ACCELERATING IMPLEMENTATION OF THE INVESTMENT CASE FOR MATERNAL, NEWBORN AND CHILD HEALTH IN BANGLADESH, NEPAL, INDONESIA AND THE PHILIPPINES

REGION: ASIA AND THE PACIFIC
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GLOSSARY/ACRONYMS

AusAID Australian Agency for International Development
BRAC Bangladesh Rural Advancement Committee
CHO City Health Office
CPDO City and the Planning and Development Office
DFAT Department of Foreign Affairs and Trade
DHSS District health systems strengthening
DoH Department of Health
DP Development partners
DTPS District Team Problem Solving
EAPR East Asia and the Pacific Region (UNICEF)
EBP Evidence-based planning
EPI Expanded program on immunisation
HMIS Health management information system
HSS Health systems strengthening
IC Investment case
IHE Bangladesh Institute of Health Economics
IMP Integrated micro-planning
LLP Local level planning
LMIC Low- and middle-income countries
MNCH Maternal, newborn and child health
MoH/MoHFW Ministry of Health/and Family Welfare
PSC Project Steering Committee
TST Technical support team
UGM Universitas Gajah Mada
UHC Universal health coverage
UN United Nations
UNICEF United Nations Children's Fund
UQc University of Queensland Consortium
VDC Village development committee

CERTIFICATION

UNICEF certifies that this Activity Completion Report has been completed in accordance with the relevant guideline from DFAT Australia.

Currency conversions are described within the text where relevant.
In mid-2011 the Australian government funded a second project focusing on creating an investment case (IC) for maternal, newborn and child health (MNCH). The project closed in December 2014, after two no-cost extensions. The objective was to raise the profile of MNCH in the planning and budgeting processes of health and non-health authorities at sub-national level, with a view to improving related fund allocation and service delivery, and in the medium-term, health outcomes. The approach advocated a marked increase in the capacity of governments to: (i) document the extent to which related indicators are equitably distributed; (ii) identify constraints hampering the scale-up of cost-effective MNCH interventions; (iii) design and evaluate interventions/strategies addressing those constraints, and (iv) estimate the expected impact and costs associated with the strategies proposed. The project initially considered providing support in up to 11 countries in South and East Asia, but ultimately focused on four countries - Nepal, Bangladesh, Indonesia and the Philippines – along with small scale work in one state of India. In addition to the above four areas of focus, the project included national advocacy for MNCH, improved planning, budgeting and monitoring and evaluating the use of public funds for MNCH, through various studies and higher level work with central planning and finance authorities in all countries.

The project trajectory varied widely, with Nepal successfully completing pilots in five of 75 national districts and establishing a district IC process in a further 15 districts by 2014. In Indonesia, after much deliberation, the project was located in remote but semi-autonomous Papua Province, where the project also phased in evidence-based planning (EBP) in ten districts over three years, and established a provincial level technical support team that continues to expand the concept in three new districts in 2015, with local funding. In the Philippines, from 2013, three local government units took on EBP to identify areas of MNCH priority (for example, in Davao the focus was on child nutrition), with good leverage of local funding and newly established capacity among teams of EBP specialists. In Manila, meanwhile, evidence and planning were used to redesign the child-health benefit package of the national insurer, PhilHealth, and the content of a new package of support for newborn health. EBP was also introduced into new planning guidelines for city and province health authorities, and into the training of all new Mayors, widely expanding the concept beyond the health sector. In centralised Bangladesh, three districts are piloting local-level planning using an EBP and bottleneck analysis approach, and the project has embedded EBP in 11 other districts using other resources, expanding their initial focus on immunisation to include MNCH. In addition, in Indonesia the project also supported studies of health expenditure tracking and district team problem solving (DTPS), and in all four countries a political economy analysis underscored the broader political and financing context applying to support for MNCH, and for the project’s engagement of national authorities in each.

The IC project’s major goal was to leverage funding for and attention to MNCH at sub-national and national levels in each of the four countries, using locally-owned and generated data to highlight problems and find solutions. While there were encouraging indications of fund leverage in all pilot districts and beyond, the project was too short and country reporting systems too weak to verify increased MNCH resource allocation over secular increases. Certainly other large scale benefits were yielded by the IC approach, both financially (the Philippines insurance allocation; local- and donor-funded expansion of the EBP approach in all countries) and conceptually (in terms of heightened awareness of the benefit of using data for planning; of engaging sub-national stakeholders in prioritisation; of monitoring and evaluation at sub-national level etc.). These successes were all verified independently by an external evaluator who tracked the project from 2012-2014.
ACTIVITY SUMMARY

1. Summary data

Project title:
Accelerating the Implementation of the Investment Case (IC) for Maternal, Newborn and Child Health (MNCH) in Asia and the Pacific.

Implementation period:
Initially funded form June 2011 to June 2013, extended to June 2014 in four countries, Indonesia, Nepal, Bangladesh and India, and to December 2014 in the Philippines.

Funding:
Fully utilised. Separate funds were provided to the University of Queensland Consortium (UQc) for activities to support field implementation of the work.

Brief description:
The project followed earlier DFAT (formerly AusAID) and UNICEF support for the IC approach during 2008-2011. The immediate purpose at inception was to influence progress on the Millennium Development Goal 4 and 5 targets on child mortality and maternal health, by increasing coverage of MNCH services and improving quality of care and related policies. The longer-term goal was to provide policymakers and planners with a systematic approach to problems in MNCH, and to producing evidence to: (i) document the extent to which related variables are equitably distributed; (ii) underline constraints hampering the scale-up of cost-effective MNCH interventions; (iii) facilitate design and evaluation of interventions/strategies addressing those constraints, and (iv) estimate the expected mortality impact and costs associated with implementing the strategies proposed. Results were expected to influence the process of prioritisation, planning and budgeting in-country, especially at sub-national levels, by involving local decision-makers throughout the analysis and identification of solutions. The project goal evolved during its implementation in the four countries, with a decrease in the focus on modelling of impact and costing and greater attention to data quality and the broader context of MNCH and health prioritisation and financing.

Project geographic focus:
This evolved from a putative group of 11 nations in South and East Asia to seven in September 2011 and finally five countries – Bangladesh, India, Nepal, Indonesia and the Philippines – by mid-2012.

Activity location:
In each country the project was coordinated at national level and implemented in three or more pilot sub-national locations (Figure 1), except for the small scale activity in India that was confined to a single state, Madhya Pradesh.

The aid modality:
was a simple disbursement through UNICEF headquarters in New York, USA. It did not involve substantive channelling of DFAT funds through partner government financial or procurement systems, and project funds were not pooled with other donor resources. UNICEF partnered with national and sub-national government counterparts, and provided funding for local government and academic partners to implement activities, as agreed in country. UNICEF and the UQc agreed, planned and supported activities with domestic counterparts during each year of project implementation.

Project governance:
The work was overseen by a Project Steering Committee (PSC) comprising UNICEF, DFAT and UQc. Six-monthly progress reports were submitted to the donor, and PSC meetings were held approximately 6-monthly until early 2013, and once more in September 2014. External experts involved in the earlier IC work participated in the initial PSC meetings.

2. Activity description

Project rationale: The IC was conceived as an approach to improving MNCH outcomes at national and sub-national levels. It involves the gathering of data and analysis of key indicators to inform planning, budgeting, policy and action, and calculation of the costs and benefits of high impact interventions affecting MNCH and nutrition. It focuses on key health and nutrition problems among the most vulnerable children and families and identifies systemic bottlenecks and barriers that contribute to this vulnerability (using the Tanahashi model), and specific strategies to overcome them. Data analysis occurs first at district level, with potential benefits arising both by improving the quality, foundation of and capacity for decision-making, and through reorienting the delivery of services. Some iterations of the IC approach involved use of a detailed budgeting tool to calculate the marginal (extra) funds required to overcome these bottlenecks. By synthesizing several district analyses, there is potential for beneficial impact on policy and programme design at national level. The analyses are also expected to guide the allocation of budgets and priorities of national and international partners, and to eventually be reflected in actual implementation (e.g. increased expenditure and actions for prioritized populations, interventions and strategies). In the rationale for the approach, implementation of these strategies resolves the bottlenecks that result in MNCH disparities, increases the level and equity of intervention

1 UQ Consortium is led by the University of Queensland, and involves the Nossal Institute for Global Health, and COMPASS (University of Melbourne’s Centre for International Child Health, Menzies School of Health Research, and Burnett Institute’s Centre for International Health).

coverage, and thus decreases child and maternal mortality, morbidity and malnutrition. While these broad steps underwrite the logic of the IC approach, in practice, they are not necessarily conducted in a linear fashion; the steps feed into each other and may overlap or occur in parallel.

The project approach was refined following reviews of IC work supported by DFAT and other donors in a number of countries during 2008-11. In addition, use of the budgeting tool mentioned above was reconsidered, based on interagency and expert discussion of the various options for this budgeting in 2011, and on consideration of local government reaction to pilots involving use of the tool in 2008-11. As a result, this project refocused on improving and using evidence at district level to inform planning and budgeting; modelling and costing tools were not central to the project’s approach. Indeed, to differentiate this project from the earlier work, use of the term IC was replaced in project communications by “evidence-based planning” (EBP) in Indonesia and the Philippines and “local level planning” in Bangladesh. In addition, during this project UNICEF country offices increased their engagement of national authorities, to better understand the context and the relationships between national and subnational stakeholders, and build capacity for applying the project approach at both levels.

Project countries and pilot locations were pared down and revised during 2011-12. Putative IC work in Pakistan, Sri Lanka, Timor Leste, Laos, Papua New Guinea and Vanuatu was dropped due to competing priorities and technical and political considerations. Baseline IC-type analysis was undertaken in Madhya Pradesh in India, but the full IC approach has not been implemented, and the analysis will instead be used to influence state planning similar to a traditional report, and as a contribution to national and regional knowledge on MNCH. In the remaining four countries, selection of final districts for piloting the EBP approach was undertaken in 2012. As mapped above, activities were piloted at district level in order to assess the impact of EBP on MNCH outputs as well as local prioritisation, planning and budget allocations.

Activities were phased into new districts in sequence. In each country, activities occurred in a sequence that involved: (i) baseline analysis using local data gathered under supervision, according to the IC methodology, (ii) identification of areas of poor MNCH performance and priority interventions, (iii) implementation of those interventions and (iv) evaluation of outputs and outcomes, also under supervision. In parallel, in each country national-level advocacy for and contextualisation of the IC approach was undertaken, with a view to sustaining and replicating the approach according to local capacity and need. An overview of activities in the four countries is provided in Table 1.
Table 1: Overview of activities undertaken in four IC countries: 2012-2014

<table>
<thead>
<tr>
<th>Country</th>
<th>Level</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepal</td>
<td>National</td>
<td>Engage national partners</td>
<td>MoH engagement and approval of district plans</td>
<td>Expand knowledge of and commitment to the IC approach at national level</td>
</tr>
<tr>
<td>Sub-national</td>
<td>5-district IC pilot</td>
<td>Expand to 8 new districts</td>
<td>Expand to 7 more districts</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>National</td>
<td>Advocacy of LLP</td>
<td>Tools and training devt</td>
<td>Call to Action advocacy</td>
</tr>
<tr>
<td>Sub-national</td>
<td>Foundation activities on LLP &amp; design of HMIS strengthening</td>
<td>3-district IC pilot, then an EPI-focused pilot in 11 districts and 2 Cities</td>
<td>Engagement with UN MNCH agencies to expand IC approach</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>National</td>
<td>National advocacy on IC strategy</td>
<td>DTPS Review</td>
<td>Web-site and video dissemination</td>
</tr>
<tr>
<td>Sub-national</td>
<td>3 Papua district pilots</td>
<td>Expand to 4 new Papua districts</td>
<td>Expand to 3 more Papua districts</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>National</td>
<td>Review of previous IC work and decisions on approach</td>
<td>PhilHealth child package work Newborn health package Mayoral training Planning guideline upgrade</td>
<td></td>
</tr>
<tr>
<td>Sub-national</td>
<td>Davao EBP work Quezon City EBP work</td>
<td>Puerto Princesa EBP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As mentioned, taking local context into account, in each country certain national-level activities were also undertaken, both with project funds and other resources, to assess and influence the related policy environment. Examples included financial flow analysis in Indonesia, using evidence to influence social health insurance benefit packages in the Philippines, national support for local level planning (in partnership with other United Nations (UN) agencies) in Bangladesh and work to expand support for EBP beyond project pilot districts in Nepal. In addition, the national context was assessed in an analysis of the political economy of MNCH and health in all four countries in 2014.

The project was destined to succeed or fail on the basis of local relationships with key stakeholders, including government, local academia and development partners (DPs). In each country it was evident that the focus of the project on planning, budgeting and local engagement was also a priority for government and DPs. In Nepal and Bangladesh, the project coincided with major political upheavals but bipartisan political support for improving community-level MNCH. In the Philippines, the Aquino Health Agenda (emphasising “bottom-up budgeting” and decentralisation), and in Indonesia major reform of health financing and local (District Team Problem Solving - DTPS) and donor-funded (such as USAID’s Kinerja and UNDP’s Millennium Development Goals Acceleration Framework) approaches to strengthening local government planning and management capacity provided important context for this project. Local academia played a role in implementation, monitoring and evaluation, to a varying degree, in each of the four countries. Table 2 lists the key partners for project implementation in the four countries.
<table>
<thead>
<tr>
<th>Country</th>
<th>Level</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepal</td>
<td>National</td>
<td>Family Health Division, Dept of Health Services, MoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nepal Public Health Foundation (NPHA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Research and Social Development Forum</td>
</tr>
<tr>
<td></td>
<td>District</td>
<td>District Health Offices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>District Development Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Village Development Committees</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>National</td>
<td>Directorate of General of Health Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Institute of Health Economics (non-DFAT funded)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line Directors of Primary health care/MNCH, Health Information Systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Planning</td>
</tr>
<tr>
<td></td>
<td>District</td>
<td>District hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sub-district health complexes (Upazilas)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>National</td>
<td>National Development Planning Authority (Bappenas)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ministry of Health Department of Maternal Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Universitas Gadjah Mada (UGM)</td>
</tr>
<tr>
<td></td>
<td>Provinces/Districts</td>
<td>Province and 10 District Health &amp; Devt Offices (DHO/Bappeda)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>University of Cendrawasih</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jayapura Health Polytechnic / Papua Health Training Institute</td>
</tr>
<tr>
<td>Philippines</td>
<td>National</td>
<td>Department of Health - Bureau of Local Health Development and Family Health Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>University of the Philippines - National College of Public Administration and Governance - Centre for Leadership, Citizenship and Democracy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Philippine Health Insurance Corporation (PhilHealth)</td>
</tr>
<tr>
<td></td>
<td>District</td>
<td>Davao City Local Government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quezon City Local Government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Puerto Princesa City Local Government</td>
</tr>
</tbody>
</table>

**Project funding** for UNICEF was managed in New York, with disbursements to UNICEF Regional Offices in South Asia (ROSA) and East Asia and Pacific (EAPRO) and on to the five UNICEF country offices.

**Cross-cutting issues** were common to each country and were alluded to above. These included: (i) the need to take the local political, economic, development and health sector context into account during final project design and implementation (e.g. government funding/overarching prioritisation or preferred approach to planning and budgeting; decentralisation or lack thereof; other DP activity; parallel government activity or projects focusing on similar issues or aspects of the work; access and security; health systems issues (human resources; logistics etc.); (ii) financing issues, including reliability and timeliness of government disbursements; (iii) local experience with accountability for performance and capacity for data gathering and analysis; computer literacy; and (iv) varying capacity and opportunities for national engagement etc.
3. Expenditure / Inputs

Project funding was provided for the planned two year implementation period, from June 2011. Although this period was extended, these were no-cost extensions. There were no other project inputs although in-kind support was received from UNICEF and government stakeholders for activities at national and district levels.

Inputs included:
- Funding support for planning, implementation, monitoring and evaluation of activities (personnel at UNICEF headquarters, regional, country and field offices; consultations, travel, meetings, training on the IC approach; field assessment visits; training and engagement of local EBP support teams in the Philippines and Indonesia; district health office teams, other district stakeholders and academic public health and health economic support at the local level in Nepal and Bangladesh.
- Information technology equipment for UNICEF staff and government counterparts in project provinces and districts in project countries and regional and headquarters support offices.
- A sub-contract with project independent evaluator Prof Don Matheson, who worked over the period 2012-2014 according to terms of reference agreed in advance.
- Costs associated with dissemination, discussion and promotion of the IC approach at local and national meetings and international conferences, in publications and online.

Table 3: Summary of project financing disbursements/usage

EAST ASIA

UNICEF East Asia and Pacific Regional Office

Activities covered:
- Salary support for monitoring and technical support to IC work
- Travel for country visits
- Travel for Steering Committee meetings

UNICEF Indonesia Country Office

Activities covered:
- Meetings with national, provincial and district partners
- Organization of Steering Committee meeting
- Salary support for implementation and monitoring of IC work
- Travel within country to districts
- Workshops for capacity building
- Contracting of national research institutes to implement and support IC work
- Participation in regional workshop
- Local support to independent evaluation

UNICEF Philippines Country Office

Activities covered:
- Meetings with national, provincial and district partners
- Organization of Steering Committee meeting
- Salary support for implementation and monitoring of IC work
- Travel within country to districts
- Workshops for capacity building
- Contracting of national research institutes to implement and support IC work
- Participation in regional workshops
- Local support to independent evaluation
SOUTH ASIA

UNICEF Regional Office for South Asia

Activities covered:
- Salary support for monitoring and technical support to IC work
- Travel for country visits
- Travel for Steering Committee meetings

UNICEF Nepal Country Office

Activities covered:
- Meetings with national, provincial and district partners
- Salary support for implementation and monitoring of IC work
- Travel within country to districts
- Workshops for capacity building
- Contracting of national research institutes to implement and support IC work
- Seed grants to support implementation of district IC plans
- Participation in regional workshop
- Local support to independent evaluation

UNICEF Bangladesh Country Office

Activities covered:
- Meetings with national, provincial and district partners
- Travel within country to districts
- Participation in regional workshop
- Local support to independent evaluation
- Immunization and local level planning follow up
- Capacity development of health managers

UNICEF India Country Office

Activities covered:
- Access Bottlenecks Costs and Equity of Health Services (ABCE) analysis in Madhya Pradesh
- Hiring of State Coordinator for ABCE Project
- Travel within country to districts
- Contracting of Public Health Foundation of India to conduct study

HEADQUARTERS

Activities covered:
- Contracting of independent evaluation
- Contracting of political economy work
- Salary support for monitoring and technical support to IC work
- Travel for country and regional office visits
- Travel for Steering Committee meetings
- Organization of regional workshop
- Participation and support to Global Symposiums on Health Systems Research
4. Approach/strategy adopted and key outputs received

As described above, DFAT funding enabled UNICEF to undertake a set of activities at sub-national, national and international levels to further investigate, pilot and evaluate the IC approach in Bangladesh, Nepal, Indonesia and the Philippines. The sequencing and outputs varied by country, such that it is of benefit to report on these countries individually, as well as on how the project informs health systems strengthening and MNCH prioritisation, planning and budgeting in a wide variety of global settings.

4.1 Description of approach, activities and outputs, by country

Approaches were determined and activities implemented according to different preferences and schedules across the four countries, due to stakeholder perspectives based on previous experience, concomitant activities, preparedness, securing of local agreement on pilot sites and approaches, selection of domestic partners and availability of local personnel among all stakeholders. Clear guidance on this was provided by the PSC meeting held in January 2012, where it was acknowledged that the IC should be viewed as a modular rather than a linear approach, with the bottleneck and equity analyses likely to be relevant at national and sub-national levels in all countries, but the impact (lives saved) modelling, costing analysis and scenario testing of more interest to some countries or locations than others. Moreover, as the PSC report notes: “while the [district level] bottleneck and equity analysis would appear to be … valued by all countries … opportunities [should be sought] … to engage upstream decisions about national policies, plans, budgets and resource allocations. The key was to be strategic, but also pragmatic and opportunistic”. This and subsequent PSC meetings in 2012 and 2013 also clarified the roles of UNICEF and the UQc in the field work, differentiating advocacy and research, ensuring local agreement to and participation in the activities undertaken, and also emphasising accountability for and measurement of project outputs. The April 2013 PSC meeting clarified the requirements for agreed outputs at country level, which were developed and used in subsequent interim reports. These agreed outputs have been adapted for use in Tables 7-10 below.

4.1.1 Indonesia

The earlier work on the IC in Indonesia gave this country considerable pre-hoc experience on the concept and components of the approach. Four districts in central and eastern Indonesia had already implemented an earlier version of the IC from 2008, and demonstrated that Indonesia’s model of decentralisation limited the degree to which district authorities have substantive resources under their control, and that the evidence base for local planning and budgeting was weak. Moreover, in many parts of the country, an approach to MNCH service planning (DTPS) had been “established” but implemented unevenly across the country. Absence of a systematic, data-driven approach to planning and priority-setting for MNCH services was acknowledged. Accordingly, at the same early 2012 PSC meeting, which included high level participation of the Indonesia Ministry of Health (MoH) and the Ministry of National Development & Planning (Bappenas), it was determined that the next iteration of the IC/EBP would be located in the far eastern province of Papua. Although this province has very limited local data on MNCH, it has considerable control over certain funds designed to promote local autonomy, as well as the worst MNCH situation in the country.

Influences on the success of the earlier pilots were noted and considered in the work that followed. These included “clogged and fragmented” financial systems unconducive to predictable and timely funding, even where district plans were well-conceived; fragmented authority to change policy between differing layers of government, and competing approaches to improved planning and budgeting. It was agreed to study and draw attention to the financing issue, open dialogue with both the MoH and Bappenas on the issue of local authority, and also to assess the possibility of incorporating bottleneck analysis into the existing DTPS approach to MNCH service strengthening. With the acknowledgement of these high level areas of focus, UNICEF Indonesia agreed with domestic partners to fund a national review of DTPS and also of MNCH financing (amounts, origins, pathways, timing in relation to local planning etc.). These activities were conducted in 2013.

The DTPS review identified that a serious lack of technical and financial support and rotation of government personnel is hampering implementation of DTPS, resulting in poor planning of and low allocation of funds for district-level efforts on MNCH. In response, the MoH is in the process of revitalizing the national DTPS team and has improved the DTPS module, incorporating bottleneck analysis. A ministerial decree is now being processed to make this module formal with legal status. A national team appointed by the MoH will be deployed in 2015 to refresh training of provincial and district DTPS teams through a cascading process.

The fund-channelling and health expenditure tracking review, undertaken by Indonesia’s National Development Planning Agency (Bappenas), in coordination with the MoH Bureau of Planning and Budgeting with technical support from Universitas Gajah Mada (UGM), identified systemic bottlenecks hampering the effectiveness of intergovernmental fiscal transfers in the health sector, from central level to health facilities. Among other things, it found out that there are delays in fund distribution,

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fund liquidation at health centre level, as well as lack of sensitization on rules and procedures. All these findings have been taken up by government and targeted for improvement in Indonesia’s Medium Term National Development Plan 2015-2019.

EBP activities commenced in the first three selected districts in Papua in 2012, and were continued in the second group in 2013 and a third group in 2014 (Figure 1). In each case, the process involved gathering and use of local data to prioritise the interventions deemed most needed for achievement of the MNCH outcomes desired (for example immunization, antenatal and routine/emergency maternity care, and malaria treatment). These interventions required approval by local stakeholders across government sectors (health, development, social welfare etc.). The process relied on considerable support from a locally developed provincial EBP technical support team (TST), including individuals from local academia (University of Cendrawasih; Jayapura Health Polytechnic, and Papua Health Training Institute), the provincial government development agency (Bappeda) and health offices (PHO) and other experts. This team was convened by UNICEF and the UGM, and its existence and funding was subsequently supported officially by the Province Governor. Data gathering techniques, data interpretation, prioritisation of interventions using the Tanahashi process refined by UNICEF, and follow up implementation, monitoring and evaluation of activities were all supervised by the team, which continues to support EBP in Papua in the ten UNICEF-supported and three new districts in 2015, with ongoing approval and financial support from the Province Governor. Of note, seven senior official members of the TST are listed by title, not name, indicating a level of permanence often missing when individuals are listed by name (Figure 2). However, the technical members of the team are still named, placing the team at risk of declining capacity as these persons rotate or retire.

Beginning in 2015, Papua provincial government allocated $50,000 in seed funding to support the EBP work in three new districts. In addition, representatives from the ten original districts (two from the Health Office and one from the district Bappeda) will attend a two day workshop in Jayapura, the province capital, to share and discuss their district annual plan. Relying on input from the provincial EBP TST and continuous support from UGM and UNICEF, the government of Papua expects and hopes that EBP can eventually be introduced in all districts.

Moreover, UNICEF Maluku has recently reported that the local provincial government has also shown interest in EBP in Papua. The Papua EBP TST presented both the process and findings in the Maluku province musrenbang (government planning meeting) in early April 2015. It is anticipated that this will result in replication of the EBP approach in that province.

Figure 2A and 2B: Excerpts from the official letter of support from the Papua Governor
Additional support for EBP at sub-district level was provided in some project districts by UNICEF, in the form of integrated micro-planning (IMP) at health centre level, using some of the principles of EBP. Early experience with the IMP approach suggests that it may be a viable mechanism to translate the plans generated by district level EBP into action and also to track progress in real-time at the point of service delivery. Again, IMP creates a culture of use of data for action, accountability for results, and stakeholder participation. The latter is particularly important in Papua given the strong tribal setting and political aspirations of indigenous leaders in formal government structures. Details on IMP of various vertical MNCH activities, based on local data, were reported to DFAT in the July 2014 IC progress report. Three districts (Biak, Jayapura and Jayawijaya) are continuing with IMP using local resources.

A third area of focus in Indonesia has been dissemination of the principles and work on EBP using online media. These activities were also outlined in progress reports, and are continuing with support from UGM. Two websites with links to related material produced both internationally and in-country (http://chpm.fk.ugm.ac.id/index.php/id/ and http://www.kesehatan-ibu-anak.net/) are maintained by UGM and funded through various projects including the EBP project by UNICEF. The websites have approximately 450 visitors per day or 1,300 page views, 90% of which are domestic users. Several items of video related to EBP have been posted and disseminated, to inform replication of this approach in Papua and elsewhere in Indonesia.

Attempted analysis of the financial leverage achieved by the project in seven of the ten pilot districts in Papua is provided in Table 4. An attempt was made to compare this leverage with secular changes occurring in MNCH funding in non-project districts, but the information proved difficult to retrieve.

Activity outputs/outcomes against those agreed in Indonesia are summarised in Table 7.

### Table 4. MNCH fund allocation in EBP pilot districts in Papua, Indonesia

<table>
<thead>
<tr>
<th>Year</th>
<th>Yapen</th>
<th>Jayawijaya</th>
<th>Boven Digoel</th>
<th>Jayapura</th>
<th>Biak</th>
<th>Supiori</th>
<th>Paniai</th>
<th>Nabire</th>
<th>Sarmi</th>
<th>Mappi</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>830</td>
<td>842</td>
<td>2,119</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2012</td>
<td>1,365</td>
<td>1,040</td>
<td>4,642</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2013</td>
<td>3,617</td>
<td>1,969</td>
<td>3,938</td>
<td>1,144</td>
<td>1,288</td>
<td>1,550</td>
<td>1,800</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2014</td>
<td>2,239</td>
<td>3,140</td>
<td>2,532</td>
<td>1,413</td>
<td>1,190</td>
<td>2,850</td>
<td>4,131</td>
<td>4,480</td>
<td>3,569</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### 4.1.2 The Philippines

As in Indonesia, earlier IC work gave the Philippines considerable pre-hoc experience on the main elements of the approach. A 2011 evaluation of previous IC work in this country made it clear that it would not be appropriate to repeat its focus on costing and modelling. On the other hand, the focus of this iteration of the approach on empowering local authorities, encouraging routine gathering and use of data, and piquing the interest of local non-health authorities in MNCH and young child nutrition was very much in line with national efforts to strengthen the accountability and performance of the nation’s decentralised health sector. Considerable work had been undertaken on preparing guidelines for city and province health planning, and there was new national priority for bottom-up budgeting. Moreover, at the early 2012 PSC meeting, the project was contextualised within national moves to introduce universal health coverage (UHC) including through expanded coverage by the national health insurer (PhilHealth), performance-based financing and engagement of the private sector.

After a period of negotiation with government and other partners during which acknowledgement was made by all of the need to focus on urban areas, in late 2012 agreement was reached to focus on Davao, Quezon and Puerto Princesa Cities. As reported to DFAT in progress reports, the work was conducted over 2013-14, with a hiatus mid-term due to typhoon Haiyan. Initial training was conducted on the concepts, data gathering and interpretation, selection and implementation of priority interventions. In subsequent workshops, local teams of government health and non-health supervisors of the EBP process were trained in each city. These teams facilitated preparation of annual operational plans and proposals for additional national funding.

Analysis of the financial leverage achieved by the project in the three pilot Local Government Units (LGUs) is provided in Table 5. An attempt was made to compare this leverage with secular changes occurring in MNCH funding in non-project districts, but it was not possible to retrieve the information.
Of note, the budget for nutrition in the city of Davao increased from US$133,333 in 2013 to $255,556 in 2014 and $333,330 in 2015.

In the Philippines, the project influence and leverage on national activities was most evident. As detailed in the progress reports, the areas of focus pursued with DFAT funding were:
- Revision of the national guidelines on investment planning for health at province and city levels
- The primary care package covered by PhilHealth
- Testing computer-assisted approaches to training on Integrated Management of Childhood Illness
- Community Management of Acute Malnutrition, based on work done in Davao City
- Modelling the cost and impact of early essential newborn care interventions

Other areas of leverage using other resources included:
- Extension of the work on newborn care to build support for a revised national Newborn Action Plan, and
- Mainstreaming of EBP lessons into the national Health Leadership and Governance Program, for local government chief executives and health officers.

Moreover, lessons learned from this project have been included into new work being implemented using EBP and budgeting for resilient local health systems in the areas affected by Typhoon Haiyan.

Activity outputs/outcomes against those agreed in the Philippines are summarised in Table 8.

4.1.3 Nepal

Among the four target countries, Nepal was the quickest to initiate activities on this phase of the IC. It was also the only one to continue to refer to activities as an IC, and to aim to retain costing and modelling. Five districts were selected (Udayapur, Dhading, Kapilvastu, Jajarkot and Dadeldhura) and had already undertaken in-depth, district-specific bottleneck analysis and preparation of costed MNCH plans for presentation to the national Director General - Health Services by March 2012. This early work was supported by both UNICEF and the UQc, and was appreciated for its focusing of attention on data, the quality of the analysis undertaken, its engagement of local health and government leaders and the speed with which national government supported the approach. A decision for UNICEF to take the work forward alone was reached with the UQc, and implementation continued in these districts during 2013 and 2014. Further IC work, using the same methodology, commenced in 2013/14 in eight of the 15 worst performing among Nepal’s 75 districts, jointly identified by UNICEF and the Ministry of Health and Population, and in the other seven districts in 2014/15. These 15 were already part of the UN’s list of supported districts, ensuring that the Nepal Ministry of Health and Population fully supported the work. New national partners (the Health Research and Social Development Forum and the Nepal Public Health Foundation) supported this work, further increasing domestic capacity with the approach. Moreover, an appreciative inquiry approach to bottleneck analysis and identifying priority interventions was introduced in the 15 new districts, and the engagement of village development committees (VDCs), heads of various district offices, political leaders, journalists, representatives of non-government (NGOs) and community-based organizations, and female community health volunteers also ensured widespread buy-in to the process.

The experience in Nepal also provided the project with a good example of the importance of timing the project support and IC process in relation to existing, national planning and budgeting processes. This was arguably more important in Nepal where planning and budgeting remain centralised. The process in the first five districts was indeed suboptimally timed to coordinate with district planning processes. In the second phase, the timing of the district level health system bottleneck analysis workshop was planned ahead to ensure that it was completed before local level planning. To a varying degree, this enabled the IC process to inform and influence the allocation of budgets for MNCH in these eight districts. At project closure, for the fiscal year 2014/15, the IC planning process is fully aligned with the government planning process,
enabling District Development Committees to integrate plans developed through the IC process into their local development budgets, as well as allowing the Ministry of Health and Population to integrate them into the central budget.

Moreover, the high level of local health authority engagement also worked particularly well in Nepal, where communities have a recent history of self-reliance and “making do” given the political turmoil in that country. As documented to DFAT in July 2014: “The involvement of the district stakeholders was very important in identifying the hard to reach VDCs and communities. As they were from the districts the stakeholders were able to identify which areas needed more attention and focus to increase the equality in access to services. The district developed their own plans to address the bottlenecks that were identified during the workshop. This process helped to build the capacity of the stakeholders to develop action plans based on evidence and need and to explore and identify the locally available resources to implement the plan activities. This process also encouraged the leveraging of local resources …” which was particularly important during a budget freeze in 2012/13.

As it was for Indonesia and the Philippines, a detailed analysis of the financial leverage achieved by the project in the five original project districts in Nepal is provided in Table 6. An attempt was made to compare this leverage with secular changes occurring in MNCH funding in non-project districts, but the information was again too difficult to retrieve.

Again, activity outputs/outcomes against those agreed in Nepal are summarised, in Table 9.

4.1.4 Bangladesh

Bangladesh, like all the countries in this phase of the IC work, had pre-existing experience with the approach and was already experimenting with various options for introducing bottleneck analysis, equity analysis, costing and modelling in 2011-12. Heavily centralised budgeting and planning processes and very limited local capacity to allocate resources prevailed. Different elements of the IC process were being considered according to local capacity and circumstances in up to 23 districts where UNICEF and other UN agencies, mostly funded by Canadian aid, were already implementing the approach in part or in whole. Urban slum communities were an intended focus for this early work using the IC approach, but political instability in the country delayed the planned roll-out of the Call to Action based on the A Promise Renewed commitment to Ending Preventable Child Mortality by 2035, to which commitment the Bangladesh government had signed up. Given this existing activity and funding, and the political turmoil, the UNICEF Bangladesh Country Office was slower than other project countries to draw down DFAT project funds, and the total utilised was lower than the other three countries because other resources were available for similar activities.

Substantive use of DFAT funds for IC work commenced in 2013, when a more detailed equity and bottleneck analysis was undertaken in three remote districts (Figure 1). This occurred in line with considerable work developed in country by the same group of UN agencies with the same Canadian government funding for yet another iteration of EBP, entitled “local level planning” (LLP). After being revised to make it more analytical and evidence-based, LLP was first used to identify bottlenecks in the immunisation program and then to support planning, target setting and realistic budgeting for the expanded program on immunisation (EPI). UNICEF introduced this new LLP process in 11 low performing districts and two city corporations, resulting in the development of sub-district local level plans with more realistic budgets and detailed actions to remove bottlenecks and increase effective EPI coverage. All 11 low EPI performing districts and two city corporations had approved funding for their LLPs disbursed.

Subsequently the process was extended to MNCH activities. After the three-district pilot mentioned above, the joint UN Maternal and Newborn Health Initiative and MNCH program agreed to utilise the revised LLP methodology in their 11 districts in 2014-15. There was a need to overcome some resistance based on competing approaches from different government departments and from those using a DTPS strategy introduced years

<table>
<thead>
<tr>
<th>Year</th>
<th>Udayapur</th>
<th>Dhading</th>
<th>Kapilvastu</th>
<th>Jajarkot</th>
<th>Dadeldhura</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2013</td>
<td>35910</td>
<td>26709</td>
<td>16320</td>
<td>19871</td>
<td>17010</td>
</tr>
<tr>
<td>2014</td>
<td>27664</td>
<td>53176</td>
<td>22289</td>
<td>19467</td>
<td>118819</td>
</tr>
</tbody>
</table>
previously. Moreover, the LLP focus drew attention to the need for better data, and efforts to improve the district health management information system (HMIS) were required. Indicators for MNCH were revised and a new monitoring format, and web-based community and health facility reporting systems were introduced. These activities are now also occurring in the context of Bangladesh’s commitment to A Promise Renewed, focusing on the implementation of 10 high impact health interventions and seven strategies, with benchmarks developed for monitoring. It has also been acknowledged that LLP can underwrite similar activities in other sectors (Water, Sanitation and Hygiene, Nutrition, Child Protection etc.), and donors anxious to see a common approach applied in Bangladesh are interested in the work on indicators (as part of the HMIS) and definitions of effective coverage.

As reported previously to DFAT: “The LLP process has increased the capacity of local managers and service providers at district level to plan and budget based on local needs, and also to monitor ... effective coverage using data from the HMIS. Although a well-developed LLP has created a sense of ownership among the sub-national level managers and local communities, the funding disbursement for district health systems is still centrally managed .... The process of approval of LLPs by central Government and lengthy fund disbursement procedures obstruct the timely implementation of activities.” Other challenges are limited human resource capacity and high turnover of managers, inadequate facility readiness and inadequate decentralized authority at local level.

The program in Bangladesh took longer to gain traction due mainly to the UNICEF Country Office’s implementation of similar activities with other partners. The specific focus of the IC on data-driven EBP, bottleneck analysis, selection of interventions to strengthen local health systems and stakeholder engagement was extremely timely. The process of EBP started with the Directorate General of Health Services (DGHS) now has been taken to higher levels of the health hierarchy in the MoHFW. With technical advice provided by the Institute of Health Economics (IHE), the Director General of the government Health Economic Unit is now steering the process, linking it with pro-poor health service packages recently initiated. Again, activity outputs/outcomes against those agreed in Bangladesh are summarised, in Table 10.

4.2 Activities relevant across settings

4.2.1 Health financing and tracking

Delays in the district-level availability of nationally allocated funds are a common problem for sub-national health authorities in many developing countries, and were mentioned frequently in all the countries this project supported. In Indonesia, project-funded and other assessments of health finance channelling were undertaken by this project and as part of a Gates Foundation-funded multi-nation assessment of health expenditure tracking with respect to immunisation programs. The review funded by this project, described in section 4.1.1, identified mixed responsibilities for the acknowledged problems on both national and sub-national levels, noting that while there are problems with the timing and administration of budget processes, some delays occur within districts themselves. A study of immunisation financing has not been completed, but preliminary findings suggest similar conclusions.

Collectively these studies have contributed to the scant information available on this issue in global development circles.

4.2.2 Political economy analysis

In the final year of the project, at the instigation of senior DFAT officials during the 2013 PSC, a consultant was hired to support a political economy analysis of health and MNCH in the four main countries. The work is described comprehensively in a summary overview, separate reports for each country and accompanying briefing notes, all of which will be submitted to DFAT separately. Academic publication of the work is planned, and DFAT will be given due credit for funding the work. It is acknowledged that it would have been useful to have undertaken this work earlier in the project, as the insight it provided into the context for EBP and the IC approach may have proven useful for national advocacy with government and DPs, and for replication of the approach.

Quoting from the summary, the work found that:
<table>
<thead>
<tr>
<th>Table 7: Outputs and outcomes achieved, indicators and risks overcome during IC work in Papua province and at national level in Indonesia, 2012-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators and outputs/outcomes achieved</strong></td>
</tr>
<tr>
<td><strong>Agreed outcome objectives</strong></td>
</tr>
<tr>
<td><strong>Weaker local capacity for data gathering and interpretation, computer literacy; lack of experience in EBP; poor accountability</strong></td>
</tr>
<tr>
<td><strong>Uncertain endorsement of the TST from the new Provincial Governor and new head of the Province Health Office</strong></td>
</tr>
<tr>
<td><strong>Sustained potential for EBP in selected districts in Papua through effective functioning and full commitment for self-replication in additional three districts</strong></td>
</tr>
<tr>
<td><strong>Solid models for EBP for MNCH and Nutrition in ten selected districts in Papua, Indonesia</strong></td>
</tr>
<tr>
<td><strong>Ten districts adopted the EBP approach to local planning and budgeting, allocation of funds and implementation of selected strategies; Subdistrict integrated micro-planning, mpasas, and budget allocations</strong></td>
</tr>
<tr>
<td><strong>Around 150 participants from relevant agencies participated in establishment of the TST which consists of appointees to certain roles (not just individuals) at the PHO, Bappeda, Poltekkes, and local University</strong></td>
</tr>
<tr>
<td><strong>Agreed outcome objectives</strong></td>
</tr>
<tr>
<td><strong>Indicators and outputs/outcomes achieved</strong></td>
</tr>
<tr>
<td><strong>Risks overcome</strong></td>
</tr>
<tr>
<td><strong>Strengthened capacity for EBP</strong></td>
</tr>
<tr>
<td><strong>Initial (Jayawijaya, Boven Digoel, and Yapen) for MNCH and Nutrition in low performing districts in Papua and new focus districts (Biak, Supiori, Jayapura, and Paniai) have adopted EBP approach into local planning and budgeting, fund allocation and implementation of selected strategies</strong></td>
</tr>
<tr>
<td><strong>Three additional districts (selected by the PHO) have adopted the EBP strategies into local budgets and plans, and are funding the priority strategies they have selected.</strong></td>
</tr>
<tr>
<td><strong>Number of participants from relevant agencies participating in district EBP workshops</strong></td>
</tr>
<tr>
<td><strong>Full commitment from members of MNCH university network across Indonesia has been achieved</strong></td>
</tr>
<tr>
<td><strong>Lack of interest: approximately 450 visitors per day or 1,300 page views, 90% of whom are domestic users.</strong></td>
</tr>
<tr>
<td><strong>Participation of local government and health leadership and improved capacity for EBP, based on reports of TST</strong></td>
</tr>
<tr>
<td><strong>Knowledge generated by the EBP initiative in Papua is documented, managed and disseminated through MNCH university network platform</strong></td>
</tr>
<tr>
<td><strong>Video documentation on the process of EBP in Papua and on step-by-step bottleneck analysis developed and disseminated</strong></td>
</tr>
<tr>
<td><strong>Evidence of sustained increase in priority for selected interventions, based on previous bottleneck analysis and the IC</strong></td>
</tr>
<tr>
<td><strong>Sustained EBP in low performing districts in Papua through the strengthened role of Provincial EBP Support Team (PHO, Bappeda, Poltekkes, Bapelkes, and local University)</strong></td>
</tr>
<tr>
<td><strong>Number of participants in the data analysis training, module revision, refresher training and training on integrated micro Planning at puskesmas level</strong></td>
</tr>
<tr>
<td><strong>Uncertain support from new provincial government</strong></td>
</tr>
<tr>
<td><strong>Result of pre- and post-tests in the refresher training</strong></td>
</tr>
<tr>
<td><strong>Uncertain capacity of TST to function without support from University</strong></td>
</tr>
<tr>
<td><strong>Institutional capacity for EBP established within the Papua provincial government and academia based on support from the EBP Provincial Team to mainstream EBP practices in govt planning and budgeting</strong></td>
</tr>
<tr>
<td><strong>New Governor letter issued, stating formally the financial contribution of the Provincial Government to support the EBP Provincial Team</strong></td>
</tr>
<tr>
<td><strong>DTTS Review completed at central and sub-national levels, analysis of IMF implementation, analysis of UNICEF and DFAT funded DTPS project and review of DFAT funded health systems strengthening (HSS) Project for health expenditure tracking</strong></td>
</tr>
<tr>
<td><strong>High level support for review and revitalisation of DTPS</strong></td>
</tr>
<tr>
<td><strong>Revision of DTPS Module, incorporating bottleneck analysis</strong></td>
</tr>
<tr>
<td><strong>Completion of Fund Channelling Review at central and sub-national levels.</strong></td>
</tr>
<tr>
<td><strong>Issuance of a related Government Regulation on fund transfers from Central to Sub-national levels</strong></td>
</tr>
<tr>
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</tr>
</tbody>
</table>
### Table 8. Outputs and outcomes achieved, indicators and risks overcome during IC work in the Philippines, 2012-2014

<table>
<thead>
<tr>
<th>Agreed outcome objectives</th>
<th>Indicators</th>
<th>Indicators and outputs/outcomes achieved</th>
<th>Risks overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthened capacity for EBP for MNCH and Nutrition in the City Health Office (CHO) and the City Planning and Devt Office (CPDO) in each of three cities</td>
<td>• Key staff in the CHO and the CPDO are trained to facilitate EBP and budgeting exercises/workshops and to apply this in preparing Bottom-up Budgeting/Local Poverty Action grant proposals</td>
<td>Strengthened capacity for EBP for MNCH and Nutrition at the CHO and CPDO in each of three cities</td>
<td>• Ongoing support from CHO towards EBP and towards the priorities selected</td>
</tr>
<tr>
<td></td>
<td>• The 2014 Annual Operational Plan of each CHO and Annual Investment Plan of each City Government are prepared after an EBP process</td>
<td></td>
<td>• CHO can advocate for additional funding and increased activities from the CPDO</td>
</tr>
<tr>
<td></td>
<td>• Operational plan for EBP strategies developed in each city</td>
<td></td>
<td>• Multiple government agencies and the private sector supportive of EBP</td>
</tr>
<tr>
<td></td>
<td>• Number of LGU health staff trained on EBP implementation, monitoring and evaluation</td>
<td></td>
<td>• City has capacity to fund and then implement the additional activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In each City, the following risks were overcome:</td>
</tr>
<tr>
<td>Successful implementation of a strategy to address severe acute malnutrition (SAM) among children under 5 in Davao City</td>
<td>• Implementation of a strategy to address severe acute malnutrition among children under 5 in Davao City, through use of evidence, capacity building, monitoring and evaluation</td>
<td>Davao City launched their initiative on severe acute malnutrition in October 2013.</td>
<td>• Ongoing support from CHO towards EBP and towards the priorities selected</td>
</tr>
<tr>
<td></td>
<td>• Related operational plan and based on EBP developed</td>
<td>Related City executive order issued</td>
<td>• CHO can advocate for additional funding and increased activities from the CPDO</td>
</tr>
<tr>
<td></td>
<td>• Number of LGU health staff trained on related implementation, monitoring and evaluation</td>
<td>Large budget increment in 2014 (Table 5)</td>
<td>• Multiple government agencies and the private sector supportive of EBP</td>
</tr>
<tr>
<td>Quezon City will be able to implement evidence-based MCH strategies that consider the needs of the large informal population in District 2</td>
<td>• Specific evidence-based strategies identified by health centre and district level managers in District 2 are adopted by the CHO, funded and implemented</td>
<td>Several strategies identified during EBP workshops included and funded in the 2014 AOP and were proposed in the 2015 AOP</td>
<td>• City has capacity to fund and then implement the additional activities</td>
</tr>
<tr>
<td>Puerto Princesa City will be able to incorporate evidence-based strategies into their local health plan and budget, allocate fund, and implement the strategies</td>
<td>• Specific evidence-based strategies identified by health centre and district level managers in the City are adopted by the CHO, funded and implemented</td>
<td>Specific evidence-based strategies identified by health centre and district level managers in the City are adopted by the CHO, funded and implemented</td>
<td></td>
</tr>
<tr>
<td>National policies and guidelines for decentralized planning and budgeting, and on urban health planning and budgeting follow the principles of EBP</td>
<td>• The guidelines for LGU investment plans for health (i.e. PIPH/CIPH/AOP) and the urban health strategy of the Department of Health (DOH) are revised/updated based on a consultative process and including lessons learned from the three EBP pilots and previous IC work</td>
<td>National policies and guidelines for decentralized planning and budgeting, and on urban health planning and budgeting follow the principles of EBP</td>
<td>• High-level support for and continued engagement of the DOH on these issues</td>
</tr>
<tr>
<td></td>
<td>• Revised approaches to PIPH/CIPH/AOP</td>
<td>The guidelines for LGU investment plans for health and the urban health strategy of the Department of Health (DOH) were revised/updated based on a consultative process and including lessons learned from the three EBP pilots and previous IC work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Revised DOH Urban Health Strategy</td>
<td>Revised approaches to preparing Province and City Annual Operational Plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised DOH Urban Health Strategy</td>
<td></td>
</tr>
<tr>
<td>Leveraged prioritisation of MNCH and nutrition for funding by local government and health authorities in three LGUs</td>
<td>Participation of local government and health leadership and improved capacity for EBP; long term capacity established through training of local team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Numeric, proportional and relative increase in allocation of resources for MNCH and/or nutrition by LGU health and local government authorities in EBP pilot sites, based on historic comparison.  
• Evidence of sustained increase in priority for selected interventions, based on previous bottleneck analysis and IC process (see Table 5) | • Improved output indicators in areas of MNCH focus at local levels, as reported by UQc field analyses |
| • Participation of local government and health leadership and improved capacity for EBP; long term capacity established through training of local team.  
• Improved output indicators in areas of MNCH focus at local levels, as reported by UQc field analyses |  |
| Opportunistically-informed, high-level policy areas for which UNICEF, UQc and local counterparts have identified a need for new input, based on the evidence collected in the EBP and IC work | Opportunistically-informed, high-level policy areas for which UNICEF, UQc and local counterparts have identified a need for new input, based on the evidence collected in the EBP and IC work |
| • The PhilHealth outpatient benefit package for under 5 and school-age children is developed through a consultative process  
• National policy and guidelines on Community Management of Acute Malnutrition are adopted  
• National policy and guidelines on IMCI Computer-based Adaptation and Training Tool are adopted  
• Lessons learned on local planning and budgeting are mainstreamed into the Health Leadership and Governance Program through partnership with the Zuellig Family Foundation | • The PhilHealth outpatient benefit package for under 5 and school-age children is developed through a consultative process  
• National policy and guidelines on Community Management of Acute Malnutrition are adopted  
• National policy and guidelines on IMCI Computer-based Adaptation and Training Tool are adopted  
• Lessons learned on local planning and budgeting were mainstreamed into Mayoral Health Leadership and Governance Program through partnership with the Zuellig Family Foundation  
• Continued engagement of PhilHealth, the DOH (Family Health Unit) and the National Nutrition Council on these issues. |
Table 9. Outputs and outcomes achieved, indicators and risks overcome during IC work in Nepal, 2012-2014

<table>
<thead>
<tr>
<th>Agreed outcome objectives</th>
<th>Indicators</th>
<th>Outputs/outcomes achieved and Indicators</th>
<th>Risks overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of MNCH activities finalized in 5 original districts, with documentation of / reduction / changes in bottlenecks</td>
<td>• Revised implementation plans finalized, consulted upon, and buy-in of district government and other partners secured by 31 May 2013 • Resources secured and identified to implement the planned activities by beginning of each quarter until April 2014 • Monitoring visits undertaken on a monthly basis to provide technical support for implementation and monitoring the implementation of corrective actions • Implementation of the planned activities completed in each district with documentation of impact on bottlenecks, by 30 June 2014</td>
<td>Implementation of MNCH activities finalized in 5 original districts, with documentation of / reduction / changes in bottlenecks • Revised implementation plans were finalized and buy-in of district and national govt and other partners was secured. • Resources were identified and secured from a variety of sources by beginning of each quarter, to enable planned activities to be implemented, including in 2014. • Monitoring and supervision visits were conducted by district health and UNICEF and national research institute staff to provide technical support for implementation. • Implementation according to plans and evaluation and documentation of progress made by the districts.</td>
<td>• Political instability that undermined buy-in after it was secured. • Delays in the allocation process of resources and approval by central government, due to political instability • Travel restrictions due to strikes; delays in the engagement of consultants with sufficient skills to support the process</td>
</tr>
<tr>
<td>IC process undertaken in 8 new districts</td>
<td>• National research institutes engaged and trained by 30 June 2013 • Data collection, verification, bottleneck analysis and drafting of district plans completed with district partners by 30 September 2013 • District plans shared and discussed with central government partners by 15 October 2013 • Incorporation of IC plan with MNCH activities into the overall district plan, with buy-in and resources from district and central government to allow start of implementation, by 30 June 2014.</td>
<td>IC process undertaken in 15 new districts • National research institutes were engaged and trained. • Data collection, verification, bottleneck analysis and drafting of district plans was completed with district partners in third-quarter 2013. • Detailed district plans were developed for 8 districts, including detailed budgets, strategies and costing scenarios for the interventions. Activities were implemented in seven more districts in late 2014. These seven districts have also developed a five year action plan to address the identified bottlenecks. These action plans have also been incorporated into the five-year district periodic plans. • The eight district plans were shared and discussed with central government partners in late 2013. Incorporation of these new MNCH plans into the overall district plan, with buy-in and resources from district and central government enabled implementation to commence by 30 June 2014.</td>
<td>• Election-related delays may have made the process difficult, but local buy-in was strong. • Limited local capacity was built up; 12 staff from the two national research institutes were trained in the IC process and were actively engaged to support development of IC plans in the new districts • The timing of the IC process to meet deadlines imposed by national planning processes enabled a successful merger of new local and existing national planning processes. • Local buy-in was ensured by the inclusive process. District plans were shared with local authorities and VDC stakeholders, as well as with interested national stakeholders. Districts have committed to incorporate the MNCH plans into their five-year development plans, which are in various stages.</td>
</tr>
</tbody>
</table>
Table 10. Outputs and outcomes achieved, indicators and risks associated with the IC work in Bangladesh, 2012-2014

<table>
<thead>
<tr>
<th>Agreed outcome objectives</th>
<th>Indicators</th>
<th>Outputs/outcomes achieved and Indicators</th>
<th>Risks overcome and remaining</th>
</tr>
</thead>
</table>
| Evidence based planning for improving performance of MNCH is operationalized | • Introduction of new LLP based on IC/UNICEF’s MoRES* concept in 11 low performing districts and 2 City corporations  
• LLP is scaled up from Immunization program to Maternal, Newborn and Child Health and Nutrition program  
• Development of LLP tool based on MoRES principle  
• Scaling LLP process with IC at central level for advocacy  
• Development of sub-district micro-plan with realistic budget. | EBP known locally as LLP for improving performance of MNCH, is operationalized in Bangladesh  
• Based on experience with the IC approach, in quarter 3 of 2013 LLP was introduced by UNICEF and Govt in three remote districts. Political troubles delayed progress until March 2014.  
• LLP was then introduced in 11 low performing districts and 2 Cities (overlapping with and supporting a UN program in these areas)  
• LLP was scaled up from an initial immunization focus to include MNCH and Nutrition programs  
• Advocacy for LLP with central govt led to acknowledgement of its potential to underwrite national commitments to A Promise Renewed.  
• Development of MNCH monitoring tool for health facilities, based on IC  
• Analysis of the IC and LLP from economic perspective; results are used to advocate scale up by central health authorities  
• Revision of local HMIS indicators/expansion to include revised Commission on Information and Accountability indicators of effective coverage.  
• Plans in all 11 low performing districts and 2 Cities were approved and funds were disbursed in February 2014. Three MNCH districts’ funds were disbursed in July 2014 | • National government buy-in may have been difficult in centralized Bangladesh, but UNICEF was already engaged in health development and system strengthening with the DGHS, focusing on immunisation.  
• LLP was revised to make it more analytical and evidence-based, and to include realistic budgeting. But it competes with other processes including a local version of DTOPS. The revisions were promoted to other agencies (govt, UNFPA, GAVI, WHO) and accepted, although the process is ongoing.  
• Political instability remains the biggest problem to progress in Bangladesh. It can interrupt planned activities, such as workshops for practising IC and dissemination of the results. This risk has not been overcome.  
• Acceptance of the LLP concept by big donors (CIDA and USAID) and partners (BRAC at technical level). LLP approach is now being applied to the UN joint MNCH Initiative in 11 other districts. Save the Children use this approach in their DHSS project in Bangladesh. DFID and the World Bank are concerned about govt implementation of LLP. Promotion of an EBP approach continues.  
• The complicated approval of local plans by central Government and slow fund disbursement remains problematic. |
| The capacity of central health planners and local level health managers on EBP is improved | • Building capacity of the managers and strengthen the system as a whole for more decentralized decision making process in achieving effective coverage of health services  
• Development of MNCH monitoring tool for health facility based on MoRES/IC  
• Analysis of IC and LLP from economic perspective and its results are used for scale up by central health authorities | The capacity of central health planners and local health managers on EBP is improved  
• Capacity of managers built and health system strengthened for more decentralized decision making, to increase effective coverage of health services. In 11 EPI districts, 2 Cities and 3 MNCH districts, UNICEF facilitated training of local managers on EBP and district managers and service providers on planning and budgeting based on local needs, and monitoring effective coverage using HMIS data  
• Tool for monitoring and evaluation of health facility performance was developed based on IC concept and applied in 9 districts.  
• A strategic partnership has been established by building capacity to implement the IC approach within the Institute of Health Economics (IHE), so that Bangladesh will not depend continuously on UNICEF technical support | • High turnover of managers at national and sub-national level continues to affect development and implementation of LLPs  
• Bridging demand and supply side interventions remains challenging. Govt facilities provide many basic services but out of pocket expenses are high. More focus is required on creating demand for use of govt health facilities. LLP is reducing NGOs role in health service delivery, but they can strengthen community support to create demand, and facilitate community discussion, default tracking and community referral.  
• Limited human resources and inadequate facility readiness and inadequate decentralized authority to implement monitoring remain areas of focus and need for ongoing attention, along with national advocacy for decentralized decision making and budget allocation.  
• Continuous technical support is needed but IHE is now helping in this role |
| Political commitment to end preventable maternal and child death | • Aligning Bangladesh Call for action to end preventable death by 2035, A Promise Renewed Initiative, to IC approach by introducing high impact interventions | Political commitment to end preventable maternal and child death  
• Govt has pledged to end preventable child and maternal deaths by 2035, using 10 high impact health interventions and seven strategies, and relevant benchmarks for monitoring. The Call to Action to End Preventable Child Deaths by 2035, A Promise Renewed initiative, is aligned to the IC approach. | • Funding: IC work/bottleneck analysis is continuing with other resources.  
• Canadian DFATD has allocated US$19 million for Promised Renewed activities.  
• Ongoing technical support is required to support govt health authorities, UNICEF and other agencies remain closely engaged. |

*MoRES – Monitoring Results for Equity System: UNICEF’s institution-wide approach to evaluating the degree to which monitoring of outputs and outcomes focuses on and supports the achievement of equity.
Social and economic development processes involve much more than technocratic approaches: ‘political economy’ factors usually determine the fate of reforms. . . . [Understanding] how and why governments make and implement decisions; prioritise the allocation of scarce financial and human resources; resolve trade-offs; regulate the private sector; achieve accountability, and interact with civil society and development partners is essential to . . . international development. Understanding how governments use or don’t use evidence to shape policies and prioritise use of their own scarce resources is increasingly important. That is particularly true as more and more countries achieve middle income status, albeit with large burdens of poverty and aid programs become progressively smaller . . . . Governments that effectively and visibly deliver essential health and other services can strengthen their political legitimacy.

Understanding political economy issues has direct, significant, real world implications. After decades of resistance, and against most predictions, strong political leadership and shrewdly generated coalitions were able to legalise modern and safe family planning in the Philippines. Similarly against . . . very powerful vested interests the Philippines was able to increase taxes on tobacco, thereby generating additional finances to fund the expansion of UHC for the poor, while reducing the leading cause of non-communicable diseases. Analysing budgets also provides a revealing “real world” insight into the true priorities of governments, given the political environment in which they operate. For example, government expenditure on health in Indonesia was just 6.2% of total government expenditure in 2011, compared to the 18% expenditure on fuel and energy subsidies that primarily benefit the middle class and elite. Another example of the real world application of political economy analysis is that Nepal has achieved remarkable and sustained reductions in maternal and child mortality despite low income, and a civil war. Similarly, [although] Bangladesh ranks low on global measures of human development, budget transparency, and corruption control . . . it has [long] life expectancy, [low] total fertility rate, and [low] infant and under-5 mortality rates . . . despite very low spending on health care . . . . These examples demonstrate the relevance of political economy issues.

The analysis undertaken and the reports produced have greatly informed UNICEF and its country offices. They could also be of major interest to DFAT in determining its evolving approach to development assistance in these four and similar countries in the two regions.
5. Key outcomes

Expected outcomes

Several outcomes were expected from the project inputs implemented. They are listed in Table 11.

Table 11. Expected and achieved outcomes, and sources of evidence

<table>
<thead>
<tr>
<th>Expected outcome</th>
<th>Outcome achieved</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>Planning capacity</td>
<td>In three nations (Nepal, Indonesia and the Philippines), the IC process has been</td>
<td>• Project reports</td>
</tr>
<tr>
<td></td>
<td>established in the pilot districts, and in Bangladesh, Indonesia and Nepal, it</td>
<td>• Independent evaluation</td>
</tr>
<tr>
<td></td>
<td>has been replicated in new districts. The principal of data-driven, EBP and the</td>
<td>• Local partner reports</td>
</tr>
<tr>
<td></td>
<td>importance of local-level planning has been internalised in both project</td>
<td>• National partner statements</td>
</tr>
<tr>
<td></td>
<td>provinces and at national level in all four nations.</td>
<td></td>
</tr>
<tr>
<td>Funding leveraged</td>
<td>Evidence for substantive leverage in some districts but inconsistent. Poor district</td>
<td>• Project reports</td>
</tr>
<tr>
<td></td>
<td>finance records and short project duration made it difficult to verify this, even</td>
<td>• UQc and UGM investigations</td>
</tr>
<tr>
<td></td>
<td>in project pilot sites. An attempt to assess secular changes in non-project</td>
<td>• US-funded Traction project</td>
</tr>
<tr>
<td></td>
<td>districts failed - data was not available.</td>
<td></td>
</tr>
<tr>
<td>Use of data for planning</td>
<td>Annual planning process using locally gathered data for priority-setting and</td>
<td>• Project reports</td>
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<tr>
<td></td>
<td>budgeting. Newly established data-gathering activities at district or (in some</td>
<td>• Independent evaluation</td>
</tr>
<tr>
<td></td>
<td>cases) sub-district level. Engagement of community stakeholders (health and non-</td>
<td>• Local partner reports</td>
</tr>
<tr>
<td></td>
<td>health) in performance monitoring.</td>
<td>• UQc and UNICEF Field Office reports</td>
</tr>
<tr>
<td>Improved MNCH indicators</td>
<td>Indicators related to selected interventions (e.g. skilled birth attendance; EPI</td>
<td>• UQc activity reports</td>
</tr>
<tr>
<td></td>
<td>coverage; child under-nutrition) improved.</td>
<td>• Independent evaluation</td>
</tr>
<tr>
<td></td>
<td>Acknowledgement of the value of district-level planning and budgeting, and EBP;</td>
<td>• Locally collected data used for planning</td>
</tr>
<tr>
<td>National engagement and understanding of the IC approach</td>
<td>Replication of project approach in all nations, for MNCH and more Support for</td>
<td>• Project and UQc reports</td>
</tr>
<tr>
<td></td>
<td>the conclusions of national reviews (DTPS; health expenditure tracking; political</td>
<td>• Independent evaluation</td>
</tr>
<tr>
<td></td>
<td>economy) funded by the project</td>
<td>• Field trip reports</td>
</tr>
</tbody>
</table>

Unexpected outcomes

There were unexpected outcomes for this project on both the positive and the negative side.

On the positive side, as described above and as noted by the Professor Matheson’s independent evaluation, the project was coincidentally well-timed and well designed to promote and provide the use of locally gathered / generated data for planning and prioritisation, given the focus on UHC in all four nations. Using the adapted Tanahashi model, also adapted by UNICEF as “level three monitoring” for its “monitoring results for equity-focused systems” framework, national and local authorities in all four countries acknowledged the increased empowerment and understanding of that a focus on EBP afforded. The recent interest in EBP of government in the Indonesian province of Maluku is an indication of the appeal the approach should have in the four project countries.

The engagement of other stakeholders including DPs and the NGO sector in each country proved to be another unexpected benefit. Collectively, the engagement of government, donor agencies and NGOs in all countries augurs well for the sustainability of the project, provided funding and political stability are assured. There remain...
major opportunities for donor agencies such as DFAT to influence the processes and outcomes prioritised by the IC in these and similar nations in these regions.

There was more national engagement and greater impact at national level in this iteration of the IC than was planned and with far greater likelihood of long-term influence than anticipated. It was particularly impressive in the Philippines where the additionality of the PhilHealth work, Mayoral training and other national initiatives far exceeded what was anticipated and should have long-term impact. One example is shown by the cover of a new National Handbook on Local Investment Planning for Health, recently released by the Philippines DOH after development with the support of the IC project. This document now provides national guidance on sub-national health planning in the Philippines. This national policy-level work draws on the experience gained during the IC work in the three cities, which identified and resolved problems in sub-national health planning - including the lack of a coherent set of related policies and unclear roles of various DOH units. Substantially influenced by the EBP work, development of this handbook involved a national consultation on local health planning that UNICEF facilitated. Bottleneck analysis and the Tanahashi model are featured as tools that LGUs should use.

Similarly, links with Bappenas and the MoH in Indonesia facilitated national impact (strengthening of DTPS; attention to fund channelling; acknowledgment of the need to empower and increase the accountability of sub-national authorities for MNCH outcomes – all in the context of that nation’s evolving levels of decentralisation), and in both Bangladesh and particularly Nepal the same local empowerment and enhanced participation in and accountability for prioritisation and budget allocation was evident. In Nepal, the experience with the IC approach has contributed to increased interest at national level in decentralizing budgeting in what remains a highly centralised planning system (a pilot to do so is now planned for 14 districts). In all countries UNICEF offices made substantive efforts to promote and expand the project strategies. The degree to which these efforts succeeded was unexpected.

The project provided more knowledge that could be used as a foundation for UNICEF’s work on district health systems strengthening (DHSS). UNICEF is currently establishing its role as a partner of WHO, the World Bank, USAID and DFID in the area of HSS at both national and sub-national levels, an issue whose importance has most recently been underlined by the Ebola virus crisis in West Africa. UNICEF has experience supporting work similar to the IC strategy in around 20 nations in Africa, south, east and north Asia and the Pacific. Documentation of this work is in process and the DFAT-supported work will contribute significantly and demonstrate Australian support for this globally important area of public health.

On the negative side, especially for a project focused on the use of data, it was more difficult to prove the project’s benefit on MNCH and health financing outcomes than anticipated. Lack of data from local level is a perennial problem in low- and middle-income countries (LMICs), and especially in the poor rural areas targeted by this project. In Papua, Indonesia, some district level staff had little familiarity with spreadsheets and graphs, and internet connectivity was problematic in most rural locations, making the idea of improving the HMIS to include submission and inclusion of the content of regular reports currently impossible. In finally evaluating this project, an attempt was made to assess secular increases in local funding for MNCH in non-project districts, but it was reported back from the field that this was flatly impossible to check given current reporting systems.

The short duration of the project also made it difficult to verify the sustainability of its impact in the pilot districts, or whether it has been replicated in other locations. However, the IC process has been introduced in three new districts in Papua, and is continuing in 15 districts in Nepal, without DFAT support. In Bangladesh, LLP is now being implemented in 11 districts/two cities as part of a multi-donor/UN-supported initiative that includes bottom-up strengthening of the national HMIS, and in the Philippines the same bottleneck analysis and local budget allocation is being introduced in many locations, supported by new planning guidelines and increased centrally allocated funding available.
Another issue was the tendency, also observed commonly in LMICs, for project benefits or strategies (training, nomination to participate in groups, government approval processes etc.) to rely on named individuals rather than whoever is filling titled positions in government or academia, or to rely on the imprimatur of a leader rather than policy. Examples include the technical personnel on the Papua TST, most of whom are listed by name rather than position; approval of the Papua governor himself for the TST, rather than standing parliamentary approval, and similar examples in Nepal and the Philippines. This phenomenon may make project-instigated improvements short term if local support is not assured. Fortunately most approaches appear to have good traction and should survive the rotation of staff.

6. Expected long-term benefits and sustainability

In each country supported, district level planning in at least the pilot locations but most likely many others will be more evidence-based/data driven and will explicitly engage local stakeholders (both among the population and leadership). This will ensure prioritisation of fund allocation is driven by local needs and perspectives, not what has been determined in the national capital or cut and pasted from previous year budgets.

This local empowerment should be sustained, and will be accompanied by increased accountability, both to national level and to local communities. VDCs in Nepal, IMP in parts of Indonesia and similar engagement of local groups in the Philippines and (through community registration activities as part of the strengthened HMIS in Bangladesh) in Bangladesh are examples of such a trend at local level. Other agencies have been fostering a similar focus (USAID’s kinerja project in Indonesia; Korean-aid and UN-supported empowerment of decentralised authority in Nepal; LLP with UN support in Bangladesh and government-sponsored quashing of patronage networks and encouraging local population engagement and accountable mayoral behaviour in the Philippines). While this project generated no proof of this, it is also likely that the increasing health literacy and connectedness of rural populations in these and similar countries (through new communications media) will both increase the desire and capacity for participation in planning, relevance and quality of local services, and the potential for the population to be engaged in their monitoring and evaluation. The IC has provided a template for this engagement.

Of note, in relation to government support for this direction, in each country supported, government is giving priority to UHC, which will require redesigning of local health services according to local needs. UHC cannot be achieved by template. The strengthening of local capacity for prioritisation, use of data, planning and allocation of funds will have a major impact on the design of UHC-focused initiatives at district level, and is a major benefit of the IC focus. The project’s and related work on fund channelling should also have raised attention to this issue at national level, at least in Indonesia. To the extent that UHC will require efficient and accountable health financing with high-level capacity for reporting on national allocations for social health insurance, private sector engagement/stewardship and funding of public health initiatives, capacity for the generation and use of data will also be very important. Hence the IC focus on data generation has been relevant. In addition, specific project outputs on social health insurance (in the Philippines), HMIS (in all countries but particularly Bangladesh), a structured approach to planning and the timing thereof (in relation to national planning and budgeting processes) and the establishment of technical support for these areas (in Indonesia, Bangladesh and Nepal) are likely to be sustained.

Of course, to continue these project outputs require ongoing government support (policy, legislation, establishment of technical capacity, maintenance of human resource capacity and related stewardship, genuinely decentralised authority, a financing environment that acknowledges the social as well as economic sectors etc.). Donor support will also be important, to a varying degree in the four countries, and in other similar countries. This may be directed nationally or sub-nationally, either directly to government or through local academia. This project identified semi-independent agencies as collaborators in all four countries (Table 2), and recommends ongoing support for each of them.

This project was unequivocally a pilot of a concept that can easily and should be replicated nationally, with government support. Obviously variations on the themes piloted and demonstrated will be appropriate in different locations, such as adaptation of DTPS in Indonesia, incorporation of bottleneck analysis into local social sector planning (beyond MNCH and beyond health) in the Philippines, use of data for LLP in Bangladesh and Nepal, engagement of VDCs in Nepal and community HMIS in Bangladesh, and establishment of technical support networks in several countries. These approaches will definitely require long-term government funding and prioritisation, but are fortunately occurring in the context of rolling out of UHC in each of the four countries, and signs of proportionally higher government support for the health sector in at least the Philippines, Indonesia and Nepal.
OVERALL ASSESSMENT

7. Relevance

The IC concept was and remains highly relevant in LMICs, particularly those with a decentralised system of government (including Indonesia and the Philippines), those pursuing decentralisation (Nepal), or those considering how to do so in the local political context (Bangladesh). It underlines aspects of health governance and financing that are important for public health in poor districts, for stimulating central level funding and for UHC. It draws attention to governance, planning and financing of MNCH and of health more generally at sub-national level, which is relevant in nations that have either attempted decentralisation but with inadequate oversight or funding, or where the commitment to decentralisation is not matched by action, or remains weak, usually resulting in a focus on hardware over software in the public sector, disparities and inequity. A particular benefit of this project was the identification of local agencies to support government to implement the main strategies of the IC.

Accordingly, in each of the four countries supported there is no doubt that the project focus was highly appropriate and relevant. While it is possible that aspects of the IC approach would have been implemented without this project (for example, as decentralisation deepens and as expectations of local accountability increase, or as performance-based financing is introduced), it is unlikely that the technical approach (strengthening data gathering and HMIS; use of bottleneck analysis; selection of the most relevant interventions and related monitoring and evaluation) would have been pursued. Moreover, as also discovered in each country, there was a need for identification of local partners and capacity-building therein, at both local and (to a lesser degree) national levels. This capacity-building and the funding of local technical support remain crucial ongoing needs after this project. For example, while the Papua Governor support is encouraging, continuation of the TST and its activities in the field remain dependent on sustained local funding and political support – the same can be said of UGM in Indonesia, the IHE in Bangladesh, the NPHA and the Health Research and Social Development Forum, also in Nepal. Only in the Philippines is there clearly an adequate level of political support and funding for ongoing activities that take the IC approach.

The focus on higher value elements of health systems (planning, prioritisation, budget allocation, financing, HMIS, engagement of civil society and the general population etc.) demonstrates a maturity of the thinking underpinning the IC concept. By definition, the IC approach seeks longer term improvements with a focus on outcomes over short-term outputs. While it was difficult in this project to verify sustained leverage of funding (because the project was too short and because this proved difficult to measure), the conceptual benefits it afforded have been clearly articulated by the independent evaluator. As demonstrated by the recent Ebola crisis in three countries with a long history of short-term, small-scale development assistance and very weak governance and infrastructure, establishing accountability, HMIS, performance monitoring, financing systems and health infrastructure are important to prevent crises and improve health outcomes in poor, remote areas. It will also be imperative to the success of any future development assistance in these and similar nations. Happily, the situation in the four countries ultimately supported by this project was at a level far more able to benefit from the focus of the IC, and both UNICEF’s and the independent evaluator’s assessment is that all are moving positively in the direction intended. The caveat remains continued political support and funding.

The project focus on MNCH was important given that the national progress the four countries have made on the related global targets masks the continued inequity that characterises sub-national performance on those same indicators. Moreover, it was evident that data-driven prioritisation and planning resulted in districts commencing new work on important issues, such as undernutrition in Davao City, maternity waiting rooms and immunisation coverage in Papua and skilled birth attendance and community engagement in planning in Nepal, and a range of ongoing activities in Bangladesh. These basic but essential interventions only needed better data and analysis of the bottlenecks to their implementation to underwrite the new attention paid to them by local authorities; this is a major benefit of the IC approach as has also been demonstrated in several UNICEF-supported IC-type initiatives in Africa.

For the above reasons, the project also proved relevant in the context of directions in global public health and HSS. As indicated by the growing global interest in HSS (conferences, academic journals, high level commentary etc.), and the focus on sub-national HSS, the central themes of the IC concept are increasingly the focus of government and donor interest. As HSS is increasingly linked to UHC, private sector and community engagement and local-level, EBP and budgeting, the IC approach will have growing relevance.

Whether the project was adequately linked to the DFAT country program strategy is moot. In Nepal and Indonesia, there was a clear linkage to existing Australian government-supported activity. This continues to be the case in Indonesia, but despite ongoing needs, not in Nepal where health is no longer a focus of the DFAT program.
The project had limited engagement with the DFAT post in the Philippines and in Bangladesh. As discussed elsewhere in this Report, broadly, the IC approach is relevant to the areas of focus articulated by the new DFAT strategy, and can easily be applied beyond the health sector.

8. Appropriateness of objectives and design

The objectives of the IC approach have not changed markedly since it was first introduced in 2008, and remain highly relevant. Inequity in access to basic, locally determined and locally relevant interventions prevails in most LMICs; as a result, there is disparity in MNCH services and outcomes across gender, urban-rural, geographic, ethnic and other categories, and usually a lack of local capacity to plan and fund solutions to this disparity. This situation exists in the context of nascent attempts to establish UHC, which will impose new expectations of accountability and responsibility on sub-national governments.

The project design evolved over the first year of funding, and took account of known local capacity, the availability of and likelihood of leverage of local funding, and experience of the IC approach in these and similar LMICs. It became evident that the objective on costing of interventions, modelling and estimating outputs and outcomes was too complex for most local authorities, especially at sub-national level, and also risked imposing a set of tools that had not been initiated by the countries, and were difficult to introduce in terms of feasibility. Instead, the project focused on building capacity to collect and use data for priority-setting, planning and budget allocation; on designing and implementing interventions to address major remaining disparities and areas of poor progress; on establishing approaches to these areas (planning and activity implementation); on multi-stakeholder and community engagement; and on monitoring and evaluation of progress. These areas of focus were important and remain so. The use of pilot districts as province-level demonstration sites was ideal for the concepts the project was attempting to introduce. As the project progressed, it also focused on national advocacy for this approach, and also cross-sectoral support from non-health sectors of government at both national and sub-national levels. This is again highly appropriate in the context of governments which are attempting to decentralise accountability and (in some countries) introduce performance-based financing of the public sector.

The scope of project countries took some time be finally determined, and finally decreased from a possible 11 nations to a final five. It is clear that there were multiple influences on the initial allocation of DFAT funding to a set of activities that were not finalized, but it is also clear that this was not ideal, particularly given the plan to complete the project in the initially planned two years. Fortunately and appropriately the four main nations selected provided a range of circumstances, capacity, political scenarios and level of support and interest for the IC approach. The best support was received from the governments of Nepal and the Philippines. Indonesia’s situation is evolving rapidly (with the new government even recentralising [to province level] to a degree) and Bangladesh's burgeoning economy and progress in MNCH despite political strife provided an interesting context for DHSS. Funding was adequate for the project’s needs and was, overall, used effectively; it also leveraged or made the most of newly available practical support (the TST in Papua; new planning guidelines in the Philippines; a new focus on LLP and the HMIS in Bangladesh and nascent decentralisation and community engagement in Nepal).

In terms of project design within the four main nations finally selected, two issues stood out. The first is that project activities had to take the local context into account, not only the issues mentioned immediately above but also the existing support from the development and non-government sectors. Nepal is in the process of developing a third multi-donor approach to the health sector; Indonesia has multiple agencies supporting governance, planning and approaches to improving accountability at sub-national level, including in Papua and in the area of MNCH nationally. The Philippines is not so tangibly benefiting from major donor assistance in the health sector, but has strong and growing government support for decentralised planning and budgeting and UHC, and Bangladesh has a strong NGO sector and existing models for decentralised planning in non-health sectors, supported by the World Bank through the Ministry of Local Government. It was important for the IC project to consider these extant initiatives.

Second, the project made use of pilot districts to demonstrate the approach in each of the four main countries. To a varying degree, the models provided have yielded sustained interest in the approach, with countries either replicating the approach in new districts (Nepal, Indonesia) or incorporating aspects of the design of the IC into district-level approaches to planning and budgeting (Bangladesh and the Philippines). This leverage, in terms of approach to improving sub-national accountability and capacity, is testament to the project’s success in drawing attention to higher-level approaches to improving MNCH.

Finally, the project also incorporated national activities in each country, both to provide evidence for the IC approach and also to raise the profile of the work with national health and non-health authorities. This was successful in each country. Examples of this were provided in section 4 above.
9. Implementation issues

9.1 Financial management and fund flows

There were no major issues related to financing of this project. The project utilised the UNICEF global financial distribution and management system. Funds were disbursed to UNICEF in New York and then on to Country Offices and Field Offices as required. Requests were submitted for planned activities and personnel approximately six months in advance. Use of funds was reconciled within each Country and Field Office against activity budgets prepared in advance. UNICEF's detailed process of internal auditing was undertaken at periodic intervals in each Office; for example, it continues in 2015 in Indonesia. There are no significant leftover funds to return.

Funds were entirely utilised for activities related to the IC project at all levels of the organisation, and continue to yield benefit in the five countries, two regions and at headquarters level. Even internationally, through documentation and presentation at meetings, the DFAT-funded IC work is and will be further known as having significantly advanced both implementation science and field modelling of the IC concept and its approaches.

The question of value for money is a valid one for this project. From UNICEF’s perspective, the DFAT funding clearly enabled implementation of a set of activities and promotion of an approach that has been appreciated and sustained in various ways across four nations in two large global regions, and with implications beyond these regions. Even though DHSS and this approach is a global priority, it would unequivocally have been impossible for UNICEF or other agencies to have achieved this level of piloting and government support without this funding.

To the extent that both the recipient (UNICEF) and beneficiaries (four country governments, and indirectly the two regions in which they sit) have been able to move forward with use of data, the engagement of sub-national health and non-health stakeholders and the establishment of an evidence-based foundation for UHC in decentralised settings, the project was most definitely a success. This conclusion was also reached by the independent evaluator. Moreover, to the extent that it was possible to evaluate leverage and improved MNCH, the figures available after only one or two years of implementation in pilot districts suggest that on balance, progress was being made in the desired direction. DFAT will reflect internally on whether these achievements constitute “value for money”; but UNICEF’s perspective is that progress has been made on both tangible and especially intangible aspects of priority-setting, planning, budget management, government, attention to MNCH and providing a foundation for UHC that would not have been made without this project.

9.2 Monitoring and evaluation

The project initiated several means of monitoring and evaluation. First, an experienced evaluator, Professor Don Matheson, undertook a formal independent prospective and comprehensive assessment beginning in late 2012. His report has been submitted separately.

Second, in Indonesia and the Philippines, UNICEF relied on the eyes and ears of UQc personnel and partners. Their regular and detailed reports on project-supported activities proved informative and provided information on progress at district level, including on the personnel trained, interventions selected, results of these interventions on selected output indicators (skilled birth attendance; child underweight; vaccination coverage etc.) and attempts to incorporate the IC approach into other areas of government spending besides MNCH.

Third, UNICEF field offices in all countries provided regular updates on progress and problems. This was important in Nepal and Bangladesh and relied on field staff and the domestic partners listed earlier. The TST in Papua was a particularly effective model for field oversight that both informed UNICEF as the local donor for the project, and also established local capacity and hence credibility that stimulated government support for its continuation.

Fourth, UNICEF country, regional and headquarters personnel made regular visits to the field sites during the course of the project. While this involved lengthy travel, one should not underestimate the two-way benefit of these visits, both for the travellers, who learned details of local implementation practices (such as IMP in Indonesia; the engagement of the VDCs in Nepal; LLP and improvements to the HMIS in Bangladesh; training approaches and the impact and methods applied to deal with malnutrition in Davao), and for those receiving them, who heard first hand of how the methods were applied in other locations, and technical assistance and feedback on the approaches observed on site.

Finally, the IC project itself focused on improving data systems and the local HMIS. The extent to which the data generated was used during LLP and EBP indicated effective project implementation, and there was a clear indication that data was indeed generated and used in this way. There was also near-universal recognition of the benefit of use of data and interest in its use for prioritisation and planning, on the part of the local health and non-health leaders. Having said this, it is acknowledged that in some more remote areas, for example in Papua and in parts of Nepal, there were personnel whose numeracy and familiarity with spreadsheets, graphs and computers was limited. The project was not long enough or designed to provide this level of training of local staff, nor would it have been sustained as those trainees rotated away. A different
kind of intervention, of long-term duration and supported by government through basic and vocational education channels would be needed to improve this.

Also on the negative side, it is evident that some indicators were difficult to measure. In particular, the funding leverage stimulated by the project was uncertain. Although the allocations did indeed increase in most pilot districts and also at national level, this was inconsistent year on year, and the question of attribution versus contribution (vis-à-vis the project itself) is uncertain. In a related activity, a USAID-funded evaluation supported by the Traction project in late 2014 concluded that:

- There were changes in MNCH budget allocation, with fluctuations, and also in the total health budget
- More intensive efforts are needed to stress the importance of equitable health budget allocation within districts (i.e. below the level targeted by the IC project)
- EBP has influenced planning and budgeting but there are also external factors impacting local budget allocation
- The EBP added value, particularly through bottleneck analysis, improved data usage, cross-cutting communication and coordination with the local Bappeda
- Further effort in improving cross-sectoral coordination and the role of Bappeda in health planning is suggested.

9.3 Gender

The IC project focus on MNCH assured that its predominant attention was to the health of women as well as children in all countries. This was important both at sub-national and national levels, as not only is health and MNCH relatively underfunded in the project countries (see political economy analyses), but the majority of personnel with control over said funding are males.

Moreover, it is acknowledged that most of the authorities with whom the project interacted from government were males. The project did not have specific capacity or intent to impact on gender bias at this level, so it was important to advocate for and represent the interests of women in this way.

Many of the selected interventions in IC pilot districts had a direct bearing on women’s and girls’ health, such as antenatal and maternity care, maternity waiting rooms etc.

While the project duration was too short in pilot districts to demonstrate outcome level improvements such as in maternal or child mortality, many of the health workers benefiting from project-funded training, and most of the community personnel engaged in local prioritisation and liaison activities (VDCs in Nepal, community nutrition monitors in the Philippines, EPI and health promoters in Bangladesh and IMP and bidan di desa and posyandu personnel in Indonesia) were women. Along with the management-level focus on MNCH prioritisation and funding, this should have a sustained influence on MNCH and related outputs and outcomes. Although there is no record of this, project personnel note that women participated actively in project meetings at both administrative and implementation level. It is noteworthy that all four main project nations have either outperformed in the area of MNCH (particularly the two south Asian nations) relative to economically similar nations, or have recently stepped up funding for health and MNCH (the Philippines) or are using a focus on UHC to improve equity, especially for the poor and particularly poor women.

10. Lessons learned

This project’s limitations in both design and implementation were evident early on. They included, on the negative side:

- Too short a duration, lack of clarity on the project design and early lack of local buy-in. Time was lost in the first year of project roll-out while local government engagement and the support of sub-national UNICEF offices was secured. Recruitment of personnel and identification of local partners was slow, given the time constraints faced. The project relied heavily on the buy-in of UNICEF sub-national offices. In some cases this caused delays due to country program cycle, field office and other priorities, staff availability etc.
- Lack of clarity and early decision-making on which countries to include in the project focus, including the selection of project pilot districts in some of the countries.
- There was reluctance to include use of the costing tool that was a major part of the earlier IC project. This should have been evident from evaluations of the previous work.
- Other activities were a distraction or required local adaptation in some locations. This could have been considered earlier with better context analysis and planning. So, with varying degrees of impact, in Indonesia the project had to adapt to USAID’s Kinerja project and UN and government preferences for domestic approaches to planning and budgeting (such as DTPS and the Millennium Development Goal Acceleration Framework); in Bangladesh there was a burgeoning focus on LLP among UN and other partners, which benefited from a larger volume of funding and a more technical-focus on EPI, progress on which was easier to measure; redesigned multi-donor-funded health support in Nepal, and revisions to planning and a focus on UHC in the Philippines.

On the positive side, most of the lessons learned have been emphasised already, and/or pointed out by the independent evaluator. They include:

- Appreciation of the new use of data for priority-setting, planning, monitoring and evaluation
- Appreciation of local health and non-health engagement in planning, and of an alternative to grandfathering in the setting of budget allocations
• Demonstration of a new approach through pilots, and inclusion of capacity to replicate the approach through local support teams/expertise, and by making use of evolving attention to the issues at national level
• The focus on equity and the most deprived, which was timely and important in the context of the attention being paid to UHC, globally and in the four nations supported. While UHC has mostly been viewed through a health-financing lens, this project demonstrated that an equity focus can also incorporate priority-setting, improving quality of care, selection of new interventions and the need for data – all of them also imperative for any version of UHC that incorporates local design elements (as is appropriate).
• Inclusion of an analysis of the political economy of health and MNCH in the four nations, which was particularly appreciated by the UNICEF country offices. It provided a broader, determinant-level perspective of influences on these areas, which was highly relevant to priority-setting, planning and budget allocation.

These lessons have been utilised in the replication activities that are underway in each of the four main project nations. They have also been disseminated through standard UNICEF means (presentations at meetings, internal and planned peer-reviewed publications etc.). In addition, a suite of media products is in development, including briefing notes, video material, a web-site and other reports.

11. Recommendations for further engagement

UNICEF concurs with the recommendations of independent evaluator Professor Matheson, who concluded that the IC approach should be adapted and further supported by national and sub-national governments and by those donors able to provide long-term support for improvements to governance, planning and budgeting at local level and accountability for performance; approaches to engagement of the private sector in the context of introducing UHC and more generally; advancement of the most vulnerable women and children in developing nations, and encouraging capacity for decentralised priority-setting, planning and budgeting in health and other sectors.

UNICEF notes that several of these opportunities and areas of focus have been stated as priorities by DFAT in its 2014 announcements of the new direction of a streamlined Australian aid program. A focus on health, on women and children, on engagement of the private sector (not specifically included in this project but highly recommended as a future area of focus for a new iteration of the IC) and on encouraging local economic development, monitoring and governance are all mentioned by DFAT and Australia’s Minister of Foreign Affairs as priorities for Australian support.

This project leaves behind several ongoing areas of activity that would benefit from future support. These include:

• Implementation, monitoring and evaluation of improvements to MNCH and the engagement and stewardship of the private sector in PhilHealth’s efforts to expand and improve the quality of benefits offered to insured women and children. This may provide the first example of an LMIC government engaging effectively with the private sector since Thailand did so over ten years ago.

• Fostering of local multi-sectoral, semi-independent technical support for priority-setting, planning, budgeting, monitoring and evaluation of activities within countries, with a focus on accountability. The Papua TST is a good example, but even it needs ongoing support, and Papua is only one of about a dozen provinces in Indonesia where an IC approach would benefit MNCH and other outcomes. This is a big job – especially in the two nations with no experience of genuine decentralisation and even in those where patronage networks and parochial influences on budgeting have limited planning processes based on need.

• Less concrete but probably more important, the political economy work lends weight to a recommendation that budget and financial flow analysis, detailed knowledge of local governance and consideration of political issues is important for both government and donors in their support for decentralisation and priority-setting. This applies to any sector. While this recommendation does not lead to specific project-style recommendations, it underlines the need for future development work to include partners from multiple sectors, both within and outside government and from the public and private sectors, as informants, implementers, overseers and evaluators.

• It is evident that the IC approach was one of several being implemented to improve planning and budgeting in each of the countries. Future support in this area should ensure the focus of these other activities is incorporated into the project design from the outset. In the event, this project was able to include IC approaches in ongoing government-supported activities, including a revised DTPS in Indonesia; enhanced quality and use of evidence as a foundation for the DOH’s focus on newborn health, for the training of Mayors, for Cities and Provinces and for PhilHealth; for LLP and for a district level IC approach in a number of locations in Bangladesh and Nepal, respectively. All these activities are relatively new and would benefit from ongoing support from UNICEF with Australian or another donor’s support.

• The explicit inclusion of the private sector in planning and budgeting of public resources, and the engagement of the private sector in implementation of public-sector-funded MNCH and health activities should be a major area of focus for Australia and other donors. While the size of the health sectors in the four countries supported in this project will limit this support to models or research on approaches, it remains imperative for
the governments of LMICs with mixed health systems all over the world to devise means of utilising the private sector for the public good. This is a key area of research with few successful examples to draw on from among LMICs, and with important but difficult political economy, health financing, governance and stewardship elements. There is no doubt that the international support is needed to underwrite the engagement of the best minds to research means for emerging economies with limited resources to develop health programs that are effective, efficient and equitable, and yet allow the choice and flexibility that a vibrant private sector often includes.

- Finally, there is clearly a need for DFAT support in MNCH in these four and similar nations in South and East Asia and the Pacific. Residual inequity, old and new challenges (e.g. adolescent pregnancy, newborn mortality, poor provision of early child nutrition and developmental stimulation, child and maternal undernutrition, non-communicable diseases, migration and urbanisation – all affecting poor and the vulnerable households more than those with established incomes and good education) and broader determinants of health all continue to impact on disparate outcomes for women and children according to geography, demography, religion etc. As stated by Australian Foreign Minister Bishop, everyone benefits when women are healthy, and the poorest women have the greatest need in this regard.

12. Handover/exit arrangements

The following situation exists at the close of the project as of 31 December 2014.

All personnel employed by UNICEF to implement the project have either left the organisation or are continuing on alternative funding. No government or partner organisation staff were fully funded by the project; those whose participation was supported by daily allowances provided by the project are continuing in these roles with local funding.

All physical assets purchased with project funds are now retained by the organisation for whom they were procured (UNICEF or one of the project partners listed in Table 2).

No contractual obligations remain outstanding at the end of the project.

Some documentation related to the project but not expected as an output remains in development. This includes peer-reviewed papers on DTPS, political economy, DHSS and the use of evidence for local and national planning. Video and a website related to the project are being finalised; UNICEF will support its continuation after project completion. Due acknowledgement to DFAT will be paid.

Project activities that are continuing after project closure have been amply described above in section 4. In brief, these include EBP and LLP in project pilot sites and in some new, non-pilot sites selected after project closure; use of the IC approach in MNCH and other, non-MNCH and some non-health activities, in several locations; increased attention to HMIS more broadly, and to financing of the health sector in the context of UHC, in all four main project countries, and attempts to decentralise health sector planning and budgeting to the degree legally and politically acceptable in each country.