JUNE 2015

The H4+ partnership
Joint support to improve women's and children's health
Progress report–2014

H4+

World Health Organization · UNAIDS · UNFPA · unicef · UN WOMEN United Nations Entity for Gender Equality and the Empowerment of Women · WORLD BANK GROUP

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WHO Library Cataloguing-in-Publication Data

The H4+ partnership joint support to improve women's and children's health: progress report 2014.

1.Women's Health. 2.Child Welfare. 3.Women's Rights. 4.Child Advocacy. 5.Reproductive Health. 6.Consumer Participation. 7.National Health Programs. 8.Program Evaluation.. I.World Health Organization. II.UNICEF. III.United Nations Population Fund. IV.World Bank. V.UNAIDS.

ISBN 978 92 4 150888 9 (NLM classification: WA 300)

Photo credits:
Front cover: Jessica Lea/Department for International Development; page 8: Abbie Trayler-Smith

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Acronyms and abbreviations

BEmONC	basic emergency obstetric and newborn care
COIA	Commission on Information and Accountability for Women's and Children's Health
DFATD	Department of Foreign Affairs, Trade and Development (Canada)
EENC	early essential newborn care
EmONC	emergency obstetric and newborn care
ENA	essential newborn actions
EVD	Ebola Virus Disease
FGM	female genital mutilation
FP2020	Family Planning 2020
GARPR	Global AIDS Response Progress Reporting
GBV	gender-based violence
GFF	Global Financing Facility
H4+	UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank
IMCI	integrated management of childhood illness
IMNCI	integrated management of newborn and child illness
M&E	monitoring and evaluation
MDG	Millennium Development Goal
MDSR	maternal death surveillance and response
MNH	maternal and newborn health
PMTCT	prevention of mother-to-child transmission
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCH	reproductive, maternal, newborn and child health
SDG	Sustainable Development Goal
Sida	Swedish International Development Cooperation Agency
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

1.1 Background

In September 2008, UNICEF, UNFPA, WHO and the World Bank created the joint H4 initiative to provide harmonized support for maternal and newborn health in low-income, high-burden countries. Later joined by UN Women and UNAIDS, the retitled H4+ was tasked with supporting the advancement of the Millennium Development Goals (MDGs) of reducing child mortality (MDG 4) and improving maternal health (MDG 5). Efforts to combat HIV/AIDS, malaria and other diseases (MDG 6) and to promote gender equality and empower women (MDG 3) also fell within its purview. At the global and country levels, H4+ partners formed teams that leveraged the respective strengths of each agency to provide well coordinated technical assistance in the development and implementation of MDG action plans.

H4+ later aligned its efforts in 2010 to support the mobilization and implementation of commitments made by countries, nongovernmental organizations and the private sector to the United Nations (UN) Secretary-General Ban Ki-moon's Global Strategy for Women's and Children's Health *(1)*. The Global Strategy and its accompanying Every Woman Every Child[1] movement aim to accelerate progress towards achieving MDGs 4 and 5 by supporting country-led efforts to improve reproductive, maternal, newborn and child health (RMNCH) and most recently by sustaining the focus and momentum on women's and children's health in the emerging Sustainable Development Goals (SDGs).

As the Global Strategy's lead technical partners, the H4+ partnership holds specific responsibility for supporting countries to achieve MDGs 4 and 5 (A&B)[2] and implement their Global Strategy commitments. H4+ agencies draw on their extensive geographic reach and varying but complementary technical capabilities to facilitate this work.

The capacity of the H4+ partnership to provide joint leadership at the global level and coordinated technical assistance at the national level allows it to serve as a strategic technical platform for countries striving to actualize their Global Strategy commitments. It prioritizes low-income countries with high maternal and child mortality burdens that have set specific targets for improving, integrating and expanding access to RMNCH services. Within these countries, H4+ builds on the long history of engagement between UN agencies and Member State governments in order to support the formulation and implementation of policy and legislation that codify lasting improvements in national health plans. Moreover, governments utilize H4+ partner agencies' various areas of expertise in RMNCH service provision as well as other matters of health and social equity. Finally, the networks formed by UN agency structures promote sharing of lessons learnt at the global, regional and country levels, and enable South–South cooperation.

Several key initiatives have been established in recent years to accelerate progress towards achieving the RMNCH-related MDGs, and to maintain momentum for further improvement post-2015. Given the H4+ partnership's commitment to support implementation of the Global Strategy, its partner agencies have been instrumental in supporting harmonization across these various efforts at global and country levels. These include the High Burden Country Initiative, Committing to Child Survival: A Promise Renewed *(2)*, the United Nations Commission on Life-Saving Commodities for Women and Children, and the recommendations of the Commission on Information and Accountability for Women's and Children's Health (COIA). Additionally, in 2014, the Every Newborn Action Plan *(3)* was launched to end preventable newborn deaths, and post-2015 targets for Ending Preventable Maternal Mortality *(4)* were issued and are currently being proposed for inclusion within the Sustainable Development Goals (SDGs) for the period 2016–2030. Most recently, there has been extensive H4+ input in updating the Global Strategy for Women's, Children's, and Adolescents' Health (the successor to the existing Global Strategy) as well as its operational

1 www.everywomaneverychild.org

2 Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; Target 5.B: Achieve, by 2015, universal access to reproductive health.

framework *(5)*, and developing the Global Financing Facility (GFF) *(6)* to provide investment support for the health of women, children, and adolescents in the post-2015 agenda.

This progress report aims to document the 2014 calendar year activities of the H4+ partnership at the global level and implementation of H4+ scope of work by country teams around the world. It also provides an evidence-based assessment of both achievements and challenges encountered at global and country levels, and considerations for the future of H4+ in advancing post-2015 goals and targets related to RMNCH. Along the way, key trends and lessons learnt are highlighted through specific examples and short case studies.

The H4+ mandate: To leverage the collective strengths and distinct advantages and capacities of each of six agencies in the UN system to improve reproductive, maternal, newborn and child health (RMNCH) in the countries with high burden of maternal and child mortality and morbidity.

1.2 Objectives and methods

Objectives and data sources

The objectives of this report are as follows:

- to provide an updated overview of H4+ coordination, functionality and activities in countries in support of progress towards achieving MDGs 4 and 5;
- to bring together information on H4+ efforts to accelerate implementation of the Global Strategy;
- to inform the post-2015 development agenda initiatives by documenting and sharing H4+ lessons learnt on interagency collaboration and joint implementation.

To meet its objectives, this progress report draws on data and information gathered from the following sources:

- records tracking the development and implementation of individual H4+ country team plans and global activities;
- monitoring reports describing implementation of specific H4+ grants for joint country support work (referred to as the H4+ Joint Programme); and
- two recent surveys of countries that have made specific commitments to the Global Strategy (2014 H4+ survey) and countries with the highest burden of maternal and child deaths (2015 H4+ survey).

Programme country survey: methods

The 2015 H4+ survey aimed to assess country-level work conducted in 2014, in the 75 countries where more than 95% of all maternal and child deaths occur. The survey was initiated in April 2015, by asking country teams to provide information on their activities during 2014 via a semi-structured online questionnaire. Both quantitative and qualitative data were collected to capture country-level information on three broad themes:

- general H4+ coordination mechanisms;
- H4+ scope of work in the country and related implementation; and
- contributions to the mobilization of additional financial, technical and other resources for RMNCH.

The survey contained 36 questions, each corresponding to one of the H4+ Results Framework's eight areas of work (see Box 2.1, section 2). The survey had a response rate of 83%. After responses were captured in a database managed by the H4+ team at the WHO headquarters in Geneva, data were analysed by categorizing responses according to the three above-mentioned themes, and the H4+ Results Framework's eight areas of work.

Among the 75 countries surveyed, the following 62 countries responded to the questionnaire: Afghanistan, Angola, Benin, Bolivia, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Comoros, Congo, the Democratic Republic of the Congo, Côte d'Ivoire, Egypt, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Kenya, Democratic People's Republic of Korea, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Niger, Nigeria, Papua New Guinea, Philippines, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Somalia, South Sudan, Sri Lanka, Sudan, Swaziland, Tajikistan, Togo, Uganda, Uzbekistan, Viet Nam, Zambia and Zimbabwe.

Among these 62 countries, 38 reported either having a dedicated H4+ country team, or having H4+ as part of a UN coordinating team. Therefore, data from these 38 countries were used to develop the analysis detailed in section 3.

This report serves as a complement to the previous year's H4+ progress report, which described the work of H4+ in 2013 in the 58 countries that made specific commitments to the Global Strategy.[3] The expanded coverage of this year's survey prevents a direct comparison with the previous year's results for most objectives examined. However, to provide a snapshot of the trajectory of H4+ work over the past two years, responses to key questions from 21 countries that responded to both surveys and were included in both analyses are compared across the two years in Annex 1.

3 Of these 58 countries, 44 responded to the survey and 35 were included in the analysis of the 2014 H4+ survey. The H4+ progress report 2013, including results of that survey, is available online at: http://www.who.int/reproductivehealth/publications/reports/h4report2013/en/

2. Collaboratively accelerating results for women's and children's health

2.1 H4+ objectives and priorities

The H4+ partnership's areas of work (see Box 2.1) reflect its six member agencies' pledge to bring their collective strengths and comparative advantages together, leveraging each agency's respective technical expertise, long-term collaborative relationships with local authorities and institutions, and specific mandate regarding women's and children's health.

The H4+ scope of work includes the provision of technical support to those 75 countries with the highest burdens of maternal, newborn and child mortality and morbidity. Among these high-burden countries, there is a focus on those countries that have made commitments to the Global Strategy and countries where H4+ agencies have a strong partnership with the national government. Priority is also placed on those countries where additional H4+ support can be aligned with existing funds and programmes, such as countries supported by global H4+ grants, financed by the Canadian Department of Foreign Affairs, Trade and Development (DFATD), the Swedish International Development Cooperation Agency (Sida), or the French Muskoka Grant. The 10 countries supported by DFATD and by Sida are referred to as the H4+ Joint Programme.

Box 2.1: Areas of work of the H4+ Results Framework aimed at accelerating progress to achieve MDGs 4 and 5 in 75 high-burden countries

1. Support countries in conducting needs assessments and related assessments to identify system constraints that limit efforts to improve RMNCH; and support countries in ensuring that health plans are driven by the Millennium Development Goals and are performance-based.
2. Develop and/or determine the costs for the modules of national health plans relating to RMNCH; and rapidly mobilize new or additional resources for RMNCH.
3. Scale up the quality of RMNCH service delivery in line with domestic priorities, ensuring linkages with malaria and HIV/AIDS initiatives, and strengthen the management of procurement systems.
4. Address the urgent need for skilled health workers, particularly midwives, related cadres of personnel, and community health workers.
5. Support countries in addressing barriers that limit public demand for access to RMNCH services, with particular attention to marginalized and vulnerable groups.
6. Tackle the root causes of maternal, newborn and child mortality and morbidity, including gender inequality, low access to education (especially for girls), child marriage and adolescent pregnancy.
7. Strengthen national monitoring and evaluation systems to ensure the availability of credible data, in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health.
8. Strengthen documentation, evaluation and sharing of best practices of the H4+ mechanism.

2.2 H4+ work at the global level in 2014

The global-level activities of the H4+ partnership aim to enhance knowledge management for RMNCH, as well as advocacy for mobilizing more political and financial commitment and support for the RMNCH sector. This also contributes to enhancing global public goods and promoting the use of evidence-based practices at policy and programme levels in the countries with high burdens of maternal and child morbidity and mortality.

In 2014, the H4+ programme supported the development and dissemination of several distinct knowledge products at the global level. These included reports, frameworks, policy compendiums, tools, technical guidelines, recommendations, analyses, action plans and best practices, in addition to the use of social media.

At the global level, the H4+ team provides management, coordination, technical assistance and oversight support to H4+ countries with active H4+ teams and/or receiving specific H4+ grants.

The following subsections further detail major H4+ activities at the global level.

Generating and disseminating technical knowledge for RMNCH

H4+ provides advice and expert reviews to countries upon request to support development and implementation of national health plans, programmes and activities, and supports country access to the most up-to-date RMNCH technical information. This work includes:

- collaborating with national governments to conduct expert reviews of country plans and programmes;
- providing support in multiple capacities for development and implementation of H4+ country proposals, including assistance with obtaining funding from development partners;
- facilitating information sharing among stakeholders in academia, the private sector and staff of other global initiatives by engaging with global RMNCH research and knowledge forums; and
- convening regional and country workshops that guide development of the components of H4+'s technical agenda.

Notable achievements in 2014 include the following:

- issuing policy briefs to promote evidence-based protocols and standards for the provision of maternal, newborn and child health services and to promote discussion around the post-2015 RMNCH agenda, scope and key issues (including strategic planning for ending preventable maternal, newborn and child mortality; adolescent health-related competencies for health workers; harmonized and aligned approaches for RMNCH strategic planning, costing, review, and programme management);
- developing the *State of the world's midwifery report 2014 (7)* and launching it at the global level and in 26 countries around the world to initiate or reinforce discussion and advocacy for country-level midwifery workforce assessments, followed by development of guidance to conduct such assessments *(8)*;
- facilitating the development of *Midwifery Services Framework: guidelines for developing SRMNAH services by midwives (9)* by the International Confederation of Midwives;
- revising the *Service availability readiness assessment tool (10)* to include assessments of the quality of RMNCH care;
- developing core competencies for adolescent health and development for health-care providers in primary care settings; and
- developing fact sheets illustrating innovative and catalytic support to governments for improving health care for women and children – this documentation showcases how H4+ is addressing barriers to care, creating/implementing innovative solutions and scaling up high-impact, cost-effective interventions.[4]

Global advocacy and communications

The strategic communications and advocacy platform within H4+ is vital for creating awareness and mobilizing support for the Global Strategy. The H4+ communications group works to enhance the visibility and awareness of H4+ and its added value among members of the international development community, including decision-makers, media, development partners and the general

4 H4+ Country Innovation Fact Sheets have been developed for Cameroon, Ethiopia, Sierra Leone, Zambia and Zimbabwe and are available at the H4+ webpage: http://www.everywomaneverychild.org/networks/h4-plus

public. H4+ also promotes South–South collaboration and shares best practices for improving and scaling up RMNCH at the country level.

In 2014, H4+ held an Intercountry Communications Workshop for H4+ global-, regional- and country-level communication focal persons. The event empowered them to share knowledge, collaborate and open lines of internal communication. Countries also developed H4+ country communication plans. These plans aim to increase the visibility of H4+ and to broadcast information to the ministries of health, media and others about H4+'s transformative programmes. At a global level, H4+ showcased its unique global partnership at a UN General Assembly side event in 2014. In addition, H4+ supported its partners in conducting international campaigns that complemented H4+ messages and goals. Through these communications engagements, H4+ delivers messages that broaden and uphold the H4+ partnership.

The H4+ partnership launched its webpage in 2014, providing access to H4+ publications, tools and news dating back to 2011.[5]

Resource and partner mobilization and alignment

H4+ works at the global level to mobilize financial commitments from key development partners. In 2014, work continued in implementing several major grants that have been awarded and allocated to support 20 countries. These grants include the following:

- The Canadian DFATD committed US$ 50 million to a five-year (2011–2016) joint programme supporting Burkina Faso, the Democratic Republic of the Congo, Sierra Leone, Zambia and Zimbabwe to fulfil their commitments to the Global Strategy.
- Sida committed US$ 52 million over three years (2012–2015) to support Cameroon, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe in their commitments to the Global Strategy.
- The French Ministry of Foreign Affairs financed a French Muskoka Grant of €95 million (US$ 133 million) to support strengthening of the health systems in Benin, Burkina Faso, the Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Haiti, Mali, Niger, Senegal and Togo.
- Johnson & Johnson, the only private-sector H4+ funding partner, committed US$ 4 million over four years (2011–2015) for country-level human resource strengthening activities in Ethiopia and the United Republic of Tanzania. In the United Republic of Tanzania, grant funds are used to develop and implement pre-service nursing and midwifery curricula. In Ethiopia, efforts to scale up human resources for health, particularly the maternal and newborn health (MNH) workforce, are prioritized.

Oversight, monitoring and evaluation, and implementation of the H4+ annual workplan

At the global level, H4+ ensures implementation and monitoring of the global H4+ workplan, and provides oversight and technical support to countries as they engage in their H4+ workplan activities. Specific focus is given to the 10 H4+ Joint Programme countries supported by the grants from Canada's DFATD and Sida. In collaboration with the RMNCH Trust Fund, H4+ has developed a Programme Implementation Management (PIM) tool for use in these 10 countries and more broadly. This tool aims to facilitate management of the programme implementation by linking interventions, indicators and financial information, with an end goal of improving results and programme impact.

2.3 H4+ work at the country level in 2014

The guiding principle of the H4+ partnership is to strive to complement existing efforts by filling critical gaps in order to strengthen national health systems, promote the provision of integrated RMNCH services, and foster innovations to find solutions for context-specific issues within the health sector. The partnership provides strategic and catalytic support to strengthen national health systems, as the work of H4+ is aligned with: (i) Every Woman Every Child/the Global Strategy for Women's and Children's Health, thus leveraging high-level political attention to ensure success and results; (ii) the pursuit of the MDGs and the measuring of success in accordance with the H4+ Results Framework; and (iii) leadership and coordination mechanisms for RMNCH at

5 The H4+ webpage is available at: http://www.everywomaneverychild.org/networks/h4-plus

Box 2.2: The H4+ partnership as a vehicle to align partners around the RMNCH Country Engagement Approach, provide technical assistance, and deliver results

The H4+ partnership has been an important instrument in strengthening the collaboration among partners and supporting transformative interventions at the country level. Since 2013, when the H4+ collaboration experience informed, among others, the establishment of the RMNCH Strategy and Coordination Team and the functionality of the RMNCH Fund, H4+ has proven to be a successful vehicle in the implementation of the recommendations of the Global Strategy for Women's and Children's Health/Every Woman Every Child, the United Nations Commission on Life-Saving Commodities for Women and Children, and the Commission on Information and Accountability for Women's and Children's Health (COIA).

In this context, the H4+ partnership – at both the global and country levels – is the main engine that has powered the implementation of the RMNCH Country Engagement Approach. This Approach calls for a multi-stakeholder collaboration that allows for the development and implementation of high-impact short-term programmes, embedded in the national plans and strategies, which have the potential to accelerate the achievement of the MDGs and establish the needed systems to sustain these gains.

Until May 2015, H4+ – in collaboration with other national partners, including civil society and at times the private sector – has led the development of grants worth approximately US$ 160 million and continues to provide technical assistance to their implementation in the following 18 countries: Afghanistan, Bangladesh, Benin, Burkina Faso, Cameroon, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mali, Mozambique, Niger, Pakistan, Senegal, the United Republic of Tanzania, Uganda and Zambia. The initial results from this implementation are promising, especially as they relate to the ability of countries to adopt evidence-based policies and guidelines and implement related interventions in the hardest-to-reach areas, while strengthening information, training, and procurement and supply management systems.

Source: UN Commission on Life-Saving Commodities, 2015 *(11)*.

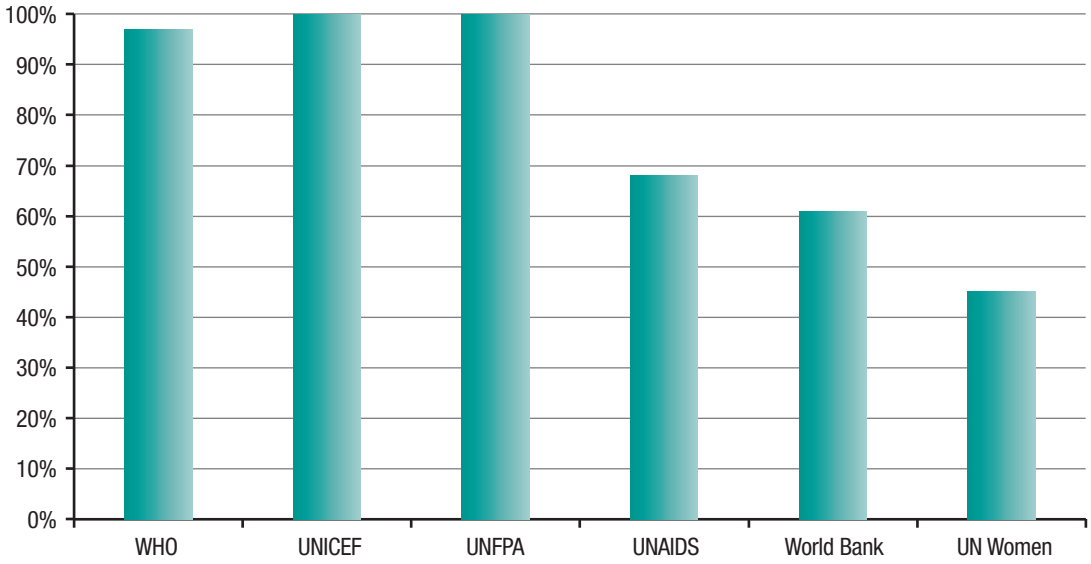
the global and country levels, thereby providing platforms for identifying and acting on opportunities for complementary and synergistic efforts.

The flexibility of the H4+ partnership and the leadership of national governments in programme planning and implementation allow each country to focus on the areas of RMNCH that need strategic and catalytic support. At the country level, programme design aims to inform policy and support evidence-based strategies for creating an enabling environment to strengthen health system building-blocks, including community participation, communication and advocacy to address root causes of adverse health outcomes in mothers and children.

In each of the countries with an H4+ mechanism or team, one H4+ agency is appointed as coordinator for the partnership and a representative from that agency acts as the H4+ focal point who facilitates joint support and implementation at the country level. The collective efforts of country teams, under the leadership of health ministries, lead the programme at the country level. Agency representation in H4+ country teams is detailed in Figure 2.1, with WHO, UNICEF and UNFPA being part of almost all H4+ teams.

According to the 2015 H4+ survey, of the 38 countries with an H4+ team, 27 reported having a joint H4+ workplan or joint project.

Figure 2.1: Percentage of countries reporting representation of each agency in their H4+ team, 2014 (N=38 countries)



Source: Analysis of data from 2015 H4+ survey.

3. Progress at the country level during 2014

H4+ has supported countries in maintaining sustained national focus on reproductive, maternal, newborn and child health (RMNCH) priorities, and in accelerating the momentum of locally led efforts to reach those objectives. Governments and development partners have worked more closely together in support of strategic national health plans. Increasingly, evidence-based RMNCH guidelines and standards of care are being incorporated at the national policy level and implemented at the community and facility level. Particularly notable progress has been made in the area of maternal and perinatal morbidity and mortality, including establishing maternal death surveillance and response (MDSR) systems and addressing the sociocultural barriers to service access that perpetuate these challenges.

Looking across all countries and areas of work covered in the 2015 H4+ survey (described in detail in section 1.2), certain themes emerge. These common areas of country-level progress in 2014 include:

- **Planning to support success:** Countries drew upon H4+'s technical and coordination capabilities to conduct RMNCH needs assessments, craft or revise national policies based on the needs identified, and then leverage resources in support of those plans and policies.
- **Building on evidence to support what works:** H4+ empowered many countries to take ownership of global RMNCH guidelines and standards of care by incorporating them into national-level policy and programmes. At the subnational level, evidence-based protocols for improving service quality were disseminated during health-care provider training sessions and scaled up as components of integrated service packages. Simultaneously, lessons learnt from the field via programme documentation, needs assessments and exploratory research on gender-related and sociocultural barriers to access were used to craft locally responsive policy and programmes.
- **Overcoming barriers through innovation:** Countries used H4+ support to develop or scale up innovations to overcome barriers to optimal RMNCH on multiple levels. This included using technology to disseminate information and expedite test results, mobile clinics to extend service to rural areas, and innovative community engagement strategies to address the sociocultural barriers to optimal RMNCH.

The results of the 2015 H4+ survey of countries are presented below, under the H4+ Results Framework's area of work (Box 2.1) to which they correspond.

Area 1: Assessing needs and identifying system constraints

Results from the 2015 H4+ survey indicate that in 2014, 15 countries conducted needs assessments that examined a variety of RMNCH domains. Many focused on the health needs of adolescents and young people. In Burundi, H4+ jointly supported an evaluation of reproductive health services for adolescents and youths, while Indonesia and the Democratic Republic of the Congo mapped adolescent needs and service provision for young people, respectively. Several countries carried out assessments of emergency obstetric and newborn care (EmONC). For example, H4+ and collaborating partners supported the Zambian government in conducting a national EmONC assessment in 397 identified health-care facilities. Numerous other countries assessed HIV-related needs, such as access to prevention of mother-to-child transmission (PMTCT) services and integration of HIV prevention and treatment into reproductive health services.

Countries also described a variety of ways in which these and previous H4+-supported assessments contributed to developing or revising health plans and legal frameworks. Many reported launching national plans related to adolescent health, as well as plans for newborn health and mortality reduction. Mozambique, for example, developed an accelerated plan for maternal and newborn mortality reduction, and Indonesia developed a national plan for the health of school-age children and adolescents, while India launched both a national newborn action plan and a national adolescent health strategy in 2014. Both the Lao People's Democratic Republic and Viet Nam developed national action plans on early essential newborn care (EENC).

Prevention of gender-based violence (GBV) was another area on which countries consistently reported. For example, Somalia developed a 2014–2017 GBV strategy incorporating prevention, care, legal assistance and coordination, while the Lao People's Democratic Republic passed a law on the prevention of violence against women and children and developed a related action plan.

Overall, 19 countries reported that H4+ had been instrumental in bringing about change to national RMNCH-related policies, and 18 reported that H4+ had catalysed transformational national RMNCH programmes (see Figure 3.1).

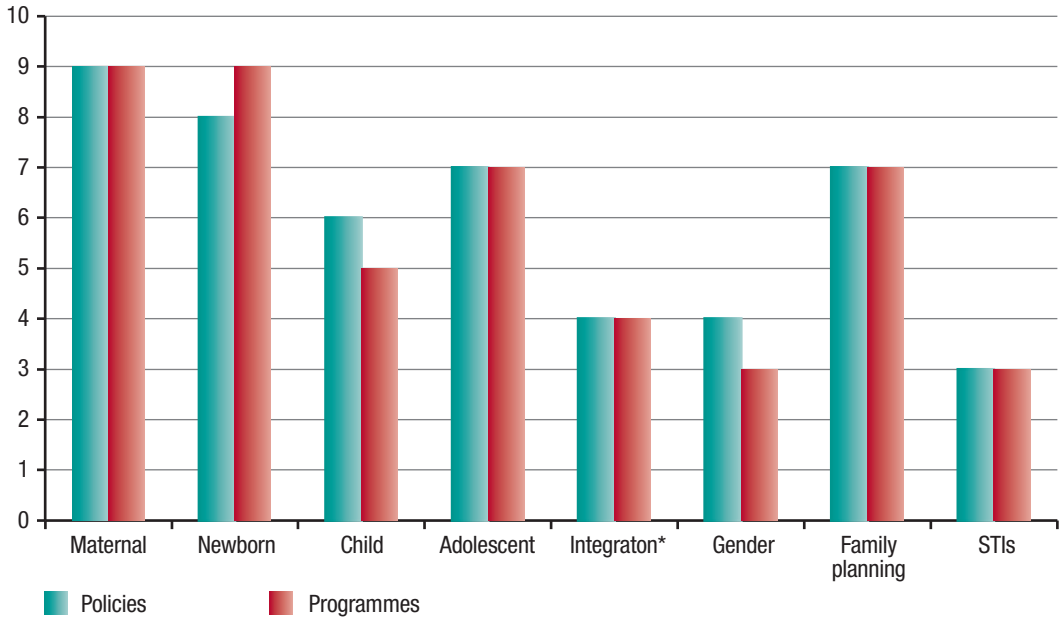
Notable examples of H4+'s role in policy change include:

- Kenya convened advocacy and capacity-building forums for county governors, parliamentarians and religious leaders from all faiths to foster political commitment for ending preventable deaths and regressive sociocultural practices.
- Mozambique developed a postpartum haemorrhage prevention strategy, and a health sector strategy for 2014–2019.
- The Philippines developed a protocol for essential intrapartum and newborn care.
- The H4+ team in Sierra Leone contributed to the development of global guidance for maternal and newborn health (MNH) service provision in the midst of the Ebola Virus Disease (EVD) outbreak, and subsequently supported the Sierra Leone Ministry of Health to adapt the guidance to country level.

Notable examples of H4+'s role in catalysing programme transformation include:

- Morocco strategically targeted their maternal and infant mortality reduction strategy to cover 60% of the population, with a special focus on the geographic areas that are lagging behind the national average.
- The Philippines developed a training package to support implementation of the new essential intrapartum and newborn care protocol, with an accompanying social marketing campaign called "Unang Yakap".
- Togo has initiated the development of MDSR and has implemented information, education and communication activities, as well as behaviour change communication, to promote usage of maternal, newborn and child health services.

Figure 3.1: Number of countries reporting that H4+ was instrumental in changing national RMNCH policies or catalysing transformational national RMNCH programmes, 2014



* HIV, malaria and RMNCH integration
Source: Analysis of data from 2015 H4+ survey.

Area 2: Developing and costing national health plans and mobilizing resources

In September 2014, the World Bank Group and the governments of Canada, Norway and the United States of America announced the creation of the Global Financing Facility (GFF) in support of Every Woman Every Child. The aim of the GFF is to support the acceleration of efforts to end preventable maternal, newborn, child and adolescent deaths, and improve the health and quality of life of women, children and adolescents in line with Sustainable Development Goal (SDG) targets and the updated Global Strategy for Women's, Children's, and Adolescents' Health.

The GFF brings partners together to provide smart, large-scale and sustainable financing to achieve and measure reproductive, maternal, newborn, child and adolescent health results at the country level. An "investment case" is at the core of GFF country financing. The objective is to have a nationwide, evidence-based, prioritized plan with a clear focus on results that both guides and attracts additional financing from the entire set of GFF partners (including national governments) over a three- to five-year period.

At the level of global coordination, the H4+ has been an active leader in the development of the technical contents of the concept note and the business plan for the GFF. A key role for H4+ at the country level will be to provide technical assistance for the development, implementation and monitoring of the investment cases. Optimizing use of these funds at the country level requires rigorously developed and costed national health plans as well as effective coordination of partners to ensure alignment to national RMNCH plans; the H4+ has previously supported countries in both respects.

In 2014, H4+ support enabled multiple countries to develop or cost national health plans that responded to needs in a variety of RMNCH-related areas. Many aimed to strengthen RMNCH systems broadly, such as Sierra Leone, where H4+ played a key role in helping the Ministry of Health and Sanitation develop a costed national health system strengthening plan. Others focused more specifically on plans for particular areas, often targeting newborn health and survival or the midwifery workforce. For example, Burkina Faso and Madagascar costed roadmaps for maternal and newborn health, and maternal, newborn and infant mortality reduction, respectively. Several countries focused on sexual and reproductive health (SRH), such as Lesotho, which drafted a national SRH strategic plan, and Haiti, which costed their reproductive health plan. Guinea developed a midwifery workforce assessment to guide their human resources for health policies and strategies. Regarding the process through which H4+ influenced national RMNCH plans, Zimbabwe emphasized the importance of H4+'s "catalytic nature of support and upstream policy work".

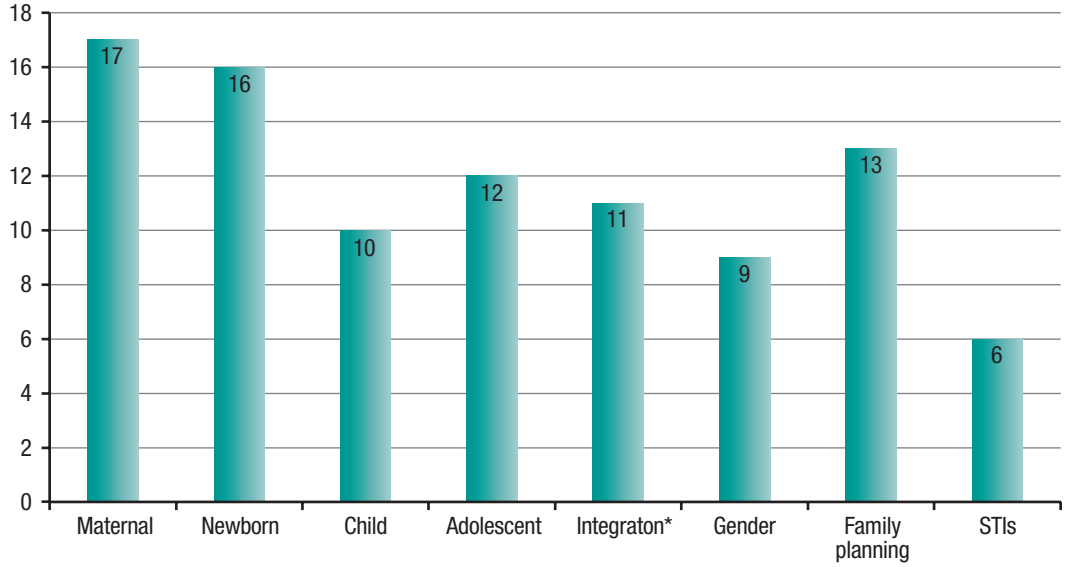
Survey results indicate that H4+ also played a catalytic role in bringing together stakeholders and harmonizing their approaches. In total, 25 of the 38 respondent countries reported that H4+ helped to effectively coordinate RMNCH partners and strengthen alignment with national RMNCH plans (see Figure 3.2). They described numerous ways in which H4+ facilitated coordination – particularly by convening regular technical and financial partner meetings – and reduced duplication of efforts. Specific examples include:

- Guinea-Bissau's and Haiti's H4+ teams expanded their quarterly meetings to include other development partners in order to harmonize approaches and strengthen complementarity of interventions for specific RMNCH issues.
- Mozambique aligned plans and key strategies between UN agencies, the United States Agency for International Development (USAID) and other development partners in the areas of SRH, newborn health, adolescent health, malaria programmes and service delivery.
- Somalia holds weekly reproductive, maternal and newborn health working group meetings, as well as child health and gender working group meetings.

Area 3: Improving quality and scaling up delivery of health services

As a critical step towards equitably enhancing standards of quality with regard to RMNCH services, many countries drew upon H4+ support to update standards of care and health service guidelines in 2014. Specifically, 22 countries reported developing and disseminating new guidelines on a wide variety of RMNCH topics, including midwifery standards, antenatal care, EENC, PMTCT,

Figure 3.2: Number of H4+ countries supported to effectively coordinate RMNCH partners and strengthen alignment with national RMNCH plans, 2014



* HIV, malaria and RMNCH integration
Source: Analysis of data from 2015 H4+ survey.

HIV and antiretroviral therapy, and family planning. India and Mozambique provide two notable examples of efforts to improve the quality of maternal health services:

- India issued numerous maternal health-related guidelines, ranging from calcium supplementation in pregnancy and management of gestational diabetes to kangaroo mother care.
- Mozambique updated standards of care to include use of misoprostol (for preventing and treating postpartum haemorrhage) at health units, as well as in the community by traditional birth attendants and community health workers.

Frequently, new guidelines and standards of care supported broader efforts to scale up integrated service delivery packages, as shown by these examples:

- Tajikistan developed guidelines for health workers and other key service providers in the paediatric AIDS programme relating to the provision of psychosocial support for children living with HIV, and their caretakers.
- Ethiopia developed content for a community-level training course for health extension workers that integrated material on GBV, gender and prevention and management of sexually transmitted infections (STIs) into broader training curricula on maternal health topics.

To enhance scale-up by promoting widespread uptake of improved RMNCH guidelines and standards of care, several countries developed pocket-guides to give health-care providers and practitioners key information in a convenient format. Pocket-guide topics included maternal and newborn health, and provision of hospital care for children.

Many countries also reported utilizing H4+ assistance to increase access to the materials needed to scale up services, particularly vaccines and other essential RMNCH commodities, as well as HIV and STI-related medicines and supplies. Notably, Sierra Leone received assistance with maintaining access to RMNCH supplies during the Ebola Virus Disease (EVD) outbreak (see Box 3.1). Other examples include:

- Cameroon was provided with the test reagents and drugs needed for PMTCT of HIV and to ensure safe blood transfusions.
- Indonesia increased access to HIV and syphilis tests for pregnant women, and also created a programme modelling supply chain management in several provinces to eliminate drug stock-outs at service delivery points.

Box 3.1: Ensuring access to RMNCH commodities during the Ebola Virus Disease (EVD) outbreak in Sierra Leone

Following the EVD outbreak, Sierra Leone's commodity supply chain was overwhelmed and all focus shifted to Ebola response items. In the midst of this disruption, the H4+ team advocated for the continued distribution of RMNCH supplies and ensured that they remained a priority. The team also worked to integrate RMNCH supplies into Sierra Leone's Free Health Care initiative. Additionally, all essential RMNCH medicines were included in the country's recently updated essential medicines list.

Area 4: Addressing the urgent need for skilled health workers

Reflecting the critical and widespread need for a well trained health services workforce, countries implemented numerous skill-building and health-care education initiatives in 2014. Overall, 21 countries indicated that they had initiated training programmes with assistance from H4+ to increase the number and quality of skilled health workers. Table 3.1 provides examples of the types of activities conducted, using information selected from four H4+ countries. Like those featured in Table 3.1, many other countries implemented training courses on basic emergency obstetric and newborn care (BEmONC), essential newborn actions (ENA), maternal death audits, integrated management of childhood illness (IMCI), and HIV prevention and treatment services.

Responses also demonstrated that countries are increasingly using the H4+ partnership to improve RMNCH services through the improvement of the capacity and quality of training institutions, and the expansion of their cadres of trained midwives, community health workers and health advocates. For example, Somalia established 11 midwifery schools across the three zones of the country. And, as summarized in Table 3.1, Cameroon's midwifery schools are currently training 250 students and produced 183 graduates in 2014.

Table 3.1: Key skill development activities for four H4+ countries, 2014

Country	Skill development activities
Burkina Faso	• 147 health-care providers trained on BEmONC • 40 doctors trained in essential surgery • 893 community health workers trained on IMCI • 180 health-care providers trained on ENA
Cameroon	• 100 health-care providers trained on BEmONC and ENA • 91 health workers trained in IMCI • 433 midwives formally trained or in training
Ethiopia	• 1215 midwives trained, including 455 in gender and responding to GBV
Togo	• 240 midwives and birth attendants at BEmONC sites trained in patient admission procedures • 28 hospitals are now prepared to conduct maternal death audits • 88 health-care providers trained in responding to GBV and care of victims of violence
Zimbabwe	• 317 health workers trained on BEmONC • 371 health workers trained on infant and young child feeding • 589 health workers trained on HIV prevention and treatment services for mothers, newborns and children • 60 community-based advocates trained to sensitize communities on sexual and reproductive health and rights issues

BEmONC: basic emergency obstetric and newborn care; ENA: essential newborn actions; GBV: gender-based violence; IMCI: integrated management of childhood illness.
Source: Country responses to the 2015 H4+ survey.

Area 5: Innovating to overcome barriers that restrict access to RMNCH services

Even with RMNCH services in place, generating and sustaining demand for these services poses a challenge to many countries. Innovation is required to identify creative solutions through which health programmes can connect with hard-to-reach populations, which often include marginalized and especially vulnerable groups and individuals. In 2014, H4+ supported 22 countries in implementing and documenting innovations in RMNCH and community engagement. Countries relied on innovation to encourage and improve access to family planning and maternal health services. Other areas of focus included expanding access to HIV testing, treatment and prevention; building the skills of community health workers to respond to obstetric emergencies and provide care for newborns; and making reproductive health services for adolescents more accessible.

Increasingly, countries are harnessing the power of new technologies and communication channels to address barriers to access, especially for the marginalized and most vulnerable. These technological innovations cannot replace high-quality service provision and evidence-based interventions, but they can help to overcome some significant barriers. Box 3.2 describes ways countries are currently using mobile phones to disseminate information and promote service utilization. Other examples of technological innovations supported by H4+ include:

- The Lao People's Democratic Republic developed systems for web-based cold chain information and vaccine stock management, and began implementation of the DHIS 2 health management information system.
- Zimbabwe implemented use of improved CD4 count testing technology for earlier detection and treatment of HIV/AIDS, and used social media to disseminate information on SRH to young people.

In addition to technology-based strategies, countries reported widespread use of community engagement methods to reduce barriers to accessing services. Many involved efforts to expand demand for services by engaging community leaders and men (husbands/partners). For example, Lesotho held an orientation meeting for traditional community leaders on maternal health, and Congo documented their "husbands' school" strategy for engaging men. Somalia disseminated messages on family planning through dramas held during ceremonies. Several countries also reported strategies to address physical barriers to access, such as mobile clinics, increased availability of contraceptives in local markets, and maternity waiting homes.

Box 3.2: Harnessing mobile phones for improved RMNCH

When asked about the use of innovations to address barriers to accessing services, multiple countries described the use of mobile and wireless technologies – or "mHealth" – to support the achievement of RMNCH health objectives and address a remarkable array of RMNCH challenges.

Mozambique's MoBIZ programme uses the power of mobile phone platforms to improve the SRH of the country's youth. This mHealth initiative builds on the country's long-standing national adolescent SRH programme, Geração Biz. It combines social marketing approaches with mobile technology to increase access to contraceptives in poor urban and peri-urban areas, and improves and sustains peer education networks by monitoring their performance in real time.

Other recent mHealth initiatives supported by H4+ partners include:

- Indonesia's Info Bidan – a mobile phone platform that builds midwives' counselling competencies;
- Zambia's Project Mwana – rapid SMS mobile technology for expediting transmission of infant HIV test results and follow-up with mother–baby pairs.

Area 6: Tackling root causes of mortality and morbidity

Countries reported several critical barriers to addressing the persistent inequities, gender inequality and marginalization that serve as root causes of persistently high levels of maternal, newborn, child and adolescent mortality and morbidity. Commonly mentioned sociocultural barriers included harmful social norms and religious value systems that placed women and girls in a subordinate position to men and perpetuated harmful practices such as GBV and child marriage, which directly impede access to RMNCH services. Reports from countries also emphasized structural barriers such as poor access to education, poverty and lack of economic opportunity, and legal systems that encoded socially prescribed power differentials. Countries with high burdens of HIV/AIDS reported that stigma against people living with HIV is also a major barrier.

To respond to these underlying sociocultural issues, several countries reported that, with H4+ support, they conducted exploratory investigations to inform policies and programmes related to these barriers. Notably, these included maternal death audits to better understand the critical factors leading to maternal mortality within the specific country context. Other exploratory strategies described included:

- Kenya held advocacy forums to explore social norms contributing to maternal mortality and morbidity, and conducted an adolescent needs assessment to inform their national comprehensive sexuality education curriculum.
- Viet Nam measured stigma and discrimination faced by people living with HIV, including stigma encountered by women in SRH care settings, and used the study results to advocate for a more enabling environment to promote service access for people living with HIV.

Additionally, H4+ assisted 22 countries with developing and conducting demand-creation activities for RMNCH services which were sensitive to the identified social norms and relevant structural barriers. At the community-level, activities described included sensitization, mobilization and advocacy. For example, Ethiopia trained women's association members in strategies for addressing social and structural barriers, and trained health managers in gender mainstreaming and addressing social norms in their areas of work. At the national level, efforts often involved bringing together high-level stakeholders to raise awareness about deeply rooted barriers and to leverage their political, financial and technical strengths in support of initiatives to address these barriers.

Reflecting the importance of improving adolescent SRH in order to address maternal and child mortality and morbidity, many countries reported updating SRH-related educational curricula to meet international guidelines, adapting these curricula to the local context and needs of adolescents, and extending coverage.

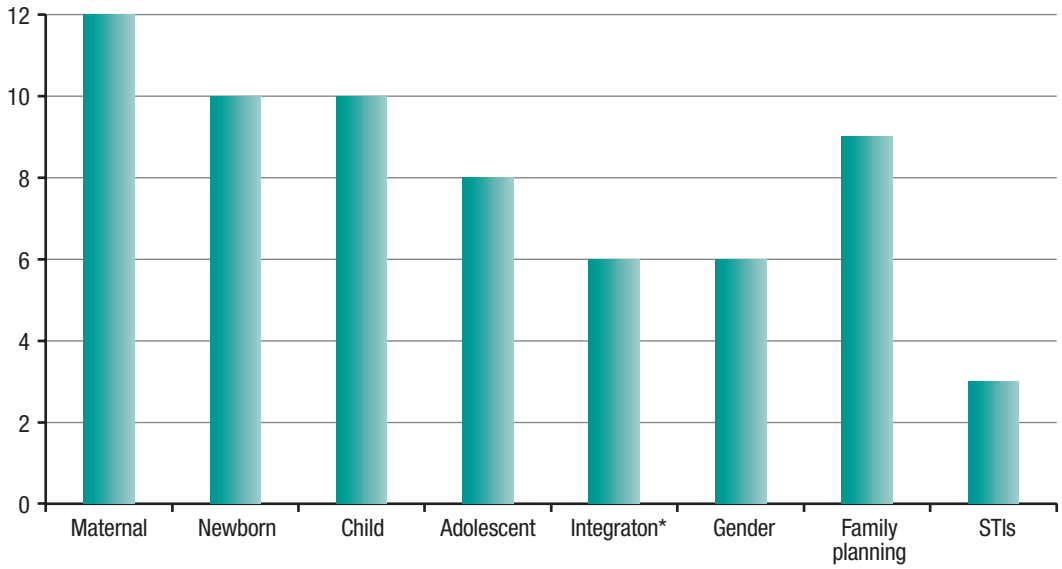
Notably, 28 countries reported that the H4+ mechanism had worked to integrate principles of gender equity and human rights into its programming, planning, coordination, monitoring or technical assistance in 2014. Examples of this integration supported by H4+ include:

- Liberia rolled out integration of gender mainstreaming strategies into all sexual health and RMNCH activities.
- Mozambique trained police officers on responding to reports of GBV.
- Swaziland integrated principles of gender equality and human rights into its national SRH policy, as well as all related strategies, training materials, guidelines and assessments.

Area 7: Ensuring availability of credible data

Supporting countries in strengthening monitoring and evaluation (M&E) systems to ensure availability of credible data is a core area of work for H4+. As detailed in Figure 3.3, 20 countries received H4+ support for routinely producing and reporting on internationally agreed RMNCH indicators. These included core indicators which were identified by the Commission on Information and Accountability for Women and Children's Health (COIA) as part of a larger framework in support of the Global Strategy working to ensure commitments to women's and children's health are kept and measured *(12)*. In preparation for 2015, a pivotal year for the global RMNCH community, many countries received support in 2014 for preparation of reports on the Millennium

Figure 3.3: Number of H4+ countries supported to routinely produce and report on internationally agreed RMNCH indicators, 2014



* HIV, malaria and RMNCH integration
Source: Analysis of data from 2015 H4+ survey.

Development Goals (MDGs), as well as reports related to their commitments to other global RMNCH initiatives such as Family Planning 2020 (FP2020) and the Global AIDS Response Progress Reporting (GARPR). Countries also reported having incorporated COIA indicators into their routine statistics. Both Uganda and Kenya drew on H4+ support to prepare RMNCH scorecards.

In 2014, countries made significant strides in developing and implementing new systems for tracking and reporting maternal and perinatal mortality. Eighteen countries reported strengthening or establishing maternal death surveillance and response (MDSR) systems, and 12 reported establishing such systems for newborn deaths. Specific examples include:

- Cameroon trained 199 service providers to implement maternal and newborn death reviews and surveillance.
- The Democratic Republic of the Congo developed guidelines for maternal, newborn and child deaths surveillance and response.
- India finalized guidelines for conducting maternal near-miss analysis, and drafted perinatal and newborn death audit guidelines.
- Morocco developed regional-level capacity for routinely conducting maternal death audits and the Ministry of Health produced two reports on the subject.
- Nigeria has increased the number of states conducting MDSR following the development of national guidelines and subsequent approval by the National Council on Health.

While these activities demonstrate the progress being made in relation to collection of credible data, countries also emphasized the need for continued progress in this area. They noted the importance of continuing to strengthen M&E systems, as well as processes for documenting lessons learnt and best practices.

Area 8: Documenting best practices, sharing knowledge and assessing H4+

Countries noted a variety of ways in which the added outputs and impact of the H4+ coordination mechanism were assessed in 2014. At the subnational level, H4+ supported documentation and dissemination of lessons learnt from specific programmes and activities. Examples include:

- Mongolia documented their Reaching Every District (RED) strategy, and has submitted results for dissemination at international conferences.
- Viet Nam documented and shared best practices in implementation, innovation, leadership and advocacy in RMNCH and supported two key health policy forums.

A number of countries reported holding regular regional- and national-level review meetings to share the findings from documentation and evaluations, and to facilitate their translation into programmes and policies. Box 3.3 provides an example of how findings from H4+-supported research informed a nationwide programme to increase facility-based delivery in Zambia.

In addition to documenting H4+ activities as described, many countries used national-level joint review meetings to assess the H4+ mechanism itself. Such meetings allowed sharing of knowledge and enabled H4+ agencies, government representatives and other development partners to streamline their agendas and reduce duplication of efforts.

Box 3.3: Translating evidence into policy and programming: Zambia's "mama kits"

In Zambia, H4+ funded a study in Chadiza and Serenje Districts to evaluate the impact of the "mama kits" or layettes (i.e. sets of clothing, bed linen and toiletries for newborns). These kits were introduced as non-monetary incentives with the intention of improving demand for institutional delivery. In light of evidence supporting the effectiveness of the kits as incentives, in 2014 the Ministry of Community Development and Mother and Child Health issued a policy statement instructing all districts to plan and budget for the procurement of mama kits to incentivize use of facility-based delivery services by pregnant women. The kits are provided to mothers upon delivery in a health-care facility and contain nappies, a *chitenge* (wrapper), a blanket, a baby vest, baby booties, baby lotion, a baby hat and baby soap.

Zambia's experience with the mama kits was documented at the global level and is now featured as one of five H4+ country innovation fact sheets.[6]

6 This factsheet is available at: http://www.everywomaneverychild.org/images/Zambia_H4_Fact_Sheet_r2.pdf

4. Value added by H4+, and next steps

The previous sections of this report have addressed the key activities that countries have carried out in 2014 across the eight areas of the H4+ Results Framework. The 2015 H4+ survey also provided an opportunity to gather country-level perspectives regarding how H4+ has functioned as a strategic and facilitative mechanism more broadly. Therefore, this section addresses the ways in which H4+ was perceived to have added value to existing systems, suggestions for how the mechanism could be further strengthened, and insights into the potential roles of the H4+ in the post-2015 era.

4.1 H4+ achievements

When reporting the main achievements of H4+ in 2014, countries highlighted outcomes at both the national and subnational levels. At the national level, countries emphasized the value of H4+'s role as a coordination mechanism for the six partner agencies, explaining that it:

- improved harmonization of stakeholder agendas, thereby turning potentially competitive organizational relationships into partnerships;
- reduced duplication of initiatives by H4+ partner agencies;
- "has been able to demonstrate that delivering as one UN is possible", as reported by the Democratic Republic of the Congo.

Countries reported that the mechanism facilitated stronger cooperation with national governments, exemplified by reports from the following countries:

- In Haiti, H4+ partners aligned themselves with the national reproductive health strategic plan and supported the costing of a maternal, newborn and child health strategic plan.
- In Uganda, H4+ promoted technical collaboration and implementation of joint projects, and also strengthened trust with government counterparts.

In addition to supporting countries to develop or revisit costed national plans and strategies for improving reproductive, maternal, newborn and child health (RMNCH), H4+ empowers countries to document their RMNCH priorities and progress towards achievement of the Millennium Development Goals (MDGs). Further, the focus of support is to incorporate evidence-based tools, including protocols and standards, into national guidelines to ensure full access to rights-based, quality information and services for women, children and adolescents in the area of RMNCH.

Finally, the H4+ was reported to be effective in maintaining and generating support and funding for RMNCH, through:

- facilitating external partner alignment with national RMNCH priorities;
- mobilizing increased resources from external partner organizations and the private sector by presenting coherent national strategies; and
- mobilizing increased domestic resources for RMNCH at national and subnational levels.

Specific examples provided include:

- In the Democratic Republic of the Congo, H4+ supported the creation of a domestic budget line for maternal and newborn health (MNH) at the provincial level, and an increase of the national budget line for RMNCH, and more specifically for family planning.
- In Kenya, high-level advocacy supported by H4+ generated private sector support and funding for RMNCH.
- In Nigeria, H4+ raised bilateral funding for maternal, newborn and child health initiatives.

Countries also noted high levels of activity at the subnational level, with H4+ support credited with achievements relating to country-specific RMNCH needs. Following are some examples:

- In all 10 H4+ Joint Programme countries, the capacities of health-care facilities were expanded for the provision of emergency obstetric and newborn care (EmONC), integrated management of newborn and child illnesses (IMNCI), and prevention of mother-to-child transmission (PMTCT) services.
- Gambia expanded coverage of prevention of mother-to-child transmission programmes to new areas.
- Guinea-Bissau implemented a free health care strategy for women and children under 5 years.
- Liberia conducted a supply-chain bottleneck analysis, reviewed RMNCH protocols and developed job aids.

The variability in these examples demonstrates H4+'s contribution to creating the infrastructure needed to channel funds to locally identified RMNCH priority areas.

4.2 Areas for improvement and challenges encountered

Countries identified areas for improvement that reflected the need to continue to build on the strengths of the H4+ mechanism described above. Where formalized H4+ coordination was not in place, partner agencies recognized the need for it. Where there was formal coordination, country teams recognized the benefits of a joint, funded workplan. Specifically, many countries mentioned the need for:

- continued improvement of coordination, particularly in those countries where joint workplans had not yet been developed;
- increased inclusion of external partner organizations, including civil society, throughout the agenda-setting and workplan development process;
- increased resource mobilization and expedited disbursement, in order to adequately fund jointly determined agendas;
- strengthened monitoring and evaluation, documentation and dissemination of best practices and lessons learnt;
- supported scale-up of successful RMNCH policies and programmes in order to achieve adequate reach and coverage.

Operational challenges encountered during 2014 both echoed the areas for improvement identified above and demonstrated the diverse and challenging contexts in which countries strive to improve RMNCH outcomes. Many countries commented on the challenge of being forced to choose among multiple pressing priorities due to budget limitations. Others mentioned the difficulties of bringing together a diverse range of stakeholders to initiate coordination. A significant subset of countries encountered disruptions of RMNCH activities due to political shifts and humanitarian crises. Many noted the constraints imposed by a lack of human resources qualified to provide RMNCH services, and the challenges of implementing and scaling up programmes in settings with limited infrastructure.

4.3 The road ahead

Following the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health in 2010, H4+ played an instrumental role in generating commitments to RMNCH improvement from countries. H4+ then leveraged the complementary strengths, competencies and technical expertise of its partner agencies to support countries in their efforts to fulfil those commitments.

In 2015, in preparation for the transition from the era of the MDGs to the era of the Sustainable Development Goals (SDGs) and the post-2015 development agenda, the updated Global Strategy for Women's, Children's, and Adolescents' Health will serve to build on the momentum of the MDGs and support countries to lead improvements in reproductive, maternal, newborn, child and

adolescent health (RMNCAH). The expansion of the updated Global Strategy to encompass adolescents as well as humanitarian settings presents opportunities to strengthen the role of H4+ and calls for the inclusion of new actors within the UN family to focus on this work.

By reducing fragmentation and synchronizing complementary mandates, H4+ strengthens UN partner agency effectiveness and allows them to "speak with one voice". Building on this experience in joint planning and the strength of interagency partnerships, the H4+ is well positioned to continue to serve as a mechanism for catalysing commitments to RMNCAH goals, to provide technical assistance and capacity-building to support countries in achieving those commitments, and to follow up with countries to promote learning and accountability. By first empowering governments to develop and cost strategic health plans, countries maintain ownership of subsequent programmes and initiatives as H4+ follows through with provision of technical support.

In the post-2015 development agenda, capitalizing on trusted relationships between the UN agencies and national governments, the H4+ can further promote evidence-based policies to tackle the root causes of maternal, newborn, child and adolescent mortality and morbidity, including gender inequalities and sociocultural and financial barriers. It can further intensify the work of addressing equity, quality, accountability and sustainability as proposed in the sustainable development agenda. The comparative advantage of each agency will ensure a multisectoral response to RMNCAH challenges, and their common focus on the most disadvantaged and vulnerable populations improves the health and well-being of those in greatest need. The technical leadership of each agency also ensures effective support for countries to plan and implement integrated strategies to improve RMNCAH, with a focus on universal rights to affordable, accessible, easily available, and quality RMNCAH services.

H4+ has long supported the development and costing of national health plans, built with context-specific priorities in mind and with a broad base of input and support towards building resilience in national health systems. By playing on its strengths in facilitating engagement with domestic and external partners, including development partners, H4+ can further stimulate resource mobilization around these national health plans. More specifically, H4+ can play a key role at the country level to provide technical assistance for the development, implementation and monitoring of RMNCAH investment cases.

The collective, collaborative and cooperative efforts of H4+ have already shown promising results in support of improved RMNCAH in many countries. However, post-2015, further commitments will be needed from countries and development partners to capitalize on the gains of this unique partnership and make a crucial contribution to the health of every woman, every child and every adolescent.

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Annex 1: Comparing H4+ activities in 2013 and 2014 in 21 countries responding to both surveys

To examine the trajectory of H4+ work over the past two years, a comparative analysis was conducted using data from the subgroup of 21 countries that reported their activities for both 2013 and 2014. This subgroup comprises the countries in the overlap between the 38 countries that completed the activities section of the recent 2015 H4+ survey (data for 2014), and the 35 countries that contributed data during the 2014 H4+ survey (data for 2013).

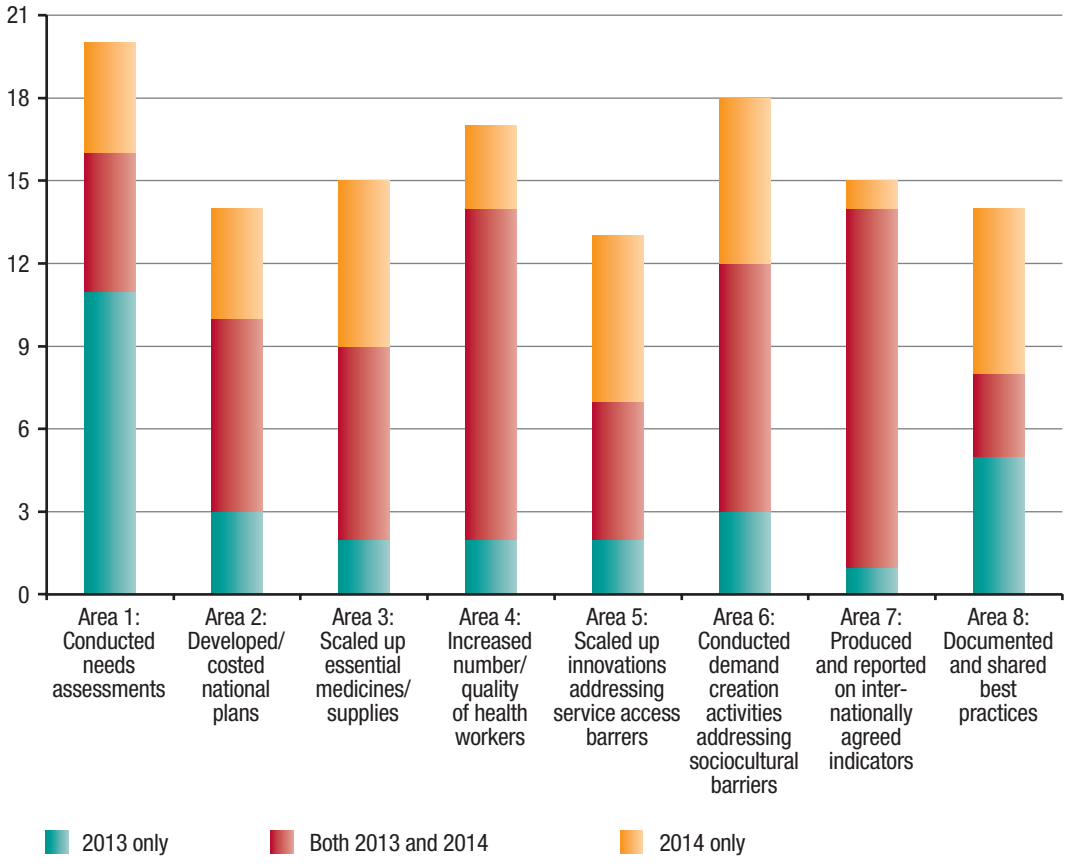
The following 21 countries were included in this analysis: Burkina Faso, Cameroon, Chad, Comoros, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea-Bissau, Haiti, Indonesia, Kenya, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Mongolia, Sierra Leone, Tajikistan, Viet Nam, Zambia and Zimbabwe.

The 2014 and 2015 H4+ surveys used identical wording to inquire about RMNCH activities implemented in each of the eight areas of work during the preceding year. This allowed for direct comparison of the reported 2013 activities and 2014 activities within this subgroup of 21 countries.

Figure A.1 below summarizes these comparisons for key activities across H4+'s eight areas of work. It displays the number of countries that reported implementing each activity, broken down by the number of countries that reported that activity in 2013 (green), in 2014 (orange), or in both years (red).

The most common activities reported by these 21 countries in 2013 (green and red sections) were: needs assessments (16 countries); increasing the number and quality of health workers (14 countries); conducting demand-creation activities to

Figure A.1: Countries reporting key H4+ supported activities across the eight areas of work during 2013 and 2014



Source: Analysis of data from 2014 and 2015 H4+ surveys.

address barriers (12 countries); and routinely producing and reporting on internationally agreed indicators (14 countries). Most countries reported continuing to implement these activities in 2014 (red and orange sections), with the exception of needs assessments, which were only conducted by 9 of the 21 countries in 2014 (this was the least common reported activity in 2014, along with documenting and sharing best practices, also reported by just 9 countries). Scaling up essential medicines and supplies replaced needs assessments in the list of the most common activities reported in 2014 (13 countries).

Looking at activities that countries reported implementing in 2014, but did not report in 2013 (orange sections), the activities where reported implementation increased the most were in areas 3, 5, 6 and 8 (see Figure A.1). Activities in these four areas were initiated by six countries each in 2014. Three of these areas of activities that increased substantially – scaling up essential medicines and supplies, scaling up innovations to address service access barriers, and documenting and sharing best practices – were those that the fewest countries reported implementing in 2013.

Since 2008, the H4+ partnership mechanism has supported technical collaboration aimed at improving reproductive, maternal, newborn and child health. While this analysis is limited to 21 countries and only looks at the two most recent years – the sixth and seventh years of the H4+'s existence – it shows a clear trend of continued, steady progress, and a logical maturation of country-level work. For example:

- The vast majority of activities that the countries implemented in 2013 were sustained in 2014, with the exception of needs assessments, which are not needed on a yearly basis.
- Countries' efforts to scale-up activities (areas 3 and 5) increased substantially in 2014.
- Newly initiated activities in 2014 were concentrated in areas where implementation was lowest in 2013.
- In all eight areas, over half, and in some cases nearly all, of the countries reported drawing on H4+ support to implement key activities during this two-year period.

Annex 2: Case studies

1. Liberia: H4+ response to the Ebola crisis

Overview

Liberia has a population of about 3.9 million and the H4+ Joint Programme has interventions in three counties that account for about 8% of the total population (Grand Kru, population 54 415; Maryland, 179 870; and River Gee, 78 469).

The focus of the H4+ work in these hard-to-reach counties is to support the country (in close collaboration with the Ministry of Health) in achieving MDG 5 and to contribute towards MDGs 4 and 6 by scaling up the implementation of evidence-based, high-impact sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) interventions through the continuum of care.

Originally, the plan was to introduce key results-oriented interventions (e.g. chlorhexidine for umbilical cord care and anti-shock garments for management of postpartum haemorrhage), to scale up high-impact interventions and to enhance the skill sets of key human resources.

However, the recent Ebola Virus Disease (EVD) outbreak necessitated a radical rethink of programming priorities. The outbreak began in Guinea in December 2013 and swept through Liberia beginning in March 2014, causing:

- the loss of 189 critical health workers and increased fear among surviving health workers, which forced complete closure of health-care facilities in most counties;
- a reduction in the number of well functioning health-care facilities that were able to provide maternal and child health services, including referral services for obstetric and neonatal complications;
- the increased likelihood of maternal and newborn morbidity and mortality and the increased risk of health worker exposure to Ebola-infected blood and body fluids during childbirth;
- the spread of misconceptions and fear, which significantly reduced utilization of health-care facilities and services by community members and increased mistrust of the health system;
- an increase in home deliveries and reduction in skilled birth attendance.

This combined with poverty, poor geographic access, poor logistical support, widespread gender-based violence (GBV) and other harmful traditional practices threatened to push already unacceptably high maternal and newborn morbidity and mortality completely out of control.

Accordingly, while the activities listed below were the major priorities for the H4+ team, circumstances unavoidably slowed both the rate and intensity of implementation of these activities. While the H4+ team was not on the front lines of the acute response to the EVD outbreak, the work of the H4+ partners was and continues to be critical to ensuring that the key SRMNCAH components of the health system that were ravaged by the outbreak can be repaired and strengthened.

These priorities have not changed, and indeed will be strengthened by the projected activities in the H4+ workplan for 2015–2016. As Liberia recovers from this significant shock, we anticipate that the rate and intensity of implementation of these activities will increase.

H4+ action at the country level in 2014

H4+ expanded its support to respond to EVD and improve SRMNCAH services in three additional counties (Gbarpolu, Grand Cape Mount and Rivercess) that were among those hardest hit by the EVD epidemic.

In all counties, H4+ support directly contributed to the following activities:

- RMNCH community health protocols, standards and guidelines were reviewed and revised.
- The national curriculum for pre-service midwifery schools was reviewed and updated.
- A plan for elimination of mother-to-child transmission (eMTCT) of HIV and syphilis was developed and validated.
- The skills of health-care providers were enhanced through the development of BEmONC and adolescent sexual and reproductive health (ASRH) training modules.
- Kangaroo mother care (KMC) units were established in three referral hospitals.
- The use of chlorhexidine for umbilical cord care was scaled up.
- Medical technology (drugs, medicines and supplies) was provided for both basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC) services in the identified health-care facilities in Gbarpolu, Grand Cape Mount and Rivercess counties.
- Community dialogue forums were introduced and peer-to-peer groups formed to address gender inequality.
- High frequency radios were provided and maintenance teams established in 18 health-care facilities to support referrals.

H4+ outputs in 2014

Maternal and newborn health (MNH) results:

- MNH protocols were reviewed and job aids developed.
- The maternal and newborn death surveillance and response protocol was developed and the case-based investigation form was updated.
- 200 community health volunteers were identified to provide community-level RMNCH services in the Gbarpolu, Grand Cape Mount and Rivercess counties.
- 72 skilled health workers were trained and mentored on provision of SRMNCAH services.
- 1800 pregnant women benefitted from postpartum family planning counselling.
- Neonatal sepsis was prevented in 180 newborns in part through the use of chlorhexidine for umbilical cord care.
- Use of a non-pneumatic anti-shock garment for management of postpartum haemorrhage played a key role in saving 22 mothers' lives.
- 11 newborn lives were saved in part through KMC.

Midwifery training results:

- 12 midwifery training schools across the country were equipped with essential teaching–learning aids.
- 21 nurse-tutors were trained on the use of teaching–learning aids provided by the programme.
- Standards for midwifery practice were developed for Liberia.

Supply chain, adolescents and media results:

- Stock-outs of SRMNCAH drugs and supplies were minimized in 83% of programme facilities.
- 26 adolescent peer groups were established in 26 catchment communities, and they provided peer-to-peer support, and conducted training on treatment adherence and awareness-raising activities on SRH issues and services.
- Journalists from one national and three community radio stations from the programme counties (two participants from National Radio, two from Grand Kru, three from Maryland and three from River Gee) were trained on SRMNCAH reportage (awareness-raising through radio broadcasting is ongoing).
- At the county and community levels, media networking was initiated on sensitizing women's and men's groups, with a specific focus on targeting male community leaders, individuals and families, to mitigate sociocultural barriers that restrict access to essential MNH services.

Looking forward

As the EVD outbreak is brought under control, and Liberia can turn its full attention towards the long road ahead to health system recovery, the H4+ team is a ready partner. Its 2015–2016 workplan is designed to help the country rebuild its SRMNCAH systems. Key priorities include strong support for the Ministry of Health's human resources plan, and attention to strengthening SRMNCAH service delivery to ensure adequate levels of drugs, commodities and related supplies. Work is scheduled to reinforce the referral system and the infrastructure (water and electricity) at service delivery sites to assure uninterrupted full-time operation.

These programmatic improvements, when combined with strengthened M&E capacity at the national and county levels, and with more prompt transfer of funds and programme implementation, as well as improved preparedness for emergencies, will prepare Liberia to face the challenges in the future.

2. Success in promoting gender equality: overview of integration of gender into RMNCAH programming through demand-creation interventions

A critical area of work for H4+ is to tackle the root causes of maternal, newborn and child mortality and morbidity, including gender inequality, low access to education (especially for girls), child marriage and adolescent pregnancy. H4+ recognizes that poor maternal health outcomes are often a result of gender inequality. Sociocultural beliefs and practices that discriminate against women – such as a lack of prioritization of women's health, limited access to financial resources and restricted individual autonomy – can have limiting effects on women's access to health care. Similarly, harmful traditional practices such as female genital mutilation (FGM) and child marriage have detrimental effects on children's, adolescents' and women's health. Recognizing the implications of gender inequality for reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcomes, H4+ programming takes an active approach on the supply side (health systems and inputs) as well as the demand side (community engagement, health seeking behaviour, women's empowerment) to implement gender-responsive interventions and pursue improved RMNCAH outcomes.

In 2014, amongst all countries with H4+ joint teams, 30 countries reported that they have included gender integration into RMNCAH programming and 24 reported specific results related to gender integration. Five countries conducted needs assessments related to gender and 44% of H4+ joint teams included UN Women. In addition, 17 countries reported interventions focused on structural barriers to RMNCAH services and other barriers to access linked to social norms. Specific gender-related barriers documented by H4+ country teams included: lack of access to financial resources, social and cultural norms limiting women's mobility and decision-making abilities, health worker attitudes, low levels of literacy, gender-based violence, early marriage and FGM.

H4+ actions and outputs: addressing harmful gender norms to increase access to RMNCAH services

Twenty-two countries reported focusing activities at the country level on addressing demand-side barriers to increase service uptake, especially for marginalized and most vulnerable women and adolescents. Key strategies for this area are described below.

- **Mapping of community perceptions, resources and structures to understand their roles in health seeking behaviour.** Assessments were undertaken in Cameroon, Côte d'Ivoire, Liberia and Zimbabwe to better understand barriers restricting access to RMNCAH services – barriers related to gender inequality and sociocultural norms and practices – as experienced by women in the community and in health-care settings. These assessments documented and mapped issues of quality of care, client satisfaction with services, community structures, community knowledge and perceptions of health seeking behaviour, as well as linkages between violence against women and maternal health. Findings from the assessments have been utilized to develop targeted community engagement activities (such as women's forums and men's forums and media campaigns) and messages focused on gaps in knowledge and prevalent harmful norms and practices.
- **Awareness raising, dialogue creation and knowledge building within communities around RMNCAH and sexual and reproductive health services.** Radio and social media programmes in Cameroon, Côte d'Ivoire and Liberia have shown significant results in increasing awareness of the importance of uptake of RMNCAH services, as well as opening up critical discussions about gender roles in the process of health-related decision-making in households.
- **Strengthening of community participation and leadership in health sector decision-making platforms.** In Zimbabwe, 121 community groups and 29 men's and women's forums met to collectively prioritize critical issues which represent barriers to RMNCAH services and to create spaces for discussions about harmful practices and specific needs. Examples of issues highlighted include staff shortages at health-care facilities and commodity stock-outs. These community forums involved 2628 people. In Côte d'Ivoire, 45 local committees were created to address harmful social and cultural practices. In Cameroon, 343 health committee members concerned with assessment of the quality of health services, focused on provision of rights-based care.
- **Build capacity of community health workers (CHWs) and facilitators.** The development of gender-sensitivity training curricula for ministry of health staff, CHWs and community organization members has been accomplished through the H4+ partnership. In Ethiopia, 228 government officials and CHWs were trained.

Looking forward: policy implications for ensuring gender-responsive service delivery

Evidence generated from catalytic work produced through the H4+ partnership must focus on addressing harmful gender norms. Community systems strengthening highlights interventions that can be further scaled up, evaluated and incorporated into national RMNCAH plans.

3. Strengthening H4+ support for realizing the health and well-being of adolescents

Background and health challenges faced by adolescents

The inclusion of adolescent health in the UN Secretary-General's updated Global Strategy for Women's and Children's Health represents an unprecedented opportunity to increase efforts to ensure that every adolescent has the knowledge, skills and opportunities for a healthy and productive life, and enjoyment of all human rights.

Adolescents can be key drivers of positive change for themselves, their communities and the broader society. At the same time adolescence represents a critical stage of life characterized by rapid biological, emotional and social developments that expose girls and boys to various risks. In 2012, an estimated 1.3 million adolescents died from preventable or treatable causes,[7] and girls are particularly vulnerable during this period of life. Every day in developing countries, 20 000 girls under the age of 18 give birth, putting them at risk of death and injury, including conditions such as obstetric fistula.[8] Maternal mortality is the second leading cause of death among adolescent girls aged 15–19 years.[9] Worldwide, up to 50% of sexual assaults are committed against girls under 16,[10] and some 30% of girls aged 15–19 experience violence by a partner.[11]

Health and well-being of adolescents depend on multiple factors, including economic (poverty, inequality), sociocultural (gender, early marriage), biological (e.g. prevalence of malaria, water-borne helminths, HIV), physical and environmental (e.g. road conditions, housing, pollution) factors, and thus require a multisectoral approach. Three key interventions are vitally important to facilitate a healthy transition from adolescence to adulthood: health education; access to health services; and policy interventions for a supportive environment at home, in communities and countries.[12]

H4+ action at the country level in 2014

To ensure adolescents have a voice, choice and control over their own bodies and are enabled to develop the capabilities required for a productive, healthy and satisfying life, the H4+ partnership supports adolescent health interventions in several countries. H4+ support for adolescent health consists of technical and coordination support for the development or revision of:

- needs assessments on sexual and reproductive health and rights (SRHR) of adolescents and youths;
- adolescent health plans, strategies and legal frameworks;
- sexual and reproductive health (SRH) guidelines and their dissemination; and
- comprehensive sexuality education (CSE) curriculum and modules.

For example, in Burundi, the H4+ team has supported the Ministry of Health to conduct an assessment of the reproductive health (RH) needs of adolescents and young people; it has contributed to the development of the National Strategy for Adolescent Health and the Youth-Friendly Services National Policy; and it has disseminated guidelines for RH services for adolescents and youths. In Indonesia, H4+ has supported the development of the National Action Plan for School-Age and Adolescent Health 2015–2019, and the development and dissemination of the National Standards of Adolescent-Friendly Health Services. In Viet Nam, H4+ has dedicated specific funds to support the development of SRH services for adolescents and youths in various regions of the country, and it has contributed to the monitoring of the quality of sexuality education in schools. Finally, with the support of H4+ Canada funds, the H4+ team in Zimbabwe has supported a study on pregnancies among adolescent girls; the resulting data will be used to guide SRH interventions for adolescents and youths.[13]

7 Adolescents: health risks and solutions. WHO fact sheet No. 345. Geneva: World Health Organization; updated May 2014.

8 State of world population 2013 – motherhood in childhood: facing the challenge of adolescent pregnancy. United Nations Population Fund; 2013 (http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf, accessed 28 May 2015).

9 Ibid.

10 UNFPA and young people: imagine. New York (NY): United Nations Population Fund; 2003.

11 Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.

12 Expert Consultative Group for EWEC on Adolescent Health. Realizing the health and well-being of adolescents. Every Woman Every Child (EWEC) Technical Content Workstream Working Paper on Adolescent Health. United Nations; 2015 (in progress).

13 2015 H4+ survey results as reported in this H4+ progress report 2014.

Looking forward

As the Global Strategy for Women's, Children's, and Adolescents' Health is being finalized and its five-year implementation plan developed, the H4+ teams around the world aim to further support governments in addressing the major health problems faced by adolescents, including injuries and violence, mental health and self-harm, communicable and noncommunicable diseases, and maternal mortality and morbidity.

In line with its vision, the H4+ partnership focuses on improving the health and well-being of the most disadvantaged and vulnerable populations and it can play a critical role in identifying those adolescents who are the most vulnerable. H4+ can also leverage the comparative advantage of each agency to improve adolescent health in countries and can work with the national governments to ensure a multisectoral response beyond the health sector. This response should include:

i. Health interventions, such as: health education (including CSE); access to and utilization of integrated health services (especially SRH services); immunizations (human papillomavirus [HPV], tetanus booster, rubella, hepatitis B, measles); medical and psychological support for mental health problems and violence; and nutritional supplementation.

ii. Non-health interventions, such as: quality education and schooling at least through secondary level; safe water and sanitation; opportunities for physical activity; training in livelihood and employment skills; elimination of child marriage and female genital mutilation/cutting; participation in decision-making and political process; and social protection.

iii. Policies and laws protecting adolescents, such as: ensuring access to quality, private and confidential SRH care; enact and enforce tobacco, alcohol, illegal substance abuse and food policies to reduce adolescents' exposure to dangerous and unhealthy substances; set the minimum age of marriage to 18 years; and strengthen data collection and analysis relating to adolescents for evidence-based policy formulation and programme delivery.

Acknowledgements

The H4+ Global Team, composed of representatives from UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank, gratefully acknowledges its colleagues in the following countries: Afghanistan, Angola, Benin, Bolivia, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Comoros, Congo, the Democratic Republic of the Congo, Côte d'Ivoire, Egypt, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Kenya, Democratic People's Republic of Korea, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Niger, Nigeria, Papua New Guinea, Philippines, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Somalia, South Sudan, Sri Lanka, Sudan, Swaziland, Tajikistan, Togo, Uganda, Uzbekistan, Viet Nam, Zambia and Zimbabwe for completing the 2015 H4+ online survey and sharing insights on value addition, challenges, and lesson learnt from H4+ coordination mechanisms.

This report was coordinated and compiled by the World Health Organization and the United Nations Population Fund, under the guidance of Lale Say and Laura Laski. Lianne Gonsalves (WHO) led the development of the report with Jean-Pierre Monet (UNFPA). The writer for the report was Elena Broaddus. Jane Patten and Christel Chater from Green Ink were responsible for editing and layout, respectively.

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