EVALUATION OF ACCELERATING THE IMPLEMENTATION OF THE INVESTMENT CASE FOR MATERNAL, NEWBORN AND CHILD HEALTH IN ASIA AND THE PACIFIC PROGRAMME

SYNTHESIS OF FINDINGS FROM BANGLADESH, INDONESIA, NEPAL AND THE PHILIPPINES
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September 2014
Professor Don Matheson
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<tr>
<td>CIPH</td>
<td>City Wide Investment Plans for Health</td>
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<tr>
<td>DFAT</td>
<td>Department of Foreign Affairs and Trade (Australia)</td>
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<td>DFATD</td>
<td>Department of Foreign Affairs, Trade and Development (Canada)</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DP</td>
<td>Development Partner</td>
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<td>DTPS</td>
<td>District Team Problem Solving</td>
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<td>EBP</td>
<td>Evidence Based Planning (Bangladesh’s and Indonesia’s version of the IC)</td>
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<td>EBaP</td>
<td>Evidence Based Planning and Budgeting (Philippines’ version of the IC)</td>
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<td>FCHV</td>
<td>Female Community Health Volunteer</td>
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<td>IC</td>
<td>Investment Case</td>
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<td>IP</td>
<td>Implementation Partner</td>
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<td>MBB</td>
<td>Marginal Budgeting for Bottlenecks</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MNCH&amp;N</td>
<td>Maternal, Newborn and Child Health and Nutrition</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MoHP</td>
<td>Ministry of Health and Population</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PIPH</td>
<td>Province Wide Investment Plans for Health</td>
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<tr>
<td>RMNCH&amp;N</td>
<td>Reproductive Maternal, Newborn and Child Health and Nutrition</td>
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<td>SBA</td>
<td>Skilled Birth Attendants</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>UQc</td>
<td>University of Queensland Consortium</td>
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<td>WHO</td>
<td>World Health Organization</td>
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An evaluation has been conducted from 2012 to 2014 of a UNICEF programme that supported district and/or city level planning and budgeting processes in four countries: Bangladesh, Indonesia, Nepal, and the Philippines. The programme was funded by the Department of Foreign Affairs and Trade (DFAT, formerly AusAID) of the Australian Government.

The program brought together global and local implementation partners. UNICEF head and regional offices provided technical support in the four countries. The University of Queensland Consortium also supported the programme in Indonesia and the Philippines. National NGO and academic partners also formed part of the implementation partnerships in each country.

Originally the programme was called the “Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific”, however in all four countries the approach, and the name, were modified. In response to concerns about the cumbersome nature of the original Investment Case approach, all countries rationalised the data requirements. There was also reduced use of detailed costing and modelling at the subnational level.

The main findings were that the programme was transformational for the local level actors involved. It increased the use of and understanding of local data, its use for advocacy, and it enabled them to leverage some increased resources for maternal and child health, in some cases across different sectors.

The programme had a strong emphasis on equity, and in most cases was carried out in high need areas. The current trajectory in all countries is overall health improvement, but the rate of improvement is much slower for high need communities as compared with lower need communities. The programme encountered limitations in its application to the communities with highest need due to the lack of stable and skilled local health leadership and the absence of relevant, local health information.

The programme had minimal influence on national level priority setting and budgeting. However it did contribute to national policy measures concerned with decentralising health planning and budgeting processes that are occurring in all four countries.

The evaluation found that support for subnational planning and budgeting processes had significant impact, but the approach needs further modification if it is to be brought to scale and made sustainable. Multiple donors promoting different approaches to planning and budgeting is as likely to be as disruptive of local processes as it has been of national processes in the past. A coordinated approach from the main health development partners in support of government led subnational policies is recommended. The scope of the planning and budgeting process undertaken at the subnational level needs to increase to encompass the main health related activities at this level.

A different planning and budgeting process for MCH, Malaria, NCDs for example, is not tenable at this level, and a comprehensive approach is required, in conjunction with a prioritisation process based on meeting locally identified needs.

The engagement of the private sector was weak in all cases, despite private health provision and out-of-pocket expenditure being the dominant form of provision and expenditure in most of the countries in the evaluation. Future activities need to incorporate effective ways of engaging with private sector actors. Engagement of the district hospital, other sectors, and NGOs was variable across the different countries, and a more consistent approach to engaging the different sector actors would be desirable in future.

The approach to the highest need communities needs to be adapted to support the development of local leadership and health information as necessary foundations for the planning and budgeting process.

The evaluation concludes that this programme has been a successful “probe” into the complex and context dependent sub national planning and budgeting systems for health in these four countries. The increased attention being paid to the situation in cities and districts has broad and positive impacts, and focusing donor and government attention at this level is likely to increase overall system performance.
INTRODUCTION

This report is a synthesis of the findings from the Evaluation of Accelerating the Implementation of the Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific Programme, which was conducted in Bangladesh, Indonesia, Nepal and the Philippines between September 2012 and June 2014. This ‘Synthesis Report’ focuses on the cross-cutting issues that have emerged out of the evaluation findings. The Programme is referred to as the ‘Investment Case’ (IC) throughout the report.

This is a final report of the Evaluation, and is the last of 10 reports. A fuller account of the experience in the four countries can be found in the individual country reports. A general description of the Reproductive, Maternal, Newborn and Child Health and Nutrition (RMNCH&N) challenges and the specific countries’ relevant health budgeting and planning system can be found in the four country ‘Baseline Reports’. The methodology is described in more detail in the ‘Inception Report’.

This programme was a result of a collaboration between the Australian Government (DFAT) and UNICEF.

METHODOLOGY

This evaluation has used a number of approaches, tools and sources of information. The evaluation design was developed using the information provided in the Terms of Reference (TOR) for this evaluation, and information from initial discussions with the key contact people during country visits to Bangladesh, Indonesia, Nepal, and the Philippines. These visits enabled an initial contact to be made with national stakeholders (UNICEF, Government Officials, Development Partners (DPs), and Implementation Partners (IPs)).

Mapping the evaluation

The design summary was based on the evaluation objectives specified in the TOR for the IC evaluation. For each objective, a set of relevant questions was prepared, building on those supplied in the TOR by the steering group. Both qualitative and quantitative information was considered for each objective.

This set of questions was used to guide initial thinking on the content and key components of the evaluation based on the programme objectives and goals already identified. The evaluation was conducted in two phases.

PHASE I: PROGRAMME MODELS AND INCEPTION PHASE

During the Inception phase, the first step was to define what those implementing the project expected to happen because of project activities. Programme logic or theory¹ was used to develop the perspective of each of the UNICEF country offices. The programme logic developed a model that identified and linked programme outcomes with interventions and processes, and the theory and assumptions or principles underlying the programme. The model provided a map for the programme, illustrating how it was expected to work, what activities need to come before others, and how desired outcomes are to be achieved.

The logic model started with the assumptions that were being made when the programme was first being formulated. It then identified the resources the programme needed to accomplish the set of activities, and then how these resources and activities will work together to achieve the expected outcomes. In this case, the objectives for IC have been identified within the TOR. This was further explored at the country level, and the different

country contexts were incorporated as noted above. At the same time as the programme models were being developed, the evaluator, in association with local consultants, developed a baseline report on the situation of RMNCH&N in the specific countries, referred to as the ‘Baseline Reports’.

**PHASE II: FINAL EVALUATION**

Phase II was completed between March and June 2014. During this period, the evaluator revisited the four countries and, with the assistance of a local consultant, conducted interviews at the national and sub-national levels of the health systems. In Nepal, Indonesia and the Philippines it was possible to revisit districts that were visited in Phase I. In Bangladesh, the districts had not been chosen at the time of the first phase of the evaluation.

**QUALITATIVE INFORMATION**

A total of 117 interviews and 13 group discussions were conducted during the two phases of the evaluation. The interviews included participants from government, UNICEF, other Development Partners, NGOs, Implementation Partners, academic institutions, health workers and communities. The interviews were semi-structured in approach, using the evaluation questions as the starting point. Written notes were taken during the interview process. These were later analysed using NVivo² qualitative analysis software. In this process, interviews were coded according to their coverage of evaluation questions, and additional themes that emerged in the course of the evaluation were captured.

The interviewees were selected on the basis of their exposure to the IC activities. The districts and cities visited were those where significant IC activity had occurred, and where logistic arrangements (such as senior staff availability) were feasible at the time of the visit. This was a deviation from the original design which was for the districts to be randomly selected.

The qualitative responses give an insight into the current views and opinions of those most involved in the IC activities. Because of their timeliness, they present stronger evidence for what is happening than do the quantitative measures, which are reporting on events that have happened at least a year ago.

**QUANTITATIVE INFORMATION**

At the same time as qualitative data collection was occurring, quantitative data was also collected from the national and district administrative data sets. Administrative data sets were explored as well as national survey data because the information is more up to date, and detailed information is available down to the health facility level.

A limitation of the administrative data sets is that changes may be occurring due to changes in the process of data collection rather than the level of activity in the health sector. The focus of the evaluation is to look for trends in the data, rather than the absolute values, due to the unreliability of denominator information.

In all countries there were difficulties in establishing accurate denominator populations, particularly in relation to urban migration depleting rural populations and increasing urban populations - at a rate of six per cent a year in many areas. In addition, the movement of people to access services outside of their geographical location is a particular issue, especially for communities living adjacent to large urban centres and where roads and transport make particular services more accessible.

A further limitation of the quantitative data is that it includes specific indicators that may not be representative of the overall RMNCH&N efforts. The impact of specific interventions may not be apparent for a number of years. The IC, at the earliest, would be having an impact one year after it was introduced, and only if the bottlenecks identified were able to be addressed in that timeframe. Many bottlenecks, such as workforce numbers, can take a number of years to address. Lastly, only one dimension of inequity is considered, geographical location.

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² NVivo is a qualitative data analysis (QDA) computer software package produced by QSR International. It has been designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required.
As a proxy for changes in RMNCH and Nutrition the following indicators have been chosen due to their availability:

1st ANC: 1st ANC Visit as % of Expected Pregnancy
4th ANC: 4th ANC Visit as % of Expected Pregnancy
SBA: Delivery Conducted as % of Expected Pregnancy By a Skilled Birth Attendant
Measles: Measles % coverage 9-23 months old children
DPT3: DPT3 % coverage
CPR: Contraceptive prevalence rate (modern methods excluding condoms) of Reproductive Age
NOPD: Percent of New Out Patient Visits as % of Total Population (an indicator of wider health system activity)

An attempt was made to find specific quantitative data indicators (see Box). These were chosen as they represented performance in Child Health, Maternal Health, and Reproductive Health. In addition, the percentage of new outpatients in a given year was included as an indicator of overall accessibility of health services. No indicator was used for nutrition due to the difficulty of identifying a suitable indicator that could be consistently applied in the different settings.

This evaluation does not assess the effectiveness of particular aspects of the tool used, but does assess the overall impact of IC activities, tools and processes.

**FORMATIVE APPROACH**

At the conclusion of each country visit a feedback session was held with UNICEF country office staff to consider the findings. These sessions provided additional information and commentary and this was taken into account in the evaluation’s findings. At the end of Phase I, feedback was provided on the initial findings.

Before the completion of this report, preliminary findings were discussed with all four countries. This process included a feedback workshop with stakeholders, including district and national government participants.
SYNTHESIS FINDINGS

Evaluate the impact of the IC on how planning is undertaken, programmes are delivered, policies are crafted and the processes by which budgets are decided

(A) What was the process of planning and budgeting prior to the introduction of the IC?

At the national level, the policy, planning and budgeting processes have not been significantly impacted by the IC activities. The IC activities have been largely focused on sub-national planning processes.

In all countries there have been previous processes implemented to improve sub-national health planning, for example the Local Level Planning process in Bangladesh since 1998, District Team Problem Solving (DTPS) planning process in Indonesia since 2005, Province Wide Investment Plans for Health (PIPH) and City Wide Investment Plans for Health (CIHP) in Philippines since 2007, and a previous attempt at a local health planning mechanism in Nepal. There are also examples of concurrent planning exercises supported by donors such as micro planning for immunisation, and others for specific disease states or interventions in Bangladesh and Indonesia. Despite these efforts, there were serious shortcomings reported in the experience of local level health planning in the districts and cities visited, prior to the IC activities:

“There were no planning tools in use prior to IC.”
– District health manager

“Previously we had planned ‘top down’ only.”
– City health manager

“Prior to this, planning was left to each department, and budgets did not change year in year out. It missed deep analysis, and activities had very little impact on the problem.”
– City planner

“Planning processes were a “copy and paste” exercise in the past. Now they look more deeply at the benefits of particular expenditures.”
– District government health programme manager

In all four countries, although district- and city-level planning had been introduced in the past, often with donor support, it had not been sustained, had not developed beyond a pilot phase, or had become a meaningless paper exercise performed by the planner filling out a template.

(B) What was the understanding of the key challenges/deficiencies of existing plans and budgets, especially in terms of addressing the needs of MCH and of the most deprived?

The first point to make in regards to this question is not so much the challenges and deficiencies, but the level of success the four countries are experiencing in addressing RMNCH&N. National statistics indicate that the countries are progressively improving their performance in relation to Millennium Development Goals (MDGs) 4 and 5, and this is borne out at the service level when RMNCH&N indicators are tracked over time, as seen in the country reports.

In all four countries, there is a focus by the national leadership at the highest level on progress towards the MDGs, including MDG 4 and 5. In three of the four countries, there is an established pattern of increased investment in health, with two countries, Indonesia and the Philippines, embarking on very substantial policy initiatives directed at attaining Universal Health Coverage.

Performance in relation to the different components of RMNCH&N tends to follow a similar pattern of improvement in all four countries. Immunisation consistently has the highest level of coverage, while continuity of care for pregnant mothers (as seen through fourth ANC visits) and birth attendance by a skilled birth attendant is consistently low.

Despite, or possibly because of the general performance improvements, inequalities are increasing in all countries. Improvements are occurring across the populations, but the rate of improvement is faster for the better off populations (as seen in Bangladesh) and districts (as seen in Nepal), those near main centres, and those districts with committed and supportive leadership at both the administrative and political level.

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3 A description of these processes is found in the Baseline report.
5 PIPH was adopted on a pilot basis by 16 provinces in 2007, followed by 21 more in 2008, including six provinces from the Autonomous Region of Muslim Mindanao (ARMM). http://www.doh.gov.ph/content/province-wide-investment-plan-health-piph.html
How was the IC introduced, process used, aspects of IC used, resources, timing and time taken, organisations and people involved?

The Intervention, the ‘Investment Case’, Changed Significantly During the Course of the Evaluation

At the beginning of the evaluation, the Investment Case was described as a process with the following steps (in no particular order):

- Advocacy for public health planning
- Organisation and analysis of national and sub-national specific data
- Identification of system bottlenecks
- Strategies to address bottlenecks
- Costing, budgeting and financing of these strategies
- Leverage and advocacy of partners and government
- Implementation of plans and monitoring frameworks
- Scaling up with an equity focus
- Evaluation.

The IC process was to be assisted by specific tools: Marginal Budgeting for Bottlenecks (MBB) and Matrix.

The list above remains the overall scope of the activities, but significant change has occurred in the way the specific tools have been applied. Both the research preceding this evaluation, and the findings at the inception recommended that the tools be simplified. Their original formulation was seen as too cumbersome to be used as regular planning tools and beyond the capacity of most administrations. To quote one senior government official during Phase I:

“The tool is way beyond the capability of my staff. They currently struggle with any Excel. It is something that should be used for research purposes, say once every five years.”

This view was held most strongly by some of the government officials who had been exposed to training in the MBB tool. This negative perception of the Investment Case approach persisted into Phase II and was still influencing the views of some government and development partners. To quote from a development partner in Phase II:

“For planning purposes it has a number of difficulties. It is difficult to use nationally because it goes to the micro. It was not seen as a planning tool in the original design by Tanahashi. In practice, the feedback we have is that it is a difficult tool. Lower levels are requesting a simplified tool.”

In all four countries the approach, including the use of the tools, was simplified. Comments about the difficulty of the tools were not being echoed by the key users at the sub-national level during Phase II, suggesting that the original experience of the use of the IC has clouded judgements about it.

The major modifications to the approach have been to simplify the data requirements, and reduce the emphasis on costing and modelling. This reduction in scope is most explicit in the sub-national activities in Indonesia and the Philippines where IPs note:

“We stopped using the Matrix as it was too complicated. We have also simplified the tracers.”

“Cost and impact analysis has been dropped.”

In all cases, there is now increased emphasis on the bottleneck analysis as the core of the intervention, alongside equity assessment.

Re-branding has occurred in all four countries because senior UNICEF country-level officials were aware of the negative image that the term ‘Investment Case’ has for some government officials and development partners.
The term ‘Investment Case’ has either been modified or replaced. In the Philippines it is called Evidence Based Planning and Budgeting (EBaP); in Bangladesh, Evidence Based Planning (EBP); in Nepal, District Investment Case (DIC); and in Indonesia, Evidence Based Planning (EBP). In addition to the simplification of the tools and the change in name, most countries shifted their emphasis from the application of a ‘tool’ to focus primarily on the ‘process’ of sub-national planning, and to take greater cognisance of the specific needs of the district or city in which they were operating:

“The process is now very much city led, responding to city needs.”
– IP, Philippines

Individual countries have made more specific changes. In Nepal the DIC activities are used in association with an approach called ‘Appreciative Inquiry’. This introduces a significantly different dimension to the district planning process, with an emphasis on building on strengths inherent in communities and helping to create ownership of the issues. In the Philippines, the UNICEF office has been very explicit about its focus on process:

“In the previous IC, modelling and costing were the focus. In the new approach, there is greater emphasis on process and the use of local data, applied where appropriate to inform decision making.”

This evaluation will continue to use the term ‘Investment Case’ to describe the programme, but it should be noted that what has been done has moved away from the original description of this approach.

THE FOCUS AND IMPACT IS ON THE SUBNATIONAL LEVEL

The primary focus of IC activities in all four countries has been on the health sector planning at the sub-national level. This activity has had a direct and positive impact on the planning process at these specific locations, as well as potentially impacting on national planning guidelines for sub-national health planning.

(D) How effective and efficient was the IC process?

There is strong evidence from the qualitative data of the effectiveness of the IC process at the local level in each of the four countries. This is covered in more detail when impact is discussed below.

Evaluating the efficiency of the process presents a number of challenges. The IC activity has appropriately taken a different direction in response to the differing context in the four countries. In each situation, the approach is innovative, and has depended on the opportunities that existed in the country at the time. It is also introducing new skills and processes, so the actual cost of the IC programme over the last two years, during its implementation, is expected to be greater than its likely cost in an establishment phase.

In terms of technical efficiency, the relationship between resources and health outcomes, it is too soon to assess the health outcomes that have been achieved. In addition, the programme is operating in an environment where there is not a successful, sustained introduction of a planning process of this nature to compare it with. The significant impacts that have been achieved are discussed below.

In terms of productive efficiency, the comparison of differing interventions to achieve a specific outcome, there are at least two (if not more) models now operating. In Indonesia there is the approach of developing institutional capacity to support the process, using three layers of academic institutions (global, national and provincial), as well as a team inside the provincial administration and a focus of activities on just one province. In Nepal and Bangladesh, there is engagement across different regions with national academic institutions and NGOs, with technical support from UNICEF’s regional and national office. In Nepal, there is use of a complementary programme, Appreciative Inquiry, which is being delivered as part of the IC approach. From the evidence available in this evaluation, a judgment cannot be made on the relative value of these approaches.

Over time, one would expect the reliance on international technical support, either from UNICEF or University of Queensland Consortium (UQc) to diminish over time as the capacity and capability of the national and provincially based institutions grows. A future focused programme could consider making that transition more explicit in the programme design.

There were efficiency concerns raised in a number of countries in regard to the relationship between IC activities and pre-existing planning and policy activities. Micro planning, which UNICEF also supports, was the most prevalent of these, and enjoyed a level of confidence with those involved:

“The main planning activity has been micro planning, which has been very successful.
Malaria deaths have been reduced from 11 to 2.
We have micro planning for TB and EPI as well.”
– Sub-district level manager
In one country, micro planning was being applied by UNICEF at the facility level, at the same time as the IC was being applied at the district level. These approaches have more similarities than differences, and their portrayal as discrete is inefficient.

An interesting perspective on the separation of planning approaches was expressed by one senior government official who was familiar with the IC activities:

“The IC is a step towards integrated planning. At least it starts to incorporate different RMNCH&N interventions, whereas micro planning is on single topics. One could see EBP as a step towards integrated planning.”

– National level government officer

At the national level, two of the four planning leaders expressed a strong view that district level planning processes should be comprehensive:

“We need a comprehensive LLP tool, not one for [Primary Health Care] PHC, different from MCH, different from malaria.”

– National level government planner

“The IC is quite good, but we need efficient use of resources. It does not include an integrated approach. We can’t be doing a separate IC for MCH, malaria, [Tuberculosis] TB. We need a comprehensive approach. We can’t take five days out for each of these.”

– National level government health planner

The degree of difficulty has been discussed earlier. The ‘difficult’ part of the IC approach has been absorbed by the IPs so that there is more focused activity at the district level. The predominant view from the districts and cities was that it did involve more than the existing planning process, but that the previous process was inadequate. The IC activity were seen as part of their core activities:

“Is it efficient? It’s our core business. It is what we should be doing. The present process is not difficult.”

– District level health manager

A related efficiency issue is the relationship between the IC activity and the existing government policies. Concern was expressed from some government officials that the IC activity did not take adequate notice of existing government policies, so was inclined to come up with solutions that were outside the policy settings, and hence unable to be supported. UNICEF in some instances is effectively using the IC activity to model interventions (such as the policy approach to severe acute malnutrition in the Philippines), with the view to leveraging change in national policies. This issue has been addressed in some countries by giving more formal recognition of national policy settings in the IC process.

(E) What were the ‘products’ produced by the IC process? Who received them, and when?

The specific products and processes are described in the relevant country reports.
Evaluate the impact of the IC on government processes, including the political and subsequent budgetary priority given to MNCH&N

(A) Did the IC impact on governments’ planning, budgeting and monitoring processes?

ENGAGEMENT WITH DATA AND INFORMATION

The most consistently reported impact from those involved in the IC activities has been the engagement with data and information, and local data in particular. The impact of this has been to improve both the planning process and decision making:

“One advantage [of IC] is the importance of data. This means that when we go to the BUPATI (Head of a Regency) there is no need to debate as the data is there.”
– District level government official

“The BAPPEDA (regional body responsible for development and planning) head is also keen on EBP. He asks “where is the data?” now when an issue comes up.”
– Provincial health planner

“EBP has been useful, helped us use data, identify what the problems are, and use strategies to address them. Prior to EBP we did not look into the detail in the planning process, just responded to the larger problems such as MCH. The quality of data has improved.”
– Government provincial official

The IC activity has also exposed the weaknesses in existing local information systems to support the planning process and in some instances has resulted in improvement to that system:

“It was also clear that we were not collecting some indicators – and we intend to change the information system now to collect more meaningful data – for instance, before we did not know if a child was given a prescription or actually got medicine for pneumonia - so we did not know who was actually treated. Now we go back to data for evidence for all of our purchasing.”
– City health manager

The programme in all four countries put considerable effort into the preparation of evidence and data to be used at local-level workshops. This work was conducted by local universities and the University of Queensland in Indonesia and the Philippines, and through support from the UNICEF regional offices in Nepal and Bangladesh. There are mixed views as to whether the data requirements of the current IC process are still too onerous, some saying it is well within their capacity, others suggesting it is still too cumbersome and reliant on external involvement to collect and analyse the data. There are also mixed views as to whether existing routine information systems should be modified to meet the data needs of the IC process, or whether it requires a separate data collection system and process.

In summary, it is clear that the IC activities have put data and information systems on the agenda of these local planning processes, and created an opportunity for engagement with data sources that were not previously used.
MOBILISING RESOURCES

The overall purpose of the IC activities was to mobilise resources and use them effectively to improve maternal and child health. This evaluation has found that IC activities at the sub-national level have been successful in mobilising resources, and the manner in which these resources were mobilised differed in each of the countries. These differences were partly due to the approach taken to the IC activities, and partly due to the opportunities that pre-existed in the particular location.

The IC activities in the Papua Province of Indonesia were able to demonstrate an increase in MCH funding in the three districts during the period of IC activity. The 89% increase between the two years needs to be seen against a background of an overall trend of increasing health funding for the districts. Persistence of the MCH budget increases in future years should continue to be assessed. In addition, the approach was effective in mobilising resources from non-health sector actors in support of improved RMNCH&N in one Papuan district.
“It has enabled us to work with other sectors.”
– District level government public health unit official.

It also facilitated more efficient resource use within the health sector, as reported by another Papuan district official:

“It encourages Puskesmas (health centres) to do integrated activities. For example, immunisation and filariasis doing outreach together. This did not happen before.”
– District level health programme manager

In Nepal, the local government operates a decentralised planning process and there is currently no political representation at the local government level, due to a political impasse for the last ten years. Consequently the district is run by an administrator.

So, while health financing is highly centralised and specified, local government resources are decentralised and communities can, through the local administrator, allocate funding with some flexibility, including across sectors.

The other exceptional features of the Nepali health system are the high level of community engagement in the governance of health facilities, and the widespread use of Female Community Health Volunteers (FCHVs) in the delivery of health services.

The IC activities in Nepal were effective in mobilising resources through quite a different mechanism. District health budgets are controlled from the national level through the ‘red book’ which specifies line items in the district budget. There is no flexibility - if funds are not expended on a particular item, they cannot be used by the district for an alternative purpose but are returned to the Treasury. So, in response to the inflexibility of national health funding, the DIC process mobilised funds through local government funding and resources at the district and village levels.

The impact of IC activities, in Dhading District, included the employment of 60 Auxiliary Nurse Midwives (ANMs), 28 of whom are funded directly by local government. It has also helped identify the need for innovative approaches to improve access, resulting in the establishment of 11 ‘health service delivery points’ in an effort to make services accessible within 30 minutes by the whole population. Dhading health district has a history of being able to mobilise local government resources for health, when compared with other districts.

In the Philippines, the focus has been on three cities, Quezon, Puerto Princesa and Davao. Cities in the Philippines have a degree of local autonomy, both fiscally and administratively. In Quezon City the IC activities have improved the ability of the district managers, who are mainly health workers, to describe and advocate for their particular needs, on the basis of the IC process. This has been successful in improving the response to requests from districts. Now evidence is being used in resource allocation decisions by the city health authorities. In Davao, a stakeholder meeting at the beginning of the IC activities focused on malnutrition, and while in the initial phase the response was largely from UNICEF (supplies, training and policy), there is a strong indication that the city
will be directly investing new resources in this programme in the coming year. Half of the proposed funding increase to health will go to this project.

In Bangladesh the IC activities are at an earlier stage, and the evidence in Cox’s Bazar related to resource mobilisation is mainly focused on the coordination of the donor activities within the district.

In summary, in three of the four countries, there is evidence of resource mobilisation for RMNCH&N outside of the direct support from UNICEF and other donors. In Bangladesh and Nepal, UNICEF is directly funding activities at the district level, but this decentralised funding arrangement is being given close attention by the respective governments as they consider a more general policy of decentralisation. In the Philippines, the initial IC activities in Davao were heavily supported by UNICEF resourcing, training and technical assistance, but this activity has helped initiate a substantial investment in RMNCH&N by the city itself.
EMPOWERED THOSE INVOLVED

The consistent feature to emerge from the interviews with the district officials involved was the positive impact that they experienced from engagement in the process. This was a consistent finding across all the districts and cities visited.

“I’m very enthusiastic about the IC process. Especially the wide engagement with stakeholders and the community. Its main impact has been to highlight the equity dimension.”
– District health manager.

“The LLP process was really relevant and achievable. It was a good learning process. We really tried to find the bottlenecks.”
– Upazila manager

“The EBaP has been very helpful for health centre managers. They are good clinicians but poor administrators. They were not using the monthly reports effectively. They were not able to integrate logistics and clinical services. The EBaP has empowered them.”
– City health officer

The enthusiasm of those involved at the district and city levels was translated into increased ability to lobby for resources (Nepal, Philippines, and Indonesia) from the government and from other sectors.

(B) What particular aspects of the IC made the most impact on planning and budgets, and in what circumstances: the bottleneck and equity analysis? The fiscal space analysis? The estimates of coverage and lives saved? The scenarios? The relationships with IPs?

The IC as applied did not routinely undertake ‘fiscal space analysis’, and ‘scenarios’. Bottleneck and equity analysis, and estimates of coverage were consistently applied. From the views expressed in the course of the evaluation, the exploration, preparation and presentation of local data and information was the element that had the most significant impact, followed by the bottleneck analysis. In one instance, in the Philippines, the IC approach was used to model different scenarios for the care of the newborn, in response to a request from a senior official.

(C) Has the IC approach helped to frame and better articulate the way MNCH is characterised, and the way decisions are made?

The main impact has been on the district planning process, inclusive of but not restricted to RMNCH&N. The use of bottleneck analysis enabled exploration of demand and supply side issues in the planning process, and was an entry point to a better understanding of the health system’s dynamics. In a similar sense, the realisation of the meaning and use that could be made of data, particularly local data, has improved the way RMNCH&N, and other issues, have been characterised.

The additional positive change has been the involvement of actors outside the health sector in the RMNCH&N planning process, as occurred in some districts of Indonesia and Nepal through its engagement with local government, and in some cities in the Philippines.

(D) What has been the impact on RMNCH&N programmes and policies?

The IC activities have had limited impact on national RMNCH&N policies to date. Some activities have been directed at the national policy level, but the timing of the evaluation is such that it is too soon to determine any impact. Examples include the modelling and costing exercise to improve neonatal health; and the development of national integrated management of acute malnutrition guidelines in the Philippines.

Another policy initiative related to the IC activities, also in the Philippines, is the engagement of UNICEF in the development of primary health care policy by the national insurer, PhilHealth.

INFLUENCED THE NATIONAL APPROACH TO SUBNATIONAL PLANNING

The main impact of the IC activities on the national policy process has not been on national RMNCH&N policy, but on the policy and guidelines for sub-national health planning.

In Indonesia, the existing sub-national planning process for MCH, the DTPS, is currently being revised. There is a proposal to embed an element of the IC, bottleneck analysis, within the revised approach.

In Nepal, there is an increased interest in decentralisation. This is a result of the political process, and the probability that the new constitutional arrangements will involve a degree of decentralisation. The Ministry of Health and Population (MoHP) is having discussions about increased budgetary flexibility within the health district. Both these processes have yet to result in any policy or guideline; however the IC experience is of interest to senior
policy makers as they contemplate how decentralised arrangements might work.

In Bangladesh the planning section of the Ministry of Health and Family Welfare (MoHFW) is revising its Local Level Planning (LLP) process for health, and this process has the active involvement of UNICEF who are advising about the use of IC in future LLP guidelines.

In the Philippines, the Department of Health’s (DOH) Bureau for Local Health Development is also revising its planning guidelines for provinces and cities. UNICEF has contracted a group to assist in this process.

Influence on national RMNCH&N policy and budgeting is less apparent. An exception to this is the three-day workshop that UNICEF and the University of Queensland ran with the Director of Child Health in the Philippines, where they applied the IC approach, including scenario modelling, to identify priority interventions for the newborn. This was very well received by the Director. It is too soon to tell the extent that this will influence government policy and resource allocation in this area.

In summary, in all countries the IC activities have opened up opportunities to engage in policy dialogue on national approaches to sub-national planning. Although at the time this report is being written, none of these processes have proceeded to the point where the governments’ positions are finalised, it is highly likely that the IC activities will influence the government’s approach to sub-national health planning. This offers the prospect of improved processes at this level, and a positive impact on maternal and child health.

The extent that these new approaches will have an equity focus is unclear. In all countries the existing planning processes have an equity dimension. The main challenge is how to overcome the barriers to equity in implementation.

(E) Is there a difference observed between districts involved in IC activities and those that are not?

As noted earlier, it is still too early in the IC process to detect health outcome impacts of the IC activities. Most of the IC planning workshops began in 2012 or later, and their resulting budgetary decisions were not implemented until 2013 at the earliest. Of those decisions, some could be implemented within a year (such as specific supplies) but others will take a number of years to implement - such as increased trained health workers.

The review of administrative data does inform the evaluation in two aspects. Firstly the districts and cities targeted were not always the highest need geographical areas in the country concerned. The second aspect was that the districts and cities were already on an established trend, and that the higher need areas appeared to be showing less or no improvement whereas the areas of less need (relatively) were showing greater improvement. These trends also need to be considered against a background of improving service provision nationally.

These two aspects are illustrated in the case of Nepal in Figure 2.
The performance of IC districts in Nepal (Dadeldhura, Udayapur, Dhading, Kapilvastu and Jajakot) shows the districts chosen for the IC activities are on quite different trajectories from a service improvement perspective. Firstly, note the consistent improvement of the national coverage by Skilled Birth Attendants (SBA), from 32% to 41% over the three-year period.

Secondly, Dadeldhura is performing at twice the national average, so from this perspective is not a high need district. Dhading, with the longest experience with the IC, is improving faster than the rest, moving from 22% to 37% coverage in the period. Jajakot and Kapilvastu are showing little or no improvement for this indicator.

This pattern is also seen in other countries. In Indonesia, Papua is the highest need province, but the IC districts were not the highest need districts in the province. In the Philippines, the cities chosen have performance above the national average, although there is some uncertainty over the denominator data. The exception is Bangladesh, where the districts chosen are the highest need districts.

It should be noted that assessing inequality of access has its limitations if it is decided at a high level of aggregation. Higher performing districts (such as Dadeldhura or the Philippine cities) have high inequalities of access within them, with lower access in urban slums in the case of the cities, and remote areas in the case of Nepali Districts.

The characteristics that were most apparent in those districts and cities that were performing well were the capability and capacity of the local health leadership and the extent that it was supported by the political administration. With committed leadership and support, very significant improvements are made. Without it, the IC activity appears to have little impact.

The available data was explored to see if there is any specific impact from bottleneck reductions. This implies the following steps:

- BNA completed
- Specific bottleneck identified
- Funding / resourcing increased in the area of the bottleneck
- Successful budget execution and implementation
- Removal of bottleneck
- Performance improvement consistent with original prediction

The timing of the evaluation limited the extent that this cycle was completed. However, in Nepal and Indonesia, IC activity has been in place long enough in some districts for this cycle to be completed. In Nepal, a series of reviews were being instigated, to see if attention to previous bottlenecks had delivered the expected results. This is still a work in progress, and the methodology of the review will need to rely much more heavily on the local data components.

(F) Has the IC approach influenced the way decisions are made?

The IC activity has had a significant impact on decision making and planning at the local level. It has introduced and supported concepts such as the importance and use of local data and the examination of the local health system from a systems perspective. It has also built local capacity to support those processes, and in some instances, is beginning to influence routine data collection.

The question of sustainability was discussed extensively throughout the evaluation. In most instances, the ‘concepts’ and ‘changed way of thinking’ were seen as significant in themselves and would have a sustained legacy, with or without a supporting programme. The sustainability of a programme dedicated to IC activities was seen as less likely, unless the lessons from the past attempts to establish sub-national planning and budgeting approaches are picked up.

(G) Has the IC approach strengthened the power of key actors engaged in RMNCH&N at national or sub-national levels? For example, increasing their visibility, credibility, coordination, collective action, leadership, or available resources?

In all four countries the IC activity has strengthened the power of the local-level health managers and planners who were actively engaged in the process and, to a limited extent, mobilised resources. In the most cases
the conduct of the IC has enabled the local-level health administration to advocate to higher authorities within the health system, using data and evidence in ways that they did not before.

In the Philippines the facility heads were better able to articulate their needs to the city authorities, and the City Health Officer in another instance was able to successfully leverage city resourcing. In Nepal the heads of the district were better able to present their needs at regional and national planning forums. In Indonesia, the activities were having a direct impact on political decision making at the local level.

The activities undertaken with the IC have enabled both UNICEF and local actors to take advantage of “political windows” that have occurred in each jurisdiction. The consistent example discussed above is the participation in the sub-national planning deliberations that are occurring in all four countries.

Document the current use being made of the IC in four countries

(A) What is the nature and intensity of IC activities at the time of evaluation?

The IC activities are continuing in all four countries, and an account of current activities is included in each of the country reports.

(B) Do different stakeholders, including DPs, have consistently different views on the usefulness of the IC methodology in promoting improved MNCH across countries? What might explain this?

The IC activities examined as part of this evaluation had a previous history in the four countries which had negatively influenced the views of many stakeholders. The problem that this presents is that opinions gathered may be reflecting more on the previous activities than the current round of activities.

Overall, development partners voiced critical or sceptical views of the IC activities. These views included the degree of difficulty of the IC approach, the need to be open to other approaches, the lack of evidence of effectiveness and the lack of attention to building core district capacity.

The experience of governments, including at the subnational level, is of multiple development partners promoting their particular approach or methodology. The IC activities to date have had limited ‘buy in’ from senior national officials and decision makers, largely because it is seen as one of many similar approaches. It is still perceived by many as a tool in an environment where tools are not in short supply.

“*This situation [multiple DP led district initiatives] makes the districts confused. So we will let districts decide which approach is easiest for them to be implemented.*”

– Provincial level official

At times the IC and other such initiatives compete with rather than complement the government’s own attempts to address the same issues.

“*It’s like donors keep coming with a new car, abruptly changing to the new car each time, different from the last. Government wants the one they are used to and have experience of.*”

– Senior government adviser

The perceptions of senior government officials and DPs have not changed significantly since Phase I of this evaluation. In some instances, due to staff changes, there is less awareness of the approach now than 18 months ago. The exception to this is the potential headway being made in sub-national planning approaches in all the countries.

(C) What is the role of the IC methodology vis-a-vis other planning and implementation activities?

The way in which the IC activities have evolved in these four countries is to place greater emphasis on the process and less on the IC methodology itself. The methodology has been simplified in most countries, retaining core elements such as the use of tracers and bottleneck analysis, and less use of modelling and costing scenarios.

The adaptation of the approach in relation to local planning tools and guidelines is a work in progress. It is too soon to say which elements will be retained, but from what is being discussed, it seems the bottleneck analysis is likely to persist. Countries differ in their approach to the degree the local planning process will be separate for MCH, or more comprehensive.

In most countries the IC has been used to coordinate other donor activity at the district level where it has been applied, such as GAVI in Bangladesh.

(D) How have the IC activities influenced the policy and funding choices of other development partners?

Other development partners have contributed to the resulting budget configurations following the IC activities at the district level. Now that the funding period for this activity is coming to a close, the IC approach is being taken up in some instances as the preferred approach, such as its adoption by DFATD (in Bangladesh.)
DISCUSSION

The original ideas behind the Investment Case were based on the premise that developing countries were not prioritising pursuit of the MDGs relevant to mothers and children, investment in RMNCH&N was insufficient from both countries and donors, and there was insufficient uptake of the most cost effective, evidence-based interventions available as were being described at the time in the Lancet.

From this set of problems, an approach was developed to influence national and global development outcomes, with a strong emphasis on equity, by the use of specific tools that brought together the evidence base for interventions, the pattern of disease in particular countries and communities, the cost of specific interventions, and a way of analysing the different components of the health system.

This evaluation looks at the evolution of this approach, as it was applied in four countries - Bangladesh, Indonesia, Nepal, and the Philippines - between 2012 and 2014.

The situation of the countries has changed since the IC approach was originally conceived; countries are prioritising MDGs, they are investing in health, and they are making progress on the maternal and child health-related MDGs.

In addition, the configuration of the health system for each country differs considerably. Decentralisation is the dominant feature in the Philippines and Indonesia, whereas centralisation typifies the Bangladesh and Nepal health systems. The workforce configuration also differs markedly. Female Community Health Volunteers are a significant feature in Nepal, the private sector is most dominant in Bangladesh, and the Philippines has well developed tertiary facilities.

Appropriately, the investment case as an intervention has changed to meet this changed set of circumstances. There is less emphasis on ‘making the case for investment’ and more on how to invest effectively. The activity reported on is primarily occurring at the subnational level, in districts and cities. The emphasis has shifted from a focus on specific tools to a focus on the process of subnational planning.

In summary, the programme has been applied to complex health systems, which differ according to the local context, and which are changing rapidly over time, as indeed is the IC programme. This evaluation attempts to describe what was occurring in this complex, context-dependent dynamic system. Given the complexity, there is a focus not only on the technical tools themselves, but how they have been adapted to the particular context, time, and health system.

This process of adaptation is seen in the name changes that occurred, the modification of the IC activities to reduce their scope and degree of difficulty, and the changes in approach to meet the requirements of subnational planning and budgeting processes. This adaptation has clearly been successful at creating a positive and transformational experience for those involved at the local level. The changed perceptions on the use and meaning of data, and improved understanding of the components of health systems at the local level, are very significant achievements.

Health sector participants and the IPs both concur that it is the discussion that the planning process initiates that is most valuable:

“In this process we try to find the root of the problem. We ask why, then why, then why. We find the underlying causes. It is a very good process.”

– District level government manager

Another very significant finding is on the use of data and information, particularly local data and information. By and large data systems in these countries draw data to the centre, and it is seldom used and analysed at the subnational level, let alone the facility level. So, engaging in a process where local data is valued and mined for the insights it can bring locally is a very important action.

National health authorities generally have a low level of confidence in the capacity and capability of subnational managers. The “IC” process has considerably boosted the confidence of the local level managers involved, so in time one would hope this confidence will be recognised by the central authorities.

Positive adaptation is also seen in the way the IC programme has managed to lever increased resourcing; at the local body level in Nepal and the Philippines, and across other sectors in Indonesia.

The positioning of the IC programme in relation to more general approaches being taken by governments to decentralise health planning and budgeting is also a considerable adaptation from the original concept of the IC, which focused more exclusively on national RMNCH&N policy.

There are several areas where this process of adaptation needs to continue if a sustainable sub-national planning and budgeting system is to be established. The effectiveness of the approach is limited when certain preconditions are not met and this may be inadvertently
increasing rather than decreasing between-district inequalities. For instance, its impact in different districts is strongly dependent on the health leadership in the district. Where there are weaknesses in the leadership, either because of capability or political tensions or frequency of turnover, the IC activities have achieved less traction. It also requires a pre-existing local information system – where this is absent, using local data as a basis for IC analysis is not possible. The leadership and information system weaknesses are more likely to occur where the health needs are highest, limiting the use of the IC in these areas, and consequently its use as a tool to improve equity. A more tailored capacity and capability approach is required for these very high need areas.

The renewed interest in all the countries in increasing the sub-national planning, budgeting and decision-making capability is a political window at which the IC activity is presenting itself as a potential policy solution. However, the process of adaptation needs to continue if the IC is to deliver a sustainable solution. The immediate areas that need to be addressed are the scope of the IC activities (RMNCH versus a comprehensive approach) and the agreement amongst DPs to develop a more coherent approach to the use of specific tools.

In regards to scope, there is a strategic choice to be made. To continue to drive through a vertical approach at the district level, in the same fashion as vertical approaches have been used at the national level, or to look across systems and conditions, and support a comprehensive approach to district planning and budgeting. If the latter course is chosen, then the approach will need to include a component on prioritisation, as at present the priorities are set nationally, if not globally. The majority of respondents at district level and in national planning departments favoured a comprehensive approach.

The sole focus of the current IC approach, limited as it is to RMNCH&N, was an issue in many districts and also of concern to national planning officers. At the district level, there is very limited planning capability, and district officials need to develop a comprehensive plan across the health portfolio. They do not want to be undertaking an intensive planning process for RMNCH&N separate from malaria, separate from TB, and in future, NCDs. There was a consistent call for a comprehensive approach to planning from different levels of the government systems. The IC activities have filled a real need to improve planning at the local level, and brought some attention to local planning issues. Many districts were already looking at using the bottleneck analysis more widely to address other issues, including, in some cases, planning exercises outside of the health sector.

On numerous occasions in the course of the evaluation it was pointed out that the IC activities only went so far – that they made a difference in the short term, but unless fundamental issues were resolved, the activity and enthusiasm would not be sustained. The main concern raised in this regard was the lack of response to issues arising out of the planning process and the disconnection between the IC and existing national policies:

“Previous planning attempts have failed because the information gathered had no impact at all on budget allocation.”
– National government planning officer

“The weakness of the EBP is it is not linked into available national programmes. Sometimes the districts are unaware that there is a national programme already to address the bottleneck”

The pre-existing planning approach that most interviewees were familiar with was WHO’s Health Systems Framework and its ‘System Building Blocks’. Many saw the building blocks, particularly the availability of ‘health workforce’, as more profound than the issues raised in the IC process. It was frequently observed that responsibility for these issues was sitting well outside the responsibility of those involved in the planning processes at the local level:

“HR issues sit outside of our responsibility.”
– National level government programme director

“[I]t won’t work without building HR capacity.”
– National level development partner

“Before EBAP I would have said our main issue was HR and not the commodities. The response of the city has been to increase the supply of commodities which has made a difference but the HR issues remain.”
– District manager

The WHO Building Blocks and the IC approach are not distinct ways of thinking about planning. It is unfortunate that they are now perceived as distinct choices to make in how to approach planning processes.

The lack of a shared approach between development partners, even within the ‘One UN family’, does little for the credibility of the DP organisations at the national level, and even less at the local level. Once again a strategic choice needs to be made by the DP organisations involved: to continue to have competing, separately branded tools and approaches, or to genuinely look at the strengths and weaknesses of the different approaches, and subsume these inside the countries’ subnational planning guidelines and frameworks. As discussed in this report,
these different approaches have more commonality than differences. They all share an enthusiasm to incorporate best international evidence-based practice; they all share a reliance on good quality, timely local data and information; they are all interested in both supply and demand side influences; they all espouse an equity focus; and they all apply aspects of a systems approach.

The increased interest in sub-national planning that is occurring at the national level in these four countries could also be a political window for the DPs involved to evolve a more coherent cross-agency approach.

The scope of the existing IC activity also varied in terms of who was involved and this is an area of further potential adaptation. In some cases, it was restricted to the health sector and may or may not involve the district hospital (Bangladesh, Philippines). In other cases the focus was more inter-sectoral (Indonesia, Nepal). In most cases a broad approach to RMNCH&N was used. In one case, the initial focus was on one aspect, malnutrition. In all cases there was weak or no engagement with the private sector, even when the private sector was the main provider of health services. This flexibility in scope has a positive aspect, as it enables the IC to respond to local opportunities. However it also needs a rationale, based on engaging with appropriate local actors.

Further adaptation is required to strengthen the relationship to actual planning and budgeting. While the IC approach has opened the eyes of those involved to system issues, its relationship with existing national plans and strategies is not explicit, and its timing is out of sequence with established planning and budgeting cycles. The IC’s strength is improving understanding of what to focus on to achieve system improvement. It also explores strategies to drive improvement. However it does not replace the need to develop core systems such as quality, logistics, and health workforce that are identified in the IC process.

For example, the IC approach may identify quality as a bottleneck, but it does not provide a systematic approach to building a quality system within health systems and institutions. It may identify areas for increased budget and attention, but it does not build a subnational budget, nor assist with the skills necessary to change budget allocations within an existing system. Budgets are rarely built around the broader needs of a population, more often around the needs of a particular facility or organisation.

An additional issue is the need for the IC to be part of a cyclical planning and review process. The process of examining performance is often described in the quality literature in terms of Plan Do Study Act (PDSA) cycles. Rather than being ‘one-off’ activities, IC processes need to be positioned inside regular planning and review cycles. The question needs to remain active: did the extra resources spent on raising demand increase the system performance by the expected amount? In no case was this proven, however, the key issue is that it forms the basis of further enquiry, rather than seen as a one off. The reasons it worked or did not work are as important as showing its effects.

The final adaptation opportunity is in relation to evidence. The IC programme has effectively made global evidence available to local decision makers. The Lancet series is an example of this, but so much more needs to be done in this space. While global evidence is important, it needs to be better blended with national and subnational evidence. Here we have four countries that are demonstrating improved health system performance in many areas. Much more value could be derived from increasing the understanding of why system performance is improving in these particular settings at this time.

The political economy question is: do the distribution of resources in the district and city health budgets reflect the power relations in the district, or do they follow evidence-based decisions having considered cost and benefits, and international best practice? In other words, are decisions around budget allocation evidence-based or political economy based?

Firstly, one must recognise that the ‘evidence base’ itself is shaped by the political economy of the health development sector. The Lancet series, written by a relatively small elite from the public health, research and clinical community is not free of political economy influences.

Putting that to one side, the second issue is the engagement in the planning and budgeting process of the powerful actors in the sector. The planning and budgeting process of districts and cities in the four countries did not involve the private sector, despite the dominant role that private provision plays in service delivery. This is more of an oversight given senior figures within the public sector in the district and the facilities are also working in the private sector, the public and the private sector share patients, and share training institutions. The question is not should they be engaged – they already are intimately engaged in public sector activity - the issue is how to effectively engage the private sector to improve system performance.

The same ‘blind spot’ applies to the engagement of the districts’ most powerful institution, the hospital, and the most powerful profession, the medical profession. Bangladesh engaged the hospital sector through the use of “non tracers,” and in Nepal there was senior clinician participation in the planning meetings. Clearly more work is required to explore ways to make this engagement more effective.

The other political economy question relates more directly to UNICEF and its role and influence in the four countries. In each country UNICEF is the most trusted government
adviser on child health – it is UNICEF’s advice and approval that is sought as the final arbiter on child health policy. The same does not apply to matters of health planning, or maternal health, where WHO is more likely to be seen as the key adviser. The IC activity has meant a shift in focus from primarily child health, to local level planning. These political economy considerations are another reason that development partner consensus should be sought on the best approach to local level planning.

The longer term sustainability of the approach was extensively canvassed in the course of this evaluation. All four countries have a history of introducing sub-national health planning, and in each case it has not been sustained or has not been able to be scaled up beyond the pilot sites. This experience has brought to light the issues that need to be addressed if this programme is to evolve into a more permanent part of sub-national planning and budgeting systems.

In addition to the points raised above in relation to adaptations, which themselves would assist in sustainability, there is a need to set realistic time frames. To manage an effective transition to more decentralisation takes place over a period of at least a decade rather than 1–2 years.

Of more fundamental importance is the responsiveness of the wider systems in which the sub-national planning and budgeting system is immersed. No matter how sophisticated the local method, if the resulting plan is ignored by those with higher authority, then the activity will not be sustained. Here also lies an opportunity. In countries with increasing investment, there are also trials of new funding mechanisms, such as the Resource Allocation Framework in Bangladesh, or the PhilHealth primary health care package in the Philippines, or the moves to Universal Health Coverage in Indonesia. These mechanisms can potentially be used to give more autonomy and authority to the periphery.

The IC activity can be seen as a probe into a complex system – as much can be learnt about the nature of the system and the way it responds. The response to the use of the IC in these four countries has opened up a vast array of options and opportunities in how sub-national planning and budgeting systems could be supported in these four countries. It has also opened up other opportunities to influence broader national developments that were not readily apparent at the outset.
CONCLUSION

The IC programme represents an example of a learning system, where the approach has been modified to meet local needs and adapted to differences in local context. It has shown the ability to adapt to the needs of a sub-national planning environment, and achieved transformational change in the local level participants in the planning process.

Its proximal impact, as reflected in the enthusiasm and empowerment of the local officials concerned, is a very significant finding. In particular, it has transformed the way they use data and information, and it has transformed their understanding of dynamics of the health system at the local level. More importantly, it has given them tools to voice locally understood needs. It has also, to a limited extent, mobilised new resources – from communities, from donors, and from local government authorities.

The involvement of a wider stakeholder group in the planning process generated by the IC work has clear benefits, and its ability to attract and focus resources in some settings has considerable potential. The learnings from this process are also being incorporated into the thinking about how sub-national planning of health services should occur.

Increased focus on this area is likely to bring considerable benefits to the health of women and children, and the work to date has placed UNICEF and its partners in a unique position to assist in this process.

The programme has been less successful in influencing national policies and priorities related to RMNCH&N at the national level. However it has influenced the way national governments are approaching the revision of policies and guidelines that support local level health planning in general.

In some countries it has also provided an entry point for engagement in very significant national policy formation not directly related to RMNCH&N.

The programme has successfully positioned itself as an innovative and active participant of widespread efforts to strengthen sub-national planning and budgeting for health. To realise the opportunity that this presents will require sustained activity and further adaptation.
RECOMMENDATIONS

Based on the evidence presented in this evaluation, the main recommendation is that the work being conducted under the rubric of the IC programme should be continued and strengthened. UNICEF should continue to evolve the approach in response to the differing country contexts.

The current approach needs to be described and branded without the ‘baggage’ of the past IC activities, which were regarded as too complex to be widely useful at the subnational level. The focus should be on meeting local needs in context, rather than on a particular tool.

At all levels, including globally, there is an opportunity to build a consensus about a consistent approach to planning for health at the sub-national level that builds on but moves beyond siloed approaches of the past, and particular methodologies being championed by particular DPs. This evaluation has affirmed the way the modified ‘IC’ has transformed planning and budgeting at the local level. It does not exclude the possibility that other approaches could have the same effect.

In particular:
- The main development partners with an interest in supporting subnational health planning and budgeting to agree on a consistent approach. This could involve developing a menu of planning and budgeting approaches for which there is evidence of effectiveness.

- The IC programme should be incorporated under the authority of emerging local level planning and budgeting initiatives underway in each country, and not be separately branded.

- The approach to the poorest communities needs further development to support the capacity and capability of local sector leadership and information systems as prerequisites to participation in the planning programme.

- The issue of the scope of subnational planning processes needs to be re-visited in relation to:
  - who is involved: districts, hospitals, private sector, NGOs; and
  - the overall scope of activities - MDG 4, 5 or a comprehensive approach.

- Support the collection and analysis of local evidence of system improvement to complement the global understanding of best practice.

- Support the use of the programme as an integral part of the country’s planning and budgeting process, supporting the cyclical nature of planning, and quality improvement.

- To gain maximum leverage for MCH from the moves towards universal health coverage will require additional operates across countries should be established to assist during this process.
## Synthesis Report Recommendations

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<td><strong>Development partner coordination</strong>&lt;br&gt;The main development partners with an interest in supporting subnational health planning and budgeting to agree on a consistent approach. This could involve developing a menu of planning and budgeting approaches for which there is evidence of effectiveness.</td>
<td>UNICEF, WHO, World Bank, UNFPA, DFAT.</td>
<td><strong>Rationale</strong>&lt;br&gt;The current approach is fragmented, and there is low probability of bringing district planning processes to scale while there are competing approaches focusing on specific diseases. <strong>Risks</strong>&lt;br&gt;Important that the quality of the planning approach is not compromised in the attempt to arrive at a consensus.</td>
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| **Continued IC activities**<br>Long term donor funding is required to support further development of the “IC approach”, the collection and analysis of local evidence of system improvement and to speed the translation of the global understanding of best practice into implementation at the local level. | UNICEF, UQ, DFAT, DPs, National and regional academic institutions, Governments. | **Rationale**<br>The use of technical expertise from UQ (in Indonesia and Philippines) and from UNICEF regional/country office (in Nepal and Bangladesh) is a crucial part of the design of the IC approach. It facilitates the IC approach bringing together evidence of international best practice and local evidence of system performance to support system improvement. These elements need ongoing support – the “evidence” such as in the Lancet series for instance, needs constant updating as technology and service provision evolve. The support for local institutional capacity development (strongest in Indonesia and Nepal) adds an important element in promoting and sustaining the use of local health information at the local level. The support for local evidence generation based on experience in the local context, is a third element that is currently underdeveloped. There is considerable system improvement occurring in some parts of the four countries, which would benefit from a focused research agenda, based on the country specific experience. **Risks**<br>Currently the intellectual leadership of the IC activities is primarily sitting outside the countries concerned with implementation – this is a significant risk to sustainability, should this support be withdrawn. |

At the time of this evaluation, there remained a high level of reliance on technical support from outside the countries concerned. There should be a managed transfer of technical capability to the countries themselves, as well as greater support for the generation of local evidence based on the country context.
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<td>Merge with Government’s local health planning processes.</td>
<td>UNICEF (HO, RO, CO), Government health authorities with responsibility for local planning and budgeting.</td>
<td><strong>Rationale</strong>&lt;br&gt;A consistent finding in this report has been the desire by governments to improve their local level planning in decentralised systems (Indonesia and the Philippines) and to explore more decentralised planning and funding in centralised systems (Nepal and Bangladesh). Decentralised planning approaches have been tried in the past, but not sustained, or not developed beyond the pilot phase. This recommendation is aimed at positioning the future IC activities inside government approaches to develop sustainable decentralised planning. The IC activities have brought renewed vigour and attention to this activity, but currently the acceptance or “buy in” from the appropriate national and regional government authorities is weak. This is partly because it has been introduced as a “separate tool” in competition with existing tools and approaches, rather than as a way to strengthen and build on existing country led initiatives. It is also due to its prior reputation as being cumbersome, and its limited scope. This recommendations is not suggesting that the core elements of the IC approach be dropped - quite the opposite - they should be maintained, but within and not outside of government processes. These processes should be supported to evolve further to meet local needs and priorities.</td>
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<td>The IC programme should be incorporated under the authority of emerging local level planning and budgeting initiatives underway in each country, and not be separately branded.</td>
<td><strong>Risks</strong>&lt;br&gt;The greatest risk is in sustaining subnational planning approaches in the long term, irrespective of their technical quality. To mitigate this risk, the necessary prerequisites for IC activities (leadership and functional information systems), need to be built at the local level. In addition, a receptive response to budget proposals or decentralised allocation of resources is required from the national level. Past attempts have faltered once donor attention has shifted to other areas before the approach is embedded in the health system.</td>
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<td>Revise the approach to the most vulnerable districts.</td>
<td>UNICEF COs</td>
<td>Rationale</td>
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<td>The approach to the poorest communities needs further development, in particular to support the capacity and capability of local sector leadership and information systems as these are prerequisites for participating in the planning programme.</td>
<td></td>
<td>Although there is a strong equity focus in the IC activities, the approach has been less effective, or not applied, in the districts where the needs are greatest. Unless this is actively addressed, inequalities between districts may increase. The evidence from this review suggests that local leadership and functional information systems are necessary prerequisites for the IC activities, and these need to be built as a first step in these communities.</td>
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<td>Risks</td>
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<td></td>
<td>An unintended consequence is worsening disparities if extra investment and support is not provided to address critical barriers and ensure adequate leadership and information systems are in place in the most vulnerable districts.</td>
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## Recommendations

**Revise the scope of IC activities.**

The issue of the scope of subnational planning processes needs to be re-visited in relation to:

1. Who is involved; districts, hospitals, private sector, NGOs; and

2. The overall scope of activities - MDG 4, 5 or a comprehensive approach.

### Actioning agency/ body

- UNICEF, UQ, Government health authorities with responsibility for local planning and budgeting.
- WHO, UNFPA, WB, ADB (and other DPs) at the global level.

### Rationale and risks

#### Rationale

- The IC activities to date have, in different countries, engaged other sectors (Indonesia), the hospital (Bangladesh, Nepal), and NGOs (most countries). There has not been consistent engagement of the private sector, despite the private sector being the main health service provider in some countries and despite public health sector employees being actively engaged in private sector health delivery. The IC approach supports a focus on discrete, specific activities in the NGO and government parts of the sector, rather than taking a system wide approach. To be effective and sustainable as a local planning tool, the process needs to engage all significant actors at the local level. The nature of that engagement needs to be tactical, not treating all stakeholders as though they have equal contributions to make. For example, a regulatory or a contracting approach to engaging the private sector may be appropriate.

- The current IC activity is confined to RMNCH&N. At a local level, there was a strongly expressed view that a comprehensive planning and budgeting process is needed, inclusive of but not confined to RMNCH&N. There is not the capacity or capability to have separate approaches for CDs, NCDs, maternal and child health etc. In addition, equity issues are seldom confined to one disease state, and require a comprehensive approach. This also raises the issue of prioritisation. The IC approach promotes MCH as the priority. The difficulty for officials at the local level, is how to marry different donors’ and central government “priorities” with appropriate responses to the unique needs of the local population. The IC would need further development to support a more comprehensive approach to prioritisation, planning and budgeting.

- A comprehensive approach will require a change in the behaviour of donors. To approach subnational health planning systems in a comprehensive way would contrast to the current practice of advocating in a siloed fashion for specific diseases, populations, and interventions, as occurs at the national level.

#### Risks

- There is a risk that this approach would mean that insufficient priority was given to MCH, allowing other priorities to come on the agenda. This risk is offset by improved overall system performance and efficiency gains from a more comprehensive approach, as well as the gains from using an evidence-based process to establish appropriate priorities for the population in question.
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<td>Improving the evidence base and its connection to National Policy</td>
<td>UNICEF, IPs</td>
<td><strong>Rationale</strong>&lt;br&gt;The IC activity is strongly based on international evidence. There is less emphasis on evidence arising from the experience within the country, and on the countries own policies. UNICEF in all countries plays a significant role in child health policy nationally. In some instances the IC activities were operating in parallel to national policy, and in most instances, there was a dearth of locally generated health systems research evidence. In one example, IC findings were recommending local activity that was not supported by national policy. In another, there was insufficient recognition of the national policy initiatives in the IC workshop discussions. Further work is required to understand how locally generated research and national policies are recognised and supported within the IC processes.</td>
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<td>Improve ICs ‘fit’ with planning and budgeting cycles.</td>
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<td><strong>Rationale</strong>&lt;br&gt;The original design of the IC was as an advocacy tool, to be used at the national level. There have been a number of adaptions leading to its current role as a support for subnational planning and budgeting processes. Central to these, is the recognition of the cyclical nature of the planning, budgeting and implementation process – also known as the PDSA (Plan, Do, Study, Act) cycle in the quality improvement literature. A longer term benefit of the IC activities would be in supporting subnational system improvement, taking into account this action review cycle. It would be less about ‘one off’ advocacy, and more about continual learning and use of relevant evidence at the local level. This development would also link the IC activities with the growing body of support globally for quality improvement approaches within health systems. <strong>Risks</strong>&lt;br&gt;There is a risk that the support required to run this process as part of the regular planning and review cycle would overburden the system at the local level. The design would need to ensure it did not place too much demand on local management.</td>
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<td><strong>Establish a UHC technical support group</strong></td>
<td>UNICEF, DFAT.</td>
<td><strong>Rationale</strong></td>
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<td>To gain maximum leverage for MCH from the moves towards UHC will require additional technical resources. A technical support group that operates across countries should be established to assist during this process.</td>
<td></td>
<td>The interest national governments are taking in various forms of Universal Health Coverage creates a strategic opportunity to influence the health systems in these countries for years to come. The experience of the IC activity at the local level could provide valuable input into this process. These processes are at the policy formation stage, and more concentrated input of a technical nature is required if the expected impact on equity and MCH are to be achieved. There is also an opportunity to leverage off the experience in different countries, and to disseminate this directly into the policy formation process.</td>
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