated global knowledge products in RMNCAH. After doing so, they either jointly, or in their separate areas of expertise, develop technically sound and relevant global knowledge products which serve important needs at both the global and country level.

At the behaviour change level, policy makers in programme countries support the investments made under H4+JPCS as a result of competent management and quality technical support (and their own involvement in setting programme priorities). They also rely on global knowledge products developed with H4+JPCS support for establishing commitments and setting priorities in RMNCAH.

The points of contact from the global to the country level identified on the second part of the overall theory of change correspond to those illustrated in part one so need not be described here.

Key causal assumptions: global level

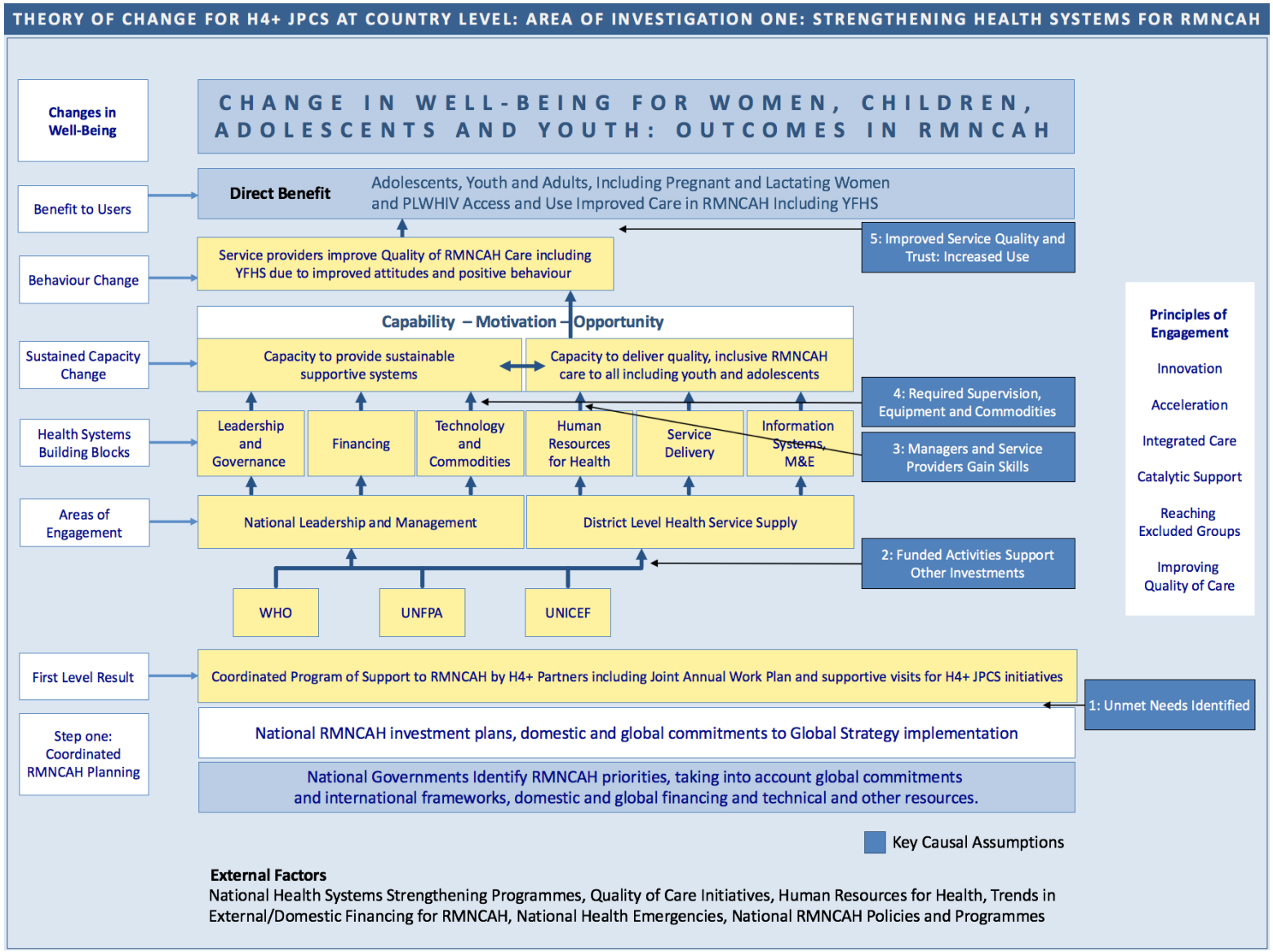
1. The systems and procedures used for planning, managing and results reporting for H4+JPCS (both within and among partners) are flexible enough to be responsive to the evolving needs of stakeholders in programme countries, especially national health authorities as expressed in national plans, policies and programmes. *(Relates to area of investigation three: responsiveness to national needs and priorities)*.
2. H4+ partners are able to allocate responsibility for developing global knowledge products in RMNCAH by taking into consideration both the critical needs at a global and country level and the distinct advantages in mandate, technical capacity and experience of each partner. They are also able to collaborate and undertake joint development of global knowledge products wherever appropriate. *(Relates to area of investigation three: responsiveness to national needs and priorities and area five division of labour).*
3. H4+JPCS supported global knowledge products are technically sound and relevant to the needs of policy makers in programme countries and they, in turn, are able to respond by incorporating policies, commitments and priorities in RMNCAH as expressed in those products into national plans and programmes. *(Relates to area of investigation two: responsiveness to national needs and priorities).*
4. Through its involvement in providing technical support to country teams and to regular cross country consultations, the global/regional technical team is able to identify and to help promote successful innovations in support to RMNCAH, both within and across countries. *(Relates to area of investigation four: innovation and scale up).*

5 The combination of a well-managed and accountable H4+JPCS programme, sound and relevant technical support to country teams, and well respected and relevant knowledge products, is further supported by coordinated advocacy and messaging by partners. As a result, policy makers in programme countries are receptive to policy engagement and advocacy for RMNCAH. *(Relates to area of investigation one, strengthening health systems in RMNCAH and two: responsiveness to national needs and priorities).*

3.2.3 Identifying pathways of change for area of investigation one

It is useful at this point to present an example of how the overall theory of change can be used to generate useful information on issues and causal assumptions at a level which corresponds to a specific area of investigation of the evaluation. By working with the overall theory of change – country level, the evaluation team was able to illustrate the different causal pathways and identify causal assumptions relating to area of investigation one: strengthening health systems for RMNCAH.

Figure 3: Theory of Change for H4+JPCS at Country Level: Strengthening Health Systems



- The boxes shaded in yellow illustrate the pathways through which H4+JPCS support at country level contributes to strengthening the quality of care in RMNCAH, especially on the first six of the eight output areas of the H4+JPCS. These yellow boxes are aligned with the two main areas of supply: national leadership and management and the supply of district level health services.
- While it varies across countries, in those countries supported with funds from Canada, most of the activities and investments on the supply side of health systems strengthening for RMNCAH flow through the WHO, UNFPA and UNICEF (although the latter is also involved quite often in demand promotion). Generally speaking, UN Women and UNAIDS are the agencies most heavily engaged on the demand creation side of health systems strengthening – corresponding to the two white boxes at the far right of the row marked health systems approach.
- The points where the global/regional team engage with and support health systems strengthening for RMNCAH have already been identified under the overall theory of change and need not be repeated.

Key causal assumptions: investigation area one strengthening health systems

1. H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unserved needs in the eight areas of health systems support for RMNCAH. The needs in each of the eight areas are not fully met by other sources of support and, importantly, programme support can build on investments and activities underway with national and external sources of finance and support to accelerate action.
2. H4+JPCS support to local and district levels provides appropriate inputs and funds activities capable of complementing other investments and contributing to strengthening service delivery in RMNCAH. In particular, the funded activities are appropriately sequenced and matched to support provided by other programmes and sources.
3. RMNCAH managers and service providers trained (pre and in-service) with support from H4+JPCS realize intended gains in competence and skills. These gains in skills and competencies are tested and verified during and after training.
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.
5. The combination of improved quality of services in RMNCAH and increased capability and opportunity for service users (especially marginalized women, youth and adolescents) 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. Note: this effect will not result from H4+JPCS initiatives alone but is dependent on effective investment and support to RMNCAH services supply and demand by other programmes and from other sources of investment.

3.3 Using the theories of change in evaluation design

The use of the theory of change to identify causal pathways for the remaining five areas of investigation is illustrated in Annex 1. In addition, Annex 1 includes the theory of change for the H4+JPCS programme in Zimbabwe which was developed based on the exploratory mission. It served as the template for the country level portion of the overall theory of change for the programme. The pathway theories of change provided in Annex 1 include identifying numbers for the causal assumptions associated with each. These can be found in the evaluation matrix presented in Chapter 5.

4 METHODOLOGY

4.1 Evaluation approach

The evaluation is designed to meet its objectives and successfully carry out a core set of evaluation tasks by using contribution analysis as its central, theory based, analytical approach. Successful application of contribution analyses begins with the development of a credible theory of change for the H4+JPCS that is capable of illustrating the causal links and causal assumptions which inform it, as presented in Chapter 3.

Contribution analysis was selected as the most suitable overall approach to addressing the evaluation tasks identified in the Terms of Reference (ToR):

- Documenting results in reproductive, maternal, newborn, child and adolescent health (RMNCAH)[10] at global regional and national levels, especially those identified in the results framework for the H4+JPCS
- Credibly identifying and documenting the contribution made by the H4+JPCS to observed results in RMNCAH
- Ensuring coverage of the evaluation criteria and indicative areas of investigation as detailed in the terms of reference
- Generating lessons learned and opportunities for improved cooperation by the H4+ partners for support to improved access to quality services in RMNCAH
- Addressing the rights focus of the H4+JPCS as it aims to incorporate attention to gender equity and social inclusion into its achievements.

Applying contribution analysis as the central analytical approach of the evaluation requires the completion of the following steps (Mayne 2008: 2).

1. Set out the attribution problem to be addressed
2. Develop and adapt a theory of change for the programme and its related assumptions
3. Gather existing evidence on the theory of change and the changes have taken place along identified causal pathways
4. Identify the contribution of the H4+JPCS to those changes (the contribution story)
5. Seek out additional evidence where it is needed
6. Revise the theory of change and identify the contribution of the H4+JPCS to positive outcomes in RMNCAH.

The first of these steps was carried out during the preparatory phase of the evaluation and the preparation of the terms of reference (ToR) with the identification of evaluation criteria and indicative areas of investigation. The second step was carried out during the inception phase and is illustrated in Chapter Three and Annex One. The second step resulted in draft theories of change for H4+JPCS and a set of evaluation questions and causal assumptions which cover the evaluation criteria and areas of investigation as set out in the ToR.

Steps three to five are the focus of the data collection phase of the evaluation which is the subject of the Inception Report, while step six will be undertaken during the analysis phase.

[10] The evaluation uses the term reproductive, maternal, newborn, child and adolescent health (RMNACH) because it is becoming more common in international discourse and H4+JPCS programming at country level often has a significant component aimed at improving access to quality care for adolescents, especially girls at risk of early marriage.

All of the qualitative and quantitative evidence to be gathered during the evaluation, a process already begun during the inception phase, will be consolidated and used to:

- Document results achieved in support of RMNCAH the global, regional and country levels
- Test the strengths and weaknesses of the theory of change and identify the contribution of the H4+JPCS to results and the pathways of change for each of the evaluation areas of investigation, taking into account the interdependence of outputs and their close association (e.g. capacity building/demand creation; integration/equity; innovation/acceleration, information systems/ accountability)
- Identify the linkages and connections between H4+JPCS action at the global and regional level and contributions at country and district level
- Identify effective innovations and programme elements which can be used to inform collaboration by the H4+ partners in the emerging architecture for supporting RMNCAH, especially relating to platforms and mechanisms for coordination, cooperation and collaboration.

4.1.1 Important considerations in applying contribution analysis to H4+JPCS

In applying contribution analysis to the evaluation of the H4+JPCS, it is important to give careful consideration to a number of characteristics of the programme which are particularly relevant because of the chosen analytical framework:

1. The programme is meant to by catalytic. It aims to build on the ongoing work of national and local health authorities in RMNCAH and the support provided to that work by other programmes and organizations, including bilateral and multilateral development agencies and international non-governmental organisations (NGOs). Contribution analysis explicitly recognises that outcomes are almost always the result of multiple influences and efforts, and cannot normally be attributed to any one intervention.
2. Contribution analysis incorporates elements of realist evaluation and, as a result, is particularly useful in recognizing the role that context plays in the achievement of results. As a group, the ten H4+JPCS countries face a wide ranging set of daunting contexts including: the recent Ebola virus emergency, recent histories of conflict, and varying degrees of economic and social crisis and recovery. They all share a common experience of a high burden of maternal and child mortality and disease. In applying the chosen data collection and analysis methods, the evaluation will need to be especially careful to situate the programme contribution into the changing global, national, and local contexts.
3. The H4+JPCS aims to accelerate progress toward achievements in RMNCAH at global, regional and national levels but with its primary emphasis on action in the ten programme countries. Eighty-six percent of combined Canada and Sweden overall programme funding was spent at the programme country level in 2014 (UNFPA 2015a). In order to accelerate progress in improving RMNCAH while remaining catalytic at country level, one important strategy used by the H4+JPCS has been an emphasis on innovation and the scaling up of proven approaches to strengthening RMNCAH services. The implication for the evaluation is that contribution analysis in this instance will need to take account of the causal linkages and assumptions underlying the full cycle of innovation: from identification of an opportunity to experimentation, documentation, and adaptation of the results.
4. The global and regional levels of H4+JPCS, while accounting for a relatively small proportion of expenditure, have significant roles in the programme. These different roles indicate that the evaluation will need to take into account the interlinkages between the global/regional and country levels of programming. These interlinkages are reflected in the evaluation matrix and the date collection tools developed for the evaluation.

4.2 Data collection

The evaluation will use a combination of qualitative and quantitative methods for data collection and analysis and will triangulate the information drawn from each method by consolidating them through use of the evaluation matrix presented in Chapter 5. Quantitative methods (closed elements of the online survey, profiles of financial data, trend analysis of RMNCAH outcomes data) will help to relate the programme operations to trends in both inputs and outcomes, especially at national and sub-national levels. Qualitative methods (document reviews, interviews, focus group discussions, open elements of the on-line surveys) will provide the evaluation with a deeper insight into the operations of the H4+JCPS, and its contribution to outcomes in RMNCAH.

Data collection methods include:

- A comprehensive review of global, regional and country level documents
- A review and profiling of internationally available data on outcomes in RMNCAH for the 10 programme countries
- Key informant interviews and focus group discussions with key stakeholders at global, regional, national and sub-national levels
- Four field country case studies (the Democratic Republic of the Congo (DRC), Liberia, Zambia and Zimbabwe)
- Six desk country case studies (Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, Guinea Bissau and Sierra Leone)
- An on-line survey of H4+JPCS supported agencies, partners and national health authorities in the ten programme countries and key stakeholders in the wider group of countdown countries.

The methods and tools to be used in the data collection phase have been developed and tested during the inception phase. However, they will continue to be refined prior to full deployment in document reviews, surveys and field country case studies.

4.2.1 Document Review

The document review process began immediately at the beginning of the inception phase and will continue throughout the data collection phase. During the inception phase, the document review was used to reconstruct the intervention logic and to develop the overall and pathway theories of change described in Chapter 3. The review provided a basis for preparations for the exploratory mission to review the H4+JPCS programme in Zimbabwe, and the refinement of the evaluation approach and methodology.

During the preparatory phase, the Evaluation Management Group, under the leadership of the Evaluation Office at UNFPA, developed a database of relevant documents on the H4+JPCS at global and regional levels in cooperation with the H4+ partners, especially H4+ coordinators in the ten programme countries. These documents were arranged in a nested system stored on the internet and accessible to the evaluation team through a Google drive. During the inception phase, and into the data collection phase, the evaluation team will supplement this data base with additional relevant documents.

The task of systematically reviewing the documents in the database is a formidable one. By reviewing the contents of the various folders electronically, the evaluation team has identified some key characteristics of the database as it currently stands (March 24, 2016);

- There are a total of 8,348 documents in the database, including word documents, PDF files, excel spreadsheets and power point presentations. This number also includes 100 folders of compressed files in ZIP format.
- The database includes a wide range of items which are not in document form including photos, electronic mail messages, web pages and videos in various formats. When these are added to the documents, the total of all the items in the database is 14,282.
- The documents and other items are deposited in a structure of nested folders and include duplicates and multiple drafts of the same document but these are not always dated or identified as such.
- While the database is large and complex it is not always complete for some important categories of documents. For example, not all of the ten countries uploaded stakeholder maps in the designated folders when the database was reviewed electronically on March 24.
- While there was an effort to encourage H4+JCPS coordinators to upload documents into the database in compliance with rules for assigning documents to the correct folders, these have not always been followed. As a result, it is not always possible to determine if a particular document has, in fact, been placed in the database (since it may have been misfiled).

While reviewing the documents based on their current organisation represents a formidable challenge, the evaluation team will apply a systematic approach to ensuring that those documents most relevant to the evaluation are obtained and properly reviewed.

This process begins with the identification of a set of core documents for review, including:

- H4+JPCS annual work plans at global and country levels
- H4+JPCS results frameworks and results reports at global and country levels
- H4+JPCS annual reports
- Minutes from the H4+ Joint Steering Committee and in-country coordinating committees
- Programme review and evaluation documents at global and country level
- H4+JPCS planning and monitoring mission reports at global and country level
- National plans and programmes in RMNCAH in the 10 programme countries
- Documents produced by other agencies evaluating or assessing programmes and conditions in RMNCAH in the 10 programme countries
- Global knowledge products produced with the support of H4+JPCS
- Stakeholder maps at global and country level.

This set of core documents will be augmented during the data collection phase. The core documents will be copied from the current database and placed in a small set of clearly labelled folders for easy access by all evaluation team members. During the course of the evaluation, the evaluation team will identify, locate and upload other key documents from the existing database into the smaller and more accessible core document folders. The remaining documents will be accessed and reviewed using electronic means through structured key word searches.

The core documents will be used in accordance with the specifications set out in the evaluation matrix. These include, among others:

- Identifying a set of sample global knowledge products for analysis and for use as examples in discussions and interviews at country level regarding their relevance, technical quality and utility
- Profiling H4+JPCS programming in each of the ten programme countries

- Reviewing the evolution of the programme over time, especially platforms and processes for coordinated programming and collaborative action at global and country levels
- Identifying key stakeholders and upgrading the existing stakeholder maps
- Securing data on conditions and outcomes in RMNCAH at national and sub-national level where it is contained in documents
- Identifying trends in the context for RMNCAH in the programme countries.

The non-core documents will be used to supplement information gathered from the sub-set of core documents. When the key word search indicates a particular document should be upgraded from non-core to core, it will be uploaded into the smaller database of core documents. This process is already under way.

The evaluation will not limit itself to documentary sources (or to knowledge and opinions of key informants) which is internal to, or focused on, the H4+JPCS alone. In order to adequately assess the programme contribution to results, especially in health systems strengthening, it will be necessary to review documents and interview key informants with knowledge of the wider landscape of support to RMNCAH at both a global and country level.

4.2.2 Data analysis

The process of data analysis began with identifying a set of key indicators of outcomes in RMNCAH for the ten programme countries and tracking trends in those indicators over the programme period. The results of this process are presented in Annex 3.

Wherever possible, national data on outcomes in RMNCAH is drawn from the “Countdown to 2015” website. Countdown data is used as a first choice because it represents an agreed upon, multi-institutional collaboration for tracking critically important information on RMNCAH. For indicators not included in the Countdown data set, the evaluation relies on other reliable sources. The trends in national data presented in Annex 3 will be used to establish the context for H4+JPCS in each country before and during the H4+JPCS programme. The national data will also be used as a background and context for any data on RMNCAH service availability and outcomes at sub-national level.

At sub-national level, the exploratory mission to Zimbabwe indicates that there are a number of data sets which can provide useful information on the availability and use of RMHCAH services and even outcomes at district level. These include:

- Data on service availability and coverage compiled at district level for the H4+JPCS results reporting framework in each country
- District Health Management Information Systems (DHIS) data on service availability and outcomes which is often now more accessible in Zimbabwe under a more computerized DHIS2 system
- Data compiled for other initiatives operating in the same districts as H4+JPCS such as the Performance-Based Financing (PBF) programme in Zimbabwe. This programme tracks indicators of performance and service quality at the facilities level with data made available to the public on the internet.

Before and during each field country case study mission, the evaluation team leader for that country will request a set of indicators of RMNCAH service availability, use and outcomes for the districts where H4+JPCS is active. Where similar data is available from other districts, it can be used to establish context. These districts, should not, however, be used as a direct comparison. In most countries, the H4+JCPS districts of concentration were chosen specifically because they were high

burden areas with poor outcomes in RMNCAH. As a result, using even neighbouring districts as a counterfactual would be inappropriate.

4.2.3 Key informant interviews and group discussions

Key informant interviews will be carried out at global, regional and country levels and will engage the H4+JPCS partners and a wide range of stakeholders. This process was initiated during the inception phase with interviews of members of the Joint Steering Committee, headquarters staff of the H4+ partners, and representatives of Canada and Sweden. In addition, the exploratory mission allowed the evaluation team to conduct interviews with the H4+ coordinator and the Zimbabwe country team as well as representatives of the UN H4+ member organisations in Zimbabwe. The team also conducted interviews with Zimbabwean health authorities at national, provincial and district levels as well as group discussions with community members.

As the evaluation enters the data collection phase, the evaluation team will carry out structured interviews and group discussions with key informants selected across the spectrum of H4+JPCS stakeholders. Stakeholder maps have been developed at global and country levels (Annex 2). For presentation purposes the country stakeholder maps are represented by the map for Zimbabwe. Table 3 provides a list of some of the most important stakeholders for interviews and group discussions.

Table 4: Categories of key stakeholders for interviews and group discussions

Level Stakeholder	Key Stakeholders for Interviews and Group Discussions
Global/Regional	• H4+ Joint Steering Committee members • Other members of the global/regional H4+ team • Current and former donor representatives – Canada and Sweden • Staff at the Partnership for Maternal Newborn and Child Health (PMNCH) • Staff of the independent Expert Review Group (iERG) • Staff of the Global Financing Facility • Staff of international NGOs and federations active in RMNCAH for example the International Confederation of Midwives
Country	• H4+JPCS coordinators • H4+ country teams and staff of H4+ member organisations including representatives • Staff of multilateral and bilateral agencies active in support of RMNCAH and knowledgeable of support to HSS for RMNCAH • Staff of international and national NGOs active in RMNCAH • National health authorities including staff responsible for reproductive health, family health, youth and adolescent health and HIV and AIDS (PMTCT) and services in RMNCAH • Senior staff of national authorities responsible for women's affairs, gender equality, youth and adolescents • Health authorities at provincial and district levels • Staff of district hospitals and health facilities providing care in RMNCAH

Level Stakeholder	Key Stakeholders for Interviews and Group Discussions
	• Staff of other lead agencies implementing specific H4+JPCS supported initiatives at national and local level including NGOs • Community groups and advocacy organizations representing marginalized group members at national and local level • Groups of community members making use of or in need of services in RMNCAH including adolescents and youth (unmarried and married), pregnant and lactating mothers, women seeking or receiving perinatal care, women in mother waiting facilities and others depending on the focus of initiatives in the countries and districts under review

Draft protocols for interviews and group discussions are provided in Annex Five. They were developed and first tested during the Zimbabwe exploratory mission, and will be further refined based on experience and on the content of the evaluation matrix.

4.2.4 Field country case studies

Objective

The field and desk country case studies are the core of this evaluation. Together they cover all ten programme countries which account, in most years, for more than 80 percent of programme expenditures. The remaining 20 percent spent at global level is, in turn, intended to provide essential support to the work of H4+JPCS at country level. The overall objective of the field country case studies is to provide inputs useful to addressing all six evaluation questions as they apply at country level. By answering these questions, the studies allow for testing the most important causal assumptions which underlie the H4+JPCS theory of change, and credibly verifying the programme contribution to results in RMNCAH.

Operational Planning and Scheduling

The relevant field country case study team leader is responsible for advance planning of each field country case study. They will also ensure that accessible country relevant documents are obtained and reviewed prior to the field country case study mission. Advance, on the ground, logistical planning will be led by the evaluation team national research assistant in each country, working closely with the H4+ coordinator. This process has already begun in all four field case study countries. Constant and open communications between the relevant field case study team leader, the national team member, and the H4+ coordinator will be maintained prior to the field visit.

Table 5: Timing and lead responsibility for the field country case studies

Field Case Study Country	Team Leader	Dates
Zimbabwe (Pilot)	Ted Freeman	June 6 to June 22
Liberia	Allison Beattie	May 30 to June 15
Zambia	Allison Beattie	July 6 to July 22
DRC	Jacques Emina	August 8 to August 24

In each field case study country, the evaluation team will follow the same basic plan of operations.

Table 6: Operational plan for field country case studies

Basic Operational Plan for Field Country Case Studies	
Task	**Timing**

Refine data collection instruments and operational plan	Basic outline plan communicated by end of inception phase – detailed plan agreed at least two weeks prior to mission start up
Develop and transmit detailed requests for data	One month prior to mission start up
Refined operational plan	Two weeks prior to mission start up
Confirm logistics, transport, permissions for district level work	No later than one week before mission start up
Field mission start	Monday week one
Meeting with H4+ coordinator and group discussion with H4+JPCS country team	Monday of week one
Briefing with country Evaluation Reference Group	In the first two days of the mission
Meetings and interviews with key stakeholders in the capital	First two to three days of the mission
Travel to first province/district	
Provincial and district work in district one chosen for concentration of H4+JPCS activities	Second half of week one
Travel to second province/district	Weekend at the end of week one
Provincial and district work in district two chosen for concentration of H4+JPCS activities	First part of week two
Return to capital and team briefing on district level evaluation information	Mid-week two
Continued meetings with key stakeholders in the capital	Second half of week two
Team workshop to develop preliminary findings and identify information and data gaps for follow up	Weekend between weeks two and three
Presentation of preliminary findings to the Evaluation Reference Group	Monday of week three
Follow up interviews and data collection	First half of week three
Debriefing of H4+ coordinator and team departure	Mid-week three
Preparation and submission of the Draft Field Country Case Study Note	Within four weeks of departure

Analysis and Reporting

Analysis begins during the field country case study mission with the preparation of preliminary findings for presentation and discussion with the country evaluation reference group (ERG). This will serve as part of the validation process and will assist the country case study team in populating the evaluation matrix. However, the presentation and discussion with the national ERG is mainly for the validation facts and careful consideration of context. Final approval of the country case study notes rests with the EMG.

On completion of the field country case study mission, each team will populate the evaluation matrix with the quantitative and qualitative country specific data gathered before and during the mission. The team will also revisit and refine the H4+JPCS theory of change at country level as it applies to a specific field case study country. This process has already begun for Zimbabwe with the development of a more detailed, country specific, theory of change diagram during the exploratory mission.

Under the direction of the country case study team leader, each team will then consolidate the data in the evaluation matrix and prepare the draft field country case study note for review by the overall

evaluation team leader. This will be done before the draft note is submitted to the internal quality assurance process. On review and approval based on the evaluation team internal quality assurance process, the note will then be forwarded to the Evaluation Management Group. It is important to note that the internal quality assurance team will determine that the content of the main body of the note is consistent with the content of the evaluation matrix associated with it. This will include assurance that the data and information in the matrix is well presented, understandable and complete, and is presented under the correct assumption.

Using the results of the field country case studies and the link to desk country case studies
The field country case studies for the evaluation have been designed in accordance with Robert Yin's definition of a case study as "an empirical study that investigates a contemporary phenomenon in depth and within its real life context" (Yin 2009: 18). As he and others have pointed out, a case study is not a research method of investigation but the subject matter of the research. As such, the field country case studies will rely on multiple data collection methods including document reviews, key informant interviews, pre-post comparisons of quantitative data trends, site observations, and group discussions.

The results of all these methods will be captured in the evaluation matrix and analysed in order to answer the evaluation questions and test the causal assumptions it contains. The ultimate result of the field country case studies will be a reasoned and balanced assessment of the contribution H4+JPCS has made to accelerating progress in improving RNMCAH outcomes in the country.

During the synthesis process and preparation of the draft final report, it will be essential to link the findings of the field country case studies to those developed for the desk country case studies. This will be made easier by the use of a common structure for both the field and desk country case studies.

The **desk country study notes** will be much shorter than those for field country cases studies and will be focused on a sub-set of the causal assumptions identified in the matrix. Nonetheless, it will also be possible to use the findings of the field country case studies as a tool for analysis of the desk studies. This is partly because some of the field and desk case study countries share very important common contextual factors; such as the common experience of the Ebola virus emergence in Liberia and Sierra Leone.

It is essential that the process of synthesizing evaluation results into findings for the draft final report is able to consider the results of all ten case studies, even though the field case studies will represent a much more in depth testing of the theory of change for H4+JPCS at country level.

4.2.5 Desk country case studies

The overall evaluation methodology and approach relies heavily on the use of case studies, not only in the field case study countries but in the six countries where a desk study will be carried out. As a result, it is important that the desk country case studies should be as systematic, thorough and analytical as possible. They must be more than just a compilation of quantitative and qualitative data and should therefore include an analytical component.

Objective:
The objective of the desk country case study notes is to analyse existing and available documentation, data and information (supplemented by phone/skype interviews with selected key informants) on the H4+JPCS in selected countries. The desk-based case study notes will contribute to the overall evaluation with supplemental input to answer the evaluation questions and to triangulate with other data collection methods, i.e., field-based country case studies and the online survey. The

desk-based country studies will provide descriptive and illustrative input for the overall evaluation synthesis report through the identification of key issues and lessons learned.

Timing:
The desk-based country studies will be carried out in the period May to July 2016. They will be completed prior to the availability of the draft field country case study notes.

Countries/persons responsible:
Members of the core evaluation team will be assigned at least one desk-based country case study to complete, which will ensure that the team has a broad understanding of country context for H4+ programme activities during the synthesis process. The countries and assignments are noted below.

Table 7: Evaluation team assignment for desk country case studies

Country	Responsible Team Member
Burkina Faso	Camilla Buch von Schroeder
Cameroon	Camilla Buch von Schroeder
Côte d'Ivoire	Jacques Emina
Ethiopia	Lynn Bakamjian
Guinea Bissau	Allison Beattie
Sierra Leone	Ted Freeman

Methodology:
The methodology will consist of a comprehensive review of available documents and data on the planning, implementation and monitoring of H4+JPCS activities in the countries.

Table 8: Documents to be reviewed for the desk case studies

Desk Case Study Documents to be reviewed
• Implementation agreements between UN agency and government and partner organizations
• H4+JPCS annual work plans
• H4+JPCS annual reports
• Minutes from H4+ in-country coordinating committees
• Special programmatic documents or technical reports
• Progress updates
• Meeting reports
• Other agency documents to provide general background on related RMNCAH in-country context, policies, plans and/or special initiatives

The documentary evidence collected will be supplemented by two to three phone or Skype interviews with key informants familiar with H4+JPCS implementation in the country. The key informants will be selected in consultation with the H4+ coordinator and will likely include a representative from the Ministry of Health, the H4+ in-country coordinator, and perhaps another key implementation partner (for example, the Ministry of Women's Affairs). The purpose of these interviews will be to clarify points and obtain additional in-depth information. Information gleaned from the review will be organised in an evaluation matrix, which consists of a subset of evaluation questions that are best addressed through documentary evidence. In addition, a dataset of key indicators for RMNCAH at the national level will be included in each desk-based country note. The deputy team leader will review final drafts of completed desk-based country case study notes and related matrices for quality assurance purposes prior to finalisation.

4.2.6 Online Survey

Objectives

The online survey will be used to collect evidence on the H4+JPCS in terms of its relevance, responsiveness, utility and perceived level of contribution to outcomes in RMNCAH in and beyond the ten programme countries and at regional and global levels. It will directly address a number of the important assumptions used to test the theory of change for the programme. The link between the online survey responses and specific evaluation questions and assumptions is illustrated in the evaluation matrix in Chapter Five. The survey will solicit responses from staff from the H4+ member organisations as well as programme stakeholders and partners.

Operation and content

Using Survey Monkey, a web-based survey tool, two draft questionnaires have been developed that explore the work of the H4+ at global, regional and country levels. One questionnaire is aimed at H4+ colleagues working at global, regional and country levels. The second questionnaire is shorter and aimed at H4+JPCS stakeholders and partners. Contacts for both groups will be gathered from H4+ coordinators in the 38 countries with an H4+ coordinating structure. Contacts for the other 37 countries will be gathered through consultation with UNFPA lead technical staff for RMNCAH. The evaluation team will review contacts provided by the coordinators and will actively follow up to ensure that an adequate number of appropriate respondents is identified. As needed, they will be supported in this endeavour by the EMG and the global coordinator.

The questionnaires combine both open and closed questions and create opportunities analysing both qualitative and quantitative material. The finalised questionnaires will be comprised of approximately 20 to 25 substantive questions. These will be refined by the evaluation team and tested prior to the survey launch. The draft questionnaires are provided in Annex Four. The questionnaires should be online by 1 May 2016, and remain online until the last field country case study mission is started. Each respondent will have a three weak time frame for completing the survey with two reminders sent if their response is not completed in the original time period.

Sampling frame and targeting strategy

The survey will aim for the widest dissemination possible. The questionnaires will be sent proactively to all H4+JPCS staff working on RMNCAH including the H4+ coordinator and country team members in each of the programme countries, and to those in the countries outside the programme which have a designated H4+ coordinator, as well as staff at regional and global levels. Using a letter describing the objectives and content of the survey, the H4+ coordinators will be requested to forward the link to the survey to a wide range of programme partners in each H4+JPCS country, together with a brief explanation of the evaluation and the purpose of the survey. At the regional and global level, the sampling pool will include the H4+JPCS global technical team and staff of the H4+ partner organisations working in reproductive health and RMNCAH. H4+ regional and global coordinators will be asked to nominate stakeholders from outside the H4+ partnership who could be invited to complete the questionnaire as well. The aim of this sampling and distribution procedure will be to secure the widest possible response, including from the countdown countries not participating in the programme.

4.2.7 Sampling and Triangulation

Sampling

It is important to note that for all forms of data collection and subsequent analysis (document reviews, key informant interviews, group discussions and online surveys), the evaluation does not make use of a randomized, statistically valid sampling processes.

Instead, in each case, the evaluation follows a strategy of either a census approach (identifying and securing access to **all** of the most important key informants or critical documents) or a purposive

sample. The purposive samples are aimed at selecting specific sources of information which are as illustrative as possible of the contribution made by the H4+JPCS to results in RMNCAH. For example:

- **All ten programme countries** are subject to either a field or country case study
- **A set of core key documents** has been identified and secured for each country case study
- **Key informants at central level in each field case study country** have been purposively chosen through consultations between the evaluation team and the H4+ coordinators to identify partners and other informants most knowledgeable about the programme and its contribution to results, while ensuring the evaluation has access to a diverse set of experienced key informants. The initial list of key informants is expanded in each country during the evaluation mission as new candidates are identified
- **Sub-national provinces and districts** in each field case study country have been identified based on the level of activity supported by H4+JPCS members in those provinces and districts, and to allow for a clear illustration of work in diverse geographic but high-burden districts
- **Potential respondents to the online survey** are being identified through consultations with H4+ coordinators or UNFPA technical lead staff in each countdown country
- **Quantitative data on results indicators** is being gathered from all potential sources at country level in order to build a profile of progress relative to the H4+JPCS intended results. Variations may be expected from country to country, but not as a result of different sampling strategies.

This approach is especially relevant for an evaluation with a strong methodological focus on case studies. The research goal of the case studies is not to arrive at a point estimate of stakeholder opinion, or a statistical estimate of a quantitative outcome, both goals which are best achieved through statistically valid, random sampling approaches. Rather, the case studies in this evaluation focus on identifying the contributions made by H4+JPCS to a set of shared outcomes: a goal much more readily served by using a census approach where possible and a purposive sampling approach where it is not.

Triangulation

In applying contribution analysis as a central analytical approach, the evaluation will rely on triangulation both across and within categories of data sources. The evaluation will, for example, triangulate the responses of different key informants at global, regional and country level, to ensure that differences of experiences and opinions are not lost to the analysis. Key informant interview and group discussion results from different health facilities and districts within each field case study country will also be triangulated and compared. Similarly, the results of the online surveys will be compared and triangulated with the opinions and experiences related by key informants in the field case studies.

The central focal point for triangulation of all qualitative and quantitative information will be the testing of key causal assumptions relating to each of the areas of investigation/evaluation questions. This is especially appropriate given that challenging and validating causal assumptions is a core task in contribution analysis.

4.3 Limitations of the methodologies

The scope and depth of the end line evaluation of the H4+JPCS represents a significant methodological challenge. The evaluation approach taken serves to meet that challenge by using a grounded, theory based approach, which has been proven in other, similar evaluations (Danida

2014). Nonetheless, the approaches and methodologies used in the design do have some inherent limitations and risks:

1. The availability of quantitative and qualitative data will vary significantly from country to country, including the field case study countries.
2. The context for each of the ten programme countries is quite unique, although there are some commonalities. Findings of the field country case study notes will need to be carefully calibrated to take note of differences in context.
3. Care will be required in assessing the contribution of H4+JPCS in the context of other programmes of support to health systems strengthening at national and sub-national level. This is a difficult area of analysis and will require the evaluation team to take account of alternative explanations for the results observed. This can be done with specific reference to the eight output areas of H4+JPCS as identified in the theories of change.
4. On line surveys, while inexpensive and efficient, often struggle to achieve reasonably high response rates. The evaluation team will work diligently at identifying the sample frame and will use reminders to boost the response rate. Nonetheless, it will be important to recognise the limitations of the surveys when analysing the responses.
5. The identification of causal pathways in all six areas of investigation of the evaluation with associated causal assumptions for testing (as identified in ToCs in Chapter Three and Annex Four) opens up many avenues for further data collection and analysis. The evaluation team will need to be both focused and efficient in gathering data, populating the evaluation matrix, and arriving at findings and conclusions. There is a risk of lack of focus if this is not done in a disciplined way.

While these risks and limitations are real, they do not seriously weaken the overall validity of the evaluation design or the suitability of the methods chosen for data collection and analysis. If the work of the evaluation is centred on the careful use of contribution analysis and grounded in a recognisable and realistic theory of change, past experience indicates that it should meet its objectives.

5 PROPOSED EVALUATION QUESTIONS

5.1 Developing the evaluation questions

Working with the nested theories of change and the causal pathways described in Chapter 3, the evaluation team developed an overall evaluation question (with sub-questions as necessary) for each of the six areas of investigation of the evaluation. These were then matched with the relevant causal assumptions identified under the appropriate theory of change (ToC) (so that they could be narrowed and made more specific), before matching them with indicators, data collection methods and sources.

In some cases, the overall and pathway theories of change have highlighted specific aspects of the areas of investigation which call for closer attention. One example is the crucial importance of effective mechanisms for coordinated programme planning, especially at national level and under the leadership of national health authorities. This has been reflected in the questions for area of investigation five; division of labour.

5.1.1 The evaluation questions

Table 9: Evaluation questions

Evaluation Questions
Area of Investigation One: Strengthening Health Systems
1. **Evaluation 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?[11] a. To what extent has regional and global technical support from H4+ helped enable country teams and national health authorities to identify opportunities, develop innovative approaches and design technically sound initiatives to strengthen health systems for RMNCAH? b. To what extent have H4+JPCS programmes at country level supported health systems strengthening interventions which are catalytic and have the potential to build on existing or planned interventions with international or national sources of funding? c. Are H4+JPCS supported investments sufficient in reach and duration to contribute to lasting changes in capacity for service providers which can sustain behavioural change? d. Are H4+JPCS supported investments at sub-national level (especially in high burden districts) capable of demonstrating approaches to health service strengthening which can be taken to scale at sub-national and national levels?
Area of Investigation Two: Expanded Access to Integrated Care
2. **Evaluation 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 marginalized groups and in support of gender equality? a. How have H4+ interventions contributed to strengthening the quality and appropriateness of care in RMNCAH provided to marginalised and excluded (encompassing skills and attitudes of staff, availability of equipment and supplies and timing of services)? b. To what extent have H4+JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women? c. How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care? d. To what extent do H4+JPCS investments and activities (alone or in conjunction with other programmes of support) contribute to developing trust between service providers and users of RMNCAH services and are these efforts sustained? e. To what extent have H4+JPCS investments contributed to positive changes in outcomes in RMNCAH?
Area of Investigation Three: Responsiveness
3. **Evaluation 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?

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

Evaluation Questions
a. Is the basic structure of the H4+JPCS (decision making structures, management processes, approval mechanisms, disbursement rules and procedures) able to respond to evolving and changing contexts and situations in a timely and appropriate manner? Does the structure place countries at the centre of the programme? b. As the programme has evolved over time, has it become more flexible in responding to changing contexts and events, for example the Ebola Viral Disease outbreak or to changing national plans and priorities?
Area of Investigation Four: Innovation and Scale Up
4. Evaluation 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)? a. How do H4+JPCS partners and health authorities and other stakeholders at national and sub-national level recognized potentially effective innovations in RMNCAH? b. How is information on the success or failure of innovations supported by the programme gathered and made accessible to decision makers within and across H4+JPCS countries? c. What evidence indicates that successful H4+JPCS supported innovations have been replicated across districts, at national level or in other programme or countdown countries?
Area of Investigation Five: Division of Labour
5. Evaluation Question Five: To what extent has the H4+JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities? a. Has the H4+JPCS programme contributed to the development of effective and robust platforms and operational systems for coordinating support to RMNCAH at country level by the partners? Will these platforms and systems persist in one form or another beyond the period of programme funding? b. Do the resulting programmes of support to RMNCAH at country level make best use of the individual strengths of H4+ partners? Is there a distinguishable value added over the existing programmes of the H4+ partners? c. Do efforts at coordination result in collaborative programming? d. Has the programme contributed to strengthening platforms and systems for global and regional coordination by H4+ partners in support of RMNCAH including coordinating partner contributions to the development of global knowledge products?
Area of Investigation Six: Value Added for the Global Strategy
6. Evaluation 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"? a. To what extent has H4+JPCS contributed to more effective advocacy for international and national commitments to operationalize Global Strategy principles and accelerate actions to strengthen RMNCAH investments and systems? b. During the life of the programme, how well did the H4+ partners support existing global structures (for example, the PMNCH, the iERG, the Commission on Information and Accountability) for supporting action in RMNCAH?

Evaluation Questions
c. 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

5.2 The evaluation matrix

The tables below show the full evaluation matrix. For each area of investigation, the matrix identifies: (i) the evaluation question; (ii) the corresponding evaluation criteria; (iii) the rationale for including this area in the evaluation; (iv) the chain of reasoning identified in the reconstructed theory of change. This is followed by (v) the "unpacking" of the questions into a series of assumptions, (vi) together with their indicators and (vii) sources of information, both quantitative and qualitative. Although each area of investigation has been tabulated separately, the important links and synergies between them will be fully explored in the data collection and analysis. The data collection sources and methods indicated in the evaluation matrix are descriptive and do not contain information on the sampling methods used for selection within each category. These are described in section 4.2.7.

Pathways of change for each investigation area have been mapped on the diagram of the reconstructed theory of change. The evaluation hypotheses ("assumptions for verification") have been developed from the pathways, focusing on the key links and processes for each area of investigation.

Table 10: Evaluation matrix for evaluation question one: Strengthening health systems for RMNCAH

Evaluation Question One: Strengthening Health Systems for RMNCAH	
1. Evaluation 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? a. To what extent has technical support from H4+ global/regional teams helped enable country teams and national health authorities to identify opportunities, develop innovative approaches and design technically sound initiatives to strengthen health systems for RMNCAH? b. To what extent have H4+JPCS programmes at country level supported health systems strengthening interventions which are catalytic and have the potential to build on existing or planned interventions with international or national sources of funding? c. Are H4+JPCS supported investments sufficient in reach and duration to contribute to lasting changes in capacity for service providers which can sustain behavioural change? d. Are H4+JPCS supported investments at sub-national level (especially in high burden districts) capable of demonstrating approaches to health service strengthening which can be taken to scale at sub-national and national levels?	
Evaluation Criteria	Relevance, Effectiveness, Sustainability, Coordination, Value Added
Rationale	Both the Canada and Sweden collaborations with H4+ in support of the JPCS have as one of their stated objectives strengthening national health systems for RMNCAH. The programme theory of change at country level is dominated by efforts to strengthen health systems and improve quality of care in RMNCAH.
Chain of Reasoning	The assumptions developed from the theory of change for H4+JPCS in relation to this evaluation question follow the logical chain from coordinated identification of needs through to provision of support which is catalytic and which effectively contributes to capacity development among both service providers and users. The assumptions also explore the extent to which support to training and other forms of capacity development is accompanied by measures to address other elements of behaviour change including

	motivation and opportunity. Finally, the assumptions provide the means to examine whether H4+JPCS support can combine with other initiatives to contribute to the use of strengthened services and quality care in RMNCAH with the potential to improve well-being.	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
Assumption 1.1 H4+ partners, in consultation with national health authorities and other stakeholders, are able to identify critical and unserved needs in the eight areas of health systems support for RMNCAH. The needs in each of the eight areas are not fully met by other sources of support and, importantly, programme support can build on investments and activities underway with national and external sources of finance and support to accelerate action.	• Needs assessments are undertaken for elements of RMNCAH such as EmONC • Consensus among H4+ partners and national health authorities on barriers to effective action in support of systems strengthening for sexual reproductive health and rights • Programme work plans address identified areas of system strengthening as priorities • Trends in outcome indicators for RMNCAH at national and sub-national level	Documents • Needs assessment reports • Work plans and monitoring reports • Minutes of coordinating committee meetings (country level) Interviews and Discussions • H4+ coordinators • National/sub-national health authorities • Bilateral/multilateral development agencies supporting RMNCAH system strengthening Data • National and sub-national outcome data on RMNCAH (Countdown and DHIS2 where available) Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 1.2 H4+JPCS support to sub-national levels funds activities capable of complementing other investments and contributing to strengthening service delivery in RMNCAH. The funded activities are appropriately sequenced and matched with support to health systems strengthening provided by other programmes and sources.	• Work plans incorporate links to other national programme at district level • Design of programme supported investments takes account of incentives structures and design of other programmes • H4+JPCS funded inputs available at district level on-time and without conflict with those of other programmes • Experience of provincial and district health teams	Documents • Work plans and monitoring reports • Minutes of country level coordination and review meetings Interviews and Discussions • H4+ coordinators • National/sub-national health authorities • Bilateral/multilateral development agencies supporting RMNCAH system strengthening • Site visits to supported facilities

Assumption 1.3 RMNCAH managers and service providers trained with support from H4+JPCS realize intended gains in competence and skills These gains in skills and competencies are tested and verified during and after training.	• Gains in skills and competencies verified by follow up and supervision • Gains in skill noted by supervisory staff • Users of RMNCAH services report satisfaction with services from trained staff	<u>Documents</u> • Minutes of country level coordination and review meetings • District visit reports by H4+JPCS partners and health authorities <u>Interviews and Discussions</u> • H4+ coordinators • National/sub-national health authorities • NGO staff supporting demand improvements • Community members <u>Site Visits and Observations</u> • Hospitals and health centres • Maternity waiting homes or equivalent • Youth friendly service sites
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.	• H4+JPCS funded inputs available at district level on-time and without conflict with those of other programmes • State of needed infrastructure and equipment in health facilities in supported districts • Availability of equipment and essential RMNCAH supplies • Experience of provincial and district health teams	<u>Documents</u> • Minutes of country level coordination and review meetings • District visit reports by H4+JPCS partners and health authorities <u>Interviews and Discussions</u> • H4+ coordinators • Health facilities staff • Community members <u>Site Visits and Observations</u> • Hospitals and health centres • Maternity waiting homes or equivalent • Youth friendly service sites
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.	• Trends in data on use of RMNCAH service at national and sub-national levels • Views of service providers and community members (especially vulnerable group members) • Views/experience of national and local health authorities and managers • Views/experience of staff of NGOs representing vulnerable groups	<u>Documents</u> • Minutes of district coordination and review meetings • Interviews and Discussions • H4+ coordinators • Health facilities staff • Community members <u>Site visits to health facilities</u> <u>Data</u> • District level data on service use

Table 11: Evaluation matrix for evaluation question two: Expanded access to integrated care

Evaluation Question Two: Expanded Access to Integrated Care		
2. Evaluation Question Two: To what extent have H4+JPCS investments and activities contributed to expanding access to quality integrated services across the continuum of care for RMNCAH, including for marginalised groups and in support of gender equality? a. How have H4+ interventions contributed to strengthening the quality and appropriateness of care in RMNCAH provided to marginalised and excluded (encompassing skills and attitudes of staff, availability of equipment and supplies and timing of services)? b. To what extent have H4+JPCS interventions contributed to expanding access to marginalised and excluded groups, especially adolescents, youth, and poorest women? c. How has H4+ contributed to strengthening the integration of services across the RMNCAH continuum of care? d. To what extent do H4+JPCS investments and activities (alone or in conjunction with other programmes of support) contribute to developing trust between service providers and users of RMNCAH services and are these efforts sustained?		
Evaluation Criteria	Relevance, Effectiveness, Sustainability, Coordination, Value Added	
Rationale	Both the Canada and Sweden collaborations cite among their objectives scaling up integrated RMNCAH services in pursuit of equity and greater social inclusion. Interviews at headquarters of H4+ partners and donors further emphasized the importance of accelerating integration along the continuum of care for reasons of equity of access to quality care.	
Chain of Reasoning	The five assumptions developed from the pathway theory of change relevant to this area of investigation trace the causal links from the targeting of interventions to reach marginalised groups with increased access to the continuum of care in RMNCAH through to the sustainability of newfound trust between service providers and users. In tracing that pathway the assumptions identify requirements for adequate reach of supported service, coordinated sequencing of support, and the ability of support to overcome barriers to access.	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
Assumption 2.1 H4+JPCS supported initiatives are targeted to increasing access for marginalized 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).	• Design objectively identifies barriers to access for vulnerable groups: location, timing, cost, security and privacy of services and implementation addresses accordingly • Attendance and use of services by vulnerable group members • Views of facilities staff and community members • Views of staff of NGOs representing vulnerable group members	<u>Documents</u> • Work plans and results reports at country level • Minutes of district coordination and review meetings <u>Interviews and Discussions</u> • H4+ coordinators • Health facilities staff • Community members • Site visits to health facilities <u>Data</u> District level data on service use
Assumption 2.2 H4+JPCS support to capacity development, and to effective demand by community members has adequate reach to effect access to quality services for marginalized groups. H4+JPCS support addresses the three dimensions of sustainable	• Distribution of supply and demand side interventions for improved access to quality of care at district level • Supervisors report improvements in quality of care in assisted facilities • Staff of assisted facilities report appropriate skills are supported	<u>Documents</u> • Work plans and results reports at country level • Minutes of review meetings <u>Interviews and Discussions</u> • H4+ coordinators • Health facilities staff • Community members

Evaluation Question Two: Expanded Access to Integrated Care		
capacity improvement: capability, opportunity and motivation for sustained provision of quality care.	by needed equipment and supplies • Community members report positive change in skills and attitude of service providers	• Site visits to health facilities <u>Data</u> District level data on service use
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.	• H4+JPCS funded inputs available at district level on-time and without conflict with those of other programmes • State of needed infrastructure and equipment in health facilities in supported districts • Availability of equipment and essential RMNCAH supplies • Experience of provincial and district health teams	• Documents • Minutes of review meetings • District visit reports by H4+JPCS partners and health authorities • Interviews and Discussions • H4+ coordinators • Health facilities staff • Community members <u>Site Visits and Observations</u> • Hospitals and health centres • Maternity waiting homes • Youth friendly service sites
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.	• Attendance and use of services by vulnerable group members • Views of facilities staff and community members • Views of staff of NGOs representing vulnerable group members	• Documents • Work plans and results reports at country level • Minutes of review meetings • Interviews and Discussions • H4+ coordinators • Health facilities staff • Community members • Site visits to health facilities <u>Data</u> District level data on service use
Assumption 2.5 Demand creation activities and investments have sufficient resources and are sustained enough over time to contribute to enduring positive changes in the level of trust between service users and service providers in RMNCAH. Investments and activities aim to change service providers' attitude and behaviour toward users in an effort to build mutual trust. Improvements in service quality and access are not disrupted by failure to provide adequate facilities, equipment	• Duration of H4+JPCS support to trust building initiatives between providers of integrated care in RMNCAH and community members • Attendance and use of services by vulnerable group members • Views of facilities staff and community members • Views of staff of NGOs representing vulnerable group members • Disruptions in support provided by H4+JPCS to investments in demand promotion and	• Documents • Work plans and results reports at country level • Minutes of review meetings • Interviews and Discussions • H4+ coordinators • Provincial and district health management teams • Health facilities staff • Community members • Site visits to health facilities <u>Data</u> National and district level data on service use

Evaluation Question Two: Expanded Access to Integrated Care		
and supplies of crucial commodities in RMNCAH. H4+JPCS support is not subject to disruptions which can weaken trust and reverse hard won gains.	confidence building at community level • Designs of programme supported initiatives aimed at trust building between communities and service providers include exit strategies.	

Table 12: Evaluation matrix for evaluation question three: Responsiveness to national needs and priorities

Evaluation Question Three: Responsiveness to National Needs and Priorities		
3. Evaluation Question Three: To what extent has the H4+JPCS been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level? a. Is the basic structure of the H4+JPCS (decision making structures, management processes, approval mechanisms, disbursement rules and procedures) able to respond to evolving and changing contexts and situations in a timely and appropriate manner? Does the structure place countries at the centre of the programme? **b.** As the programme has evolved over time, has it become more flexible in responding to changing contexts and events, for example the Ebola Viral Diseases or to changing national plans and priorities?		
Evaluation Criteria	Relevance, Responsiveness, Coordination	
Rationale	If the H4+ partnerships and the H4+JPCS programme is to serve its mandated role in support of the operationalization and implementation of the Secretary General's Global Strategy for Women and Children's Health, it must uphold the principle of national leadership of effective action in RMNCAH. In addition, there is an obvious effectiveness argument that the programme must align with national priorities and plans and respond to significant changes in context.	
Chain of Reasoning	All four causal assumptions identified for the theory of change for pathway three, responsiveness to national needs and priorities, deal with the process of establishing and operating effective, country led systems and processes for coordinating H4+JPCS programming at country level across the H4+ partners and, especially, with national and local health authorities (along with other actors).	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
Assumption 3.1 H4+ partners supporting RMNCAH in JPCS countries have been able to establish effective platforms for coordination and collaboration among themselves and with other stakeholders (including work plans, activities and investments, and results monitoring frameworks and systems) using H4+JPCS funds and with technical support from the global/regional H4+ teams.	• Country work plans, monitoring reports and minutes of meetings address coordination mechanisms and issues • Views of H4+ coordinators, national and local health authorities and other agencies supporting RMNCAH on adequacy of coordination measures • Participation across the range of stakeholders in coordination and review meetings at national and local level	<u>Documents</u> • H4+ work plans and monitoring reports • Minutes of coordination meetings • National plans and policies in RMNCAH • Interviews and Discussions • H4+ coordinators • National health authorities • Bilateral and multilateral agencies supporting RMNCAH at country level

Evaluation Question Three: Responsiveness to National Needs and Priorities		
	• Work plans reflect national plans, policies and priorities in RMNCAH	• Provincial and district health management teams • Health facilities staff • Staff of NGOs engaged in programming for RMNCAH with and without H4+JPCS support <u>Online Survey</u> • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
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.	• Membership of coordinating committees • Decisions and records of meetings of coordination and review committees for H4+JPCS indicate leadership role of national health authorities • Views of participants in H4+JPCS coordinating bodies at country level	<u>Documents</u> • Minutes of coordination meetings <u>Interviews and Discussions</u> • H4+ coordinators • National health authorities • Bilateral and multilateral agencies supporting RMNCAH at country level • Provincial and district health management teams • Staff of NGOs engaged in programming for RMNCAH with/without H4+JPCS support <u>Online Survey</u> • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
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.	• Country work plans, are adjusted over time to respond to changes in needs, priorities and context for RMNCAH • Minutes of coordination and review meetings at national and sub-national level indicate changes in the orientation and content of H4+JPCS supported initiatives • Views of participants in coordination and review mechanisms	<u>Documents</u> • Minutes of coordination meetings • Minutes and reports from joint country and district review missions. <u>Interviews and Discussions</u> • H4+ coordinators • National health authorities • Bilateral and multilateral agencies supporting RMNCAH at country level

Evaluation Question Three: Responsiveness to National Needs and Priorities		
		• Provincial and district health management teams • Staff of NGOs engaged in programming for RMNCAH with/without H4+JPCS support
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.	• Links from H4+JPCS coordinating committees to other forums for coordinating actions in support of national health sector plans and priorities • Post-programme funding plans incorporate H4+JPCS coordinating bodies into national and sub-national health sector coordinating bodies. • Post programme structures retain focus on RMNCAH	<u>Interviews and Discussions</u> • H4+ coordinators • National health authorities • Bilateral and multilateral agencies supporting RMNCAH at country level • Provincial and district health management teams • Staff of NGOs engaged in programming for RMNCAH with/without H4+JPCS support <u>Online Survey</u> • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities

Table 13: Evaluation matrix for evaluation question four: Innovation and scale up

Evaluation Question Four: Innovation and Scale Up	
4. Evaluation Question Four: To what extent has the programme contributed to the identification, testing and scale up of innovative approaches in RMNCAH (including practices in planning, management, human resources development, use of equipment and technology, demand promotion, community mobilisation and effective supervision, monitoring and accountability)? a. How do H4+JPCS partners and health authorities and other stakeholders at national and sub-national level recognized potentially effective innovations in RMNCAH? b. How is information on the success or failure of innovations supported by the programme gathered and made accessible to decision makers within and across H4+JPCS countries? c. What evidence indicates that successful H4+JPCS supported innovations have been replicated across districts, at national level or in other programme or countdown countries?	
Evaluation Criteria	Relevance, Effectiveness, Efficiency, Sustainability
Rationale	Both the Canada and Sweden collaborations with the programme emphasize the importance of identifying and supporting innovative approaches in RMNCAH for adaptation and roll-out in programme and other high-burden countries. Annual reports and work plans at the global and country level also emphasize the importance of innovation and scale up. Finally, since H4+JPCS activities in all 10 countries are concentrated in a sub-set of sub-national geographic areas such as districts, innovation and scale up are necessary conditions for the programme to make a credible contribution to national gains in RMNCAH.
Chain of Reasoning	The assumptions identified using the pathway theory of change for innovation as illustrated in Annex one, follow and serve to verify the causal links from identification of opportunities for

Evaluation Question Four: Innovation and Scale Up		
	innovation in RMNCAH to adaptation within and across programme countries (and to other high burden countries). Along the route, the assumptions also address the role of global knowledge products and technical support to innovation from the global/regional H4+JPCS team.	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
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.	• Needs assessments and situation reports highlight opportunities for innovation • Country work plans include plans for implementation of innovative experiments • H4+ coordinators at country level and national and local health authorities agree on the suitability and potential success of identified innovations • H4+JPCS investments focused on innovation reflect practices noted and promoted in global knowledge products of H4+ partners	Documents • H4+JPCS work plans and monitoring reports • Minutes and reports of country and district review meetings Interviews and Discussions • H4+ coordinators • National health authorities • Bilateral and multilateral agencies supporting RMNCAH at country level • Provincial and district health management teams • Health facilities staff taking part in innovative approaches Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
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.	• Views of H4+ country team members on quality and extent of technical support from global/regional team for identifying and documenting innovations • Guidelines and practical tools for identifying, supporting and monitoring innovations in RMNCAH provided to country teams by the global /regional team.	Documents • H4+JPCS guidelines for developing and monitoring work plans • H4+JPCS guidelines on innovation Interviews and Discussions • H4+JPCS coordinators at global, regional and country level • National health authorities in programme countries
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.	• Reports exist at country level documenting success or failure of experiments undertaken • National health authorities are aware of and accept evidence on the success or failure of experiments and innovations.	Documents • Monitoring reports on innovations • Minutes and reports of country and district review meetings Interviews and Discussions • H4+ coordinators • National health authorities • Provincial and district health management teams

Evaluation Question Four: Innovation and Scale Up		
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).	• Examples of adaptation of successful innovations in national policies and programmes for RMNCAH • Views of national health authorities on the utility and practicality of innovations supported by H4+JPCS • Estimates made of the costs of scaling up identified innovations.	Documents • Summary reports on innovations • Minutes and reports of country and district review meetings • National programmes and guidelines incorporating innovative approaches Interviews and Discussions • H4+ coordinators • National health authorities • Provincial and district health management teams • Bilateral and multilateral agencies supporting RMNCAH in the same countries
Assumption 4.5 H4+JPCS mechanisms for promoting successful innovations across the 10 programme countries and among non-programme countdown countries are effective.	• Reports, records and minutes of country to country H4+JPCS meetings include messages on successful innovations • H4+JPCS annual reports and other communications material highlight successful innovations for use by non-programme countries • Examples of adaptation of innovations tested in one programme country in other H4+JPCS countries • Examples of adaptation in non-programme countdown countries	Documents • Minutes and reports of country to country H4+JPCS meetings • Annual reports and other H4+ communication materials Interviews and Discussions • H4+ coordinators • National health authorities in programme and non-programme countries Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 4.6 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.	• Citations of successful H4+ supported innovations in RMNCAH in global knowledge products.	Documents • Global knowledge products produced with the support of H4+JPCS Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities

Table 14: Evaluation matrix for evaluation question five: Division of labour

Evaluation Question Five: Division of Labour		
5. Evaluation Question Five: To what extent has the H4+JPCS enabled partners to arrive at a division of labour which optimises their individual advantages and collective strengths in support of country needs and global priorities? a. Has the H4+JPCS programme contributed to the development of effective and robust platforms and operational systems for coordinating support to RMNCAH at country level by the partners? Will these platforms and systems persist in one form or another beyond the period of programme funding? b. Do the resulting programmes of support to RMNCAH at country level make best use of the individual strengths of H4+ partners? Is there a distinguishable value added over the existing programmes of the H4+ partners? c. Do efforts at coordination result in collaborative programming which is more effective than separate initiatives? d. Has the programme contributed to strengthening platforms and systems for global and regional coordination by H4+ partners in support of RMNCAH including coordinating partner contributions to the development of global knowledge products?		
Evaluation Criteria	Efficiency, Sustainability, Coordination	
Rationale	Interviews undertaken during the Inception Phase at both headquarters and country office levels of H4+JPCS partners have emphasized the essential role of coordination and an appropriate division of labour if the programme is to effectively contribute to improvements in RMNCAH outcomes and the goals of the Global Strategy and the "Every Woman Every Child" movement. In addition, there is a strong efficiency argument that failure to arrive at an appropriate division of labour among H4+ partners at global, regional and country levels will lead to overlap, duplication and waste. Finally, as programme funding comes to an end there will be a continuing need for the H4+ partners (soon to be H6) to demonstrate an effective division of labour as they continue to work is support of the Global Strategy.	
Chain of Reasoning	The first three assumptions for this evaluation question are derived from the pathway theory of change for area of investigation five (division of labour) at country level. They address the establishment and effective functioning of mechanisms and processes for coordinating support from H4+JPCS agencies at country level. The last four assumptions for this evaluation question are derived from the theory of change pathway for area of investigation five at global level. They address the establishment and effective operation of mechanisms and processes for coordinating the work of H4+ partners at global level. At both global and country levels, the assumptions address the extent to which the division of labour contributes to more effective support to results in RMNCAH.	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
Assumption 5.1 H4+ teams at country level in collaboration with key stakeholders have established forums for coordinating programme action and division of labour in H4+JPCS financed and supported activities in particular and in RMNCH generally.	• H4+JPCS coordinating committees established and functioning in all 10 programme countries • Minutes of coordinating meetings reflect discussions and decisions on division of labour	Documents • Minutes and reports of coordination and review meetings • H4+JPCS work plans and results reports Interviews and Discussions • H4+ coordinators • National health authorities in programme countries
Assumption 5.2	• For responsiveness to national and sub-national context see	Documents

Evaluation Question Five: Division of Labour		
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.	indicators and data sources for Assumption 3.3 under evaluation question three – responding to national needs. • H4+JPCS work plans provide examples of H4+ partner agencies working in geographic and technical areas appropriate to their mandate, capacities and experience. • H4+JPCS work plans provide examples of collaborative support to geographic and technical areas of RMNCAH by H4+ partners	• Minutes and reports of coordination and review meetings • H4+JPCS work plans and results reports <u>Interviews and Discussions</u> • H4+ coordinators • National health authorities in programme countries
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.	• H4+JPCS work plans do not show examples of overlap or duplication of effort by H4+ partners • National health authorities report that the process of consultation and coordination of H4+JPCS programming was effective in avoiding or eliminating overlap and duplication of effort • At sub-national levels, H4+JPCS partners provide support to the eight components of health system strengthening which does not result in overlap and duplication • Examples of effective joint advocacy at country level by H4+JPCS partners • Views of national health authorities on the coherence, consistency and credibility of policy engagement and advocacy by H4+JPCS partners	<u>Documents</u> • Minutes and reports of coordination and review meetings • H4+JPCS work plans and results reports <u>Interviews and Discussions</u> • H4+ coordinators • National health authorities in programme countries • Bilateral and multilateral agencies supporting RMNCAH in programme countries • NGOs active in support to RMNCAH in programme countries <u>Online Survey</u> • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 5.4 Global structures, systems and processes for identifying needs and opportunities and for planning, budgeting, approving and monitoring and reporting on H4+JPCS initiatives recognise and encourage agencies' distinct advantages and contribute to an effective division of labour.	• H4+JPCS global work plans provide examples of H4+ partner agencies working in technical areas appropriate to their mandate, capacities and experience. • H4+JPCS global work plans provide examples of collaborative support to geographic and technical areas of RMNCAH by H4+ partners	<u>Documents</u> • Minutes of the Joint Steering Committee • H4+JPCS global work plans and results reports • Global knowledge products supported by the H4+JPCS <u>Interviews and Discussions</u> • Members of the Joint Steering Committee

Evaluation Question Five: Division of Labour		
	• Proceedings of the Joint Steering Committee of H4+JPCS show evidence of discussion and appropriate allocation of roles among H4+ partners at global level	
Assumption 5.5 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.	• H4+JPCS global work plans provide examples of H4+ partner agencies working jointly in advocating for commitments to the Global Strategy • Proceedings of the Joint Steering Committee of H4+JPCS show evidence of coordination of global level advocacy and communications in support of the Global Strategy. • National health authorities report consistent messages and credible advocacy at global level from H4+JPCS partners regarding commitments to the Global Strategy principles and priorities.	Documents • Minutes of the Joint Steering Committee • H4+JPCS global work plans and results reports • Global knowledge products supported by the H4+JPCS Interviews and Discussions • Members of the Joint Steering Committee • National health authorities Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 5.6 Working from an integrated work programme at global level, H4+JPCS partners produce technically sound and operationally useful knowledge products for strengthening national systems and practices in RMNCAH in collaboration or through consultations with other H4+ partners.	• H4+JPCS global work plans incorporate the production of global knowledge products • Global knowledge products focus on priority needs of national health systems for effective strengthening of health systems for RMNCAH in order to improve access and quality of care • Global knowledge products are viewed as relevant and technically sound (as well as practical) by national health authorities in programme other countdown countries	Documents • Minutes of the Joint Steering Committee • H4+JPCS global work plans and results reports • Global knowledge products supported by the H4+JPCS Interviews and Discussions • Members of the Joint Steering Committee • National health authorities Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 5.7 H4+JPCS agencies cooperate effectively to communicate the content of global knowledge products produced with H4+JPCS support and to advocate jointly	• Global work plans include resources allocated to communicating core messages of global knowledge products • Examples of H4+ partner collaboration in publicizing new	Documents • H4+JPCS global work plans and results reports • Global knowledge products supported by the H4+JPCS Interviews and Discussions

Evaluation Question Five: Division of Labour		
for their use by programme and non-programme countdown countries.	or revised global knowledge products • Views of national health authorities and staff of bilateral and multilateral development agencies providing support to RMNCAH on the visibility of global knowledge products supported by the H4+JPCS	• Members of the Joint Steering Committee • National health authorities • Staff of non H4+JPCS partner bilateral and multilateral development agencies and international NGOS active in support of RMNCAH <u>Online Survey</u> • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities

Table 15: Evaluation Matrix for Evaluation Question Six: Value Added for the Global Strategy

Evaluation Question Six: Value Added for the Global Strategy		
1. **Evaluation Question Six: To what extent has the H4+JPCS contributed to accelerating the implementation and operationalisation of the Global Strategy and the "Every Woman Every Child" Movement"?** a. To what extent has H4+JPCS contributed to more effective advocacy for international and national commitments to operationalize Global Strategy principles and accelerate actions to strengthen RMNCAH investments and systems? b. During the life of the programme, how well did the H4+ partners support existing global structures (for example, the PMNCH, the iERG, the Commission on Information and Accountability) for supporting action in RMNCAH? c. As programme funding ends, to what extent can the lessons learned in implementing H4+JPCS inform the work of the H6 partnership, allowing it to better contribute to energizing global structures and processes in support of the Global Strategy 2.0		
Evaluation Criteria	Relevance, Effectiveness, Value Added	
Rationale	As noted in the evaluation Terms of Reference (ToR) (p.9), subsequent to the launch of the Global Strategy the H4+ partnership became its "technical arm" with the aim of contributing leadership in the areas of reproductive, maternal newborn and child health (RMNCH). Both the Canada and Sweden programmes of collaboration with the H4+ partnership identify as their highest order objectives for the H4+JPCS programme accelerating progress in the implementation of the Global Strategy 2010.	
Chain of Reasoning	The assumptions for evaluation question six trace the effects of the H4+JPCS from its origin in 2011 and expansion in 2012. They specifically examine the impact of targeted funding on global activities in support of the Global Strategy 2010 and, in particular, the extent the programme contributed to more effective advocacy and communications work.	
Assumptions for Verification	**Indicators**	**Data Collection Sources and Methods**
Assumption 6.1 The establishment of H4+JPCS in 2011 and its expansion in 2012 helped strengthen the rationale	• Global knowledge products supported by H4+JPCS included strengthened policy messages for action in RMNCAH	<u>Documents</u> • Minutes of the Joint Steering Committee

for and extent of policy support for coordinated action in RMNCAH at global, regional, national and sub-national level by the H4+ agencies.	• National health authorities and staff of bilateral and multilateral development agencies and international NGOS report effective advocacy for RMNCAH by H4+ partners working together	• Global knowledge products supported by the H4+JPCS Interviews and Discussions • Members of the Joint Steering Committee • National health authorities Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
Assumption 6.2 By providing targeted funding for global activities (and funding the coordinating office) H4+JPCS programme funding facilitated the development of knowledge products and joint, coordinated advocacy in RMNCH by H4+ agencies which would not have otherwise been undertaken.	• Perceived Increase in the rate of production of global knowledge products in RMNCAH by H4+ partners • Views of H4+ coordinators and members of the Joint Steering Committee on the incremental nature of knowledge products developed with H4+JPCS support • Examples of needed knowledge products which could not be developed without JPCS support	Documents • Minutes of the Joint Steering Committee • Global knowledge products supported by the H4+JPCS Interviews and Discussions • Members of the Joint Steering Committee • National health authorities Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities
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.	• Global work plans include resources allocated to communicating messages of global knowledge products • Views of national health authorities on the consistency of advocacy work on RMNCAH by H4+partners	Documents • Minutes of the Joint Steering Committee Interviews and Discussions • Members of the Joint Steering Committee • Staff on bilateral and multilateral development agencies and international NGOS active in RMNCAH • National health authorities Online Survey • H4+JPCS supported agencies in country • H4+JPCS partners at regional and global level • Country and global level H4+ stakeholders and national health authorities

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".	• See indicators and results reported for question one: strengthening health systems for RMNCAH	• See data collection sources and methods for question one: strengthening health services for RMNCAH

5.3 Evaluation criteria covered by the evaluation matrix

Table 15 relates the evaluation questions and their associated assumptions to each of the evaluation criteria detailed in the evaluation terms of reference (p.16). The table illustrates that all the identified criteria are addressed in the evaluation matrix.

Table 16: Evaluation Questions in Relation to the Evaluation Criteria

Evaluation Question	Relevance	Respon-siveness	Effective-ness	Efficiency	Sustain-ability	Coordi-nation	Value Added
1. Strengthening health systems	X		X		X	X	X
2. Expanded access to integrated care	X		X		X	X	X
3. Responsiveness to national needs	X	X				X	
4. Innovation and scale up	X		X	X	X		
5. Division of labour				X	X	X	
6. Value added for global strategy	X	X					X

6 NEXT STEPS

Immediately following completion of the current inception phase, work will commence on the data collection phase, which will include activities at the global, regional and country levels. This section sets out the next steps for the data collection phase.

6.1 Data collection phase: global and regional levels

Over the period from mid-April to end August 2016, the evaluation team will undertake the following data collection tasks at global and regional levels.

1. Conduct the comprehensive review of documents compiled during the preparatory phase by the H4+JPCS global, regional and country teams as supplemented by documents gathered by the evaluation team during the inception and throughout the data collection phase. Gaps in information will be addressed by requesting additional documents where needed.

2. Continue profiling of national level data on outcomes in RMNCAH which can provide important contextual information for assessing the results of the H4+JPCS in each of the 10 programme countries. This process has begun with the identification of key indicators available from recognized sources such as the Countdown to 2015 collaboration for monitoring national progress in maternal, newborn and child survival. This data has already been profiled for all ten countries and is presented in Annex 3.
3. Continue profiling H4+JPCS expenditures using data compiled by the global coordinator and the H4+ country teams. This will include annual expenditures by area of output and agency for each programme country as well as at global level.
4. Carry out a review of selected global knowledge products produced with the support of H4+JPCS in order to assess their utility for national health authorities and H4+ country teams as a key indicator identified in the evaluation matrix.
5. Carry out additional selected interviews at global and regional level in accordance with the stakeholder map in Annex 2.

6.2 Data collection phase – country level (country case studies)

6.2.1 Field country case studies

1. Building on the work done during the exploratory evaluation mission to Zimbabwe, refine and finalize interview guides, discussion group protocols and other data collection instruments to be used in the field country case studies.
2. Complete detailed logistics and work planning for the four country case study missions to the Democratic Republic of the Congo (DRC), Liberia, Zambia and Zimbabwe. This process has begun with the operational plan for the main field data collection mission to Zimbabwe and scheduling the missions in coordination with each of the four field missions. In the case of Zimbabwe, the national health authorities have also given verbal clearance of the mission schedule.
3. Carry out the four field country case study missions in accordance with the following schedule in table four in Section 4.2.4.
4. On completion of the field country case study mission the evaluation country case study team leader will engage with team members to produce the draft field country case study note which will be submitted to the Evaluation Management Group (with appropriately timed consultation with the national ERG). The field country case studies will use the full evaluation matrix as it applies to country level assumptions and results as detailed in Chapter 5.

6.2.2 Desk country case studies

1. Finalise the desk case study protocol presented in Chapter Four and the evaluation matrix presented in Annex 6.
2. Review the core set of country case study documents identified in the country case study protocol.
3. Conduct telephone or skype interviews with a sub-set of two to three key informants familiar with the H4+ implementation in the country being studied. These will be identified in consultation with the H4+ coordinator in each of the six countries.
4. Draft desk country case study notes in accordance with the structure proposed in the protocol.

6.3 Data collection phase: internet surveys

1. Finalise the online survey questionnaires.
2. Finalise the sample frame and implement targeting strategy for contacting survey participants.
3. Conduct the online survey of staff working for H4+ partners and staff of national health services and other stakeholders.

6.4 Consolidation of data

The evaluation core team will undertake a data analysis workshop to consolidate data, review the completed evaluation matrices and the draft country study notes (field and desk), and analyse the results of the online survey. This will allow the core team to identify preliminary synthesized findings and conclusions across all evaluation questions and areas of investigation. This workshop will be followed by a joint evaluation team and evaluation management group workshop to discuss the results of the data collection phase, including the case study findings. The joint workshop will mark the beginning of the reporting phase for the evaluation.

6.5 Team composition with assigned tasks and key dates

6.5.1 Team members and assigned tasks

The assigned tasks for the data collection phase will be carried out by a core team led by Ted Freeman and including Lynn Bakamjian, Dr Jacques Emina and Dr Allison Beattie. This core evaluation team will be assisted throughout by Camilla Buch von Schroeder and Erling Høg. In each of the field case study countries, the team will be joined by an experienced national research assistant: Thenjiwe Sisimayi in Zimbabwe; Jean Ekongo in the DRC; Beyant Kabwe in Zambia; and Minnie Sirtor-Bowier in Liberia.

Table 17: Evaluation team assigned tasks: Data collection phase

Team Member	Main Role	Field Country Case Study Tasks	Desk Country Case Study	On-Line Survey	Document and Data Review
Ted Freeman	Team leader	Team Lead Zimbabwe	Author: Sierra Leone	Support survey design and analysis	Quality assurance and analysis
Lyn Bakamjian	Deputy team leader	Team Member: Zimbabwe	Protocol design and quality assurance Author: Ethiopia	Support survey design and analysis	Analysis
Dr Jacques Emina	Health systems research	Team Lead: DRC Team member: Liberia and Zambia	Author: Côte d'Ivoire	Support survey analysis	Analysis
Dr Allison Beattie	RMNCAH	Team Lead: Liberia and Zambia	Author: Guinea Bissau	Lead survey design and analysis	Data specification
Camilla Buch von Schroeder	Case study researcher	Team Member: DRC	Author: Cameroon Author: Burkina Faso	Support survey design and analysis	Data specification
Erling Høg	Document review and data analyst				Lead data researcher technical lead for automated document review

Team Member	Main Role	Field Country Case Study Tasks	Desk Country Case Study	On-Line Survey	Document and Data Review
Thenjiwe Sisimayi	Zimbabwe Research assistant	Team Member: Zimbabwe			
Jean Ekongo	DRC Research assistant	Team Member: DRC			
Beyant Kabwe	Zambia Research assistant	Team Member: Zambia			
Minnie Sirtor-Bowier	Liberia Research assistant	Team Member: Liberia			

6.5.2 Task schedule for data collection phase

Schedule: Data Collection Phase of the End Line Evaluation of the H4+JPCS Programme		
Activity	**From**	**To**
Data Collection: Global and Regional		
1. Comprehensive document Review	Ongoing	May 30
2. Profiling national MRNCAH data	Ongoing	May 30
3. Profiling H4+JPCS expenditures	Ongoing	May 16
4. Review selected global knowledge products	April 26	May 30
5. Additional Global Regional Interviews	April 26	August 1
Data Collection: Field Country Case Studies		
1. Finalise Interview and Group Discussion Protocols	April 6	May 16
2. Field case country mission logistics	May 15	July 24
3. Zimbabwe field mission (pilot)	June 6	June 22
4. Liberia field mission	May 30	June 15
5. Zambia field mission	July 6	July 22
6. DRC field mission	August 8	August 24
7. Draft field country case study notes delivered	July 13	September 21
Data Collection: Desk Country Case Studies		
1. Finalise desk country case study protocols and evaluation matrix	April 6	April 26
2. Review core desk country case study documents	April 26	July 5
3. Conduct telephone and Skype interviews	April 26	July 5
4. Draft desk country case study notes completed	May 16	September 9
Data Collection: Internet Survey		
1. Finalise survey questionnaires	April 26	May 16
2. Finalise sample frame	April 26	May 16
3. Conduct online survey	May 30	August 8
Data Consolidation – End of Data Collection Phase		
1. Data consolidation workshop	September 29	September 30

6.6 Quality assurance for deliverables

Plan for the Quality Management, Monitoring, and Auditing – In connection with the services offered by Euro Health Group (EHG) for the current evaluation, the EHG Quality Assurance Management System has been adapted to the particular conditions of the assignment. EHG is an ISO 9001:2008 certified company and consequently complies with standard ISO 9001:2008 requirements with regard to quality management.

Contents of the Final Quality Plan – a specific quality assurance plan has been designed in order to ensure that:

- the technical assistance provided by the consultant fulfils the requirements of UNFPA and is in full conformity with the scope of services as described in ToR including the quality assurance grid (see Annex 9 of the ToR) as well as in the technical proposal
- the evaluation is a learning exercise for all involved
- findings are derived from data and based on evidence; a high quality analysis ensures that findings are sound, credible and able to withstand criticism
- Conclusions provide clear answers to the questions and present a substantiated value judgement on the merits and worth of the programme.
- Recommendations are related to the conclusions (without replicating them); they are prioritized, useful, operational and feasible and the conditions of implementation are specified
- deliverables (including annexes) have been quality controlled and peer reviewed before submission
- key stakeholders are involved and benefit from every step of the evaluation process
- EHG is fully committed to continuously monitor, evaluate, and act to improve the services provided in full cooperation with the EMG and joint ERG.

Each deliverable quality assessment is conducted as follows:

- The team leader finalises a first version
- The internal quality manager (QM) and external peer reviewer (PR) read the document carefully; they insert detailed comments in the assessed document and rate the relevant quality criteria in a grid based on annex 9 of the ToR
- The team leader (referring if necessary to team members) responds to all major comments from the QM and PR and produces the next version
- The QM and PR immediately check whether comments have been properly integrated, then update the rating of quality criteria and edit the grid in order to highlight the main points which have been addressed through the quality assessment process
- The quality assured product is submitted to the UNFPA Evaluation Office.

7 SELECTED OBSERVATIONS

7.1 Rationale and purpose for presenting observations

The draft Inception Report does not mark the point in the evaluation cycle where even the most preliminary of findings can be previewed. However, the intensive work carried out by the evaluation team in the first two months of the assignment, combined with the considerable number of interviews and visits carried out in Zimbabwe, supports the identification of some interesting avenues for further investigation. Care must be taken in interpreting these observations as they are heavily influenced by work done at a global level and in Zimbabwe. Clearly, other important dimensions of the programme will be highlighted as the evaluation progresses.

7.2 Key observations

1. Coordination of H4+JPCS activities and investment support to initiatives in RMNCAH among H4+ partners and, in particular, with national health authorities and their counterparts at provincial and district levels, has emerged as a critically important issue and seems to be an

important factor in achieving a reasonable level of success. Indeed, coordination of action is also a critical issue at the global level for H4+ partners. The evaluation will need to pay special attention to the evolution of coordination mechanisms, platforms and processes over time. This will involve a detailed analysis of the elements and sub-elements of coordinating mechanisms in each field case study country. It will also require a common tool for assessing the extent and appropriateness of coordination mechanisms across field case study countries.

2. There is some evidence that the coordination of H4+JPCS programming at country level is a somewhat difficult task. It has taken time for coordination mechanisms and processes to gain traction and genuinely influence programming. In Zimbabwe, a key factor in the eventual apparent success of mechanisms for coordination was a clear decision by the Ministry of Health and Child Care to take an active leadership role.

3. Coordination and joint programme planning and implementation by H4+JPCS partners in turn places demands on counterparts (including transaction costs), especially ministries of health and other national government agencies. As one senior national health authority observed: "*When the H4+ partners break down some of their silos, we find we have to start breaking down some of our own.*"

4. H4+ partners and their counterparts in national health ministries have a reasonable common understanding of what they mean when they refer to innovation. Essentially, any practice which improves the ability of service providers to meet the needs of users and provide higher quality care in RMNCAH services which has not been used in the jurisdiction in question is seen as an innovation. This "I know it when I see it" approach may seem less than systematic, but it still may represent a practical response to the challenge of innovation. This is yet to be determined of course. However, what is clear is the central role played by national health authorities in following the results of innovations supported by H4+JPCS. If this interest is lacking, it seems unlikely that interventions can be scaled up.

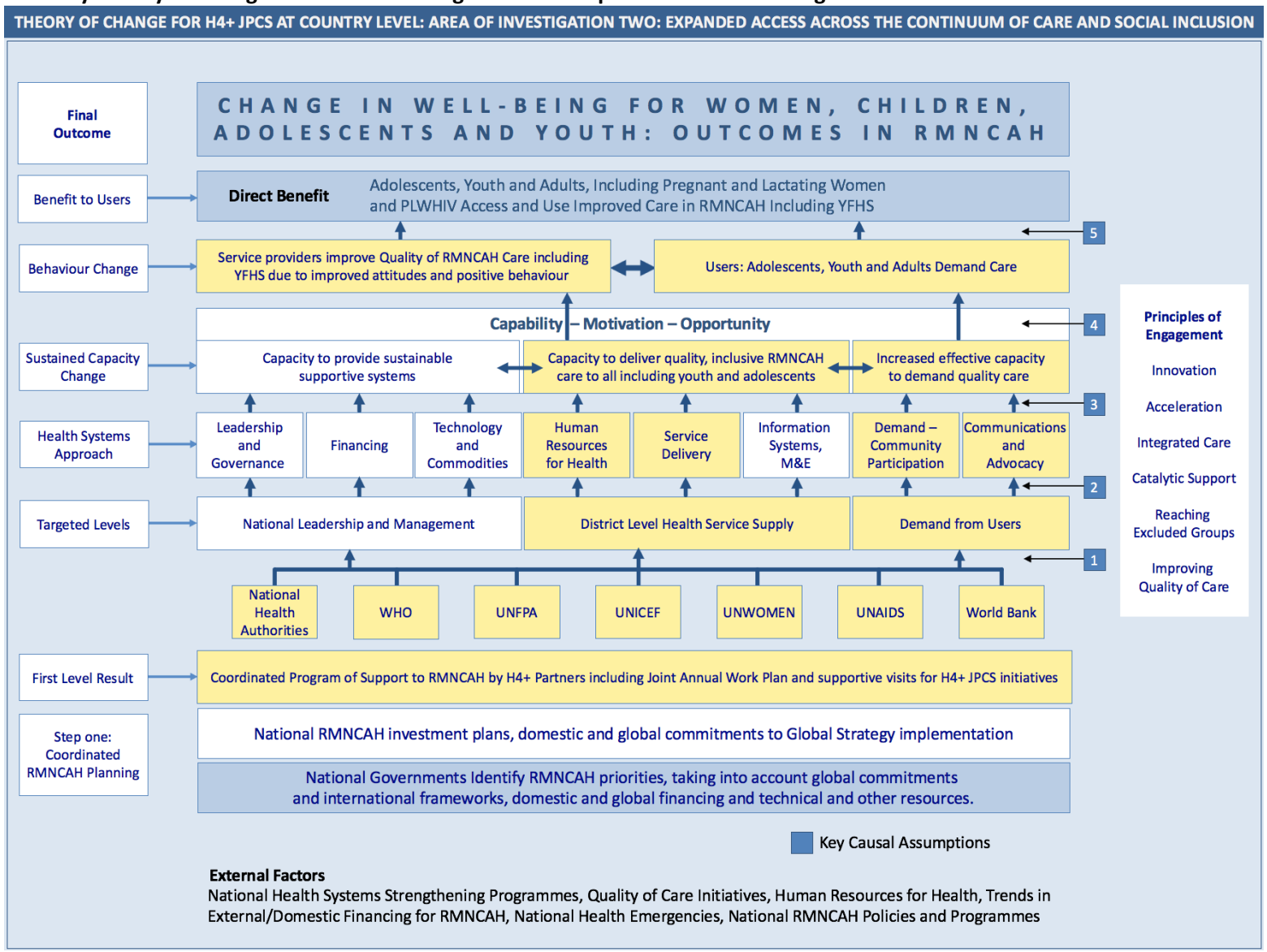
5. Work during the inception phase also raises some questions and issues regarding the reach of H4+JPCS work and its sustainability. In Zimbabwe for example, the programme operates at national level and in six districts representing approximately eleven percent of the population. Considering that some H4+JPCS funded activities target a small number of locations within one or two districts out of those six, there are questions about how much they can contribute to significant changes in outcomes in RMNCAH. This is somewhat offset by the fact that in many programme countries it seems that the H4+JPCS operates in the most underserved districts with the highest RMNCAH burden.

6. Sustainability questions also arise because of the relatively short duration of programme funding in some countries. In most countries, funding for activities only began in 2012 and often there were fairly low execution rates in the early years. If we accept that the programme took some time to become operationalised at a reasonably high level, the actual period of intensive programme operations has been fairly brief in most countries. As a result of short implementation periods, the evaluation team will need to pay close attention to whether or not H4+JPCS supported investments included some form of exit strategy.

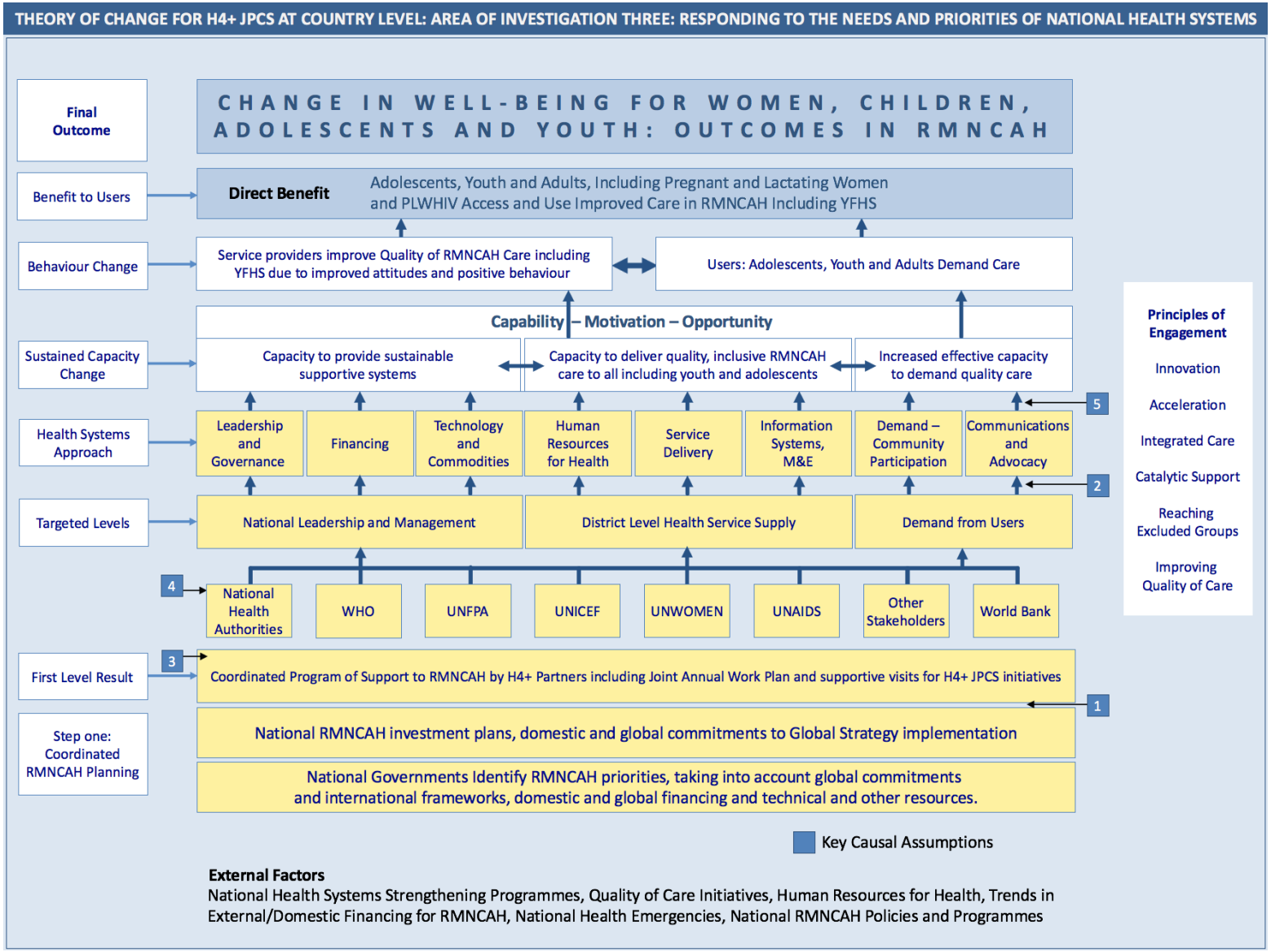
ANNEXES

ANNEX 1: PATHWAY THEORIES OF CHANGE

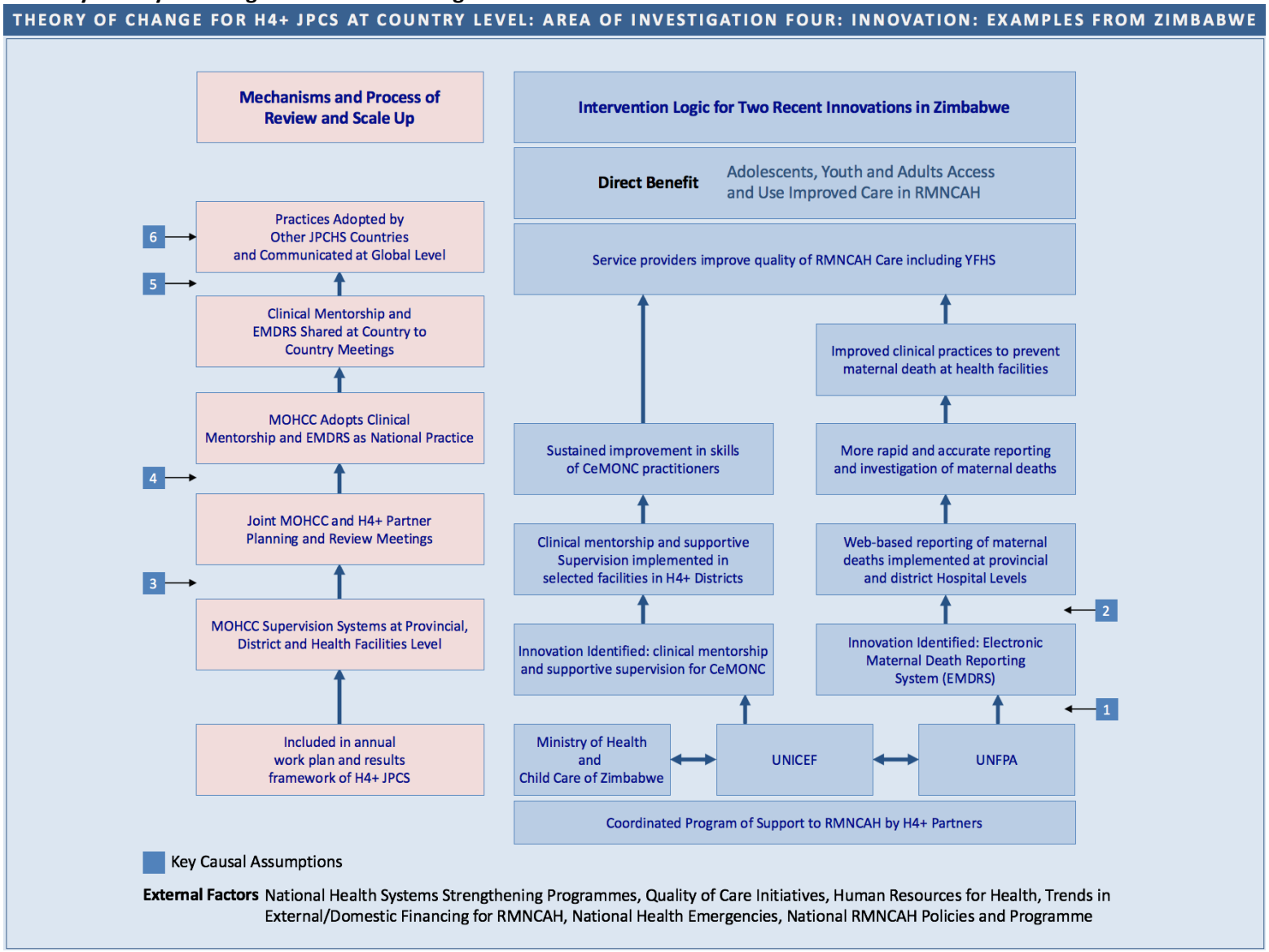
Pathway Theory of Change for Area of Investigation Two: Expanded Access to Integrated Care



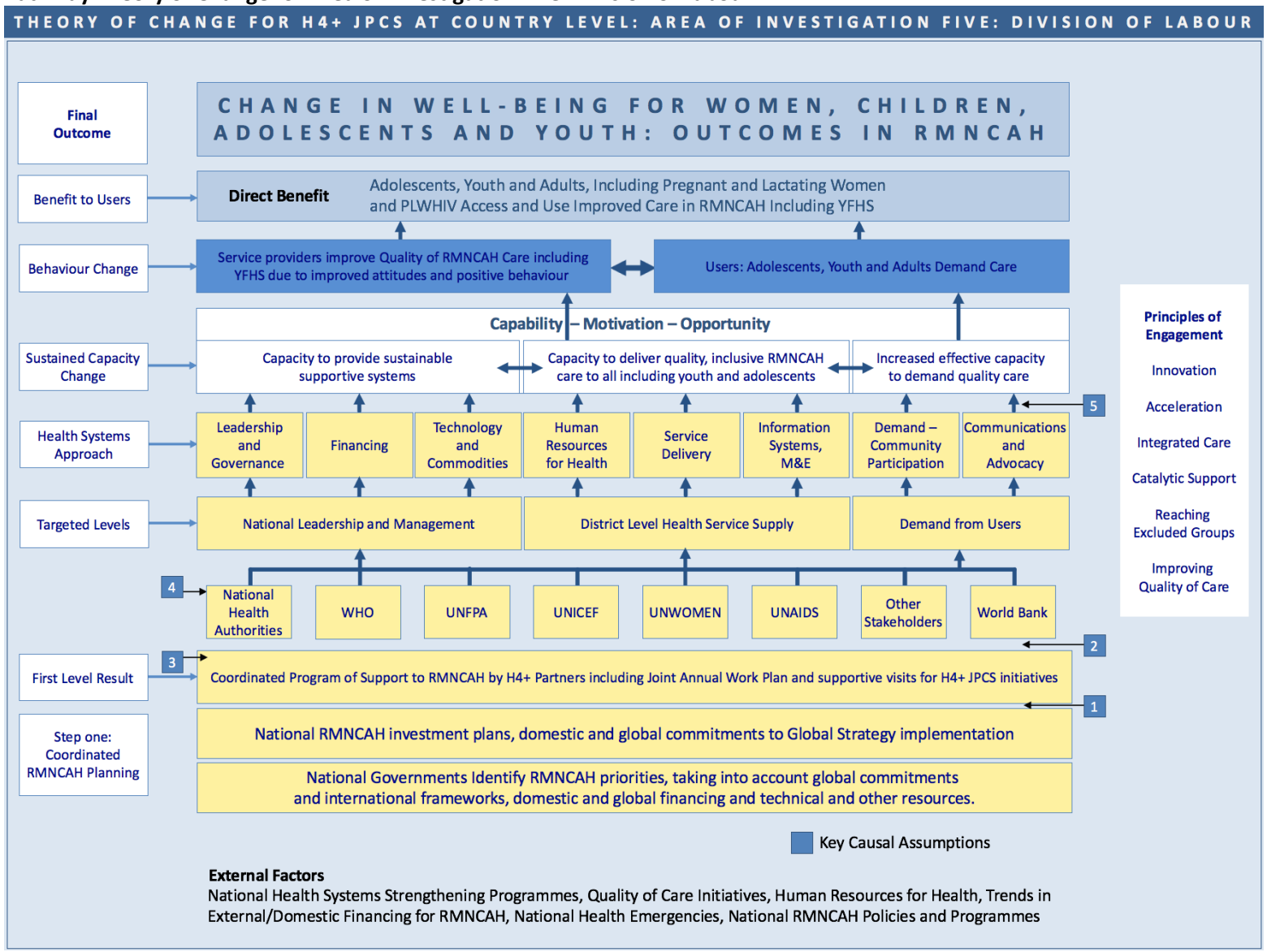
Pathway Theory of Change for Area of Investigation Three: Responsiveness to National Needs and Priorities



Pathway Theory of Change for Area of Investigation Four: Innovation



Pathway Theory of Change for Area of Investigation Five: Division of Labour



ANNEX 2: STAKEHOLDER MAPS FOR THE H4+JPCS

Part One: Global Level

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
H4+ JPCS Governing Bodies				
	H4+JPCS Steering Committee[12] (usually considered as the Global Technical Team)	• H4+JPCS Steering Committee (SC) (usually considered as H4+ Global Technical Team) consists of one seconded staff per agency from all the H4+ UN Partners with diverse RMNCAH profiles/expertise.	• Support with technical (RMNCAH) and programmatic guidance the H4+JPCS Secretariat and the 10 H4+ Country Coordinators • Takes decisions on all matters in relation to H4+JPCS • Facilitates the development and implementation of the H4+JPCS strategies. • By advising the H4+JPCS Coordinator and Country Coordinators, the SC supports countries in using H4+ JPCS results to draw evidence-based policies for effective national RMNCH and development planning, including sexual reproductive health and gender equality	Kim Dickson kdickson@unicef.org Mikael Meyer Ostergren ostergrenm@who.int Nazneen Damji nazneen.damji@unwomen.org Dirk van Hove vanhoved@unaids.org Rama Lakshminarayanan rlakshminarayana@worldbank.org Laura Laski laski@unfpa.org Ulrika Hertel Ulrika.Hertel@sida.se Luc de Bernis debernis@unfpa.org
	Global M&E Reference Group[13]	• The Global M&E Reference Group was established in November 2011, following the first H4+/CIDA[14] Implementation Planning Workshop.	• Based on the ToR key activities of the Global M&E Reference Group include:	Documents referred here (included in the global repository of documents) do not have names and contacts.

[12] See information on the H4+JPCS Joint Steering Committee in the google folder link: https://drive.google.com/drive/folders/0ByJ_UtSZ6wvaeURQZUN0c1c5TlU

[13] See the document titled: "The H4+ and CIDA Initiative for Maternal and Newborn Health - Global Monitoring and Evaluation Reference Group included in the repository of global documents. Link: https://drive.google.com/drive/folders/0B2YpVzurv-pyeWMweHVZOUJIQnM

[14] Note: In June 2013, the Department of Foreign Affairs and International Trade (DFAIT) and the Canadian International Development Agency (CIDA) were amalgamated into Foreign Affairs, Trade and Development Canada (DFATD). In November 2015, DFATD was renamed Global Affairs Canada. Thus, references to Canada's contribution may include "CIDA", "DFATD" and "Global Affairs Canada".

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		Members include global-level representatives of the H4+ UN agencies, under the overall coordination of UNICEF. The main purpose of the Global M&E Reference Group is to serve as a reference group for overall coordination and technical guidance for M&E activities relating to the 5 H4+ CIDA countries. **The Global M&E Reference Group focal points** were appointed by the respective agencies and the H4+ Steering Committee to work closely with: 1. The Country M&E Focal Points responsible for coordination and overall management of country-level activities relating to monitoring & evaluation and implementation science (see TOR Country M&E Focal Points) 2. The lead UN agency H4+ Focal Point in the country responsible for coordination of program implementation 3. The consultant/national institution/partner who will develop and implement the overall plan for data collection, and for monitoring progress on implementation of interventions 4. The external institute/organisation responsible for the mid-term and end-	- Developing key global M&E documents (e.g. Global M&E Framework, TOR for the External Evaluation) - Coordinating and facilitating country M&E workshops and M&E capacity building activities - Coordinating and facilitating mid-term evaluation and end of year evaluation undertaken by the external institute/organization - Supporting the quality and timely execution of M&E activities: Following the same UN agency framework for H4+ CIDA country implementation* each Global M&E Reference Group agency focal point is responsible for supporting their respective country-level M&E activities, working closely with the lead UN agency H4+ Focal Point, the Country M&E Focal Point, and the national institution/ partner/ consultant.	

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		term independent evaluation of the initiative • Lead UN Agencies for the 5 countries include: Burkina Faso (WHO); DRC (UNFPA); Sierra Leone (UNFPA); Zambia (UNICEF); Zimbabwe (UNICEF)		
	Country Monitoring and Evaluation (M&E) Focal Points[15]	• The Country M&E Focal Point (FP) has been appointed by the national H4+ Steering Committee to work closely with: 1. The lead UN agency H4+ Focal Point in the country responsible for coordination of program implementation 2. The national institution/partner who will develop and implement the overall plan for data collection, and for monitoring progress with implementation of interventions 3. The national H4+ Steering Committee (of which the Country M&E FP will be a member) 4. The external institute/organisation responsible for the mid-term and end-term independent evaluation of the initiative 5. The Global M&E Reference Group which includes global-level representatives of the H4+ UN agencies.	Key activities of the Country M&E Focal Point include: • Ensuring the quality and timely execution of M&E activities • Producing quarterly reports on M&E progress • Submitting M&E reporting to the Global M&E Reference Group for inclusion in CIDA reports. • Facilitating and participating in country M&E workshops and M&E capacity building activities • Facilitating mid-term evaluation and end of year evaluation undertaken by the external institute/organization	Documents referred here (included in the global repository of documents) do not have names and contacts.

[15] See the document titled: "The H4+ and CIDA Initiative for Maternal and Newborn Health - Terms of Reference: Country Monitoring and Evaluation" in the google folder link: https://drive.google.com/drive/folders/0B2YpVzurv-pyeWMweHVZOUJIQnM

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		• Lead UN Agencies for the 5 countries include: Burkina Faso (UNFPA); DRC (UNFPA); Sierra Leone (WHO); Zambia (UNICEF); Zimbabwe (UNICEF)		
Executing Agencies/ Implementing H4+ Partners				
	UNFPA Technical Division and H4+JPCS Secretariat	• UNFPA Technical Division, RMNCAH Section (TD) • UNFPA is the main managing and implementing agency for H4+JPCS. • Hosts the H4+ JPCS Secretariat; provides technical advice; oversight the work of the Secretariat. • H4+JPCS Secretariat (usually considered 'H4+ HQ team') (UNFPA TD): • Manages the H4+JPCS global and country level programme. • **UNFPA is leading/coordinating agency for** H4+ JPCS programme in DRC; Sierra Leone; Zimbabwe; Guinea Bissau; Cote D'Ivoire.	• Manages all the H4+JPCS funds; is a pass-through mechanism to other H4+JPCS UN partners and report to donors on expenditures. • Ensures financial management of H4+JPCS (disbursements and financial reporting to H4+ partners and donors) • Manages all funds for UNFPA at global level and report to corporate. • Coordinates global level activities – efforts of 6 UN partners to ensure coherence in H4+ JPCS programming. • Provides oversight, technical assistance and coordinate work from global level with all 10 countries. • Cooperates with UN and other international stakeholders working on maternal and child health and RMNCAH and contribute to global level debates on the same areas. • Provides inputs to UNFPA global programming and reporting; and joint reports on UN partners.	RMNCAH Section: Laura Laski laski@unfpa.org Luc de Bernis debernis@unfpa.org H4+JPCS Secretariat: Hemant Dwivedi dwivedi@unfpa.org Jean Pierre MONET monet@unfpa.org Michelle Park mpark@unfpa.org

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
	UNICEF	• H4+JPCS partner agency	• UNICEF has a joint coordination and implementing role. • UNICEF is leading/coordinating agency for H4+ JPCS programme in DRC; Sierra Leone; and Zambia. • UNICEF provides technical leadership and expertise on specific thematic areas. • UNICEF manages the RMNCH fund	Steering Committee member: Kim Dickson kdickson@unicef.org
	UNAIDS	• H4+JPCS partner agency	• UNAIDS contributes to all 10 H4+JPCS programmes at country level. • No leadership/coordination role.	Steering Committee member: Dirk Van Hoven vanhoved@unaids.org
	UN Women	• H4+JPCS partner agency	• UN Women contributes to all H4+JPCS programmes where it has presence at country level. • No leadership/coordination role.	Steering Committee member: Nazneen Damji nazneen.damji@unwomen.org
	WHO	• H4+JPCS partner agency	• WHO is leading/coordinating agency for H4+ JPCS programme in Burkina Faso, Liberia, and Ethiopia	Steering Committee member: Mikael Meyer Ostergreen ostergrenm@who.int
	World Bank	• H4+JPCS partner agency	• The World Bank position and contribution is seen only as part of the Steering Committee/ Global Technical Team.	Rama Lakshminarayanan rlakshminarayana@worldbank.org
Donors				
Donors to JPCS	• Sweden/Sida[16] • Canada/	• Provide funds • Oversight programme implementation and provide guidance on how to improve management and programming.		Pierre Tremblay (GAC)

[16] See document titled: "Joint Programme Document: The H4+ Global Initiative for Reproductive, Maternal, Newborn and Child Health - Project Title: Accelerating progress in MDG 4 and 5 – Collaboration with Sida", google drive link: https://drive.google.com/drive/folders/0ByJ_UtSZ6wvaTVVvcGFuSTNGaGM

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
	Global Affairs Canada (GAC)[17]			
Other Donors	• France (donor of Muskoka Collaboration)	The Muskoka Initiative was announced by the Government of Canada in G8 Summit 2010. It has helped to address the significant gaps that exist in maternal, newborn, and child health in developing countries.	The World Health Organization and World Bank estimates, from 2010 to 2015, the Muskoka Initiative will assist developing countries to: • prevent the deaths of 1.3 million children under five years of age • prevent the deaths of 64,000 mothers • give access to modern methods of family planning for 12 million couples. The Initiative includes a range of elements: prenatal care; attended childbirth; postpartum care; sexual and reproductive health services, including voluntary family planning; health education; treatment and prevention of diseases, including infectious diseases; prevention of mother-to-child transmission of HIV; immunization; basic nutrition; safe drinking water and sanitation	Key informants to be determined.
Health Platforms				
	Global Strategy for Women's, Children's and Adolescent's	• The EWEC GS2.0 is considered as a front-runner implementation platform for the SDGs. It underpins inclusive, sustainable development with	• H4+JPCS has contributed in the development of the strategy, and mobilised commitments in 31	Shyama Kuruvilla Kuruvillas@WHO.int Luc de Bernis debernis@unfpa.org

[17] See document titled: "Joint Programme Document: The H4+ Global Initiative for Reproductive, Maternal, Newborn and Child Health Project Title: Accelerating progress in MDG 4 and 5 – collaboration with Canada" google drive link: https://drive.google.com/drive/folders/0ByJ_UtSZ6wvaUjJHendkbHZWTGc

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
	Health 2016 – 2030 Every Woman Every Child (EWEC GS2.0) 2016-2030	women's, children's and adolescents' health and wellbeing. It includes nine interconnected and interdependent transformative actions intended as a package of measures to be implemented comprehensively and in parallel. These are: 1. Country Leadership 2. Financing for Health 3. Health System Resilience 4. Individual Potential 5. Community Engagement 6. Multi sectoral action 7. Humanitarian and Fragile Settings 8. Research and Innovation 9. Accountability for Results, resources and rights All transformative actions are underpinned by human-rights and equity. The EWEC GS2.0 calls on the EWEC movement to play a role to coordinate global support through: targeted global initiatives; advocacy; financing and ensuring high level political engagement.	countries; and is considered the 'technical arm' of the strategy. • H4+ contributes to EWEC GS2.0 priorities that include: - increasing national and sub-national country leadership's engagement along with that of women, children and adolescents, and encouraging civic organizations and the private sector to drive innovation, quality and equity of access. Follow up activities: 1. To request the H4+JPCS Secretariat to provide the list of countries. 2. To explore further the current and potential role of H4+JPCS, especially the one after the launch of the EWEC GS2.0.	Hemant Dwivedi dwivedi@unfpa.org Jean Pierre MONET monet@unfpa.org
	The Partnership for Maternal, Newborn and	• PMNCH is a platform for knowledge, advocacy and accountability to improve women and children's health. The Partnership plays a central role in	• The Partnership's work is based on three key priorities supporting all partners to achieve better outcomes for women and children in high-	Robin Gorna Gornar@WHO.int Lara Brearley Brearleyl@who.int Jean Pierre MONET monet@unfpa.org

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
	Child Health (PMNCH)	facilitating joint actions, mainly towards the United Nations MDGs 4 and 5, and through support for the Global Strategy 2010.	burden countries, which are: knowledge; advocacy; and accountability. Its 2016-2020 strategic framework responds to the EWEC GS2.0 and the SDGs, and focuses on: advocacy; analysis; accountability and alignment. • PMNCH hosts the secretariat to the Independent Accountability Panel which has replaced the iERG. The IAP will produce an annual accountability progress report (the State of RMNCAH) tracking results, resources and rights in the context of the Global Strategy • H4+ provides complementary advocacy for RMNCAH supporting the PMNCH leave to its role as an 'advocacy platform' of the Global Strategy 2.0).	Luc de Bernis debernis@unfpa.org
	International Health Partnership (IHP+)	IHP+ works at country level to strengthen coordination, encourage joint reporting, joint assessment and joint planning and budgeting.	Transitioning to the Health Systems Alliance 2030.	Finn Schleimann, finnschleimann@gmail.com Veronica Walford veronicawalford@yahoo.co.uk
	RMNCH - SC	The RMNCH Steering Committee no longer functions. However it was operational during two of the years covered by the Evaluation.	The RMNCH-SC aimed to coordinate partners around building country investment plans for RMNCH.	RMNCH: Pascal Bijleveld pbijleveld@unicef.org
	independent Expert Review Group (iERG):	**independent Expert Review Group (iERG):** Is a time-limited independent Expert Review Group (iERG) be established and operate until 2015. Its function is:	The iERG has been transitioned to the Independent Accountability Panel. The Panel has just started its work. It is chaired by Dr Sania Nishtar. Nine commissioners were	Review the three iERG reports: http://www.who.int/woman_child_accountability/ierg/reports/en/

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		- Global oversight: Starting in 2012 and ending in 2015, the iERG is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations. WHO lead a transparent process to establish the iERG that is comprised of 7 members. Appointed individuals exercise autonomous, professional judgment and serve in an independent capacity. http://www.who.int/woman_child_accountability/ierg/en/	selected by the UN Secretary General.	
	Global Financing Facility (GFF)	The GFF objectives are to: 1. Finance national RMNCAH scale-up plans and measure results 2. Support countries in the transition toward sustainable domestic financing of RMNCAH 3. Finance the strengthening of civil registration and vital statistics systems 4. Finance the development and deployment of global public goods essential to scale up 5. Contribute to a better coordinated and streamlined RMNCAH	• H4+ has provided technical support to countries developing Investment Cases (in the framework of GFF) * GFF, like H4+, is a major component of the global architecture.	Mikael Meyer Ostergren ostergrenm@who.int Rama Lakshminarayanan rlakshminarayana@worldbank.org Hemant Dwivedi dwivedi@unfpa.org Jean Pierre MONET monet@unfpa.org

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		financing architecture. The goal is to link the financing of RMNCAH roadmaps with longer-term planning that strengthens domestic resource mobilization and diversifies modalities of development assistance in line with a country's rate of economic growth.		
Implementing Partners (Global Activities)				
	International Confederation of Midwives (ICM)	ICM is a global organisation of midwives associations with members in more than 100 countries. It represents over 400,000 midwives globally. It is governed by an international Council made up of delegates from each of its 116 Member Associations. The Council is responsible for setting the strategic directions for the forthcoming triennium. Each triennium, in connection with Congress, the Council elects a Board for a three-year term with representation from Africa, AsiaPacific, the Americas and Europe.	ICM envisions a world where every childbearing woman has access to a midwife's care for herself and her newborn. ICM mission: To strengthen Midwives Associations and to advance the profession of midwifery globally by promoting autonomous midwives as the most appropriate caregivers for childbearing women and in keeping birth normal, in order to enhance the reproductive health of women, and the health of their newborn and their families.	Nester Moyo n.moyo@internationalmidwives.org Nester also sits on the PMNCH Board and is well placed to discuss ICM in the global context including its relationship with H4+.
	UN Foundation	The United Nations Foundation links the UN's work with others around the world, mobilizing the energy and expertise of business and non-governmental organizations to help the UN tackle issues including climate change, global health, peace and security, women's empowerment,	The UN Foundation has supported the development of the new Global Strategy for Women's Children's and Adolescents' Health. It has convened global partners to engage in the development of the new global architecture.	Anita Sharma asharma@unfoundation.org

Type of Stakeholder	Name of Stakeholder	Characteristics	Main role and functions	Contacts
		poverty eradication, energy access, and U.S.-UN relations.		

Part Two: Stakeholder Map of the H4+JPCS: Country Level – Zimbabwe Example

Type of Stakeholder	Functional Relationship to H4+JPCS	Organization	Contacts
H4+ Partners			
H4+ Coordinator	Serves as contact point between H4+ country team and the regional and global level. Coordinates and oversees preparation of joint work plans from the country team perspective. Coordinates inputs to results monitoring and accountability systems and joint preparation of annual reports. Direct liaison with the global coordinators office in UNFPA HQ. Also acts as technical specialist for Maternal Health and Family Planning, UNFPA Zimbabwe	UNFPA	• Vibhavendra Raghuvanshi, Technical Specialist Maternal Health and Family Planning: raghuyamshi@unfpa.org
H4+ Country Team Zimbabwe	Joint planning of the annual work plan and providing inputs to the joint results framework. Technical assistance and expert advice to implementing partner agencies whether government of Zimbabwe or NGOs, Managing relationship with implementing partners. Monitoring the context of RMNCAH in Zimbabwe.	UNFPA UNICEF WHO UNAIDS UN Women[18]	• Tamisayi Chinhengo, UNFPA Programme Specialist, ASRH and HIV: chinhengo@unfpa.org • Choice Damiso, UNFPA Gender Programme Specialist: damiso@unfpa.org • Dagmar Harnish, UNFPA Technical Specialist SRH and HIV • Joyce Mpaya, UNICEF HIV/AIDS Manager: jmpaya@unicef.org • Beula Senjanzi, UNICEF HIV/AIDS Specialist: • bsenjanzi@unicef.org • Trevor Kanyowa, WHO, Family Reproductive Health Officer: kanyowat@who.int • Liz Tavadze, UNAIDS Advisor, HIV Integration: tavadzel@unaids.org • Molline Marume, UNWomen Programme Specialist, Gender and HIV: molline.marume@unwomen.org
Government of Zimbabwe			

[18] At the time of the exploratory mission there was no evidence that the World Bank was an active participant in the H4+ JCPS country team in Zimbabwe.

Type of Stakeholder	Functional Relationship to H4+JPCS	Organization	Contacts
National Authority for Health: Ministry of Health and Child Care (MoHCC)	The MoHCC is the driver of national priorities, plans and programmes in health in Zimbabwe, including RMNCAH. It manages all publicly owned health care facilities from the tertiary through to the lowest level of primary care. In Zimbabwe the MoHCC is more than just a partner to H4+ JPCS as it has taken a lead role in the coordination and planning of interventions by chairing the H4+ JPCS coordinating committee and leading regular planning and review meetings at the national, provincial and district levels. It remains the most active implementing partner for H4+ JPCS investments. The MoHCC also takes a lead role in the monitoring and evaluation of H4+JPCS with a programme-supported monitoring and evaluation officers based in the ministry.	MoHCC	• Brigadier General (Dr.) Gerald Gwinji, Permanent Secretary: ggwinji@gmail.com • Dr. Bernard Madzima, Director of Family Health: madzima.bernard@gmail.com • Dr. Gibson Mhlanga, Principal Director, Preventive Services • Mr. Joshua Kotiyo, Manager, Health Information and Disease Surveillance: katiyoj@gmail.com • Dr. Angela Mushavi, National PMTCT and Paediatric HIV Care and Treatment Coordinator: mushavia@yahoo.co.uk • Susan Gwashure, HIV Testing Services Coordinator • Dr. Murungu, Deputy National ART Coordinator • Henry Chidawanyika, Project Director, Zimbabwe Health Information Support Project (Research Triangle Institute International): hchidawanyika@zimhisp.rti.org • Absolom Mbinda, Monitoring and Evaluation Officer: mbindaabso@gmail.com •
National Authority for Women: Ministry of Women's Affairs Gender and Community Development (MWAGCD)	MWAGCD has lead responsibility in the government of Zimbabwe for gender equality and for community development and mobilization. In the context of H4+JPCS they are the main policy partner of programme initiatives aimed at community mobilization and increasing access for girls and women. In Zimbabwe they work most closely with UN Women and UNAIDS in the implementation of the H4+JPCS work plan.	MWAGCD	• Mr. Wisdom Karonga, Deputy Director of Women's Affairs • Redah Manga, Administrative Officer, Women's Affairs
Provincial Health Executive, MoHCC	The provincial health authorities play an oversite, management and technical support role for the health facilities in the provinces as well as administering	Provincial Health Executive –	• Provincial Medical Director • Venus Mahati, Provincial Nursing Officer

Type of Stakeholder	Functional Relationship to H4+JPCS	Organization	Contacts
	health services provided on a province-wide basis. They have a direct link to both the MoHCC in the capital and to the District Health Executive in each district. They are important key informants as they have concrete information on conditions for RMNCAH in each of the districts as well as an overview of programmes to support health systems strengthening across the province. The Provincial Health Executive also collects and collates data for the Electronic Maternal Death Surveillance and Reporting System (EMDS) for onward transmission to MoHCC headquarters	Manicaland Province	• Jane Mandimutsira, Reproductive Health Focal Person • Emmanuel Mufambanhondo, Provincial Environmental Health Officer • Clifford Kanyunyunda, Provincial Accountant • Charles Tsangamidzi, Acting Provincial Health Services Administrator
District Health Executive MoHCC	The District Health Executive mirrors the structure and functions of the Provincial Health Team with a focus on the health facilities in the district. It is a key focus for gathering and reporting information on RMNCAH outcomes in the district and has responsibility for oversite and direction to all health facilities whether operated by the MoHCC or mission organizations.	District Health Executive (DHE): Chipinge District	• Kudzanai Guveya, Acting District Medical Officer • Plaxedes Mandevhana, Acting District Nursing Officer • Elijah Mutimurefu, DPM • Godhelp Gurai, Senior Nursing Officer • Mahlathini Honest, Nutritionist • Mukandi Bright, ADHSA • Nyamaende Lyoyd, Acting Accountant • Dube Frank, Community Health Worker • Makundanyika, District Environmental Health Officer
Mission Hospital	Almost 20 percent of health facilities in Zimbabwe are operated by faith based organizations. They are as likely to be directly supported by H4+JCPS initiatives and investments as MoHCC operated facilities. The St. Peters Mission Hospital in Chapinge received important logistical support and benefited from training, mentoring and supportive supervision in Comprehensive Emergency Obstetric and Newborn Care (CeMONC).	St. Peters Mission Hospital, Chipinge District	• Sibongile Mugarisi, Registered General Nurse • Chapoterera Rosemary, Sister in Charge • Dr. Stephen Mbiri, Government Medical Officer • Dr. Taremba Davison, Government Medical Officer
National Non-Governmental Organisations			

Type of Stakeholder	Functional Relationship to H4+JPCS	Organization	Contacts
Kapnek Trust	This national organization based in Harare had a history of providing support to the MoHCC in training, particularly in PMTCT in hard to reach districts before the advent of the H4+JPCS. Under H4+JCPS they have been working in Hurungwe and Gokwe North districts, among the six targeted high-burden districts of the programme. In addition to training in the use of Point of Care CD4 testing machines for HIV/AIDS for PMTCT they have been active in working with community groups, especially apostolic religious communities which are hard to reach with health messages and services. Their main point of contact for H4+JPCS has been as an implementing partner of UNICEF support.	J.F. Kapnek Trust	• Caroline Marangwanda, Deputy Director: cmarangwanda@octazim.co.zw • Margaret Jembere, Programme Coordinator
AfricAID	Working with UNICEF support channelled through the MoHCC which contracts AfricAID Zimbabwe. This organization has developed a model for supporting adolescents and service providers at community level to improve trust and quality of service. The Community Adolescent Treatment Supporters (CATS) model involves community-based activists working directly with health centre staff and under the supervision of the MoHCC primary councillor for the facility. The youth activists who make up the cadre of CATS must be between the ages of 19-22.	AfricAID	• Nicola Willis, Director: nicola@zvandiri.org • Martha Maudzeke, Programme Manager: marther@zvandiri.org •
Organisation for Public Health Intervention and Development (OPHID)	OPHID also worked with UNICEF support under the H4+ JPCS, mainly in Mbare district. OPHID had been working closely with PEPFAR in Zimbabwe but reports that UNICEF support helped them to bring the equity and social inclusion dimension to the work supported by PEPFAR. Their work focused on support to adolescent sexual and reproductive health as well as organizing and supporting women's groups, particularly in the maternity waiting homes.	OPHID	• Dianal Patel, Deputy Director: dpatel@ophid.co.zw • Barbara Engelsmann, Director: bengelsmann@ophid.co.zw •

Type of Stakeholder	Functional Relationship to H4+JPCS	Organization	Contacts
Women's Action Group (WAG) and Katswe Sisterhood	Supported by UNWomen and UNAIDS these two organizations based in Harare work in community mobilization for encouraging increased access to services in RMNCAH for young women and men. In particular, they work on building trust between young women, young men and health service providers.	WAG Katswe Sisterhood	• Edina Masiyiwa, Executive Director: edina@wag.org.zw • Talent Jumo, National Coordinator: talentjumo@yahoo.co.uk •
Bilateral/ Multilateral Organisations Supporting RMNCAH	There are a number of bilateral organizations providing support to RMNCAH in Zimbabwe either directly or through the support of two major efforts at Health Systems Strengthening: the World Bank's Performance Based Financing (PBF) programme and the UNICEF administered Health Transition Fund which is now called the Health Development Fund. Active bilateral donors to RMNCAH include the Department for International Development of the UK and Irish Aid. Contacts for these organizations will be developed prior to the Zimbabwe field country case study mission. International NGOs active in RMNCAH in Zimbabwe will also be contacted.		

ANNEX 3: TRENDS IN INDICATORS OF RMNCAH IN TEN H4+ JPCS COUNTRIES

Burkina Faso

Table 1: Basic info

Country income level	Low-income	
Population 2014	17.6 million	(World Bank 2016i)
Literacy rate 2007	28.7%	(World Bank 2016a)
Political/administrative system	13 administrative regions, 45 provinces, 301 departments	

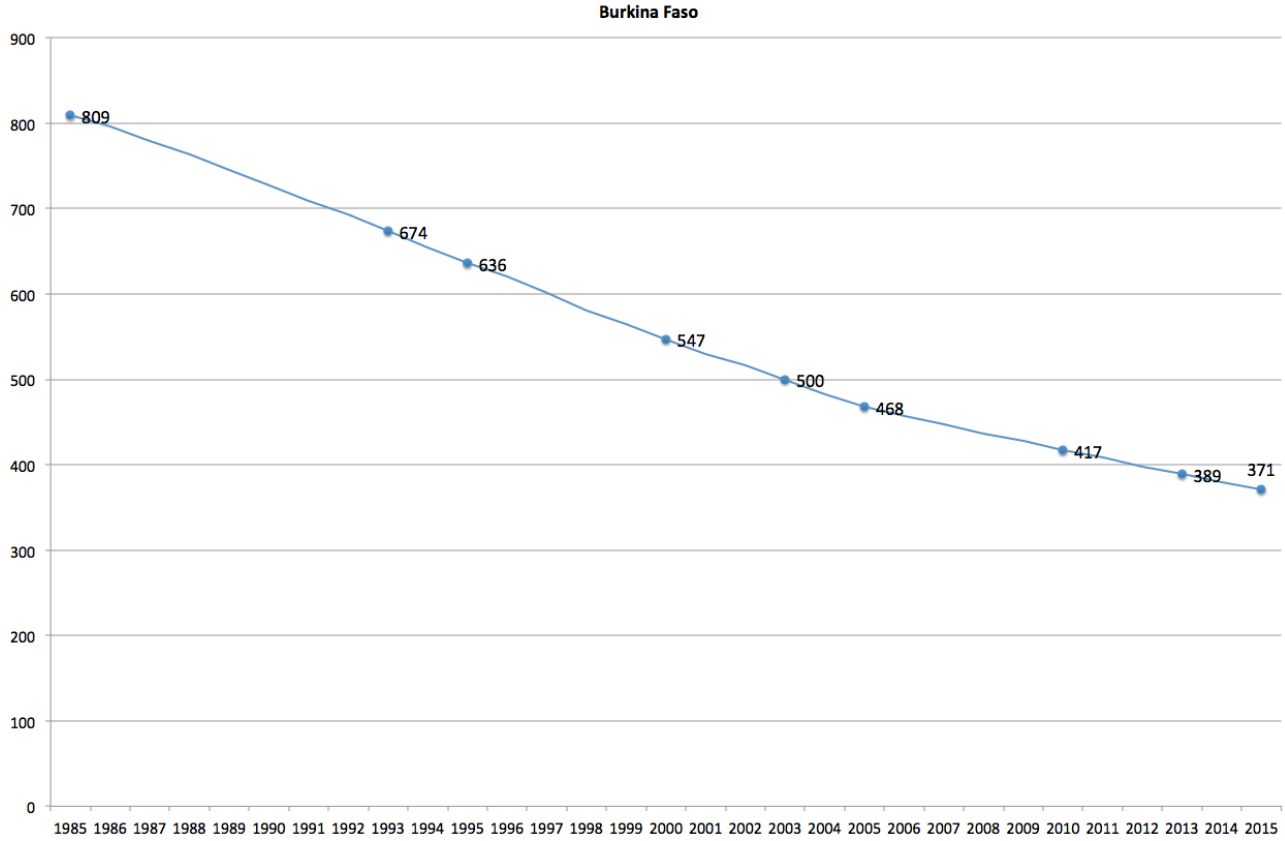
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.8%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	3.4%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	36.4%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	79.6%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

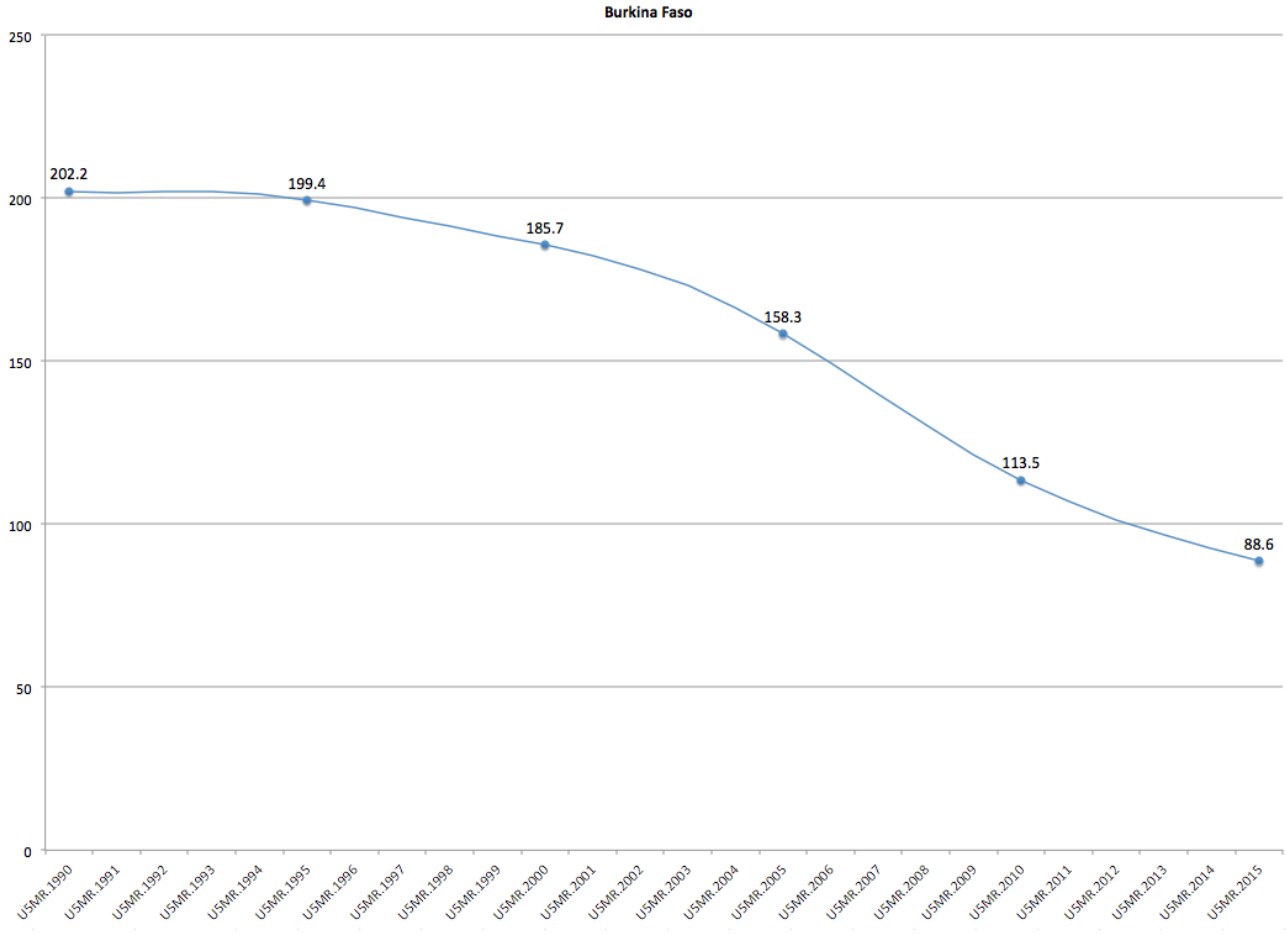
Indicator	1993	1999	2003	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	50%	28%	32%	40%	32%	(Countdown 2015a)
Indicator	**1996**	**2001**	**2006**	**2008**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	144	131	128	136	-	(Countdown 2015a)
Indicator	**1993**	**1999**	**2003**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	31.1%	25.4%	23.2%	23.6%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	636	547	468	417	371	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	27	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	61	(Countdown 2015c)
Under Five Mortality, per 1,000	199.4	185.7	158.3	113.5	88.6	(Countdown 2015a)
Indicator	**1993**	**1999**	**2006**	**2010**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	7.9	11.9%	17.4%	16.2%	...	(World Bank 2016c)
Indicator	**1993**	**1999**	**2003**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	24.6%	30.3%	29.8%	24.5%	...	(World Bank 2016k)
Indicator	**1993**	**1999**	**2003**	**2010**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	23%	23%	18%	34%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	42.8%	50.7%	57.8%	75.5%	(Countdown 2015a)
Lower bound	<1%	35.9%	42.8%	48.5%	63.0%	
Upper bound	<1%	50.9%	60.4%	68.8%	90.2%	
Indicator	**1999**	**2003**	**2006**	**2010**	**2014**	**Source**
Skilled attendant at delivery, %	31%	38%	54%	66%	...	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	26%	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	72%	...	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	6%	19%	7%	25%	50%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	1%	1%	1%	2%	...	(Countdown 2015a)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.09	0.13	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2008**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.73	0.57	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Burkina Faso



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Burkina Faso



Source: (Countdown 2015a)

Cameroon

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	22.8 million	(World Bank 2016i)
Literacy rate 2010	71.29%	(World Bank 2016a)
Political/administrative system	10 regions, 58 divisions	

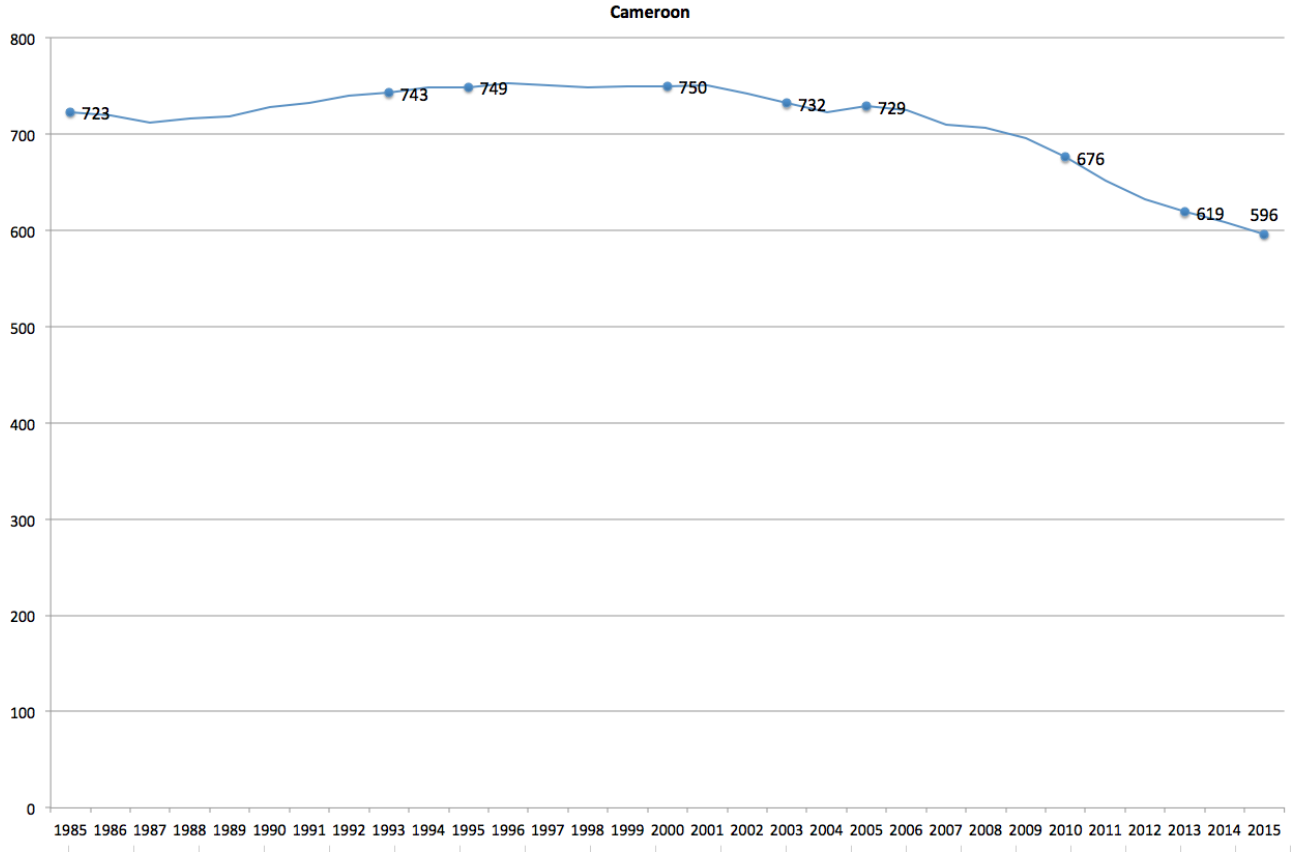
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

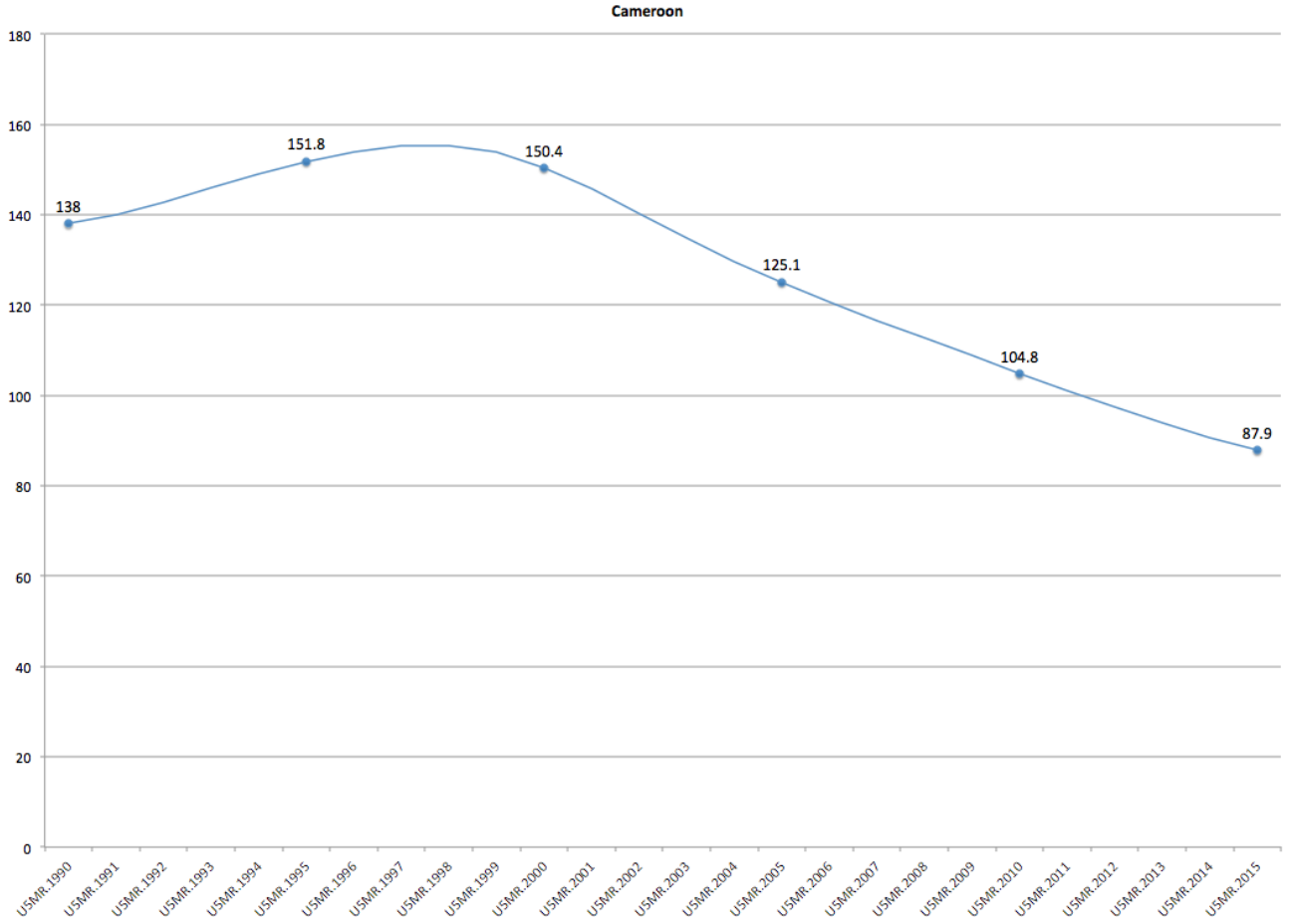
Indicator	1991	1998	2004	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	42%	48%	56%	50%	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2001**	**2005**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	142	136	141	128	-	(Countdown 2015a)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Teenage mothers, % women age 15-19	35%	31.2	28.4%	25.2%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	749	750	729	676	596	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	26	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	57	(Countdown 2015c)
Under Five Mortality, per 1,000	151.8	150.4	125.1	104.8	87.9	(Countdown 2015a)
Indicator	**1991**	**1998**	**2006**	**2011**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	16.1%	19.3%	29.2%	23.4%	...	(World Bank 2016c)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	22.3%	20.7%	20.5%	23.5%	...	(World Bank 2016k)
Indicator	**1991**	**1998**	**2004**	**2011**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	49%	52%	60%	62%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	18.6%	41.3%	53.0%	65.6%	(Countdown 2015a)
Lower bound	<1%	16.8%	37.3%	47.8%	59.5%	
Upper bound	<1%	20.6%	45.8%	58.8%	73.0%	
Indicator	**1998**	**2000**	**2004**	**2006**	**2011**	**Source**
Skilled attendant at delivery, %	58%	60%	62%	63%	64%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	37%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	12%	...	24%	21%	20%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	3%	...	2%	...	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	...	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2009**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	1.6	0.44	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Cameroon



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Cameroon



Source: (Countdown 2015a)

Côte d'Ivoire

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	22.2 million	(World Bank 2016i)
Literacy rate 2012	40.98%	(World Bank 2016a)
Political/administrative system	14 districts, 31 regions	

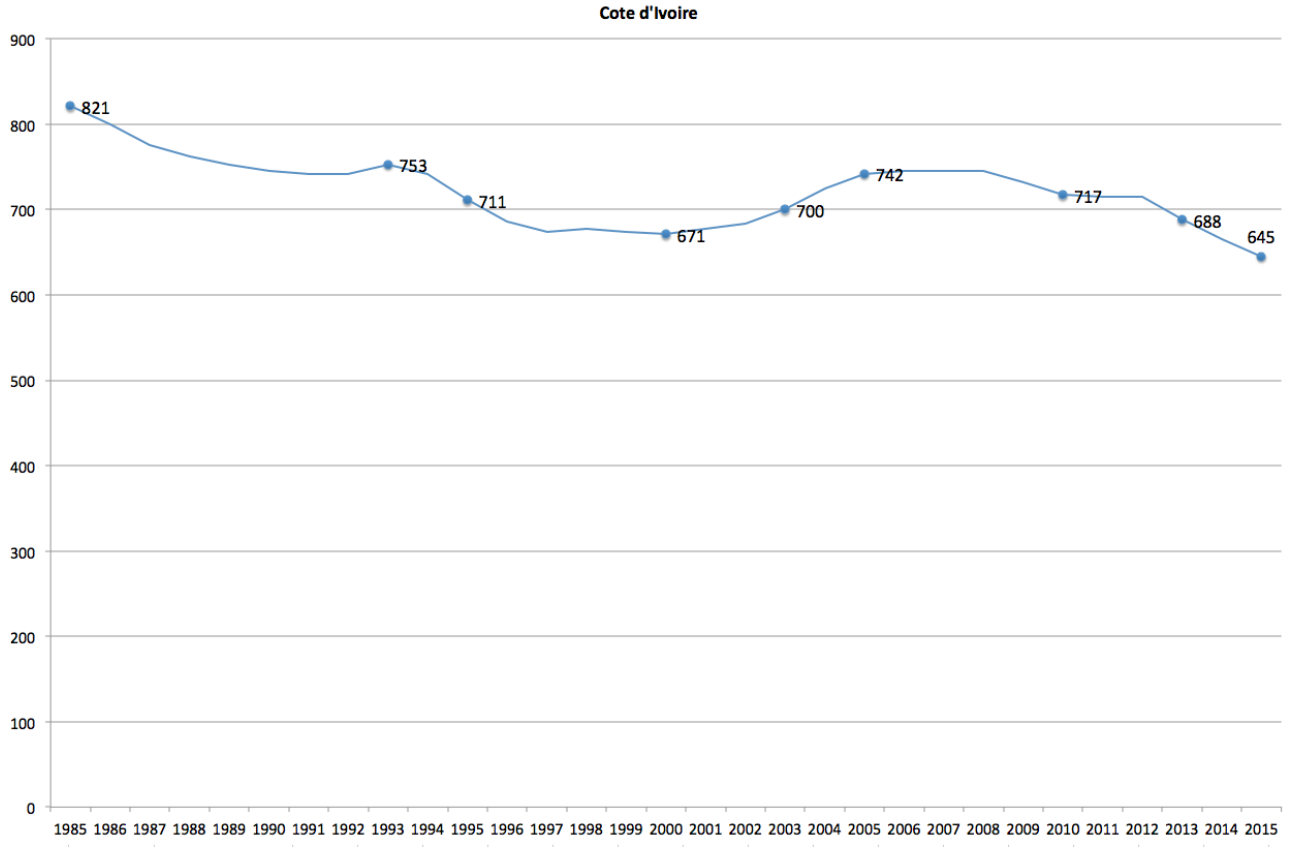
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

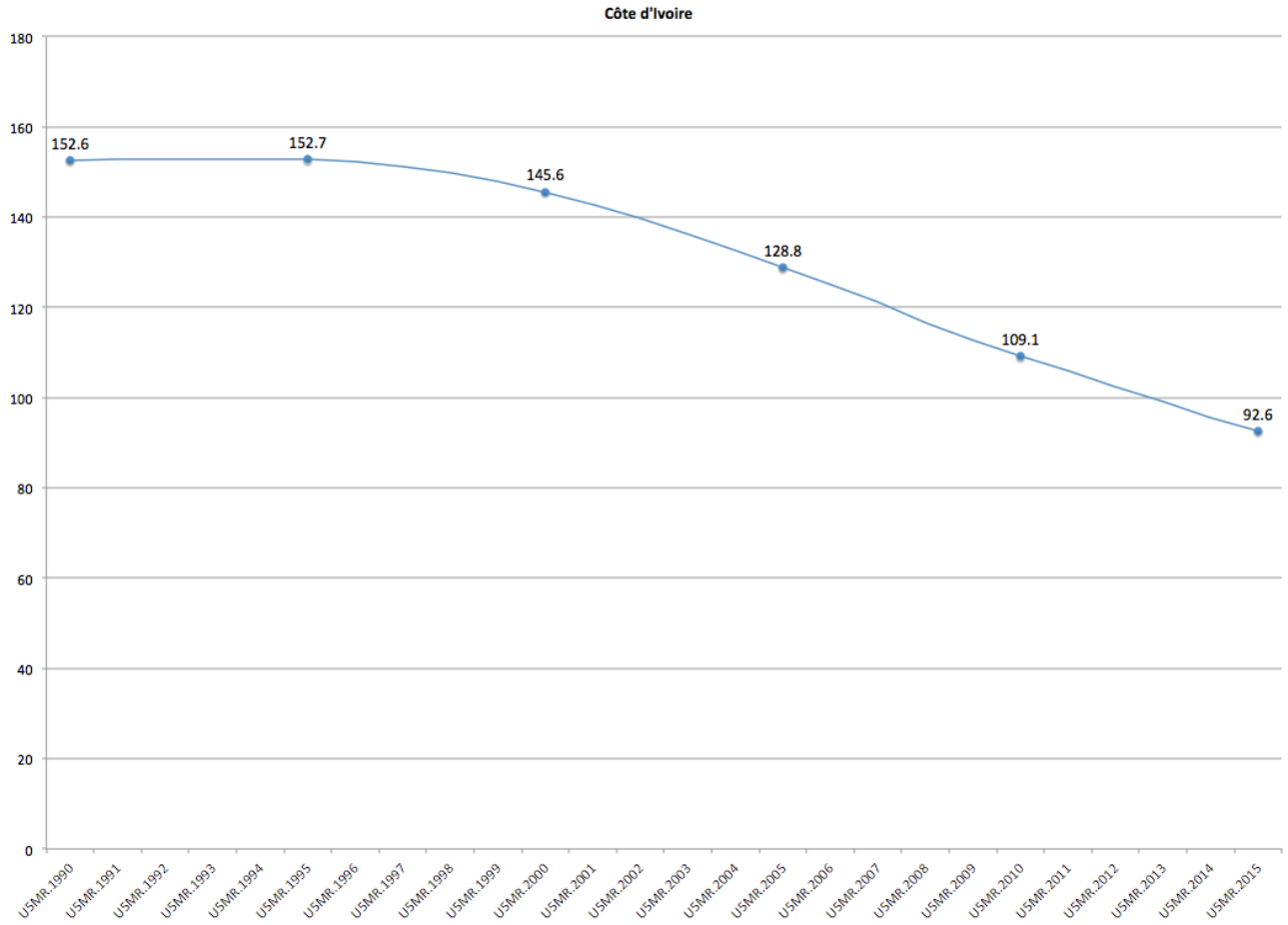
Indicator	1994	1999	2006	2012	2014	Source
Demand for family planning satisfied, % women age 15-49	27%	34%	-	45%	-	(Countdown 2015a)
Indicator	**1992**	**1996**	**2003**	**2006**	**2009**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	151	126	132	111	125	(Countdown 2015a)
Indicator	**1994**	**1999**	**2005**	**2012**	**2015**	**Source**
Teenage mothers, % women age 15-19	35%	31%	...	29.6%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	711	671	742	717	645	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	38	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	67	(Countdown 2015c)
Under Five Mortality, per 1,000						
Indicator	**1994**	**1999**	**2006**	**2012**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	11.4%	15%	12.9%	18.2%	...	(World Bank 2016c)
Indicator	**1994**	**1999**	**2006**	**2012**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	30.4%	28.9%	...	27.1%	...	(World Bank 2016k)
Indicator	**1994**	**1999**	**2005**	**2012**	**2015**	**Source**
Antenatal care, rural, ≥ 4 visits, %	29%	36%	45%	44%	-	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	...	...	...	...	...	(Countdown 2015a)
Lower bound						
Upper bound						
Indicator	**1994**	**1999**	**2000**	**2006**	**2012**	**Source**
Skilled attendant at delivery, %	45%	47%	63%	57%	59%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	34%	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	70%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	3%	4%	10%	4%	12%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	2%	3%	...	6%	3%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	...	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2014**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.6	0.48		(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Côte d'Ivoire



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Côte d'Ivoire



Source: (Countdown 2015a)

Democratic Republic of the Congo

Table 1: Basic info

Country income level	Low-income	
Population 2014	74.9 million	(World Bank 2016i)
Literacy rate 2012	75.02%	(World Bank 2016i)
Political/administrative system	10 provinces, 1 city province, 26 districts	

Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	Source
Health expenditure	Private	% of GDP, 2013	1.6%	(World Bank 2016d)
Total expenditure on health	Public	% of GDP, 2013	1.9%	(World Bank 2016e)
Out-of-pocket health expenditure	Public	% of THE, 2013	32.7%	(World Bank 2016h)
Out-of-pocket health expenditure	Private	% of PHE, 2013	69.8%	(World Bank 2016g)

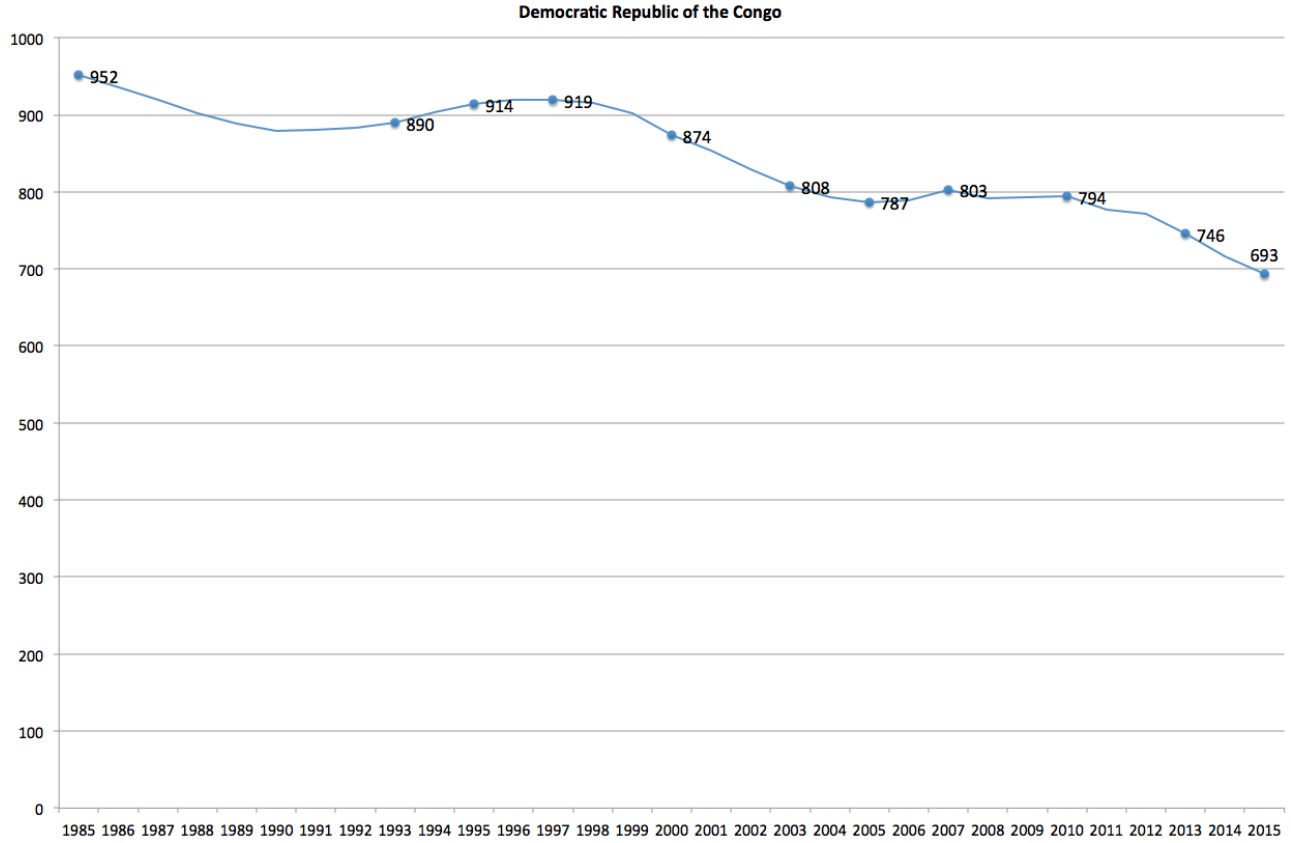
Table 3: H4+JPCS Profiling Indicators 1990-2015

Indicator	1994	1999	2007	2010	2014	Source
Demand for family planning satisfied, % women age 15-49	-	-	43%	43%	42%	(Countdown 2015a)
Indicator	**1992**	**2001**	**2004**	**2009**	**2011**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	125	117	127	135	135	(Countdown 2015a)
Indicator	**1994**	**1999**	**2007**	**2011**	**2013**	**Source**
Teenage mothers, % women age 15-19	...	...	23.8%	...	27.2%	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	914	874	787	794	693	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	30	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	75	(Countdown 2015c)
Under Five Mortality, per 1,000	176.4	161	138.4	116.1	98.3	(Countdown 2015a)
Indicator	**1991**	**2001**	**2007**	**2010**	**2014**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	7.7%	31.4%	20.6%	17.3%	20.4%	(World Bank 2016c)
Indicator	**1995**	**2000**	**2007**	**2010**	**2014**	**Source**
Unmet need for contraception, % aged 15-49	...	...	26.9%	24.2%	27.7%	(World Bank 2016k)
Indicator	**1994**	**1999**	**2007**	**2010**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	-	47%	45%	48%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	1.4%	7.8%	12.4%	46.8%	(Countdown 2015a)
Lower bound	<1%	1.2%	6.9%	10.8%	41.0%	
Upper bound	<1%	1.6%	9.0%	14.2%	53.7%	
Indicator	**1994**	**2001**	**2007**	**2010**	**2013**	**Source**
Skilled attendant at delivery, %	...	61%	74%	74%	80%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	8%	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	44%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	24%	24%	36%	37%	48%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	140[a]	(MSP 2015: 67)
Facilities providing CEMoNC, number	...	...	...	...	47[b]	(MSP 2015: 73)
C Section Rate, % of live births, women age 15-49	...	...	4%7%	7%	5%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	...	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.53	...	...	(World Bank 2016f)

[a] 140 *soins obstétricaux d'urgence de base* (SOUB) (9%) of 1,555 health facilities in total

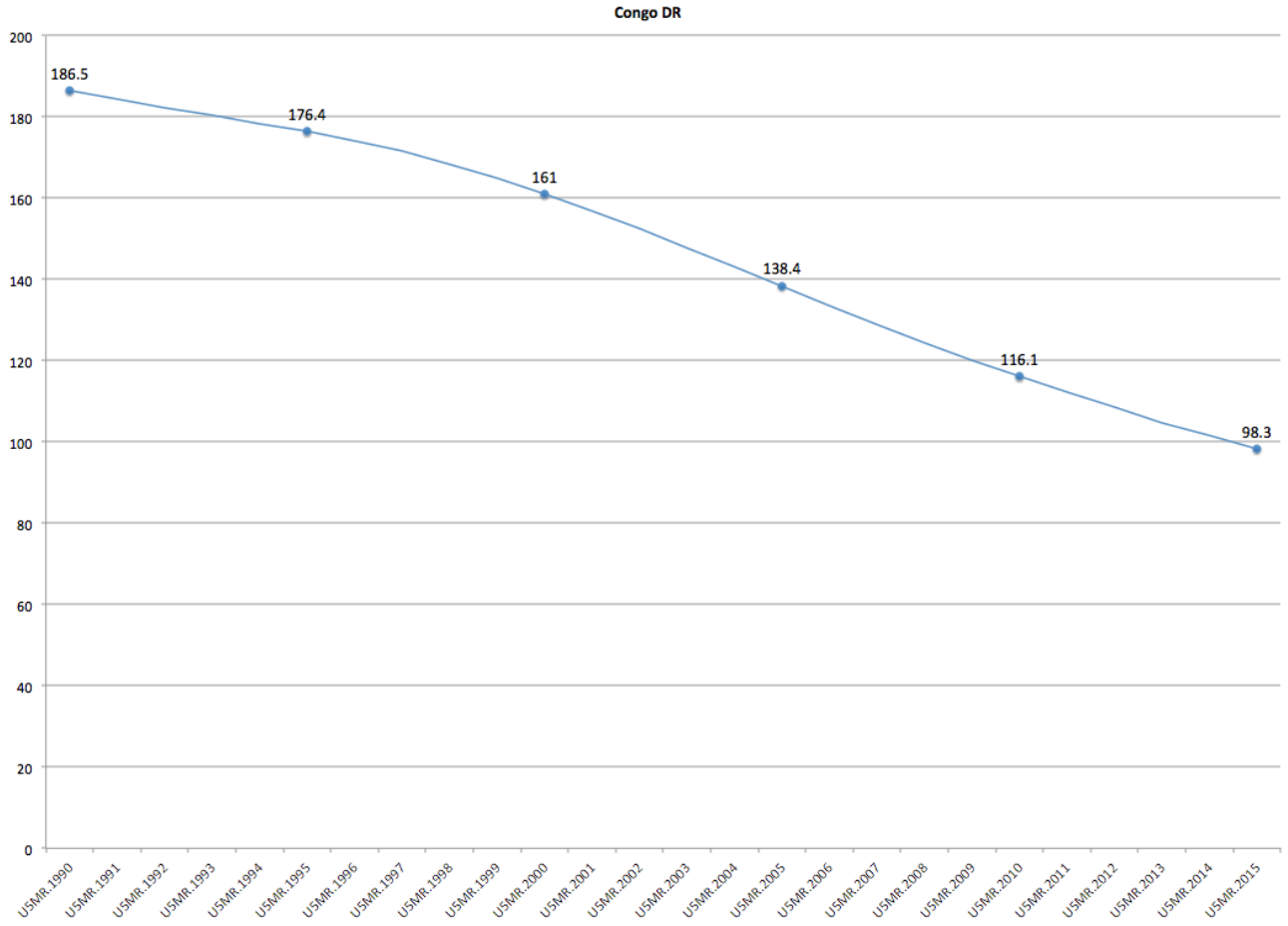
[b] 47 *soins obstétricaux complets* (SOUC) (3%) of 1,555 health facilities in total

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Democratic Republic of the Congo



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Democratic Republic of the Congo



Source: (Countdown 2015a)

Ethiopia

Table 1: Basic info

Country income level	Low-income	
Population 2014	97 million	(World Bank 2016i)
Literacy rate 2007	39.0%	(World Bank 2016a)
Political/administrative system	9 regional states	

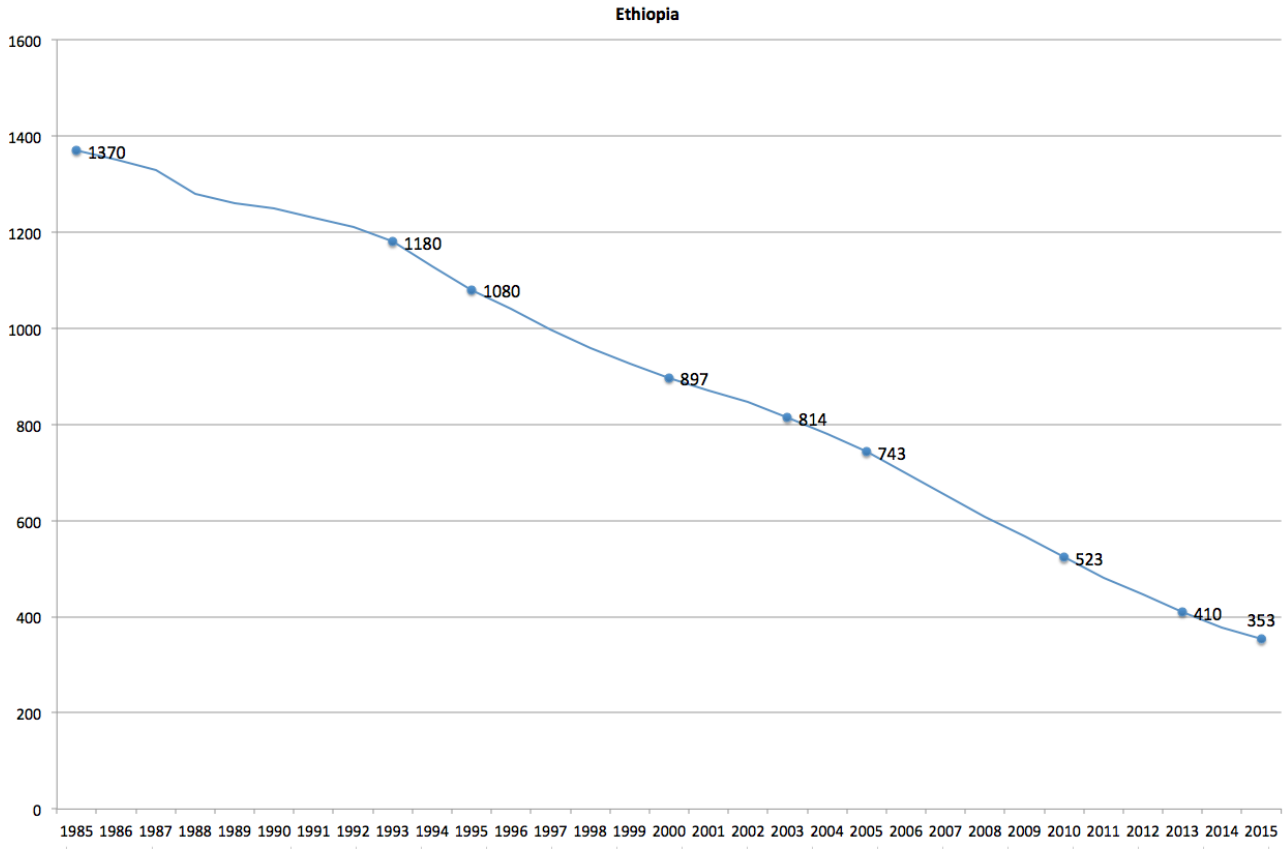
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.0%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	1.9%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	41.2%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	79.9%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

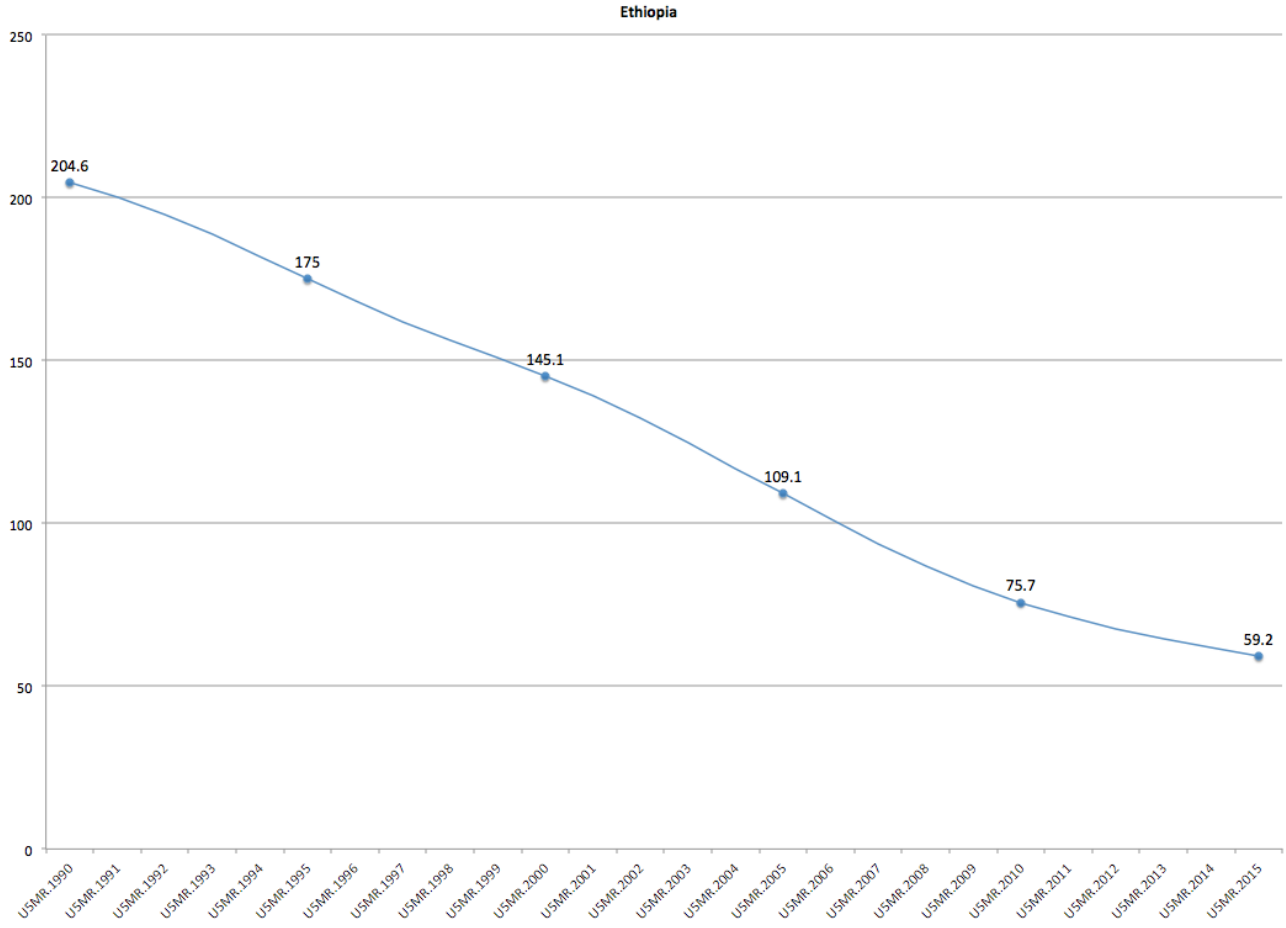
Indicator	1995	2000	2005	2008	2014	Source
Demand for family planning satisfied, % women age 15-49	70%	80%	83%	84%	82%	(Countdown 2015a)
Indicator	**1994**	**1997**	**2002**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	99	110	109	87	71	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	...	16.3%	16.6%	12.4%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	1,080	897	743	523	353	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	28	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	41	(Countdown 2015c)
Under Five Mortality, per 1,000	175	145.1	109.1	75.7	59.2	(Countdown 2015a)
Indicator	**1997**	**2000**	**2005**	**2011**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	3.3%	8.1%	14.7%	28.6%	...	(World Bank 2016c)
Indicator	**1995**	**2000**	**2005**	**2011**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	...	36.6%	36.1%	26.3%	...	(World Bank 2016k)
Indicator	**1994**	**2000**	**2005**	**2011**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	10%	12%	19%	32%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	11.9%	20.3%	52.3%	72.8%	(Countdown 2015a)
Lower bound	<1%	10.1%	17.4%	44.5%	60.7%	
Upper bound	<1%	14.0%	24.0%	61.8%	89.6%	
Indicator	**1994**	**2000**	**2005**	**2011**	**2014**	**Source**
Skilled attendant at delivery, %	...	6%	6%	10%	16%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	12%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	...	54.2%	49%	52%	...	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	...	1%	1%	2%	2%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2009**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.22	0.36	...	(World Bank 2016b)
Indicator	**1995**	**2003**	**2007**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	0.22	0.24	0.24	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Ethiopia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Ethiopia



Source: (Countdown 2015a)

Guinea Bissau

Table 1: Basic info

Country income level	Low-income	
Population 2014	1.8 million	(World Bank 2016i)
Literacy rate 2013	57.8%	(World Bank 2016a)
Political/administrative system	8 regions, 37 sectors	

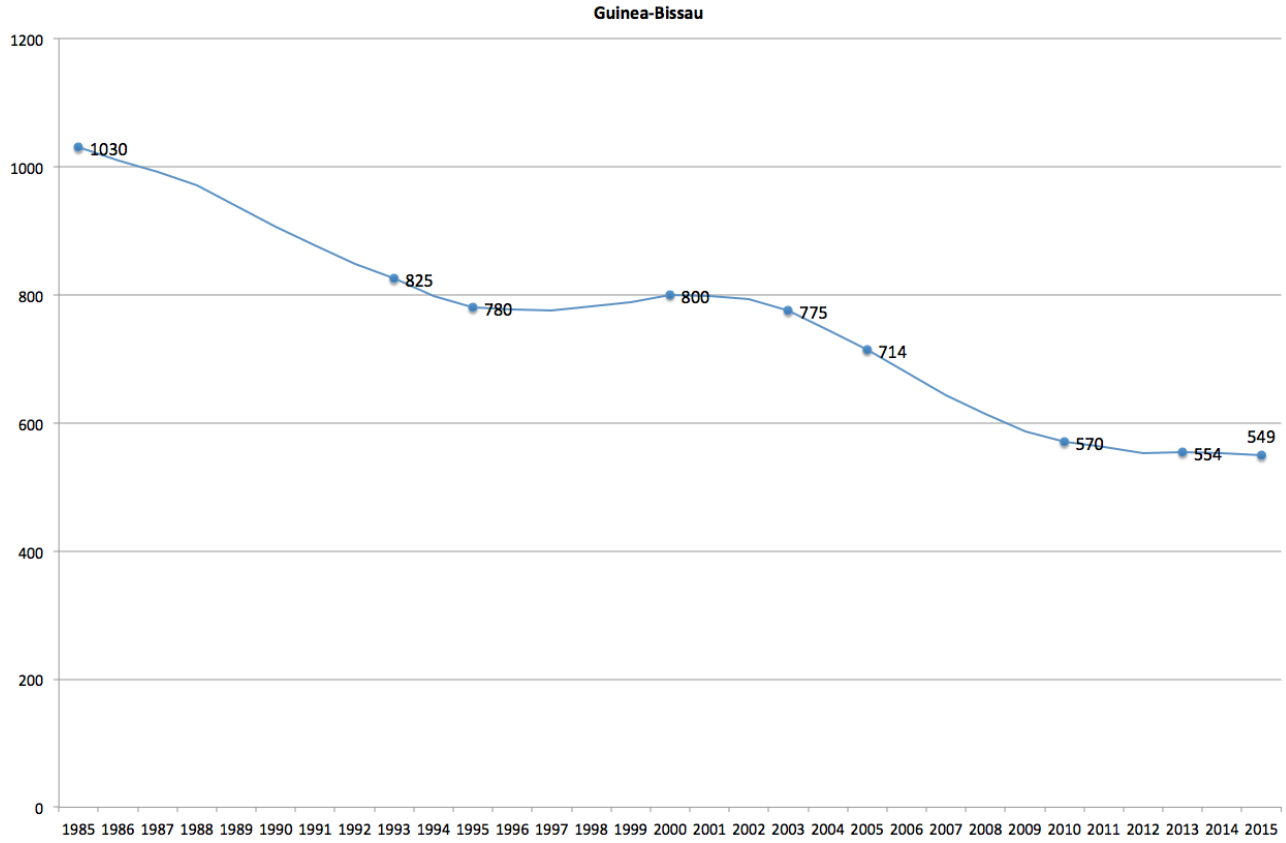
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

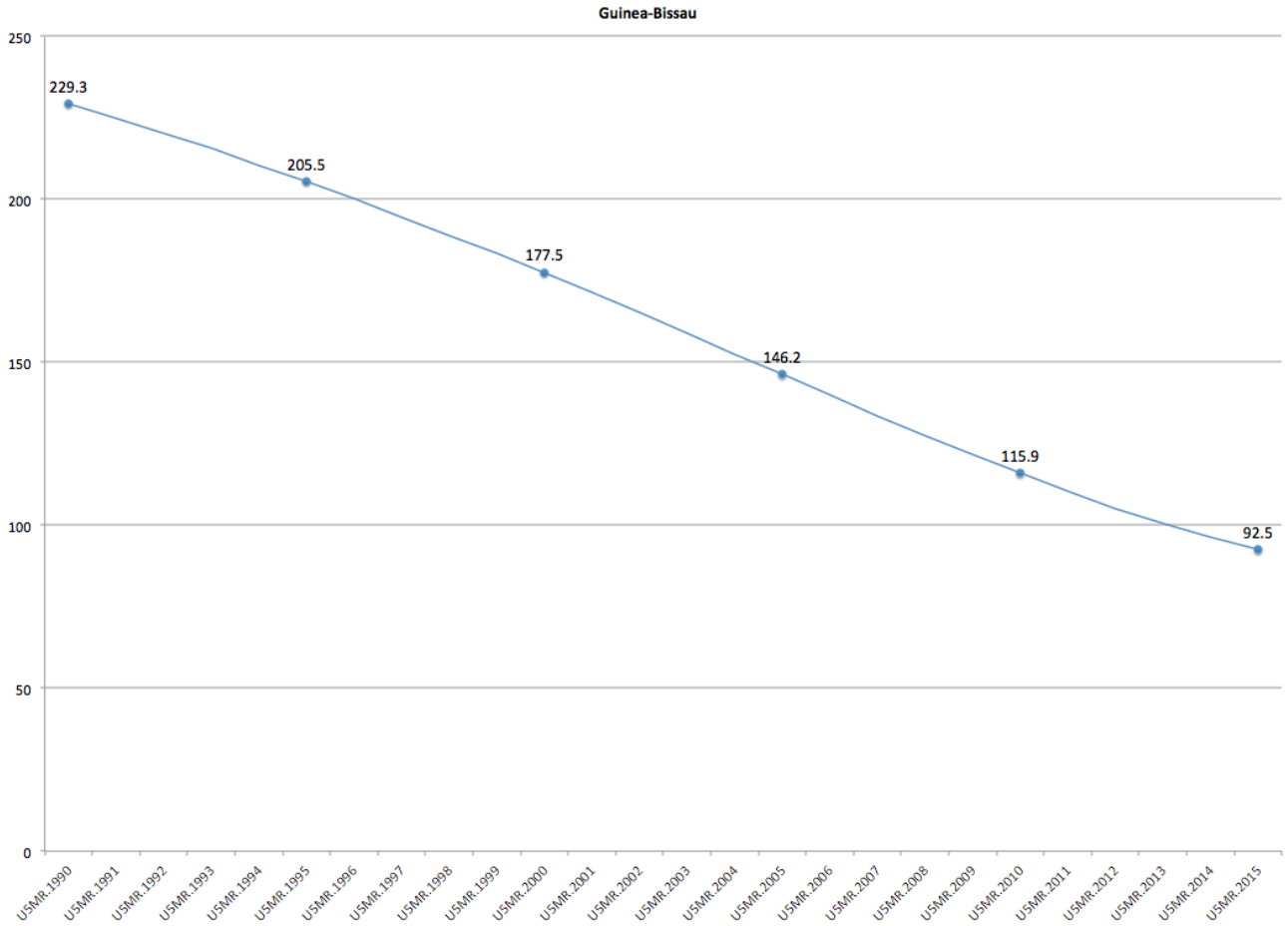
Indicator	1994	1999	2006	2010	2014	Source
Demand for family planning satisfied, % women age 15-49	-	-	-	70%	-	(Countdown 2015a)
Indicator	**1997**	**2000**	**2005**	**2009**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	-	170	-	137	-	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	...	...	...	...	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	780	800	714	570	549	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	40	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	60	(Countdown 2015c)
Under Five Mortality, per 1,000	205.5	177.5	146.2	115.9	92.5	(Countdown 2015a)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	...	7.6%	10.3%	14.2%	...	(World Bank 2016c)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	...	...	...	6%	...	(World Bank 2016k)
Indicator	**1994**	**1999**	**2006**	**2010**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	-	-	-	68%	65%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	10.8%	15.3%	32.4%	83.5%	(Countdown 2015a)
Lower bound	<1%	9.5%	13.5%	28.7%	74.1%	
Upper bound	<1%	12.5%	17.4%	36.6%	94.2%	
Indicator	**1995**	**2000**	**2006**	**2010**	**2014**	**Source**
Skilled attendant at delivery, %	25%	35%	39%	43%	45%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	...	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	...	36.5%	16.1%	38.3%	52.5%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	...	...	...	2%	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	2.9	...	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.7	0.55	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Guinea Bissau



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Guinea Bissau



Source: (Countdown 2015a)

Liberia

Table 1: Basic info

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

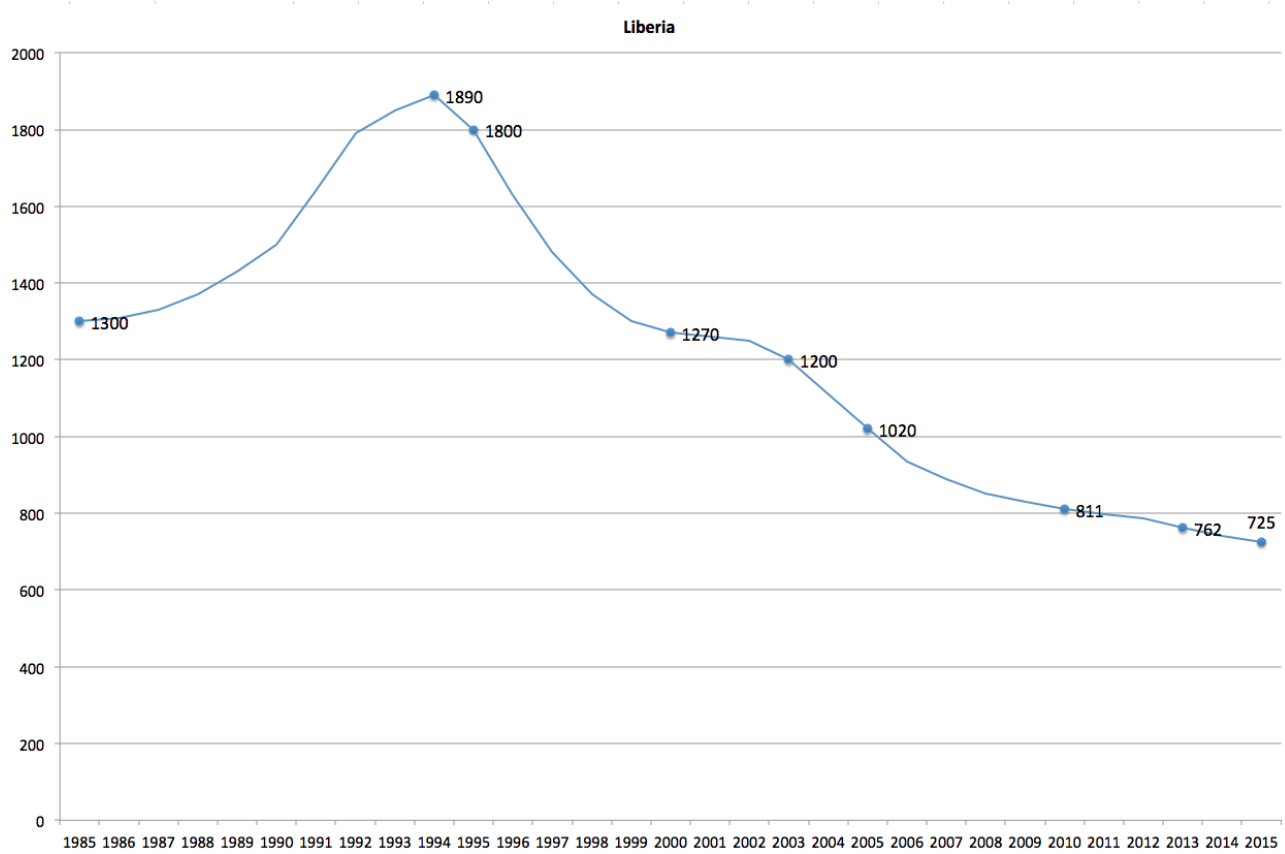
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

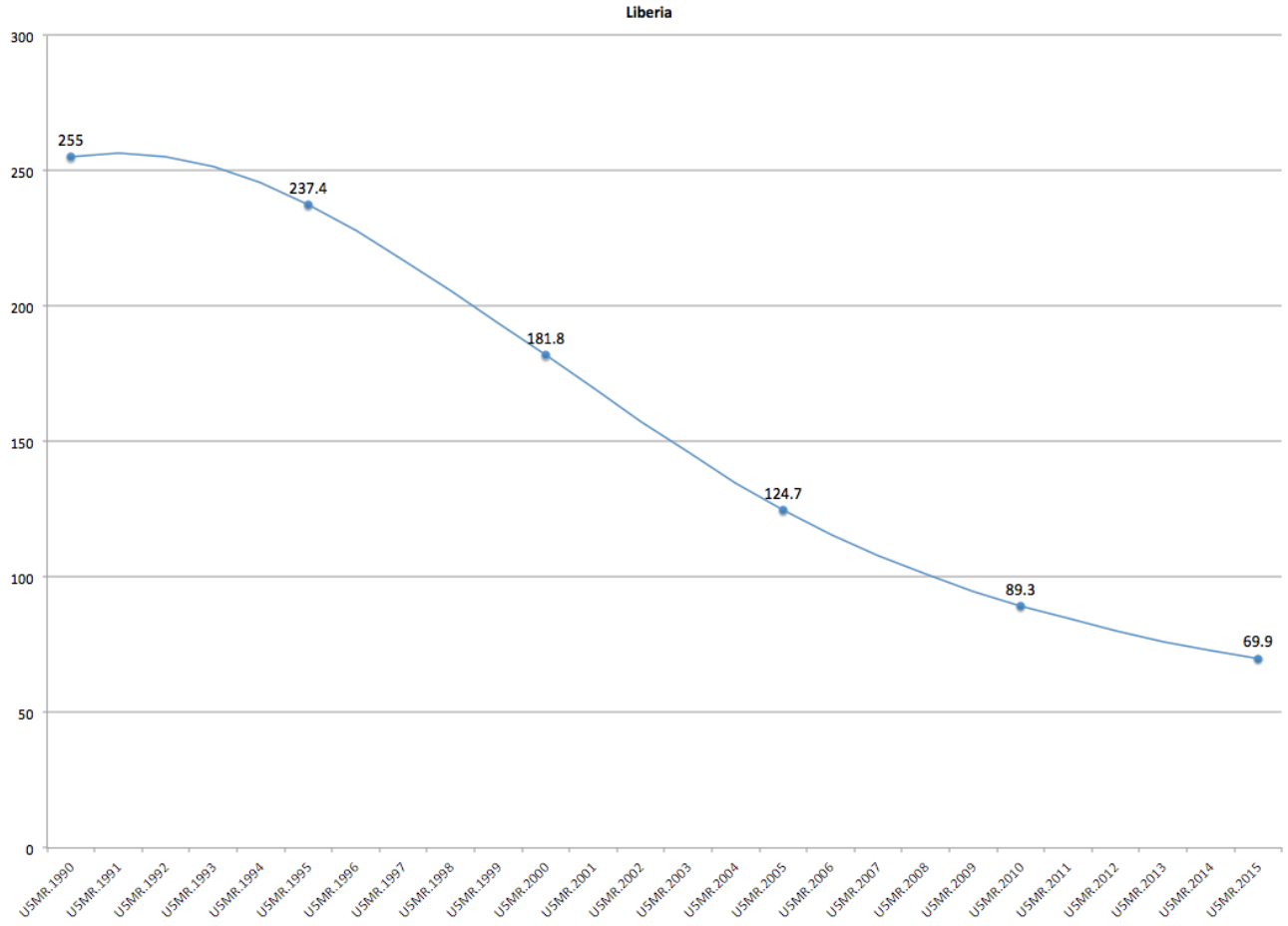
Indicator	1994	1999	2007	2011	2013	Source
Demand for family planning satisfied, % women age 15-49	-	-	24%	-	39%	(Countdown 2015a)
Indicator	**1998**	**2004**	**2006**	**2010**	**2015**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	135	137	177	147	-	(Countdown 2015a)
Indicator	**1995**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

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Liberia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Liberia



Source: (Countdown 2015a)

Sierra Leone

Table 1: Basic info

Country income level	Low-income	
Population 2014	6.3 million	(World Bank 2016i)
Literacy rate 2013	45.7%	(World Bank 2016a)
Political/administrative system	4 regions, 14 districts	

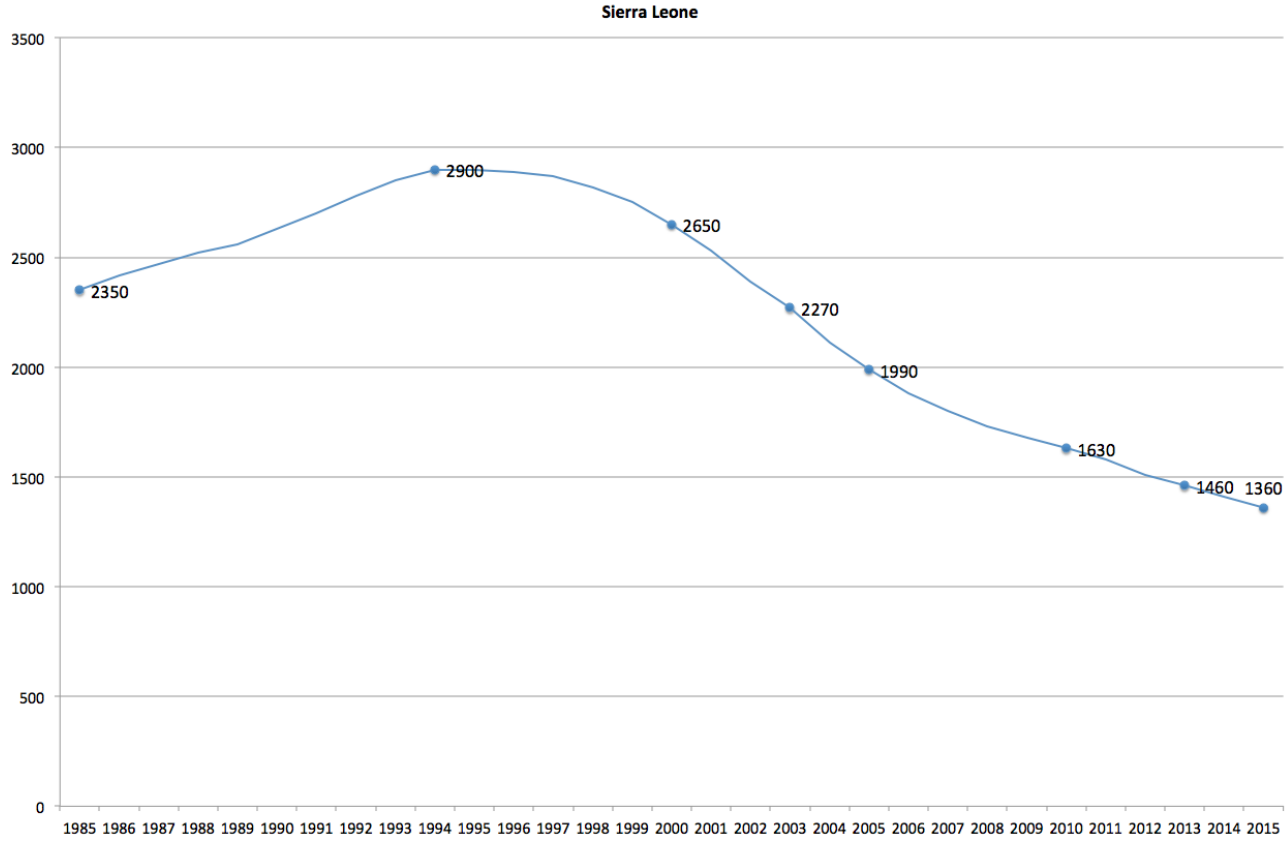
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012		(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012		(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012		(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012		(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

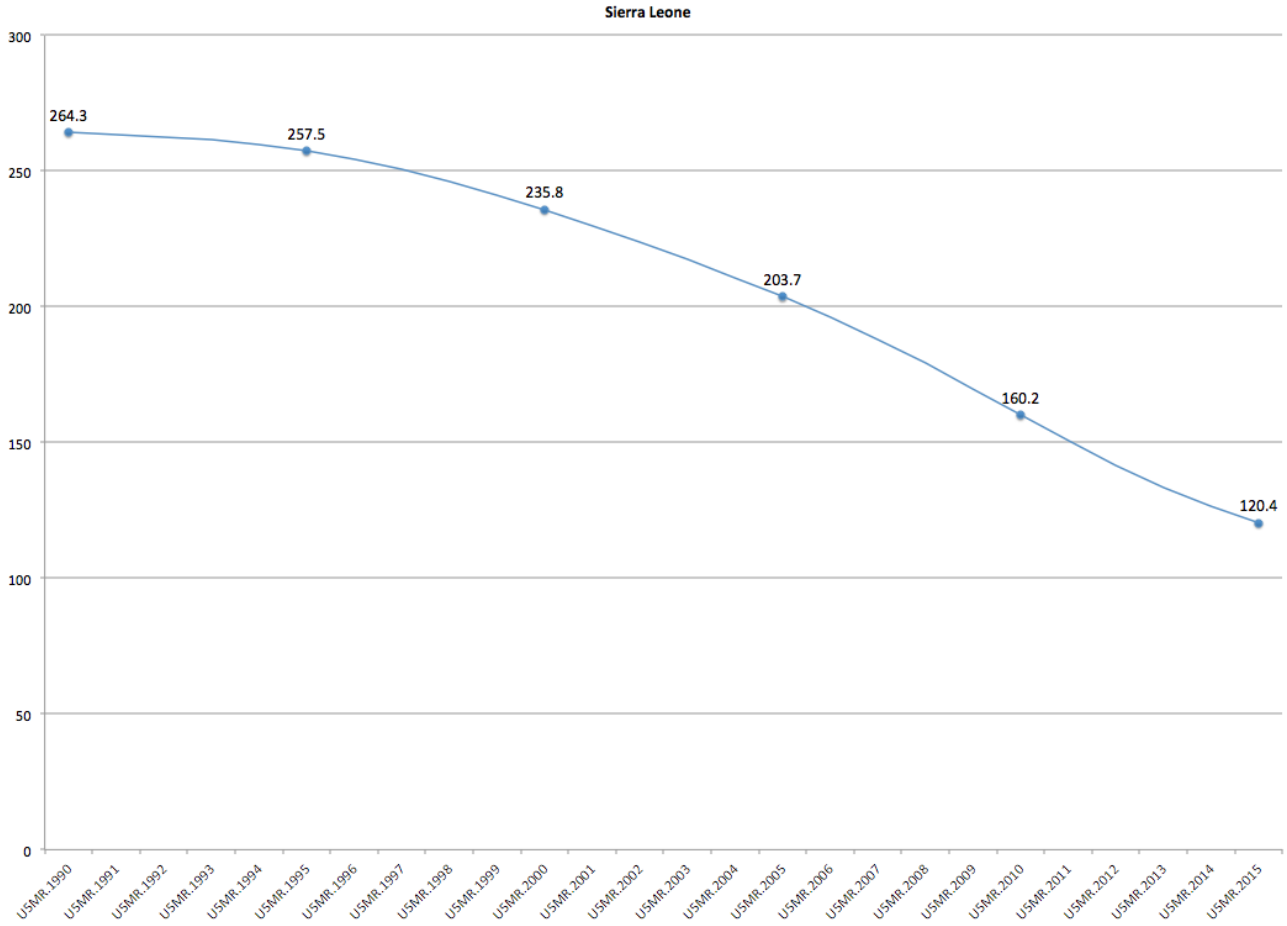
Indicator	1994	1999	2008	2010	2013	Source
Demand for family planning satisfied, % women age 15-49	-	-	22%	29%	40%	(Countdown 2015a)
Indicator	**2000**	**2003**	**2005**	**2009**	**2011**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	150	113	143	122	131	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2011**	**2013**	**Source**
Teenage mothers, % women age 15-19	...	...	...	34%	27.9%	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	2,900	2,650	1,990	1,630	1,360	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	35	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	87	(Countdown 2015c)
Under Five Mortality, per 1,000	257.5	235.8	203.7	160.2	120.4	(Countdown 2015a)
Indicator	**1992**	**2000**	**2005**	**2010**	**2013**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	2.6%	4.3%	5.3%	11%	16.6%	(World Bank 2016c)
Indicator	**1995**	**2000**	**2008**	**2010**	**2013**	**Source**
Unmet need for contraception, % aged 15-49	...	...	28.4%	27.4%	25%	(World Bank 2016k)
Indicator	**1993**	**1997**	**2005**	**2011**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	13%	17%	40%	50%	48%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	...	...	...	...	...	(Countdown 2015a)
Lower bound						
Upper bound						
Indicator	**2000**	**2005**	**2008**	**2010**	**2013**	**Source**
Skilled attendant at delivery, %	42%	43%	42%	63%	60%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	39%	...	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	73%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	4.1%	7.9%	11.2%	31.6%	32%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	...	...	2%	5%	3%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.12	0.02	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2004**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.49	0.17	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Sierra Leone



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Sierra Leone



Source: (Countdown 2015a)

Zambia

Table 1: Basic info

Country income level	Lower-middle-income	
Population 2014	14.5 million	(World Bank 2016i)
Literacy rate 2007	61.4	(World Bank 2016a)
Political/administrative system	10 provinces, 89 districts	

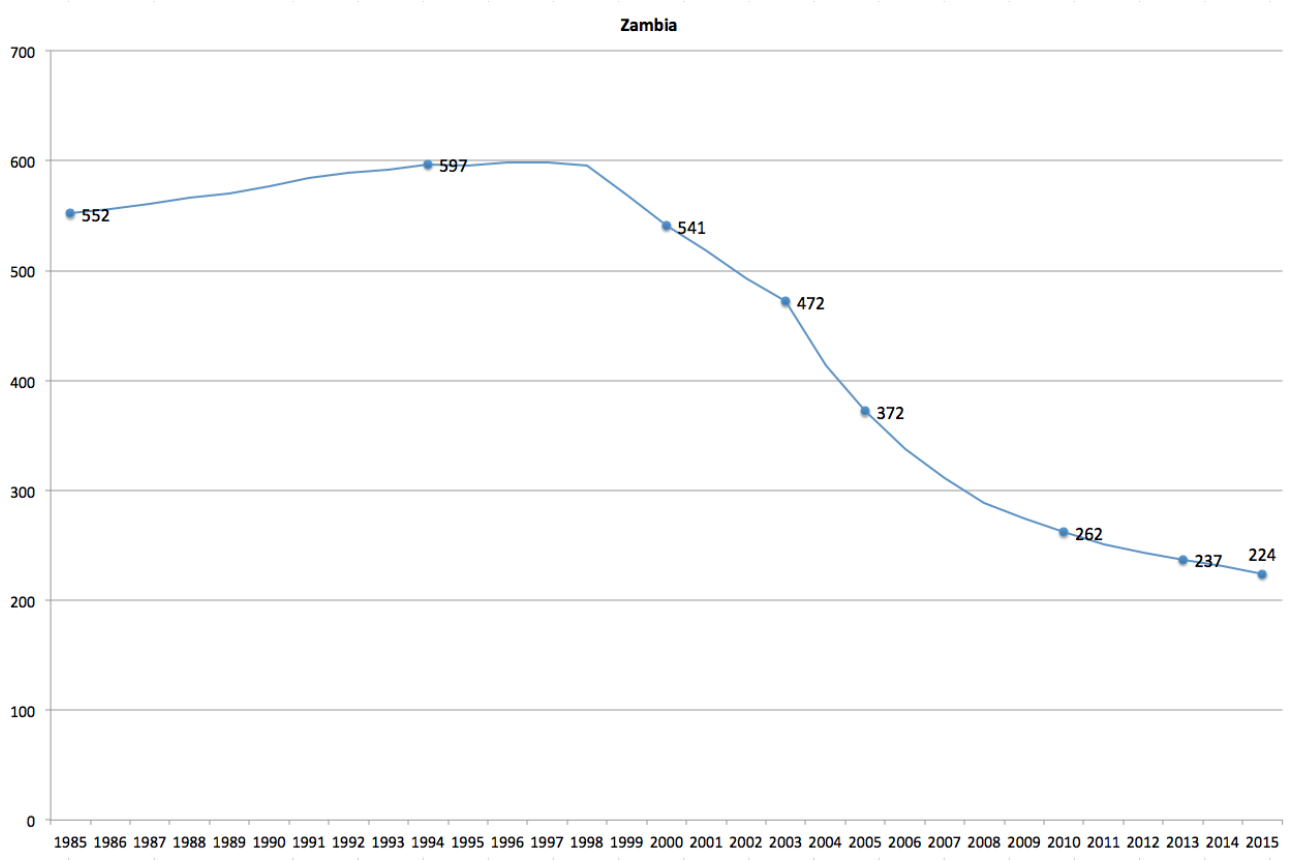
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.3%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	4.2%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	23.9%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	66.7%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

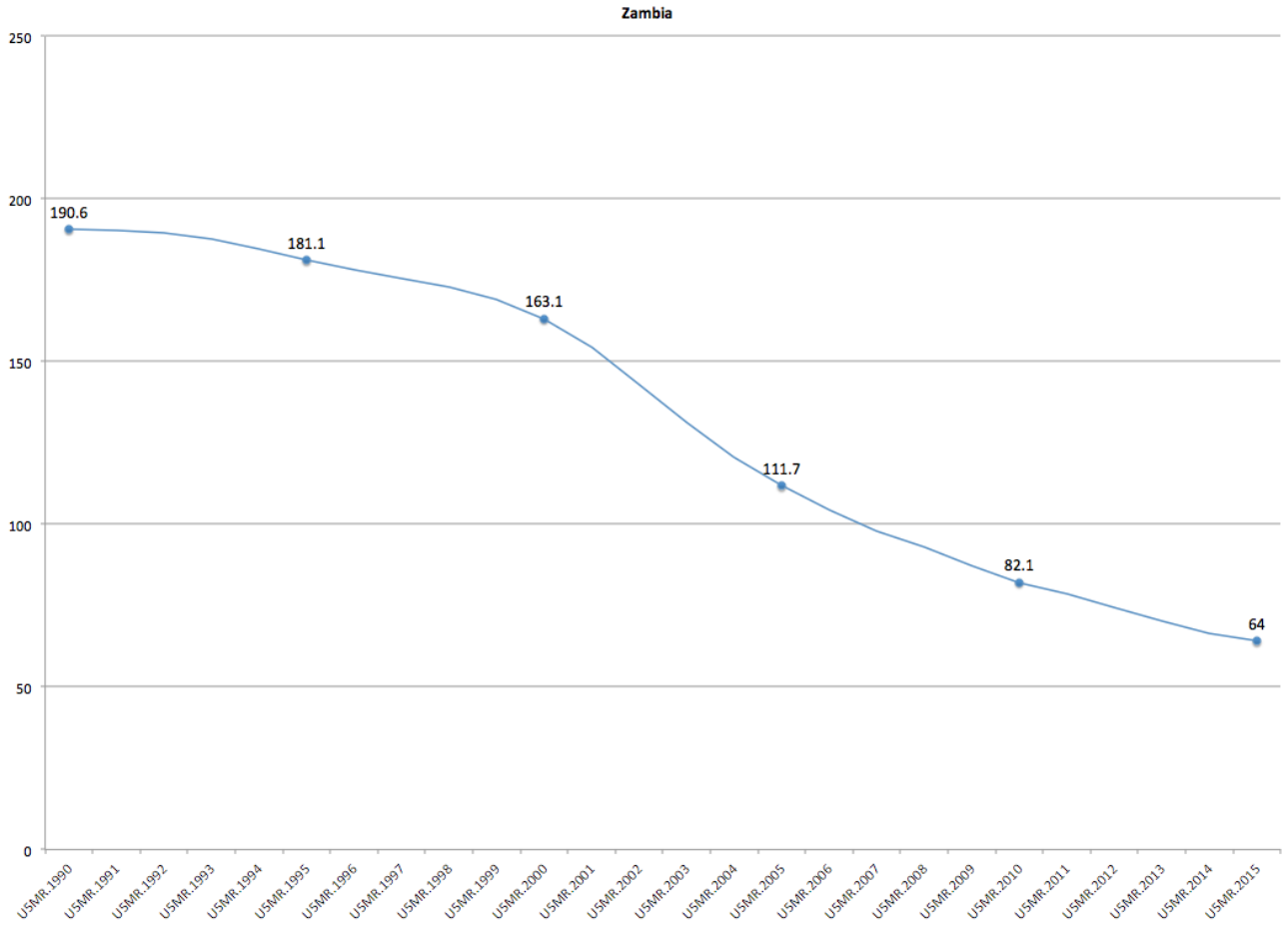
Indicator	1994	1999	2006	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	72%	76%	80%	80%	87%	(Countdown 2015a)
Indicator	**1997**	**2002**	**2003**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	108	103	101	112	120	(Countdown 2015a)
Indicator	**1996**	**2002**	**2007**	**2010**	**2015**	**Source**
Teenage mothers, % women age 15-19	30.7%	31.6	27.9%	...	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000	596	541	372	262	224	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000	...	...	...	...	21	(Countdown 2015c)
Infant Mortality, per 1,000 live births	...	...	...	...	43	(Countdown 2015c)
Under Five Mortality, per 1,000	181.1	163.1	111.7	82.1	64	(Countdown 2015a)
Indicator	**1995**	**1999**	**2002**	**2007**	**2015**	**Source**
Contraceptive Prevalence Rate, % aged 15-49	...	22%	34.2%	40.8%	...	(World Bank 2016c)
Indicator	**1997**	**2002**	**2007**	**2010**	**2015**	**Source**
Unmet need for contraception, % aged 15-49	25.2%	27.5%	26.6%	...	...	(World Bank 2016k)
Indicator	**1992**	**1996**	**2002**	**2007**	**2014**	**Source**
Antenatal care, rural, ≥ 4 visits, %	69%	71%	72%	60%	56%	(Countdown 2015a)
Indicator	**2005**	**2009**	**2010**	**2012**	**2014**	**Source**
Percent of HIV+ pregnant women receiving ARVs for PMTCT	<1%	62.9%	>95%	>95%	85.8%	(Countdown 2015a)
Lower bound	<1%	57.5%	>95%	>95%	79.8%	
Upper bound	<1%	68.8%	>95%	>95%	92.1	
Indicator	**1996**	**1999**	**2002**	**2007**	**2014**	**Source**
Skilled attendant at delivery, %	47%	47%	43%	47%	64%	(Countdown 2015a)
Postnatal care for baby, %	...	...	...	...	16%	(Countdown 2015a)
Postnatal care for mother, %	...	...	...	...	63%	(Countdown 2015a)
Exclusive breastfeeding (<6 months), % of babies age 0-5 m	19.3%	26.7%	40.1%	60.9%	72.5%	(Countdown 2015a)
Facilities providing BEMoNC, number	...	...	...	...	...	
Facilities providing CEMoNC, number	...	...	...	...	...	
C Section Rate, % of live births, women age 15-49	2%	...	2%	3%	4%	(Countdown 2015a)
Indicator	**1995**	**2000**	**2005**	**2008**	**2015**	**Source**
Community Health Workers, per 1,000 people	...	...	0.84	0.73	...	(World Bank 2016b)
Indicator	**1995**	**2000**	**2006**	**2010**	**2015**	**Source**
Nurses and/or midwives, per 1,000 people	...	...	0.71	0.78	...	(World Bank 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Zambia



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Zambia



Source: (Countdown 2015a)

Zimbabwe

Table 1: Basic info

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

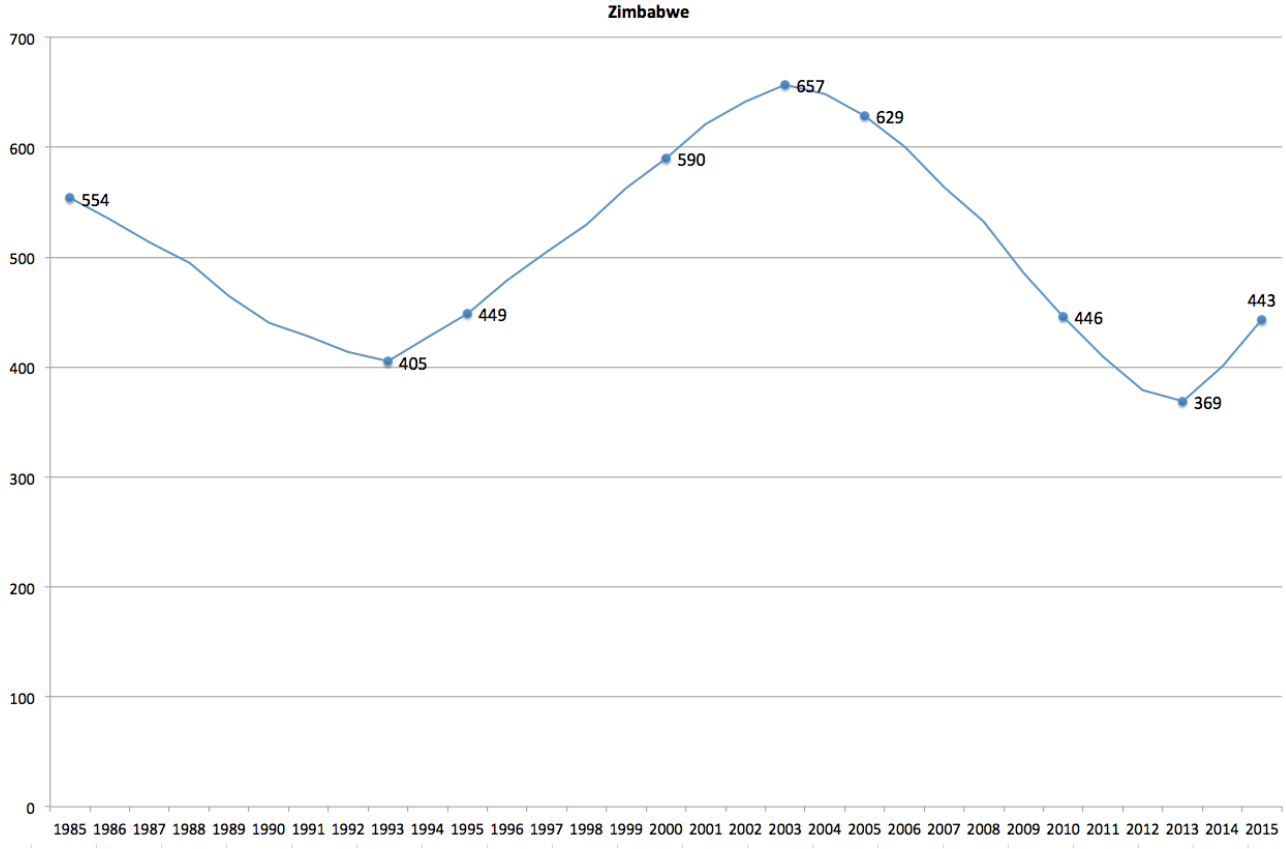
Table 2: Health Expenditures: 2010-2014

Health Financing	Type	Share	Percent	
Health expenditure	Private	% of GDP, 2012	2.3%	(World Bank 2015a)
Total expenditure on health	Public	% of GDP, 2012	4.2%	(World Bank 2015b)
Out-of-pocket health expenditure	Public	% of THE, 2012	23.9%	(World Bank 2015d)
Out-of-pocket health expenditure	Private	% of PHE, 2012	66.7%	(World Bank 2015c)

Table 3: H4+JPCS Profiling Indicators 1990-2015

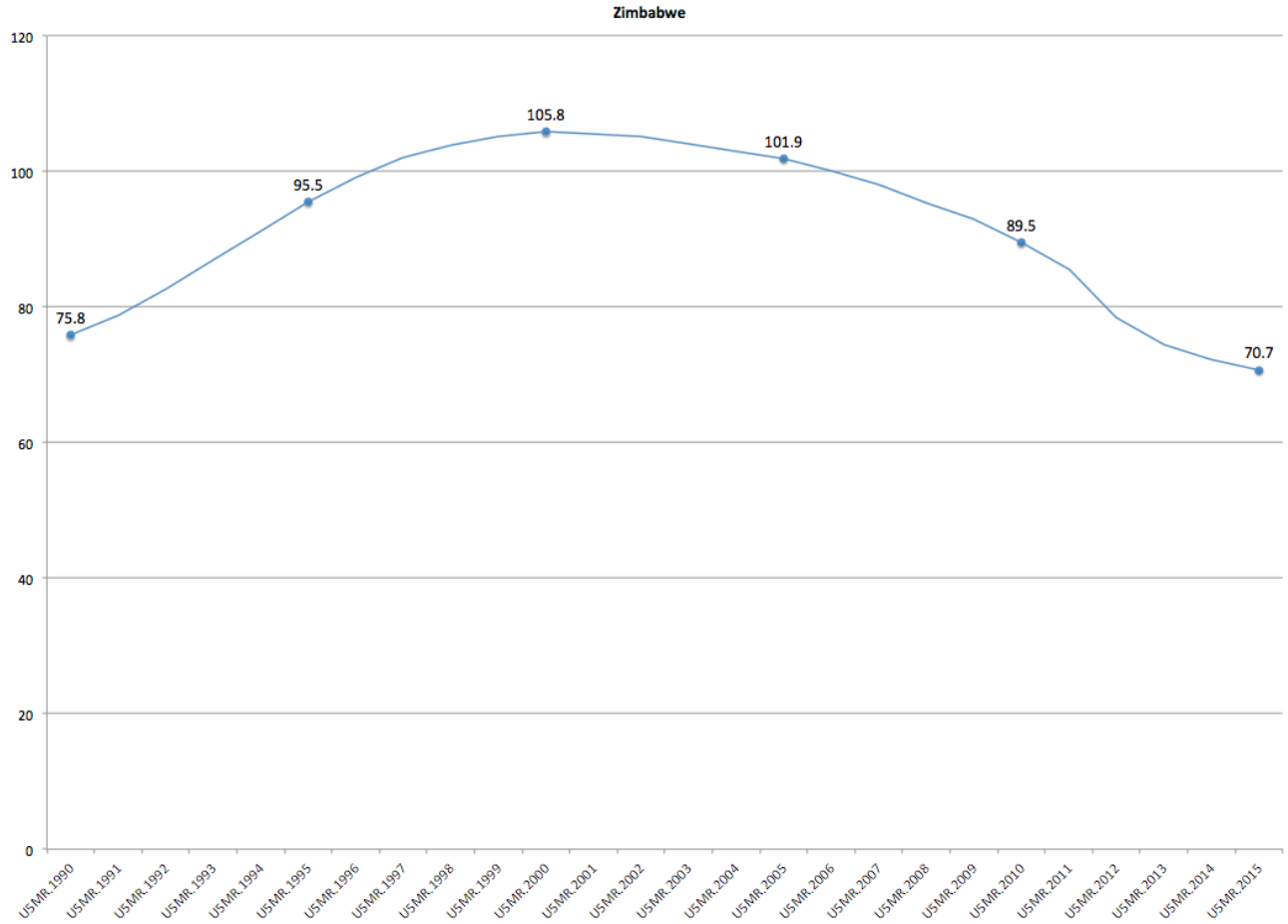
Indicator	1994	1999	2006	2011	2014	Source
Demand for family planning satisfied, % women age 15-49	72%	76%	80%	80%	87%	(Countdown 2015a)
Indicator	**1997**	**2002**	**2003**	**2008**	**2013**	**Source**
Adolescent Fertility Rate, per 1,000, women age 15-19	108	103	101	112	120	(Countdown 2015a)
Indicator	**1994**	**1999**	**2006**	**2011**	**2013**	**Source**
Teenage mothers, % women age 15-19	19.7%	20.5%	21.2%	23.5%	...	(World Bank 2016j)
Indicator	**1995**	**2000**	**2005**	**2010**	**2015**	**Source**
Maternal Mortality Ratio, per 100,000 live births	449	590	629	446	443	(Countdown 2015a)
Neo Natal Mortality Rate, per 1,000 live births	...	...	...	...	24	(Countdown 2015c)
Infant Mortality, per 1,000	...	...	...	...	47	(Countdown 2015c)
Under Five Mortality, per 1,000	95.5	105.8	101.9	89.5	70.7	(Countdown 2015a)
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 2016k)
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)
Lower bound	<1%	8.7%	28.7%	46.2%	72.4%	
Upper bound	<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 2016f)

Figure 1: Trend in Maternal Mortality per 100,000 Live Births, 1985-2015, Zimbabwe



Source: (Countdown 2015a)

Figure 2: Trend in Under Five Mortality, per 1,000 live births, 1990-2015, Zimbabwe



Source: (Countdown 2015a)

ANNEX 4: DRAFT ONLINE SURVEY QUESTIONNAIRES

Draft Questionnaire 1: H4+ Staff Only:

Intro letter and explanation on page 1 including what the survey is for, what we will do with the information, preserving anonymity in using the replies unless permission granted and timeframes etc. This questionnaire can be completed by regional and global level partners as well but some questions will not apply.

This survey has 3 parts:

1. About you/ your organisation
2. About the H4+ in your country (or area of work if global/ regional)
3. About the role of the H4+ in collaboration for RMNCAH outcomes in your country/ area of work

Part one: Contact information (in case more information is needed)

1. **Name:**
2. **Position:**
3. **Agency/ Organisation:**
4. **Email:**
5. **Where do you work?**

Dropdown menu including:
Country (if country selected, create a pop up with all countries to select one)
Regional office
Global office
Other (specify – create a box to input the specified other)

6. **Are you completing this questionnaire on behalf of more than one agency? Y/N**

If Yes, specify:

UNAIDS
UNFPA
UNICEF
UN Women
WHO
World Bank

Part Two: About the H4+ in your country

7. **In your country, is there:**
   a. A UN Coordinating Team (UNCT focusing on RMNCAH)?
   Y/N/ not applicable/ Don't know.

   b. A dedicated H4+ country team?
   Y/N/ not applicable/ Don't know.

8. In your country, when was the H4+ team established?

Multiple choice answer to select one (limited to one) of: Before 2010, 2010, 2011, 2012, 2013, 2014, 2015, Don't know, N/A

9. Check all the organisations that are part of the H4+ team in your country:

Multiple choice answer to select as many as needed of:
UNAIDS
UNFPA
UNICEF
UN Women
WHO
World Bank
Other (if checked, specify _____)

10. Does the H4+ team in your country:

a. Have a coordinating mechanism/ committee?
   Y/N
   Describe how the mechanism functions (Create a free text box with a 100-word limit)
b. How often does it meet?
   Multiple choice: choose weekly, monthly, ad hoc, rarely, never.
   Explain the frequency and how the meetings work (Create a free text box with a 100-word limit).
c. Are there H4+ thematic groups?
   Y/N?
   If Y, please explain what thematic groups (eg: maternal health, Newborn health, reproductive health etc.), who belongs and how they work (Create a free text box with a 200-word limit).

11. In your country, does the H4+ have a joint workplan (that includes the activities of at least three of the H4+ participating agencies)?

Y/N/ Other (Explain_____)
If yes, what are the start and end dates of the plan: 20__ to 20__.

12. What national strategy or plan(s) does the H4+ plan seek to support?

_____
(Open text box up to 100 words/ 500 characters)

13. What are the main objectives/ areas of focus for the H4+ plan?

_____ (Open text)

14. Financing for H4+ activities:

a. Is there funding specifically for H4+ activities (tick all that apply)?

Yes, through H4+ global H4+ programme (for example, JPCS)
Yes, (from a bilateral donor at the country level (clarify)

No
Don't know.

b. If through the H4+ JPCS funding programme, what was the financing for?
Open text: _____
And who was it from?
Canada
Sida
France/ Muskoka
Other _____

c. If at country level, what was the financing for?
Open text: _____
And who was it from?
Bilateral donor _____
Other _____

d. Space for further comments on financing if needed
_____

Part 3: The contribution of the H4+ to collaboration and coordination around RMNCAH at country, regional and global levels.

The questions in this section apply only to the H4+ collaborating team and not to individual agencies.

15. In your country, is the H4+ team involved (or has it been involved in the past) in coordinating and supporting implementation of any of the following global initiatives?

Check all that apply:

Global Strategy for Women's Children's and Adolescents' Health
Global Financing Facility (GFF)
Commission on information and Accountability (COIA)
A Promise Renewed (APR)
Global Plan towards the Elimination of new HIV infections among children by 2015
Family Planning 2020 (FP2020)
Every Newborn Action Plan (ENAP) or Ending Preventable Maternal Mortality
Other: _____

If yes to any of the above, please specify the key outputs and actions of the H4+ team, the project time frame and partners:

Text box (500-character limit)

16. In your view, what are the five **most critical health priorities** in your country/ region? For example: maternal health, cervical cancer, malaria, HIV/AIDS, TB, malnutrition, sanitation, non-communicable diseases, lack of family planning, neglected tropical diseases, diarrhoea and treatment of young children, etc.

Open text: 1000 characters

17. What are the **main health systems challenges in your country (or at global/ regional level)?** For example, access to services by the most marginalised, insufficient financing/ user fees, insufficient training, adolescents are unable to access services, not enough qualified staff, not enough health centres, insufficient drugs and commodities, quality is low, accountability etc

Open text 1000 characters

18. What are the main areas of engagement for the H4+partners in your country:

Select all that apply:

Strategy development
National Leadership
National health policy
Health systems reform
Health financing
Standards, guidelines and regulations
Health information systems and management
Quality improvement including morality audits and regulatory support
Strengthening vital statistics collection and use
Curriculum development and training (pre-service training)
Curriculum development and training (in-service training)
Key policy choices eg. Reaching adolescents
Procurement and supply chain management
Private sector engagement
Strengthening quality of care
Management & capacity-building at facility level (any health area)
Delivery of specific services (Eg. _____)
Procurement of specific commodities (Eg. _____)
Infrastructure
Community interface/ community engagement/ community mobilisation
Behaviour change and behaviour change communication
Specific programme support eg. Immunisation, FP, PMTCT Specify/ explain:

_____

19. How were these areas of focus decided? How were the geographical locations of H4+ activities decided?

Open text: 500 characters

20. What are the **main achievements** of the H4+partners in your country? Please include examples of best practice, evidence for results and examples. If you wish, you can submit documents to support your answers here (information about how to do this will be shown later).

Open text – 1000 characters

21. Based on your experience, **what are the benefits of working** at the level of the H4+ rather than as individual agencies? Please give an example if possible. Consider programmatic, economic and capacity-building examples.

Open text – 1000 characters

22. How could the H4+ country team strengthen its ways of working? What are the barriers to working better and improving coordination and collaboration? Please consider all aspects of this answer even if you cannot see a solution immediately.

Open text – 1000 characters

23. Does the H4+ collaborate effectively with other actors in the planning, funding, and delivery of RMNCAH strategies? For example, does the H4+ sit on national strategic planning & coordination committees or working groups that involve donors, NGOs or civil society groups as well as Ministry of Health and UN agencies?

Yes/ No

Open text to explain response – 500 characters.

24. What are the **challenges faced by the H4+** in your country? Are these shared among all the agencies across all their work or are these challenges to working as the H4+?

Open text – 1000 characters

25. Any further comments:

Open text – 1000 characters

Would you be available for further discussion about the H4+ and your answers in this questionnaire? If yes, please note your email address here to indicate consent for us to contact you again if needed: _____

Draft Questionnaire 2: National authorities and stakeholders:

Intro letter and explanation on page 1 including what the survey is for, what we will do with the information, preserving anonymity in using the replies unless permission granted and timeframes etc. This questionnaire can be completed by regional and global level partners as well but some questions will not apply.

Part one: Contact information (in case more information is needed)

1. Name:
2. Position:
3. Government department/ Agency/ Organisation:
4. Email:
5. Where do you work?

   Dropdown menu including:

   Country (if country selected, create a pop up with all countries to select one)
   Regional office
   Global office
   Other (specify – create a box to input the specified other)

Part Two: About your country:

6. In your country or region, is there:

Check all that apply:

A national health strategy or a regional health plan/ strategy?
RMNCAH investment plan?
A roadmap for universal health coverage?
Specific plans for HIV/AIDs, TB and Malaria?
Immunisation plans/ strategies?
A health sector strengthening or reform plan?
Other important plans/ strategies linked to the RMNCAH continuum of care?

7. In your view, what are the most critical health priorities in your country/ region? (for example: maternal health, cervical cancer, HIV/AIDS, TB, malnutrition, sanitation, non-communicable diseases, lack of family planning, neglected tropical diseases, malaria, diarrhoea and treatment of young children, etc)

Open text 1000 characters

8. What are the main health systems challenges: (for example, access to services by the most marginalised, insufficient financing/ user fees, adolescents are unable to access services, not enough qualified staff, not enough health centres, insufficient drugs and commodities, quality is low, accountability etc.)

Open text: 1000 characters

9. What are the main sources of financing for RMNCAH?

Organise this list roughly from highest to lowest:

a. Domestic resources (public finance)
b. Domestic resources (private and out of pocket spending)
c. Bilateral aid through budget or sector support or through pooled funding mechanisms
d. Direct bilateral funding to programmes
e. Multilateral funding through sector support or pooled mechanisms
f. Direct multilateral funding/ delivery to programmes.
g. NGO support.

Part 3: Contribution of the H4+ to RMNCAH

The questions in this section apply only to the H4+ collaborating team and not to individual agencies.

10. Health Sector Coordination

a. Are there co-ordination mechanisms for health partners in your country? For example, health sector coordination forum or an expanded CCM etc.

   Yes/ No/ Don't know.

   Please specify the name of the mechanism, who chairs it and who attends?

   Open text 500 characters _____

b. Do you think that the H4+ attends and participates in this coordination meeting (as the H4+ rather than as individual UN agencies)?

   Yes/ No

c. How do you get information about what the H4+ is doing/ has done?

11. In your view, what national strategic priorities does the H4+ programme seek to support?

_____

(Open text box up to 100 words/ 500 characters)

12. Are these the right areas of support for the H4+ as a group of UN Health Agencies? I.e. Does the H4+ have the knowledge, track record and expertise in these areas to offer the support? Does their programme respond to a clear gap?

13. What are the main areas of engagement for the H4+ in your country:

Select all that apply:

- Strategy development
- National Leadership
- National health policy
- Health systems reform
- Health financing
- Standards, guidelines and regulations
- Health information systems and management
- Quality improvement including morality audits and regulatory support
- Strengthening vital statistics collection and use
- Curriculum development and training (pre-service training)
- Curriculum development and training (in-service training)
- Key policy choices eg. Reaching adolescents
- Procurement and supply chain management
- Private sector engagement
- Strengthening quality of care
- Management & capacity-building at facility level (any health area)
- Delivery of specific services (Eg. _____)
- Procurement of specific commodities (Eg. _____)
- Infrastructure
- Community interface/ community engagement/ community mobilisation
- Behaviour change and behaviour change communication
- Specific programme support eg. Immunisation, FP, PMTCT Specify/ explain:

_____

- Don't know/ Not sure

14. What do think are the **main achievements** of the H4+ in your country?

Please include examples of best practice, evidence for results and examples if possible. Do you think working with the H4+ is easier/ more efficient than working

with all the Health-related UN Agencies separately? Does it make a difference in practical terms?

Open text – 1000 characters

15. Based on your experience, **what are the benefits of working** at the level of the H4+ rather than with individual UN agencies? Please give an example if possible. Consider programmatic, economic and capacity-building examples.

    Open text – 1000 characters

16. **How could the H4+ country team strengthen its ways of working / coordination efforts in the future? How could the H4+ support the RMNCAH strategy in your country more effectively**?

    Open text – 1000 characters

17. What **challenges do you face in getting better results or more efficient support from the H4+** in your country? Are these common to all the health-related UN agencies or are these challenges to working with the combine H4+ team?

    Open text – 1000 characters

18. **Any further comments**?

    Open text – 1000 characters

Would you be available for further discussion about the H4+ and your answers in this questionnaire? If yes, please note your email address here to indicate consent for us to contact you again if needed: _____

ANNEX 5: DRAFT INTERVIEW AND GROUP DISCUSSION GUIDES – FIELD COUNTRY CASE STUDIES

END LINE EVALUATION OF THE H4+ JPCS PROGRMME

Draft INTERVIEW GUIDE ONE – Central Level in the Capital

Objectives

- Develop a better understanding of the origin, strategic direction, operational objectives and structures and processes which have informed the h4+JPCS Programme in _____
- Secure the necessary information and documents to refine the Theory of Chang for H4+JPCS in _____
- Address all the evaluation questions and help provide an overview of how H4+JPCS contributes to results in RMNCAH.

Process

Working with the H4+ JPCS coordinator, the consultant will set up appointments and provide in advance a brief outline of the purpose of the visit and the main points of inquiry that will be covered.

Product

The result of each interview will be captured in a matrix to summarize key findings. The matrix will be used internal to the evaluation team and any reference in the Country Case Study Note will maintain the confidentiality of key informants.

INTERVIEW GUIDE – IN COUNTRY INTERVIEWS

Introduction

Explain that our purpose is to gather information to be used in the development of a case study of the effectiveness of H4+JPCS in _____. Results will be used to develop evaluation findings and conclusions for the overall End Line Evaluation of H4+JPCS. The case study is not an independent evaluation of H4+JPCS in _____. All responses will be kept confidential.

In our discussions today we hope to touch on a few different topics:

- How the programme became established in _____and **how it operates** including its priorities
- The **key achievements** that H4+JPCS has supported in _____over time especially in health systems strengthening and innovation
- How the programme **aligns with and responds** to changes in national (and local) needs and priorities in RMNCH-A
- How the H4+ JPCS agencies and Government and other partners **coordinate their support to RMNCH** to meet important needs and make best use of their capacities
- The **value added** H4+JPCS brings to the work of the H4+ agencies in _____so that they can do more through the programme than they could do without it.

- How the evaluation can find, access and use the quantitative and qualitative information including documents, data bases and key personnel that are needed to complete a high quality and useful evaluation.
- How we can best meet the needs of all key stakeholders during the country case study of H4+JPCS in _____

We can perhaps start with topic one: the origin of H4+JPCS in Zimbabwe, how it made priorities and how it functions today. We will probably have questions to add as we continue.

Questions

Part One: H4+ JPCS Origin, Structure and Operations (Central Level)

> *Note: this segment touches on issues areas and evaluation questions:*
> *1: Health systems strengthening – how priorities are set*
> *2. Integration and accelerated access to care – how these are targeted*
> *3: Responsiveness to national needs – how these are identified*
> *5: Coordination and division of labour – how coordination works*

1. How was H4+JPCS introduced in _____and what role did your organization (s) play in establishing its direction and priorities (for instance selecting priority districts or identifying needs and opportunities for strengthening health systems)?
2. What have been the main priorities for H4+ JPCS in _____*? (Note this may elicit a discussion about innovation and acceleration of progress in RMNCAH which related to other questions but is its still worth opening the discussion at this point.)*
3. How is the programme planned and managed in _____? How is the need for support to RMNCAH identified and how are projects/investments selected for putting in the work plan? The role of your organization (s) in this process?
4. How are programme results monitored against plans and how are changes made when required?
5. How do H4+ JPCS organizations, the Government of _____and other key actors supporting RMNCH coordinate their work on RMNCH to make sure the program makes its best possible contribution and that there is a reduction of overlap/ maximum coverage of areas and people?

Part Two: The Achievements of H4+ JPCS

> *Note: this segment touches on issues areas and evaluation questions:*
> *1: Health Systems Strengthening*
> *2. Integration and Access to Quality Care*

6. How has H4+ JPCS contributed to strengthening the health system in _____in its capacity to deliver **integrated quality care** and **improve access** to RMNCH services (and other related services)? At both national, and district levels?

> *Note: This is a good spot to enter into a discussion of how access improvements have also met the needs of Vulnerable Group members (Defined in the TOR as poor rural women, families in geographically isolated areas, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disability, indigenous*

7. Did these efforts **accelerate** progress toward strengthening the system and to achieving outcomes in RMNCH? How? and how do you know they do?
8. Have the experiences gained with H4+JPCS support in the **targeted districts** contributed to improvements in the **national** response to challenges in RMNCH? How? (Is there a clear example and evidence?)
9. Has the programme supported important experiments in innovative ways of strengthening the delivery of quality RMNCH services (including community participation and demand creation if those are not mentioned)?
10. How are the results of these experiments documented and shared? In _____and with other H4+JPCS countries?
11. Other achievements? And are the achievements we have discussed sustainable in the future? How? What has been less successful in your view? Why? Was there an opportunity to change the programme along the way? What are the lessons learned from the process?

Part Three: Responding to National and Local Needs and Priorities

> *Note: this segment touches on area of investigation and evaluation question three: responsiveness to national (and local) needs of main stakeholders in*

12. What are the major constraints and challenges facing RMNCH in _____over the last several years? Does the H4+ work seek to address any these problems? Which ones? How?
13. Does the H4+JPCS programme and its different investments and activities in supporting RMNCH align well with national plans and priorities in RMNCH including commitments to EWEC and the Global Strategy? Does it also align with needs and priorities at district level?

14. How has the programme responded to important changes in the national context for RMNCH whether in changing national policies and priorities or in events external to the health sector (economic, social, political)? Has it been effective in responding to change? As needs change, is the H4+ programming approach flexible enough to respond and adapt?

Part Four: Coordination and Value Added

> *Note: this segment touches on issues areas:*
> *5: Coordination and Division of Labour*
> *6: Value Added*

15. Can we discuss in a bit more detail how the H4+JPCS agencies make sure that their efforts are well coordinated both among themselves and with the Government of _____and local authorities? And with other donors/ actors working in this field? How does the H4+ ensure it works in coordination with others? Are these arrangements a good platform for coordinated action in RMNCH if H4+JPCS is not providing funds in the future?

16. As the H4+ agencies work together in a more coordinated have they contributed more to the national and local response to RMNCH priorities than they would have without the program? Or have they contributed in a different way (using different modalities) than they would have?

> *Note: In discussing the value added of H4+JPCS at country level it is important to note that H4+ is to act as an important channel for putting into practice the principles of the Global Strategy and EWEC, including:*
> - *Country leadership of national health systems strengthening*
> - *Coordinated support*
> - *Integrated delivery of health services and life-saving interventions*
> - *Stronger health systems with sufficient skilled health workers at their core*
> - *Innovative approaches to financing, product development and the efficient delivery of health services*
> - *Improved monitoring and evaluation to ensure accountability*

17. What type of technical support in RMNCH (and in monitoring and evaluation) is provided to H4+ JPCS in _____by from the global (HQ) and regional levels of the H4+ agencies? Is it of high quality, useful and timely? What technical support does the H4+ provide to the health services? Is it coordinated and streamlined in a better way than it might be without H4+ coordination?

18. H4+JPCS has also funded global activities including the development of global guidance and advocacy documents and guidelines for RMNCH. Have these been of particular use in managing actions in support of improved RMNCH in Zimbabwe? Examples?

- Ask for some examples and or provide prompts and ask KIs if they have ever used these particular examples. Examples include: Saving Newborn Lives -

Part Five: Documentary Information for the Answering Evaluation Issues

The content of this discussion will vary by group being interviewed and will be guided by some of the responses heard to the earlier questions, especially those on monitoring and evaluating programme success. From the documents reviewed on _____so far we could prompt the appropriate persons for:

- A more complete set of minutes of the coordinating committee for H4+JPCS than we find in the google folder for _____right now
- Records/Minutes of joint govt/H4+ agency monitoring missions to the districts
- Results of DHS surveys, Multi-Indicator Cluster Surveys and Relevant HMIS data at district level.
- National and district plans and priorities (including budgets) in RMNCH
- Investment cases/ plans, Roadmaps, National Health accounts and similar sources of information on financial support to health generally and reproductive health in particular (especially RMNCH) to put H4+JPCS programme funding in perspective (For example, if _____or any of our countries are part of the RBF programme by the World Bank – what used to be called the HRITF but is now morphing into the Global Financing Facility (GFF), we should enquire about this specifically as this programme supports investment case development and roadmaps). I think Zim had a RBF programme.
- Thematic evaluations in RMNCH by government agencies, NGOs and bilateral/multilateral development partners
- Examples of global knowledge products of H4+JPCS that have been useful in either policy or operational roles in H4+JPCS.
- In Zim, we should enquire about the Health Transition Fund as this is one of the main development efforts in the RMNCH area and some of the UN agencies were involved in it (UNICEF for example) before anyway. It raises a challenge for the H4+ with respect to their function: do they provide knowledge, technical support, capacity building training, funding, etc. For me, this is an important part of the evaluation: how does the H4+ define its most appropriate role in a country and ensure that they deliver this role and not more? They could do all sorts of things – it's about taking the right role for the needs of the country from a health systems strengthening perspective. Occasionally this will mean implementing services themselves (at the peak of the crisis in Liberia) but mainly its more hands off.

Part Six: Other Issues – Priorities for Your Organization as the End Line Evaluation of H4+JPCS Moves Forward

- **Questions?**
- If time allows, our broader questions could be:
  1. Looking back over the last several years, what are the most important contributions and achievements of the H4+?
  2. If you could do it again, what would you change?
  3. Thinking about the future, what are the critical priorities for the way the H4+ works and what it invests its efforts in?

DRAFT INTERVIEW GUIDE TWO – <u>District Level</u>

Objectives

- Develop a better understanding of the origin, strategic direction, operational objectives and structures and processes which have informed the h4+JPCS Programme in the district.
- Secure the necessary information and documents to refine the Theory of Chang for H4+PCS in this district so it can serve as a template for work in other case study countries and in _____
- Address all six evaluation questions and the six areas of investigation of the evaluation.

INTERVIEW GUIDE – DISTRICT INTERVIEWS

Introduction

In our discussions we will be asking those interviewed to share their knowledge, experience and opinion on the following topics:

- How the H4+ JPCS programme came to provide support to RMNCAH in your district and what have been its main goals and priorities as you understand them.
- The **key achievements** that H4+JPCS has supported in this district over time especially in health systems strengthening and innovation
- How the programme **aligns with and responds** to your district's needs and priorities in RMNCH-A
- How the H4+ JPCS agencies and Government and other partners **coordinate their support to RMNCH in your district** to meet important needs and make best use of their capacities
- Whether the H4+ agencies working in your district (UNICEF, UNFPA, UNAIDS, UN Women, WHO) are more effective working together through the programme so that they can do more than they could do without it.
- How the evaluation can find, access and use the **quantitative and qualitative information** including documents, data bases and key personnel that are needed to complete a high quality and useful evaluation of H4+JPCS as it operates in your district.
- How the evaluation can best meet **the needs of key stakeholders** in this district during the country case study of _____.

We can perhaps start with topic one: how the programme came to your district, how agreement was reached on priorities and how it functions today. We will probably have questions to add as we continue.

Questions

Part One: H4+ JPCS Origin, Structure and Operations (District Level)

Note: this segment touches on issues areas and evaluation questions: *1: Health systems strengthening – how priorities are set* *2. Integration and accelerated access to care – how these are targeted* *3: Responsiveness to national needs – how these are identified* *5: Coordination and division of labour – how coordination works*

1. How was H4+JPCS introduced to your district and what role did your organization (s) play in establishing its priorities (for instance selecting priority health facilities, identifying key target groups, or identifying needs and opportunities for strengthening health systems)?

2. What have been the main priorities for H4+ JPCS addressing needs in this district*? (Note this may elicit a discussion about innovation and acceleration of progress in RMNCH-A which related to other questions but is its still worth opening the discussion at this point.)*

3. How is the need for support to RMNCH identified in your district and how are projects/investments selected for putting in the work plan? The role of your organization (s) in this process?

4. How are programme results monitored against plans and how are changes made when required?

5. How do H4+ JPCS organizations, the Government of _____ and other key actors supporting RMNCH coordinate their work on RMNCH in this district to make sure the program makes its best possible contribution and that there is a reduction of overlap/ maximum coverage of areas and people?

Part Two: The Achievements of H4+ JPCS in _____

Note: this segment touches on issues areas and evaluation questions:
1: Health Systems Strengthening
2. Integration and Access to Quality Care

6. How has H4+ JPCS contributed to strengthening the health system in your district in its capacity to deliver **integrated quality care** and **improve access** to RMNCH services (and other related services)?

Note: This is a good spot to enter into a discussion of how access improvements have also met the needs of Vulnerable Group members (Defined in the TOR as poor rural women, families in geographically isolated areas, adolescents/early pregnancies, pregnant women living with HIV, women/adolescents/children living with disability, indigenous

7. Did these efforts **accelerate** progress toward strengthening the system and to achieving outcomes in RMNCH? How?

8. Have the experiences gained with H4+JPCS support in your **district** contributed to improvements in the **national** response to challenges in RMNCH? How? (Is there a clear example and evidence?)

9. Has the programme supported important experiments in innovative ways of strengthening the delivery of quality RMNCH services (including community participation and demand creation if those are not mentioned)?

10. How are the results of these experiments documented and shared to national level?

11. Other achievements? And are the achievements we have discussed sustainable in the future?

12. What has been less successful in your view? Why?

Part Three: Responding to District Needs and Priorities

Note: this segment touches on issue area and evaluation question three: responsiveness to national (and local) needs of main stakeholders in countdown

13. What are the major constraints and challenges facing RMNCH in your district over the last several years? Does the H4+ work seek to address any these problems? Which ones? How?

14. Does the H4+JPCS programme and its investments and activities in supporting RMNCH align well with district plans and priorities in RMNCH?

15. How has the programme responded to important changes in the context for RMNCH in your district? Has it been effective in responding to change? As needs change, is the H4+ programming approach flexible enough to respond and adapt?

Part Four: Coordination and Value Added

Note: this segment touches on issues areas and evaluation questions:
5: Coordination and Division of Labour
6: Value Added

16. Can we discuss in a bit more detail how the H4+JPCS agencies make sure that their efforts are well coordinated both among themselves and with the Government of _____ and local authorities? And with other donors/ actors working in this field? Are these arrangements a good platform for coordinated action in RMNCH if H4+JPCS is not providing funds in the future?

17. As the H4+ agencies work together in a more coordinated have they contributed more to your district's response to RMNCH priorities than they would have without the program?

Note: In discussing the value added of H4+JPCS at district level it is important to note that H4+ is to act as an important channel for putting into practice the principles of the Global Strategy and EWEC, including:

- *Country leadership of national health systems strengthening*
- *Coordinated support*
- *Integrated delivery of health services and life-saving interventions*
- *Stronger health systems with sufficient skilled health workers at their core*
- *Innovative approaches to financing, product development and the efficient delivery of health services*
- *Improved monitoring and evaluation to ensure accountability*

18. What type of technical support can you draw on for managing RMNCH services in this district? Do the H4+ agencies provide technical support directly or is this the responsibility of national or regional authorities. Is technical support coordinated and streamlined in a better way than it might be without the programme?

19. H4+JPCS has also funded global activities including the development of global guidance and advocacy documents and guidelines for RMNCH. Have these been of particular use in managing actions in support of improved RMNCH in this district? Examples?

- Provide prompts and ask KIs if they have ever used these particular examples. Examples include: Saving Newborn Lives -

Part Five: Information for the Answering Evaluation Issues

The content of this discussion will vary by group being interviewed and will be guided by some of the responses heard to the earlier questions, especially those on monitoring and evaluating programme success. From the documents reviewed on _____ so far we could prompt the appropriate persons for:

- Records/Minutes of joint govt/H4+ agency monitoring missions to the districts
- Relevant HMIS data at district level
- District plans and priorities (including budgets) in RMNCH
- Examples of global products of H4+JPCS that have been useful in either policy or operational roles in H4+JPCS at district level

Part Six: Other Issues – Priorities for Your Organization as the End Line Evaluation of H4+JPCS Moves Forward

Questions?

- If time allows, our broader questions could be:

20. Looking back over the last several years, what are the most important contributions and achievements of the H4+?
21. If you could do it again, what would you change?
22. Thinking about the future, what are the critical priorities for the way the H4+ works and what it invests its efforts in?

DRAFT GROUP DISCUSSION GUIDE – Service Providers District Level

Introduction:
Thanks for meeting with us today. We are a team that is preparing for the evaluation of the United Nations joint programme to support improving Maternal, Newborn, Child and Young Peoples' Health in _____ and in this district (_____).

Description of Services

- Services provided to young people, pregnant women, families including but not limited to ANC/PNC, BeMONC, CeMONC, FP, PMTCT, B+ for pregnant women with HIV, paediatric ART, community mobilization, advocacy, demand creation, other.
- How those services have changed in recent years (2012-2016)
- Challenges they face in providing services – getting better or worse?
- biggest gaps/needs/opportunities to strengthen what they do (quality and access)

Programme Support

- What support did they get from the programme? Which agencies worked with them? How?
- How did they agree on what they needed and what the programme would provide?
- How does this support fit into their own resources and the funding/support/supervision they get from government.
- Does it help them to provide higher quality services to more people, especially vulnerable groups

Strengthening Health (and other) Systems – Has the programme helped to strengthen the system for providing services by:

Training or Mentoring in any of (Respondents to list, provide prompts only if needed or to clarify):

- Supervision of health service delivery points
- Maternal death surveillance and response
- Safe delivery
- BEmONC, CEmONC
- MVA
- ETAT (Emergency Assessment and Triage
- Obstetric Fistula
- Paediatric ART
- Youth Friendly Services including dealing with adolescents with HIV
- IMNCI/growth monitoring and quality of care
- Nutrition and nutrition counselling

P**rovision of Equipment or Essential Supplies or Infrastructure**

- POC Machines for DSB HIV Testing
- Critical maternal health commodities and drugs (oxicotyn and magnesium sulphate)
- FP commodities
- Motor bikes
- Mobile phones

Monitoring and Accountability

- Strengthened HMIS systems (including electronic)
- Better MDSR
- Focusing on results
- Documenting Success

Has all this really made the system stronger? How? Will it continue to be stronger in the future
Innovating to Improve access and quality of care • What do they do differently because of the programme? • How did they decide to try a different approach? • Did it improve service quality, make it more accessible to more people, more timely, cheaper? • How do they know and how can they prove it to others? • Did this new way of doing things get shared with other districts? Other countries? How? • Do they think it will ever be practiced nation-wide is it just a good solution for their district? • How did their H4+ partner agency(ies) help (UNICEF, UNFPA, WHO, UNAIDS, UN Women)
Coordinating and Collaborating • Do they work with more than one H4+ agency? • Who do they need to coordinate their work with and how is it done? • Who leads the coordination process? • Is the effort at coordination worth it? Are results really better than just getting support from one agency? How and why?
Challenges for the Future • What are the main challenges you face in the future for providing quality care and increasing access, esp. marginalized groups to RMNCAH services? • How can they be met?
Other Issues and Questions

DRAFT GROUP DISCUSSION GUIDE – Service Users District Level

Introduction:

Thanks for meeting with us today. We are a team that is preparing for the evaluation of the United Nations joint programme to support improving Maternal, Newborn, Child and Young Peoples' Health in _____and in this district (_____).

Services Used or Sought by the Group

Note: May be obvious but worth probing a bit depending on context of the group. If it is a youth group focus on youth friendly or priority services, etc. Bulleted points are for prompting if needed. Services outside the list are useful to know especially if they are provided by an H4+ implementing partner

- Services provided to young people, pregnant women, families including but not limited to ANC/PNC, BeMONC, CeMONC, FP, PMTCT, B+ for pregnant women with HIV, paediatric ART, community mobilization, advocacy, demand creation, other.
- How those services have changed in recent years (2012-2016)
- Challenges they face in providing services – getting better or worse?
- biggest gaps/needs/opportunities to strengthen what they do (quality and access)

Who Provides the Services, Costs and Integration

- H4+ Implementing Partners (District facility, health post, NGO, etc.)
- Other sources for getting the same service if any (private practitioners, pharmacies, traditional healers, others).
- Do you have to pay, how much and to whom?
- Is the service delivered on its own or together with other? (HIV CAT, FP, PMTCT, etc.)

Is the service of good quality and has quality stayed the same, improved, got worse?

Are service providers better trained?

- Supervision of health service delivery points
- Maternal death surveillance and response
- Safe delivery
- BEmONC, CEmONC
- MVA
- ETAT (Emergency Assessment and Triage
- Obstetric Fistula
- Paediatric ART
- Youth Friendly Services including dealing with adolescents with HIV
- IMNCI/growth monitoring and quality of care
- Nutrition and nutrition counselling

Do service providers treat you will and with respect? Do they have a friendly and helpful attitude when serving peoples like you?

_____

Are the needed supplies and machines (and buildings/water/electricity) in place (same, better or worse)?

- POC Machines for DSB HIV Testing
- Critical maternal health commodities and drugs (oxicotyn and magnesium sulphate)
- FP commodities
- Motor bikes

- Mobile phones

Is anyone taking responsibility for the quality of services provided to you?

- How do they know what is happening to quality of care?
- Do they ask you? Do they take action?
- Is the whole system for providing this service stronger? How?

Changing to improve access and quality of care

- Did this service change a lot in the past few years? What are the most important changes?
- Did this change improve service quality, make it more accessible to more people, more timely, cheaper? Or did it make it worse? No change?
- Do you think this change would help other communities, other districts, other countries?
- If yes, how could they be told?

Coordinating and Collaborating

- Do you think the services you need (and get) can be provided by just one organization working on its own?
- If it takes more than one, do they work together well? *Prompt: do supplies arrive on time for care providers to give good service? Do care providers schedule work so you can get more than one service at a time? Do the different agencies work together to* meet *your needs on time or does the way they deliver services make it harder for you (wrong times, more travel costs, etc.)*

Challenges for the Future

- What are the main challenges you face now and in the future for getting quality care which meets your needs?
- How can they be met?

Other Issues and Questions

ANNEX 6: DRAFT EVALUATION MATRIX FOR DESK-BASED COUNTRY CASE STUDY NOTES

The following matrix will serve to organize information and data collected through the document review. It is aligned with the master evaluation matrix developed during the inception phase for the End-Line Evaluation of H4+JPCS, and is organized according to assumptions for each of the areas of investigation. Indicators are limited to what can be observed and gleaned from document reviews. Document sources are illustrative and are based on an initial review of what exists in the Google Drive created for the evaluation.

Evaluation 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?		
Assumptions for Verification	**Indicators**	**Document Sources:**
Assumption 1.1 H4+ partners in consultation with national health authorities and other stakeholders identify unserved needs for health systems support for RMNCAH not fully met by other sources. Programme support builds on other investments and activities.	• Joint needs assessments conducted to review health system elements critical to RMNCAH • Programme work plans directly address areas identified areas of system strengthening for SRHR	• Needs assessments • H4+JPCS work plans • Technical guidelines • Monitoring and evaluation reports • Minutes of H4+JPCS coordinating committee
Assumption 1.2 H4+JPCS support to sub-national levels funds activities capable of complementing other investments and contributing to strengthening service delivery in RMNCAH. The funded activities are appropriately sequenced and matched with support to HSS provided by other programmes and sources	• Work plans incorporate links to other national programme at district level • Design of programme supported investments takes account of incentives structures and design of other programmes	
Assumption 1.3 RMNCAH managers and service providers trained with support from H4+JPCS realize intended gains in competence and skills These gains in skills and competencies are tested and verified during and after training.	• Monitoring reports include information on training and supervision (that track gains in skills and trainee utilization of skills post-training)	
Assumption 1.4 Capacity development efforts in RMNCAH are supported with well sequenced supervision and required equipment, supplies and incentives to	• Programme reports indicate H4+ JPCS funded inputs available at district level	

allow service providers the ability, opportunity and motivation to improve service quality and access.		
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.	• Trends in data on use of RMNCAH service at national and sub-national levels	
Evaluation 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 marginalized groups and in support of gender equality?		
Assumptions for Verification	**Indicators**	**Document sources**
Assumption 2.1 H4+ JPCS supported initiatives are targeted to increasing access for marginalized 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).	• Assessments, designs and implementation address barriers to access for vulnerable groups: location, timing, cost, security and privacy of services	• Needs assessments • H4+JPCS work plans • Technical guidelines • Monitoring and evaluation reports • Minutes of H4+JPCS coordinating committee • Special studies (related to quality of care; knowledge/attitudes/practice of providers and/or users)
Assumption 2.2 H4+JPCA 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.	• Programme work plans and project documents include capacity development and demand measures to reach vulnerable groups	
Assumption 2.3 H4+JPCS support at national and sub-national level can be sequenced appropriately with support to RMNCAH from other sources, especially to allow services to be scheduled and delivered in manners appropriate to reaching vulnerable group members and building trust between providers and users.	• Programme reports indicate H4+ JPCS funded inputs available at sub-national level	
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	• Monitoring reports or studies track improved quality of care by service providers and increased use of services	

sufficient to contribute to a notable increase in the use of services and to overcome barriers to access which existed in the past.	• Trends over time in core indicators of results in RMNCH	
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 behavior 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.	• Monitoring reports or studies track improved quality of care by service providers and increased use of services • Trends over time in core indicators of results in RMNCH	
Evaluation 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?		
Assumptions for Verification	**Indicators**	**Document sources**
Assumption 3.1 H4+ partners supporting RMNCAH in JPCS countries have been able to establish effective platforms for coordination and collaboration among themselves and with other stakeholders (including work plans, activities and investments, and results monitoring frameworks and systems) using H4+ JPCS funds and with technical support from the global/regional H4+ teams.	• Country work plans, monitoring reports and meeting minutes address coordination mechanisms and issues	• H4+JPCS work plans • Monitoring and evaluation reports • Minutes of H4+JPCS coordinating committee
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.	• Membership of coordinating committees • Decisions and records of minutes indicate leadership role of national health authorities.	
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,	• Country work plans are adjusted over time to respond to changes in	

programmes, policies and guidelines at national and sub-national level. H4+ partners consult and coordinate with stakeholders at both levels.	needs, priorities and context for RMNCAH • Minutes of coordination and review meetings at national and sub-national level indicate changes in orientation and content of H4=JPCS supported activities	
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.	N/A for desk-based country case study	
Evaluation Question Four: To what extent has the H4+JPCS 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)?		
Assumptions for Verification	**Indicators**	**Document sources**
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.	• Needs assessments and situation reports highlight opportunities for innovation • Country work plans include plans for implementation of innovative experiments • Project monitoring and review reports indicate operationally successful implementation of an innovation	• Needs assessments • H4+JPCS country work plans • Technical guidelines • Monitoring and evaluation reports • Reports or other documentation related to innovation experiments • Minutes of H4+JPCS coordinating committee
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.	• Guidelines and practical tools for identifying, supporting and monitoring innovations in RMNCAH are used by country teams	

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.	• Reports exist to document the success or failure of experiments undertaken.	
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).	• Reports indicate that national health authorities have reviewed evidence and made decisions to adopt and scale up innovations	
Assumption 4.5 H4+JPCS mechanisms for promoting successful innovations across the ten programme countries and among non-programme countdown countries are effective.	N/A for desk-based country case study	
Assumption 4.6 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.	N/A for desk-based country case study	
Evaluation 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?		
Assumptions for Verification	**Indicators**	**Document sources**
Assumption 5.1 H4+ teams at country level in collaboration with key stakeholders have established forums for coordinating programme action and division of labour in H4+ JPCS financed and supported activities in particular and in RMNCH generally.	• H4+JPCS coordination committee minutes and reports mention processes and systems for coordination, synergy among partners and ensuring lack of duplication	• H4+JPCS country work plans • Reports or other documentation related to innovation experiments • Minutes of H4+JPCS coordinating committee
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.	• Country work plans provide examples of H4+JPCS partners working in collaboration in geographic and technical areas appropriate to their mandate, capacities and experience	

Assumption 5.3 H4+ JPCS agencies have used structures and processes established for programme coordination at country level to rationalized 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.	• Work plans do not show examples of overlap or duplication of effort by H4+ partners	
Assumption 5.4 Global structures, systems and processes for identifying needs and opportunities and for planning, budgeting, approving and monitoring and reporting on H4+JPCS initiatives recognize and encourage agencies' distinct advantages and contribute to an effective division of labour.	N/A for desk-based country case study	
Assumption 5.5 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.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.	N/A for desk-based country case study notes	
Assumption 5.6 Working from an integrated work programme at global level, H4+JPCS partners produce technically sound and operationally useful knowledge products for strengthening national systems and practices in RMNCAH in collaboration or through consultations with other H4+ partners.	N/A for desk-based country case study notes	
Assumption 5.7 H4+JPCS agencies cooperate effectively to communicate the content of global knowledge products produced with H4+JPCS support and to advocate jointly for their use by programme and non-programme countdown countries.	N/A for desk-based country case study notes	
Evaluation Question Six: To what extent has the H4+JPCS contributed to accelerating the implementation and operationalization of the Global Strategy and the "Every Woman Every Child" Movement.		

Assumptions for Verification	Indicators	Document sources
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.	• Program monitoring reports cite policies developed with H4+JPCS support	• H4+JPCS country work plans • Monitoring and evaluation reports at national and for supported districts • Programme reports • Minutes of H4+JPCS coordinating committee •
Assumption 6.2 By providing targeted funding for global activities (and funding the coordinating office) H4+JPCS programme funding facilitated the development of knowledge products and joint, coordinated advocacy in RMNCH by H4+ agencies which would not have otherwise been undertaken.	N/A for desk-based country case study notes	
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.	N/A for desk-based country case study notes	
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”.	• RMNCAH services in supported districts report positive results of programme efforts to increase service quality and access	

ANNEX 7: PERSONS INTERVIEWED

PERSONS INTERVIEWED AT GLOBAL LEVEL		
Organisation	**Name**	**Position**
Global Affairs Canada	Julie MacCormack	Senior Program Officer, Maternal Newborn and Child Health and Nutrition
Global Affairs Canada	Emilie Milroy	H4+ Officer
Global Affairs Canada	Pierre J. Tremblay	Deputy Director, Development Evaluation Division
Privy Council Office of Canada	Geoff Black	Senior Analyst, Foreign and Defence Policy
Sweden (Sida)	Ulrika Hertel	Senior Programme Manager, Health and Education, Department for International Organizations and Policy Support
UNAIDS	Dirk van Hove	Senior Programme Advisor
UNFPA	Louis Charpentier	Adviser, Evaluation Office
UNFPA	Hemant Dwevadi	Global Coordinator H4+ Joint Programme
UNFPA	Andrea Cook	Director, Evaluation Office
UNFPA	Jean Pierre Monet	H4+ and Maternal Health Thematic Fund Officer
UNFPA	Michelle Park	H4+ Communications Coordinator
UNICEF	Kim Dickson	Senior Advisor, Maternal and Newborn Health
UNICEF	Preshant Menon	Evaluation Office
UNWomen	Nazneen Damji	Policy Advisor, HIV
UNWomen	Katja Isaksen	Technical Support to H4+ JPCS
WHO	Blerta Maliqi	Technical Advisor, Department of Maternal, Newborn, Child and Adolescent Health
WHO	Mikail Meyer Ostergren	Programme Manager, Department of Maternal, Newborn, Child and Adolescent Health
World Bank	Rama Lakshminarayanan	H4+ Focal Point

PERSONS INTERVIEWED IN ZIMBABWE DURING THE INCEPTION MISSION		
Organisation	**Name**	**Designation**
GOVERNMENT INSTITUTIONS:		
MoHCC	Rosemary Chapoterera	Sister in Charge, St Peters Mission Hospital
MoHCC	Dr. Taremba Davison	Government Medical Officer, St Peters Mission Hospital
MoHCC	Frank Dube	CHW, Chipinge District Health Executive
MoHCC	Godhelp Gurai	Senior Nursing Officer, Chipinge District Health Executive
MoHCC	Susan Gwashure	HIV Testing Services Coordinator, MoHCC
MoHCC	Brigadier General, Dr Gerald Gwinji	Permanent Secretary, MoHCC
MoHCC	Clifford Kanyunyunda	Provincial Accountant, Manicaland
MoHCC	Joshua Katiyo	Manager, Health Information & Disease Surveillance
MoHCC	Dr. Bernard Madzima	Director Family Health, MoHCC
MoHCC	Venus Mahati	Provincial Nursing Officer, Manicaland
MoHCC	Honest Mahlathini	Nutritionist, Manicaland Provincial Health Executive
MoHCC	Makundanyika	DEHO, Chipinge District Health Executive
MoHCC	Plaxedes Mandevhana	Acting District Nursing Officer, Chipinge District
MoHCC	Jane Mandimutsira	Reproductive Health Focal Person, Manicaland Provincial Health Executive
MoHealth and Child Care (MoHCC)	Absolom Mbinda	M&E Officer
MoHCC	Dr. Stephen Mbiri	Government Medical Officer, St Peters Mission Hospital
MoHCC	Dr. Gibson Mhlanga	Principal Director - Preventive Services, MoHCC
MoHCC	Emmanuel Mufambanhondo	Provincial Environmental Health Officer, Manicaland
MoHCC	Sibongile Mugarisi	Registered General Nurse, St Peters Mission Hospital
MoHCC	Bright Mukandi	ADHSA, Chipinge District Health Executive
MoHCC	Dr. Murungu	Deputy National ART Coordinator, MoHCC
MoHCC	Dr. Angela Mushavi	National PMTCT & Pediatric HIV Care and Treatment Coordinator, MoHCC
MoHCC	Elijah Mutimurefu	DPM, Chipinge District Health Executive
MoHCC	Lyoyd Nyamaende	A/ACC, Chipinge District Health Executive
MoHCC	Charles Tsangamidzi	Acting Prov. Health Services Administrator, Manicaland

MoWAGCD	Mr W. Karonga	Deputy Director- Women Affairs, Ministry of Women's Affairs, Gender and Community Development
UN ORGANISATIONS		
UNAIDS	Michael Bartos	Country Director
UNAIDS	Lia Tavadze	Advisor for Gender, HIV Integration
UNFPA	Tamisayi Chinhengo	Programme Specialist - ASRH
UNFPA	Cheikh Tidiane Cisse	Country Representative
UNFPA	Choice Damiso	Gender Programme Specialist
UNFPA	Dagmar Harnish	Technical Specialist SRH and HIV
UNFPA	Diana Hore	Programme Analyst - RHCS
UNFPA	Agness Makoni	Programme Analyst - Maternal Health
UNFPA	Sunday Manyenya	M&E Analyst
UNFPA	Margret Masanga	Communications Officer
UNFPA	Rudo Mhonde	M &E Analyst
UNFPA	Edwin Mpeta	Programme Specialist - RH
UNFPA	Abbigail Msemburi	Assistant Country Representative
UNFPA	Daisy Nyamukapa	Programme Analyst - SRH & HIV
UNFPA	VS Raghuvanshi	Technical Specialist MH& FP
UNFPA	Bertha Shoko	Communications Analyst
UNFPA	Yu-Yu	Assistant Country Representative
UNICEF	Beula Senzanje	HIV/AIDS Specialist
UNICEF	Joyce Mpaya	HIV/AIDS Manager
UNICEF	Dr Jane Muita	Country Representative
UNWOMEN	Molline Marume	Programme Specialist Gender and HIV
WHO	Dr. David Okello	WHO Resident Representative
WHO	Trevor Kanyowa	FRH Programme Officer
NGOs		
AfricAID	Martha Maudzeke	Programmes Manager
AfricAID	Nicola Willis	Director
Kapnek Trust	Margaret Jembere	Programme Coordinator
Kapnek Trust	Caroline Marangwanda	Deputy Director
OPHID	Barbara Englesmann	Director, Organisation for Public Health Intervention and Development
OPHID	Diana Patel	Deputy Director, OPHID
RTI	Henry Chidawanyika	Project Director, Zimbabwe Health Information Support Project (Research Triangle Institute International)

ANNEX 8: REFERENCES

APR (2015). Ending Preventable Child and Maternal Deaths: A Promise Renewed, New York, A Promise Renewed. Last updated: 2015. Available from http://www.apromiserenewed.org

Countdown (2015a). Countdown 2015 data: Coverage and Demographic Indicators, Geneva, World Health Organization. Last updated: 22 September 2015. Available from http://www.countdown2015mnch.org/about-countdown/countdown-data

Countdown (2015b). Countdown to 2015: Maternal, Newborn & Child Survival, Geneva, World Health Organization. Last updated: 2016. Available from http://www.countdown2015mnch.org

Countdown (2015c). *Maternal, Newborn & Child Survival: Zimbabwe*. Geneva, World Health Organization. Available from http://www.countdown2015mnch.org/documents/2015Report/Zimbabwe_2015.pdf

CTV News (2010). Text of the G8 Summit communique: Muskoka Declaration. Last updated: 26 June 2010. Available from http://www.ctvnews.ca/text-of-the-g8-summit-communique-muskoka-declaration-1.526770

Danida (2014). *Evaluation of the Danish Strategy for the Promotion of Sexual and Reproductive Health and Rights 2006-2013*. Copenhagen, Ministry of Foreign Affairs of Denmark, Danida. Available from http://www.netpublikationer.dk/um/14_evaluation_2014_03/Pdf/evaluation_2014_03.pdf

Darnton, Andrew (2008). Practical Guide: An overview of behaviour change models and their uses. *Government Social Research*. Available from http://www.civilservice.gov.uk/wp-content/uploads/2011/09/Behaviour-change_practical_guide_tcm6-9696.pdf

FP 2020 (2015). Family Planning 2020, Washington DC, United Nations Foundation. Last updated: 2015. Available from http://www.familyplanning2020.org

Lancet Commission (2013). Key Messages of the Global Health 2035 Report, San Francisco, University of California, The Lancet Commission on Global Health, Global Health 20135. Last updated: 2013. Available from http://globalhealth2035.org/report/key-messages-global-health-2035-report

Mayne, John (2008). *Contribution Analysis: An approach to exploring cause and effect*, The Institutional Learning and Change (ILAC) Initiative, ILAC Brief 16(2). Available from http://betterevaluation.org/sites/default/files/ILAC_Brief16_Contribution_Analysis.pdf

Mayne, John (2015). Useful Theory of Change Models. *Canadian Journal of Programme Evaluation* 30(2): 119-142. Available from http://cjpe.journalhosting.ucalgary.ca/cjpe/index.php/cjpe/article/view/294

MHTF (2010). Maternal Health, HIV & AIDS, Boston, Havard School of Public Health, Maternal Health Task Force. Last updated: 2016. Available from http://www.mhtf.org/topics/mh-hiv-and-aids/

MSP (2015). *l'Enquête sur la Disponibilité et la capacité opérationnelle des services de santé en République Démocratique du Congo, DSSP/DSNIS, 2014*. Kinshasa, Ministère de la Santé Publique

PMNCH (2011). *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH)*. Geneva, The Partnership for Maternal, Newborn & Child Health, World Health Organization and the Aga Khan Foundation. Available from

http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf?ua=1

Say, Lale, and others (2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health* 2(6): e323-e333. Available from http://dx.doi.org/10.1016/S2214-109X(14)70227-X

UN (2010). *Global Strategy for Women's and Children's Health*. New York, United Nations Secretary-General. Available from http://www.who.int/pmnch/activities/advocacy/fulldocument_globalstrategy/en/

UN (2015a). *Addis Ababa Action Agenda of the Third International Conference on Financing for Development*. New York, United Nations. Available from http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

UN (2015b). *Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)*. Washington DC, United Nations Foundation, Every Woman Every Child. Available from http://globalstrategy.everywomaneverychild.org/pdf/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

UN (2016a). H4+: Joint Partnership of UN Agencies Working Together to Improve Women's and Children's Health, Washington, United Nations Foundation, Every Woman Every Child. Last updated: 2016. Available from http://www.everywomaneverychild.org/resources/archives/h4-plus

UN (2016b). H6 Announcement: Harnessing the collective strengths of the UN system to reach every woman, child & adolescent, Washington DC, United Nations Foundation, Every Woman Every Child. Last updated: 28 March 2016. Available from http://everywomaneverychild.org/news-events/news/1313-h6-announcement-harnessing-the-collective-strengths-of-the-un-system-to-reach-every-woman-child-adolescent

UN (2016c). Shaping the Future for Healthy Women, Children & Adolescents: Learn More About the Process to Update the Global Strategy, Washington DC, United Nations Foundation, Every Woman Every Child. Last updated: 2016. Available from http://www.everywomaneverychild.org/global-strategy-2

UN (2016d). UN Commission on Life-Saving Commodities. Improving access. Saving lives, Washington DC, United Nations Foundation, Every Woman Every Child. Last updated: 2016. Available from http://www.everywomaneverychild.org/networks/life-saving-commodities

UNFPA (2015a). *Final Master H4+ Canada and Sida Financial Expenditures – 2011 to 2014. Unpublished. Excel file provided March, 2015*. New York, United Nations Population Fund, Administrative Agent to H4+.

UNFPA (2015b). *Terms of Reference, End Line Evaluation of the H4+ Joint Programme, Canada and Sweden (Sida) 2011-2016*. New York, United Nations Population Fund Evaluation Office.

WHO (2007). *Maternal Mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva, World Health Organization. Available from http://www.who.int/whosis/mme_2005.pdf

WHO (2013a). *PMNCH Knowledge Summary #24. The economic benefits of investing in women's and children's health*. Geneva, World Health Organization, The Partnership for Maternal, Newborn & Child Health. Available from http://www.who.int/pmnch/knowledge/publications/summaries/knowledge_summaries_24_economic_case/en/

WHO (2013b). *PMNCH Knowledge Summary #28. New Global Investment Framework for Women's and Children's Health*. Geneva, World Health Organization, The Partnership for Maternal, Newborn & Child Health. Available from http://www.who.int/pmnch/knowledge/publications/summaries/ks28.pdf

WHO (2013c). *Promoting Women's & ChIldren's Health IntegratIng HIV, TB, Malaria and Reproductive, Maternal, Newborn and Child Health Programs*. Geneva, World Health Organization. Available from http://www.who.int/pmnch/media/events/2013/au_policy_brief_aids_tb_malaria.pdf

WHO (2014a). *H4+ partnership: joint support to improve women's and children's health*. Geneva, World Health Organization, UNICEF, UNFPA, UNAIDS, World Bank. Available from http://www.who.int/reproductivehealth/publications/reports/h4report2013/en/

WHO (2014b). *Implementing The Commission on Information and Accountability Recommendations*. Geneva, World Health Organization, Commission on information and accountability for Women's and Children's Health. Available from http://www.who.int/woman_child_accountability/news/background_progress_report_jan2014.pdf

WHO (2014c). *Success Factors for Women's and Children's Health: Multisector Pathways to Progress*. Geneva, World Health Organization. Available from http://www.who.int/pmnch/knowledge/publications/successfactors/en/

WHO (2015a). *Every Woman, Every Child, Every Adolescent: Achievements and Prospects. The Final Report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health*. Geneva, World Health Organization. Available from http://www.who.int/woman_child_accountability/ierg/reports/2015/en/

WHO (2015b). *H4+ Annual Report 2014 of the H4+ Canada and Sweden Collaborations: Strengthening and consolidating gains for reaching Every Woman Every Child*. Geneva, World Health Organization, The H4+ Partnership. Available from https://h6partners.files.wordpress.com/2015/09/h4-report-9_24-15-web.pdf

WHO (2016a). About the Partnership for Maternal, Newborn & Child Health, Geneva, World Health Organization. Last updated: 2016. Available from http://www.who.int/pmnch/about/en/

WHO (2016b). Every Newborn: An Action Plan to End Preventable Deaths, Geneva, World Health Organization, The Partnership for Maternal, Newborn & Child Health. Last updated: 2016. Available from http://www.everynewborn.org

WHO (2016c). PMNCH reports, Geneva, World Health Organization. Last updated: 2016. Available from http://www.who.int/pmnch/activities/accountability/reports/en/

World Bank (2015a). Health expenditure, private (% of GDP), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS

World Bank (2015b). Health expenditure, public (% of GDP), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

World Bank (2015c). Out-of-pocket health expenditure (% of private expenditure on health), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS

World Bank (2015d). Out-of-pocket health expenditure (% of total expenditure on health), Washington DC, World Bank. Last updated: 2015. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS

World Bank (2016a). Adult literacy rate, population 15+ years, both sexes (%), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SE.ADT.LITR.ZS

World Bank (2016b). Community health workers (per 1,000 people), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.MED.CMHW.P3

World Bank (2016c). Contraceptive prevalence (% of women ages 15-49), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.DYN.CONU.ZS

World Bank (2016d). Health expenditure, private (% of GDP), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS

World Bank (2016e). Health expenditure, public (% of GDP), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS

World Bank (2016f). Nurses and midwives (per 1,000 people), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.MED.NUMW.P3

World Bank (2016g). Out-of-pocket health expenditure (% of private expenditure on health), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS

World Bank (2016h). Out-of-pocket health expenditure (% of total expenditure on health), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS

World Bank (2016i). Population, total, Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.POP.TOTL

World Bank (2016j). Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.MTR.1519.ZS

World Bank (2016k). Unmet need for contraception (% of married women ages 15-49), Washington DC, World Bank. Last updated: 17 February 2016. Available from http://data.worldbank.org/indicator/SP.UWT.TFRT

World Bank Group (2015). Global Financing Facility: Country Powered Investments for Every Woman, Every Child, Washington DC, The World Bank Group. Last updated: 2015. Available from http://globalfinancingfacility.org

Yin, Robert K. (2009). *Case Study Research: Design and Methods*. Los Angeles, Sage Publications.

ANNEX 9: TERMS OF REFERENCE FOR H4+ END LINE EVALUATION

UNFPA – Terms of Reference: End Line Evaluation of the H4+ Joint Programme Canada and Sweden (Sida) 2011 – 2016. New York, NY: UNFPA. Retrieved from http://www.unfpa.org/admin-resource/evaluation-h4-joint-programme-canada-and-sweden-2011-2016