Accelerating the Implementation of the Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific Programme

Inception report of the independent evaluation

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Executive summary

This document describes the approach being taken to the independent evaluation of the implementation of the “Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific”. It specifically focuses on the experience of four countries: Indonesia, Nepal, Bangladesh and the Philippines.

The approach has been designed following a review of the literature, discussion with stakeholders, and a visit to the four countries involved. Issues were identified that were obvious to stakeholders and do not require further enquiry during the process of the evaluation. The first of these is that the main focus of the evaluation is to be on “evidence based planning” rather than narrowly on the investment case. Secondly, there was a need for more proactive management of IC activities, particularly in relation to the use of tools. The third issue was the importance of improving the understanding of existing planning, budgeting and prioritization before the IC is applied in a particular country of setting.

The overall objective is to assess the impact on MNCH and health equity by:

- Evaluation of the impact of the IC on how planning is undertaken, programmes are delivered, policies are crafted, and the processes by which budgets are decided in four countries;
- Evaluation of the impact of the IC on the political and subsequent budgetary priority given to MNCH&N in four countries;
- Document the current use being made of the IC in four countries; and
- Compare the IC process between the countries, and put forward lessons learned and recommendations.

Evaluation questions, derived from these objectives, have been developed. The design takes a formative approach, with insights and findings shared as they emerge. The first activity is a workshop with stakeholders to be held at the start of the evaluation. Each country has appointed a country level evaluator, and their role includes the description of the particular context in which IC activities are occurring. The evaluation is in two phases. The first phase will establish “programme logic” for the IC in the particular setting. The second phase, one year later, will examine progress based on this logic.

The findings of the evaluation will be produced in a final report, as well as delivered in a feedback session to key stakeholders in the four countries.

Introduction

As the countdown for the achievement of the MDGs proceeds, donors and implementation partners are asking if their efforts to accelerate improvements in maternal and child health are effective. A straightforward question, but to find the answer this evaluation needs to deal with the complexity of the problem.

The investment case (IC) is a complex intervention operating in diverse and complex health systems. The complexity is such that evaluators are unlikely to reach as full an understanding of the specifics of its application in particular countries as the implementation partners (IP) or the governments themselves do. What the evaluation can do is hold a mirror up to the various partners’ activities, helping to reflect their reality as seen from an
independent viewpoint. The approach being taken is to reflect back these views in “real
time”, and not wait to “tell all” in a final report that would not be available until the countdown
is nearly over.

This evaluation aims to be, with the engagement of all partners, an exercise in organisational
learning and reflection, rather than in adjudication. There is only one real winner of interest –
the life and wellbeing of mothers and children, especially those who are vulnerable and
disadvantaged.

Evaluating complex systems\(^1\) requires a response that goes beyond counting the concrete
building blocks and tools and techniques to enquire as to what is really happening here, how
are the different parts relating, what are people saying, doing, feeling, and thinking, are they
reaching across sector and disciplinary silos, and are they demonstrating the leadership
required to make the transformational changes required?

The initial visits to the four countries and other stakeholders have revealed a workforce and
organisations that are highly motivated and seriously committed to the goal. The hope is that
this evaluation will play a small part in making that goal a reality.

Rationale

This evaluation has been requested by AusAID and the Steering Committee of the
Programme\(^1\). It is an independent evaluation of the implementation of the “Investment Case
for Maternal, Newborn and Child Health in Asia and the Pacific”. It specifically focuses on the
experience of four countries in the Asia Pacific region: Indonesia, Nepal, Bangladesh and
the Philippines.

The Investment Case for Maternal, Newborn and Child Health (IC) in the Asia and the
Pacific is an AusAID funded initiative. It is a process to identify key issues and influence
impacts upon maternal and child health within a country. It involves results-based analysis to
inform planning, budgeting and policies, spelling out the costs and benefits of scaling-up
packages of high impact interventions for addressing maternal, newborn, and child health
(MNCH) and nutrition.

The IC aims to address the main health and nutrition problems of the most deprived children
and families; identify bottlenecks and barriers that contribute to this deprivation (using the
Tanahashi model\(^2\)); and identify specific strategies to overcome the barriers that have
created disparities.

The purpose of this independent evaluation is to establish to what extent use of the IC
approach improves programme service delivery, policy-making, strategies and budgets for
MNCH, and to understand how this occurs.

\(^1\) The steering group includes core agencies; AusAID (funder), UNICEF and UQc (implementation
partners) as well as ADB and PMNCH.
Background and context

This evaluation seeks to evaluate the impact of the IC as it is operating in the four countries.

The IC Process has the following steps: (in no particular order, as the local context will determine what is happening when)

- 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; and,
- Evaluation.

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

The four countries have been chosen as the focus because they have been among the “early adopters” of the IC approach and have received AusAID support. Use of the IC approach has already occurred in a substantive manner in these countries and further use is also planned. These countries also reflect jurisdictions where the IC approach has been used in different ways, and at different levels. Undertaking the evaluation in these contexts provides the ability to investigate the heterogeneity of use of the IC approach, and to understand whether there have been impacts ranging from changes to programme delivery at district level to reconsideration of budgets and policy at the national level.

Within countries the focus is on specific districts with the expectation that this will have a wider system impact. The IC approach is designed to impact at both the national and sub-national level, such that activities may focus at the district level, but are expected to have an influence at the national level as well, and also impact on international partners.

The evaluation objectives

The overall objective is to assess the impact on MNCH and health equity by:

1. Evaluation of the impact of the IC on how planning is undertaken, programmes are delivered, policies are crafted, and the processes by which budgets are decided in four countries;
2. Evaluation of the impact of the IC on the political and subsequent budgetary priority given to MNCH&N in four countries;
3. Document the current use being made of the IC in four countries; and,
4. Compare the IC process between the countries, and put forward lessons learned and recommendations.

Public health refers to “the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.” In this context it encompasses the consideration of cost effective strategic packages of MNCH services linked strongly with the local needs and the feasibility of their implementation in the local context.

Currently under development by UQc
In addition, the evaluation will aim to capture the more subtle and incremental levels of change that would indicate increased political prioritization of equity and MNCH as a result of use of the IC approach. Thus, the evaluation will utilize a study design that documents the extent to which use of the IC approach has influenced decision-making and political prioritization for equity and MNCH, as well as important contextual factors that have helped or hindered this process in different country settings. It will document case studies from countries covered by the project, to illustrate these processes in a comparative manner and highlight lessons learned.

Previous evaluation findings and lessons learned

The IC approach – using the MBB tool – has been applied in many developing countries across a range of service delivery modes since its development by UNICEF, the World Bank and WHO in 2002. The IC experience in each of the four countries discussed here – Indonesia, Nepal, Bangladesh and the Philippines – has been the subject of previous review and commentary, and this evaluation draws on the features identified and lessons learned in these evaluations, reviews and reports.

Across the literature reviewed, the IC approach has been demonstrated to support individual districts’ planning and budgeting processes, and also influenced these to some degree.

In Orissa, the IC process identified new strategies, helped prioritise these, improved the allocation of work to existing staff, and the IC costing estimates provided a rationale for needs-based funding for disadvantaged districts. The process also received government interest and support. In the Philippines, the IC process facilitated informed planning decisions based on the local context, included use of evidence and systematic discussion. The extent that IC strategies were incorporated into plans and budgets and influenced priorities is debated. In Nepal, district planning processes, including prioritisation of strategies best suited to specific contexts, were supported, and enabled inequities to be considered. In Indonesia, local plans included a large number of the IC recommendations under the District Health Office remit, and an added value for policy-makers was the links created between problems, strategies, costs, and estimated impact on mortality. And in Bangladesh the planning and budgeting reflected local needs.

Other positive outcomes that have been reported in the literature from the IC approach included that it involved, or attempted to, all levels of the health system and engaged with different levels of government. In Nepal good communication contributed to retaining the credibility of the initiative despite initial confusion over scope, relationships were identified as essential in the Philippines, communication channels were improved between state and district governments in Orissa, and in Indonesia, a MNCH network brought agencies together. Furthermore, the participation of front-line workers in the process in Orissa was shown to empower them to ‘own’ intervention targets. The Philippines study found that the IC approach may be a powerful and influential tool in influencing development partners’ priorities and resource allocations.

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iii In this section, the general term “literature” is used, encompassing the various different types of reports.
The critical importance of local level data to ensure planning and budgeting reflects local needs was highlighted in all study sites, and is clearly a key component of the IC process. In particular, disaggregated analysis illustrated equity implications of strategies and targets in Nepal and Orissa. The nuanced and in-depth analysis offered local planners in Indonesia new insights into the value of these data. However, all IC study sites also experienced issues with the time and cost intensive data requirements for the approach. Stakeholders in Orissa, the Philippines, Indonesia, and Nepal reported that data collection and collation was time-consuming, and demands on staff time contributed to delays in the work, and its subsequent usefulness. Data collation was also limited by the availability, quality, and reliability of existing local data to inform the approach.

Despite the positive impacts on planning and budgeting processes, the IC approach had varied success in influencing planning and budgetary outcomes. In the Philippines, the IC resulted in fine-tuning or confirming decisions, and so had a “useful but marginal” influence but did not have a “game changing” effect. The single most strategic recommendation - use of private sector facilities thereby saving large amounts of public financing - was, ejected as an option, and officials reverted to traditional planning and budgeting approaches. Furthermore, there were mixed views about the validity and usefulness of the costings. In Nepal the IC process did not match the government regional planning and budgeting process and so results were not easily translated into decisions or policy implications. In Indonesia, difficulties with government engagement and multi-sectoral collaboration raised questions about the extent the IC can influence decision-making. In Bandarban district, Bangladesh, although the IC conceptual approach influenced the district micro-plans, there was no evidence that the IC process influenced the costing and budgeting of these.

It is clear that the political context is a key influencing factor in the success of the IC approach. Across all sites, the IC identified areas where strategic gains could be made that were the outside the responsibility of districts and required state or national level government intervention through policy and resourcing (Orissa, Philippines, Indonesia, PLOS). These are political by nature (Jimenez Soto et al, 2012). A lack of meaningful engagement, follow-up, subsequent decreased participation, and lack of ongoing investment were also issues, and lack of integration of the IC with existing planning processes and government structures were also identified as limiting factors.

Conclusion from previous reviews and commentary

These studies have shown there are number of key actions that could be taken to improve the uptake and use of the IC approach. Integration of the IC process and framework into existing government structures, knowledge, policy and planning processes would improve the alignment of the IC activities with the existing decision-making processes, and contribute to a more comprehensive situation analysis that includes cross-cutting issues such as financing, HR, governance, and support system-related bottlenecks.

Furthermore, districts should be supported to build capacity to collect, collate and analyse data, as the basis of any planning and priority setting activities, and to coordinate and implement the IC approach. Capacity building of national researchers and policy-makers would further contribute to the ‘institutionalisation’ of the IC approach. This would be expected to increase national government endorsement of the IC process and ensure the sustainability of the approach. Allocating time and resources to conduct meaningful engagement and participation of stakeholders from all sectors and at all levels is required to
ensure their ongoing investment of time and resources. In addition, it is essential to address the political nature of planning and budgeting and investigate ways to address high-level issues within the context of the country specific political climate. Finally, it is clear that the IC process requires some simplification and a reduction in data requirements if it is to be used in routine planning and budgeting especially if this is to be done at a decentralised level and if it is to be used in future for monitoring and tracking performance.

Findings from the inception visit

As part of the preparation for this evaluation, the evaluator visited or interviewed AusAID, UQc members, and stakeholders in the four countries involved during September 2012.

Engagement with government at the national level

In two countries there was minimal current engagement or understanding of the IC activities at the national level. In Bangladesh one national planner had been very involved and supportive, but she was about to go to England for further studies. In the Philippines, there was no significant national engagement. Indonesia had engagement from the leadership of the national planning body (Bappenas), but not health planners at the national level; health planners were however involved at the provincial level. In Nepal, there was strong engagement from senior level health bureaucrats and the previous Director General of Health had been very supportive, however, the very recently incoming Director General was sceptical about the value of the IC activity.

The implications for the evaluation are that there is likely to be little additional gain by focusing on further evaluating the national level impact in Bangladesh and Indonesia unless the new IC activities intend to focus more attention on the national level. Nepal and the Philippines provide an opportunity to explore the national relationship; Nepal where active interest and dialogue is already occurring, and the Philippines where UNICEF has a seat at a cabinet level advisory body (see below).
The table below summarises the key characteristics of IC activity observed during these visits:

<table>
<thead>
<tr>
<th>Country</th>
<th>Engagement with government at national level</th>
<th>IC activity currently occurring at district level</th>
<th>Some loss of IC institutional memory</th>
<th>Sustained local capacity in NRIs to carry out IC</th>
<th>IC tool used</th>
<th>Bottleneck workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Low(^{\text{i}})</td>
<td>No(^{\text{ii}})</td>
<td>Yes</td>
<td>No</td>
<td>MBB</td>
<td>Highly valued</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Medium</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Matri x</td>
<td>Highly valued</td>
</tr>
<tr>
<td>Nepal</td>
<td>High</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Matri x &amp; MBB</td>
<td>Highly valued</td>
</tr>
<tr>
<td>Philippines</td>
<td>Low</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Matri x</td>
<td>Highly valued</td>
</tr>
</tbody>
</table>

**Current IC activities at the district level and IC institutional memory loss**

In Bangladesh and in the Philippines there has been a considerable gap in time since the IC activities occurred, such that officials involved have since changed, and no specific follow-up activities have been occurring. The IC project was described by local partners as “left hanging” and “lost momentum” in the two countries.

The high turnover of staff was a constant theme raised in the country visits. This extended from the national level (In Nepal, senior officials were only in their posts on average for 6 months) to the district level where many staff who had been engaged in the IC activities were no longer in their posts. This has important implications for programme design of capacity building and technical assistance interventions. Such interventions are often predicated on the false assumption that local actors will remain in their posts to carry out and reproduce activities in the medium term.

The implication for the evaluation is that the institutional memory of the past IC activity has been largely lost in government and partners in Bangladesh and the Philippines, so the evaluation of these past activities would reveal little additional insights. The evaluation needs to focus on new activities rather than past IC activities.

**Sustained local capacity in NRIs**

As a result of past activities, there has been an enthusiastic and committed cadre of local researchers who are well versed in the IC approach in Indonesia and Nepal. In Bangladesh,

\(^{\text{i}}\) This has changed over time. It is low now, but was high in 2009-2010. This is due to the turnover of key staff, and because there is currently no IC activity in process.

\(^{\text{ii}}\) New activities are planned, waiting on funding before the IC activity resumes.
the local expertise that had been built have since left for studies in Canada, while in the Philippines, local capacity has been built, however the university involved has indicated it will not continue to be involved in IC activities. However, it is offering to assist another university to pick it up.

The implications for the evaluation relate to assessing how sustainable capacity is built and maintained inside a country. In the Philippines and Bangladesh that capacity needs to be rebuilt almost from scratch, whereas in Indonesia and Nepal there is an established institutional strength to build on.

**Use of IC tools**

Software tool use varied considerably across the different sites. Bangladesh has exclusively used the MBB tool. In the Philippines and Indonesia, the Matrix tool was used. In Nepal, the MBB tool was used initially, and then the Matrix tool was introduced. The report to the government of Nepal in 2012 on IC activities did not use the tools but reverted to a manual calculation to determine costs and outcomes after the draft reports produced with the help of the Matrix tool were viewed by UNICEF as requiring further validation and completion.

**Bottleneck workshops**

All interviewees at the country level were very enthusiastic about the bottleneck workshops and the value that this brought to their planning discussions.

**Emergent issues requiring more immediate resolution**

The findings from these visits, along with the evidence from the published and grey material above, suggest that there are some issues relating to the investment case process where there is already widespread agreement, and little further would be gained by making them the focus of the evaluation. This is not to suggest that these issues are not important, to the contrary, they are fundamental to improving the work in this area. However, there is little to be gained by delaying a further year (before the final report of the evaluation will be available) before effective action is taken by the organisations involved. These areas are:

- What’s in a name – the “investment case” or “evidence based planning”?
- The use of software tools
- The management of IC activities
- The understanding of existing planning, budgeting and prioritization before the IC introduction

**What’s in a name – the “investment case” or “evidence based planning”?**

There is already a move amongst IPs to describe the work as “Evidence Based Planning” rather than the “Investment Case” and the associated tools. This renaming/ relabeling have already partially occurred, as in the Philippines, and clearly has support from the steering committee.\(^\text{viii}\) This is not just a semantic choice but has important implications for

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\(^{viii}\) The Steering Committee even concluded that an “Investment Case” label may no longer be appropriate: “evidenced based planning” was a more accurate term. More specifically, the term “Investment Case” seemed to imply - at least to some - an approach that everywhere and always progressed in a linear manner from (useful) bottleneck and equity analysis to (sometimes questionable) modeling, all the worse if based on any one single “tool”. The SC was always interested
implementing this project. How IPs approach their task would be very different if the purpose is “How can we assist evidence based planning in this district/nation at this time?” as opposed to “How do we apply this particular tool?” Consistent labelling is one of the issues UNICEF should resolve. The implications for the evaluation are that its focus will primarily be on evidence based planning.

The use of software tools

There have been major developments in health costing tools over the last decade. Thirteen MDG-related costing tools were evaluated in 2008\textsuperscript{15,16} including the MBB. This evaluation did not rank the tools as to their relative value, but helped to define the characteristics of the tools, and the specific role they played. The MBB tool has undergone further development since then. A locked, stable version of MBB has been available since late 2011. Other tools, such as the One Health Tool,\textsuperscript{x} which partially draws from the MBB tool, have also been developed, and are being promoted by multiple development agencies for use at the national level.

MMB and Matrix tools

Currently there are two tools being used in IC activities in the Asia Pacific region: the MBB currently supported by Dev Info\textsuperscript{a} and Matrix being developed by the University of Queensland and in use since mid-2010. Matrix was developed by the University of Queensland in response to difficulties they experienced in applying the MBB tool during district level IC work. Their intention was to design a tool that was less burdensome – reducing the number of spreadsheets and subsequent inputs required. The Matrix tool itself has been simplified further during the IC activities, with its latest version being used in the recent IC activities in Nepal and Indonesia.

Of the four countries, one has used the MBB exclusively, one has used Matrix exclusively, and two have used both tools at different times. Where local expertise in the use of the tool has been built, the skills are limited to the particular tool being used in the country. Where both the MBB and Matrix have been applied, users are not necessarily distinguishing between the two, often referring to them both as the MBB. For both tools, the level of “complexity”\textsuperscript{xi} and their reliance on a high level of external technical input was commented on frequently in the countries visited. The tools are being used exclusively at the sub-national level (usually district level), whereas the original intent and design of MBB was for use at the national level, while the Matrix was developed to be more user friendly and simplified for use at the sub national level.

The NRIs in Nepal and Indonesia both expressed a degree of confidence in the use of the tool (in Nepal’s case, one NRI felt competent in the use of both tools Independent use, in their view, would still require some backup when changes were required, and NRIs had limited experience using the costing part of the tools. This evaluation is not going to be able

\textsuperscript{a} http://www.futuresinstitute.org/onehealth.aspx

\textsuperscript{x} http://www.devinfolive.info/mbb/mbsupport/index.php

\textsuperscript{xi} This was the word used by participants, however it often referred to the size of the tools, the number of spreadsheets and data input required. Strictly speaking, the tools are complicated rather than complex.
to assess the relative merits of the MBB and the Matrix. It is already clear that the multiplicity of tools can lead to confusion and cynicism at the country level, and more so at the district level where the technical capacity to deal with complicated tools is limited. The design of tools to influence national decision making can be more “complex” than one that is suitable for district application. In addition, as planning tools, their focus on a subset of health conditions (MNCH) begs the question as to how national and district planners will assess strategies for other health conditions, such as other communicable, non communicable diseases, injuries and mental health. They will want to use an integrated planning tool, rather than a different tool for different conditions and population groups.

There seems little added value in continuing to support two different tools for investment case work. Both tools need further development to improve their stability and ease of use, particularly their applicability for use at the district level. In addition, to be most useful, the tool needs to be able to easily be adapted to meet the specific needs of different country and local contexts.

Management of the IC activities

In addition to the parallel development of tools serving the same purpose, discussion with stakeholders reveals relationship difficulties between UNICEF and UQc have arisen in some countries and not been fully resolved. The origins of these difficulties are multifaceted, including the differences between research and operational focused organisations, unclear role expectations, lack of acknowledgement in publications and insufficient engagement between the organisations at critical times during the IC process.

There is little added value in the evaluation focusing on these issues, as they are already obvious to all stakeholders, and need to be addressed.

These events indicate that further development of the IC activities would benefit from more active management of the IC activities by the Steering Committee and UNICEF, with better role definition, improved communication, and earlier dispute resolution when these occur.

The understanding of existing planning, budgeting and prioritization before the IC introduction

In most countries visited it was unclear the depth of analysis\[xii\] there had been of the existing planning, budgeting and prioritisation decision making mechanisms at the national and the district levels\[xiii\] prior to the introduction of the IC. A distinction is being drawn here between the technical proficiency of the IC activity and its ability to fundamentally change the countries own planning and budgeting processes. The previous reviews also point to the interface with the countries’ differing political contexts as a major limitation of past work. There had clearly been engagement in National Health Plans- these have received strong donor and UNICEF support, particularly concerning the technical aspects of the plans.

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\[xii\] The exception to this is the overview report, which describes the national context for Indonesia, Nepal and the Philippines: Soto et al, 2009.

\[xiii\] District ICs in Bangladesh 2010 examined financial flow systems, fiscal space analysis, and calculated OOP expenditure.
However there were low levels of engagement of the national planning departments observed at the time of the visits. Government officials and partners were often sceptical of the value that the IC process might add to their existing processes, and in no instance had it been adopted as a routine part of the national planning process. There is clearly a need for fuller engagement with existing processes, better understanding of decision making process (both evidence based and non evidence based) and design of investment case interventions to ‘add value” to existing process, rather than sit outside of them. This issue, of designing the approach in the knowledge of the existing planning budgeting and prioritisation context, would go a long way to bridging the gap between the IC activities and its subsequent traction with government processes.

Once again, this issue could be addressed during the implementation of the programme in new sites, rather than waiting a further year for the final evaluation findings.

The country context

The Asia Pacific region is one of the most diverse in the world, and any programme that hopes to be effective in the region needs to address the contextual differences that are found. For example, two issues regarding the country context have a big bearing on the role of the IC work and the level of government at which it should focus; the “fiscal space”, and the degree of centralisation or decentralisation of decision making.

Country context: fiscal space

The investment case is a mechanism for advocating for increased and appropriately applied investment in MCH.

Two of the four countries (Philippines and Indonesia) have the fiscal space and are intending increased investment in health. In the words used by the Philippines Treasurer, “Money is not an issue... what is needed is assistance to spend the money in the right way.”

Health sector spending has tripled in the last 8 years. For Indonesia, there are three significant streams of funding converging on the province of Papua where the IC activity is now focusing, that are leading to increased health resourcing. These are the commitment by the national Government to Universal Health Coverage by 2014, the existence of the OTSUS fund that gives some degree of provincial financial independence, and the likely levels of donor support for the province through AusAID and USAID. For Nepal and Bangladesh, the fiscal space is less, and the IC can be used to both mobilise funds and focus effective spending, including increased ability to spend existing resources.

Resource mobilisation is not only viewed as a national function. In Nepal the Health Ministry officials saw the main role of the investment case as leveraging local government resources, including motivating intersectoral activities.

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xv This changes depending on whether IC activity is occurring at the time, and the existence of staff with previous IC experience.

xvi As quoted by UNICEF officials.

xvii The actual mechanism by which this will be achieved is still under discussion by government.

xviii Both Dr Upreti and Dr Pradhan made this point.
The implications for the evaluation are that for Indonesia and the Philippines the IC evaluation will focus on the effective use of available funds. For Nepal and Bangladesh it needs to focus on the impact of the IC on effective spending of Government budget nationally and locally, as well as resource mobilisation.

**Country context: decentralisation**

The issue of centralisation and decentralisation also has a significant impact on the Investment case activity. In centralised systems, effective work at the district may have difficulty impacting on national level planning and budgeting. In decentralised systems, decisions at the centre may not have much influence at the sub national level. In addition, the IC project, depending on its focus, will play a role itself in empowering or disempowering different layers and actors.19

Bangladesh is a highly centralised system. There is very little autonomy given to the districts to deploy staff or resources.

Indonesia presents a more mixed picture.20 Budgets are decentralised, but often decisions made over the budgets remain centralised. Decentralisation of government services, in a significantly privatised health system may mean less rather than more local political control over the health system. Papua represents a special case in the Indonesian context because of the existence of OTSUS and donor support, potentially allowing more provincial autonomy than is available in other parts of Indonesia, however this ‘autonomy’ is in turn tempered by the political and security concerns.

Nepal at present is undergoing constitutional reform, at the heart of which is a move to a more decentralised form of government with the creation of a yet to be determined number of Provinces (States). So the situation is fluid, the form, location and powers of the sub-national structures are yet to be determined. However it is likely the current district structure will be continued. The Philippines is decentralised, with Cities increasingly playing a major role in the local government structure. The planned IC activities in the Philippines are taking an urban focus, in particular looking at the use of the IC to address the health needs of the urban slum dwellers.

A unique feature of the Philippines is the role UNICEF has in government where it is an observer on the Social Development Committee, a cabinet subcommittee. This enables UNICEF to directly report progress being made on MCH at the local government level directly to the cabinet.

<table>
<thead>
<tr>
<th>Country</th>
<th>Fiscal Space</th>
<th>Decentralisation</th>
<th>Evaluation focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Limited</td>
<td>No</td>
<td>National/District/Slums</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Yes</td>
<td>Yes</td>
<td>Province /District</td>
</tr>
<tr>
<td>Nepal</td>
<td>Limited</td>
<td>In progress</td>
<td>National/Districts</td>
</tr>
<tr>
<td>Philippines</td>
<td>Yes</td>
<td>Yes</td>
<td>National/Cities/Slums</td>
</tr>
</tbody>
</table>
Evaluation scope

The scope of this evaluation is discussed under the following sections covering the definition of the IC, geography, organisations involved, and populations. The evaluation and timeframes are not a “one size fits all”. As noted above, the way the IC has evolved and the timing differences of IC interventions mean that the evaluation will have a different scope in different countries.

Geographical

Included in the scope of this evaluation is the IC activity in Nepal, Indonesia, Philippines, and Bangladesh. Due to limitations of time and resources, one district/ city in each of the countries will be chosen for an in depth review. The selection of districts will be based on “level of need”, with districts where the needs are greatest chosen, as well as practical issues such as transport availability, the amount of other donor activity, and fit with district and UNICEF programme activities. The specific sub-national areas considered in the evaluation are:

<table>
<thead>
<tr>
<th>National</th>
<th>Sub national</th>
<th>District /City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>Papua</td>
<td>To be decided</td>
</tr>
<tr>
<td>Nepal</td>
<td>To be decided</td>
<td>xviii</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Dhaka</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>Quezon City</td>
<td></td>
</tr>
</tbody>
</table>

Indonesia

Previous IC activity has occurred in Sikka, Pontianak and Tasikmalaya; sites widely distributed across Indonesia. The current focus of IC activity is on four districts within Papua, where IC activity is at its initial stages. Papua has a number of unique features, including a separate funding mechanism through OTSUS.\textsuperscript{xix} It also has a sizeable provincial level UNICEF office (with 34 people). The concentration of activity within one province and the active engagement of provincial health and planning authorities provide a good basis for the evaluation. The district focus is still being discussed. The provincial focus will be Papua. National level engagement will be assessed, but it will not be the prime focus.

Philippines

Further Philippines IC activity is planning to focus on three cities; Quezon City, Davao City, and Puerto Princesa. Within those cities, the focus is on the highest need communities.

The investment case evaluation will focus on Quezon City, as it has the highest level of need. In addition, the evaluation will also include an assessment of the impact the IC activity is having on the Cabinet subcommittee, the Social Development Committee.

\textsuperscript{xviii} This will be resolved following discussions in Beijing, Nov 30\textsuperscript{th} and 31\textsuperscript{st}.

\textsuperscript{xix} OTSUS Special Autonomy law for Papua promoting political and economic change, approved in 2001.
Nepal

In Nepal, the district focus of the evaluation is still under discussion. Five districts underwent the IC process in 2011/12. Examination of one of these will provide insights as to the impact the activity has had immediately following the IC activity. However, there is an expansion of the IC activity currently being planned. This new process is still in its nascent phase. However this may call for re-consideration of the selected site depending on timing of the new site development. The strong National government interest will also be a focus in Nepal.

Bangladesh

Both a district and a donor partner national focus will be applied in Bangladesh. The district focus will be on an urban slum in Dhaka. In Bangladesh the IC will also focus on the impact of the IC on development partners, as this was identified as a major limiting factor by the UNICEF representative, and also raised as an important issue by government health officials.

Organizations

The organizations to be interviewed in the evaluation will differ in different levels of government and different settings. In addition, some special areas of focus were requested in particular settings (see table below). In general terms, the main focus will be the county’s health system (both government and non government) at both the national and sub national level as well as actors directly involved in the IC project (such as academic and research institutions), and key development partners UNICEF, AusAID and University of Queensland.

Although the focus is the health system, the evaluation will include other relevant parts of government depending on how health planning and decision making in regards to MNCH is organised. For instance, it may involve agencies or Ministries of Finance, Planning, Sub regional development, Women’s Affairs, Children issues, and Food, depending on their degree of involvement in the health planning and delivery processes. Nepali government officials were particularly interested to explore the extent that the IC activity had been able to influence non health local government structures to invest in health and health related activities.

In all four countries, the government is a minority funder and provider of health services\footnote{World health Statistics 2012: Private expenditure as a percent of total health expenditure Bangladesh 67%, Indonesia 54%, Nepal 68%, Philippines 64.} enquiry will need to be sought from the private sector actors as to the impact on their work of the IC activities.

Outside of this core, significant actors will vary in different countries. Where SWAP and donor coordination mechanisms are in place, documentation related to other donor activity will be sought from these mechanisms, (e.g. associated activity though GAVI, Bill and Melinda Gates Foundation, Global Fund, Save the Children). Lack of donor coordination was high on both UNICEFs and Government health officials’ concerns in Bangladesh. In the process of the evaluation, additional organisations will also be involved.
### Special focus
<table>
<thead>
<tr>
<th>Special focus</th>
<th>Requested by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh Development partners</td>
<td>UNICEF country office</td>
</tr>
<tr>
<td>Indonesia The province</td>
<td>All</td>
</tr>
<tr>
<td>Nepal The non health actors at district level</td>
<td>National health officials</td>
</tr>
<tr>
<td>Philippines The city, urban poor</td>
<td>UNICEF office</td>
</tr>
</tbody>
</table>

### Which parts of government?

The IC has, or should have, strong links to parts of government that are carrying out the same or similar functions. These include budgeting, planning and decision making bodies, as well as those with a special focus on MNCH.

In addition, attention will also be paid to government organisations responsible for collecting, generating and disseminating evidence. In this respect, Health Information Systems (HIS) are important, because over time IC activities would ideally become a normal part of their function. Also, as noted in the literature and the country visits, the quality and timeliness of local data is a major limiting factor on the usefulness of the IC exercise. HIS departments are responsible for the collection and analysis of core data, from health service activities and from health surveys. As well, ICT development has a significant interface with IC activities, where, for example, recent advances in ICT have enabled global dissemination of evidence through the world-wide web. MHealth, with its ability to collect data from the periphery in real time and disseminate it widely, has the potential to revolutionise data collection. These technical advances are also strongly supported by UNICEF activities (in the Philippines, UNICEF is running trials of mHealth data collection), so this evaluation will be interested in synergies between these developments, as well as the parts of government with these responsibilities.

### National

National Treasuries/ Finance / Planning departments
- Health section

In the national/ provincial health department:
- The health information section
- The ICT section
- The planning section
- The budgeting section
- The MNCH and N sections

Development partners coordination mechanisms with respect to MNCH & N

Academic/ research institutions

### District

District health office (management, clinical leaders)

Cross government coordination mechanisms.

Government and non-government health sector providers.
**Populations**

Equity in this evaluation refers to the distribution of health service inputs, outputs and health outcomes across different population groups. Differences could be associated with a range of factors including gender, class, caste, socio-economic status, and geography.

The IC projects have consistently chosen populations where the needs (as reflected in the maternal and child health outcomes) are high. In some instances, a pro-equity approach is being taken within these high need districts, as even high need districts are not uniform, with both high and low need families and communities. Also in the Philippines; where there is explicit intention to look within the urban population and identify high need communities, such as people living in slums.

The population of interest in the evaluation is the specific districts, and within the districts the groups of people who are experiencing the greatest inequities. Within these areas, the focus is then on children under age 5, newborns and maternal health and nutrition.

**Timeframe**

The orientation visits have been completed and these have helped inform this report.

The intention is for the baseline survey to be conducted, where possible, on new IC activities and report their development over the one year course of the evaluation. This should be straightforward in the Philippines and Bangladesh where new activities are currently getting underway. For Nepal and Indonesia, the IC activity in the chosen districts has been started in last year, so the baseline will be observing developments in the first year of IC use. The final survey will be conducted 12 months after the baseline survey.

Once the survey is complete, there will be a report back visit to the individual countries.

Time-frame for engaging with countries for the evaluation:

<table>
<thead>
<tr>
<th>Orientation visit</th>
<th>Baseline survey</th>
<th>One year review</th>
<th>Report back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>September 2012</td>
<td>November 2012</td>
<td>Oct/Nov 2013</td>
</tr>
<tr>
<td>Indonesia</td>
<td>September 2012</td>
<td>November 2012</td>
<td>Oct/Nov 2013</td>
</tr>
<tr>
<td>Nepal</td>
<td>September 2012</td>
<td>November 2012</td>
<td>Oct/Nov 2013</td>
</tr>
</tbody>
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**Note:** Within deprived districts in Bangladesh, Upazilla level analysis helped in identifying and strategizing for the most deprived pockets of populations with in district and tribal areas.
Evaluation design

This evaluation design (ED) section sets out how the evaluation will address the evaluation objectives for the IC, and proposes the methodology and process for the evaluation as a whole.

This is a ‘work in progress’ as the approach is being used as the evaluation proceeds, leading to a formative rather than a summative approach to the evaluation.\textsuperscript{xiii} The formative approach asks the questions; is it working? How well is it working? And can it be improved rather than did it work. Also key to the formative approach is the direct engagement of the programme implementers in the evaluation.

In determining an appropriate evaluation design, I have considered ‘design’ as one step within a broader framework for planning and implementing programme evaluations. The framework I have used is based on the Centre for Disease Control and Prevention’s (CDC’s) Framework for Programme Evaluation in Public Health,\textsuperscript{22} which is organised around six steps:

- **Step 1** - Engage stakeholders
- **Step 2** - Describe the programme(s)
- **Step 3** - Focus the evaluation
- **Step 4** - Gather credible evidence
- **Step 5** - Justify conclusions
- **Step 6** - Ensure use of evaluation findings and share lessons learned

The framework has an underlying logic: good evaluation is about more than gathering strong evidence and drawing valid conclusions (steps 4 and 5); it is about maximising the chances that evaluation results will be used (step 6). To do this you need to focus the evaluation on the most salient, relevant and important questions (step 3); which need to fit the full ‘landscape’ of the programme description (step 2); and by ensuring engagement with stakeholders who care about the questions and want to take action on the results (step 1).

**Step 1 – Engage stakeholders**

Engaging stakeholders is the first step in the evaluation plan, but it is also important that we represent stakeholder needs and interests throughout the evaluation process. The key stakeholders for the evaluation are AusAID, UNICEF, UQ consortium, the four governments\textsuperscript{xiii} and the RMNCH & N sector of recipient countries.

Initial engagement has included face to face visits to key stakeholders by the lead investigator through September. During these meetings, we began to identify stakeholder interests in and perspectives on the evaluation, including what they considered to be the

\textsuperscript{xiii} Summative evaluations judge the overall effectiveness of a programme and are conducted after completion of the programme (or after a programme has stabilized). These contrast with formative evaluations which focus on ways of improving or enhancing programmes and are conducted during the development or early implementation of a programme. So summative evaluation reports on a programme, whereas formative evaluation reports to the programme (based on definition in Patton MQ. 1997. Utilization-focused evaluation. Sage: California). The distinction between formative and summative has been summed up by Bob Stake: “When the cook tastes the soup, that’s formative; when the guest tastes the soup, that’s summative” (in Madaus GF. & Kellaghan T. “Models, metaphors, and definitions in evaluation” in Evaluation models: viewpoints on educational and human services evaluation. Kluwer: Boston).

\textsuperscript{xiii} The engagement with government will differs in each context, however planning, finance, HIS are key in all countries, in addition to the more specialised RMNCH & N parts of the health sector.
main purpose of the evaluation, what success (in terms of the programme and the evaluation) might look like, what are (in their opinion) the key evaluation questions, and how they might use the evaluation findings.

Ongoing engagement; a two monthly newsletter will keep stakeholders informed of progress, however the major engagement will be through a two day meeting in Beijing (focusing on country, regional and DP stakeholders) and specific in country workshops where the findings relevant to the specific country will be work shopped at the end of the project.

**Step 2 – Describe the programmes**

Clarity about the programmes’ activities, outcomes, and their inter-relationship sets the foundation for good programme evaluation. Programme logic models or programme theories are commonly thought of as appropriate tools to describe programmes in such a way. Programme evaluations based on programme theory ideally begin with a well-developed and validated theory of how the programme works. However, as in this case, it is often not clear at the outset, and an initial stage of the evaluation is to approximate such a theory within the context of the programme evaluation.

**Step 3 – Focus the evaluation**

The section “Evaluation Scope” discusses the scope of the evaluation in terms of geography, population etc, as well as the particular focus intended for each country.

**Step 4 – Gather credible evidence**

The lead evaluator will work closely with country level evaluators to gather the information relevant for the particular country context. This will be both qualitative and quantitative in nature.

**Step 5 – Justify conclusions**

As discussed previously, the conclusions from the evaluation will emerge as the evaluation continues. Already there is sufficient evidence to take some actions, as noted above. Conclusions will be reached when there is sufficient evidence that is coming from a number of sources.

**Step 6 – Ensure use of evaluation findings and share lessons learned**

The evaluation is not complete until the lessons learned have been clearly articulated and communicated back to the stakeholders concerned.

**Evaluation design – objectives, questions, data and methods**

The ED is centred on the evaluation objectives, and includes specific recommendations relating to the approach to each of those objectives, as set out below.
### Summary of IC evaluation design

<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Data sources and methods</th>
</tr>
</thead>
</table>
| 1. 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?  
- What organisations, people were involved?  
- Do political decisions on budget allocations take into account technical advice from agencies such as health or DPs such as UNICEF?  
- How are priorities arrived, at both in the health bureaucracy and within the political arm of government?  
- At what level of government are these decisions being made?  
- How was evidence used in this process?  
- How was data used in this process?  
- How was equity/inequity addressed?  
- How were gender issues addressed?  
- What focus was there on MNCH&N? | Interviews with government (national and sub-national) health officials will explore the past and current process of budget planning, prioritisation and programme development. Interviews may be one to one, or group meetings, where opportunities arise to bring parties together. It will be important to explore the decision making process, who is involved, and whether there is a tradition of using ‘evidence’ in the process of policy formulation. The extent that this discussion is relevant at sub-national levels will be determined for each country. In centralised systems there may be little sub-national planning, budgeting and decision making. In decentralised systems there is more scope in this regard. Documentation from countries will include reports from the nation’s health information system, as well as existing national health plans (both strategic and corporate plans) and budget allocations to Health, to MNCH & N, and to the districts engaged in IC activities. |
|  | (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? | Documentation and qualitative analyses from interviews will be sought from IPs and donors on general and country specific diagnostic work on the “problem” the IC was hoping to address. Documentation will include donor analysis of strengths and weakness of the country’s health system, fiscal space, and resource mobilisation for MNCH & N. |

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xxiv This will involve the role of partners in existing health planning processes (such as JAR in Nepal, or the EDP group in Bangladesh).
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Data sources and methods</th>
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</thead>
<tbody>
<tr>
<td>(C) How was the IC introduced, process used, aspects of IC used, resources, timing and time taken, organisations and people involved?</td>
<td>How and with whom have implementing partners facilitated policy dialogue on the IC? How was the technological and methodological support modified for the specific context? What was the programme or population focus? Has the approach changed with its use nationally vs. sub-nationally?</td>
<td>Documentation of the IP activities at national and sub-national levels. Where possible, the activities under the following headings will be included: Advocacy for public health planning Organisation and analysis of country specific data Identification of system bottlenecks Strategies to address bottlenecks Action plans and monitoring frameworks Scaling up (did it have an equity focus?) Evaluation A timeline will be established for each country, and the specific interventions (advocacy, training analysis etc) and the amount of resources (time, money, expertise) applied.</td>
</tr>
<tr>
<td>(D) How effective and efficient was the IC process?</td>
<td>How did it deal with priorities outside of MNCH &amp; N? What are the direct costs of the IC approach? What are the “transaction” costs of the IC approach? What level of effort is required, compared to the regular budget and planning processes? Were IC analyses completed within the planned timeline and planned resourcing?</td>
<td>Questions about the scope of the IC activities will be addressed to both IP and country officers as will the “transaction costs” as these will be experienced by both IP and country officials involved. Comparison will be made with the delivery dates of relevant information from the IC process with the countries timeline and process for establishing budgets.</td>
</tr>
<tr>
<td>(E) What were the &quot;products&quot; produced by the IC process? Who received them, and when?</td>
<td>This will rely on actual documentation from the IPs (see above), as well as country officials knowledge of the distribution of the products within the system.</td>
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<tr>
<td>Evaluation objectives</td>
<td>Evaluation questions</td>
<td>Data sources and methods</td>
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<tr>
<td><strong>2. Evaluate the impact of the IC on government processes, including the political and subsequent budgetary priority given to MNCH &amp; N.</strong></td>
<td>(A) Did The IC impact on governments planning, budgeting and monitoring processes?</td>
<td>Interviews will assess the 'meaning' government partners take from the IC activities.</td>
</tr>
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<td></td>
<td>- How did the IC activity feed into the activity and planning cycle?</td>
<td>This is directed at senior government / district officials, supported by documentation in key planning and budgeting processes.</td>
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<td></td>
<td>- What evidence is there of a connection (influence) between IC activity and planning and budgeting cycles?</td>
<td>In addition evidence of the IC activity in subsequent key government documentation will be sought.</td>
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<tr>
<td></td>
<td>- What is the impact of the IC approach on the capacities of managers, planners and other decision-makers to use evidence?</td>
<td>In decentralised settings, the impact will be assessed in terms of the investment of other parts of local government in support of MNCH &amp; N</td>
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<td>The issue of leadership will be assessed through the interviews in this section.</td>
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<td></td>
<td>(B) What particular aspects of the IC made the most impact on planning and budgets, and in what circumstances: the bottleneck and equity analysis?</td>
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<td></td>
<td>The fiscal space analysis? The estimates of coverage and lives saved? The scenarios? The relationships with IPs?</td>
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<td></td>
<td>(C) Has the IC approach helped to frame and better articulate the way MNCH &amp; N is characterised, and the way decisions are made?</td>
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<td></td>
<td>- Did subsequent government processes systematically identify bottlenecks and corrective strategies?</td>
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<td>- Did these processes have a focus on equity and MNCH &amp; N?</td>
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<td>- To what extent is this change the result of the IC or other processes?</td>
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<td></td>
<td>(D) What has been the impact on MNCH+N programmes and policies?</td>
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<tr>
<td>Evaluation objectives</td>
<td>Evaluation questions</td>
<td>Data sources and methods</td>
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</table>
|                       | • What evidence is there of implementation of equity focused strategies?  
|                       | • Is there evidence of impacts resulting from bottleneck reductions?   | The evaluation will not undertake a formal comparison between intervention and non intervention districts. However, the views of senior officials who have oversight of several districts will be sought on differences they have observed in the planning and budgetary process of IC and non IC districts. |
| (E) Is there a difference observed between districts involved in IC activities and those that are not? |                       | The evaluation will not undertake a formal comparison between intervention and non intervention districts. However, the views of senior officials who have oversight of several districts will be sought on differences they have observed in the planning and budgetary process of IC and non IC districts. |
| (F) Has the IC approach influenced the way decisions are made? | • To what extent is there a transfer of necessary skills?  
|                       | • Has it been incorporated into routine HIS activities?  
|                       | • Is the routine use of the IC approach likely to be sustained?  
|                       | • What are the government’s intentions about future use of the IC?  | Interviews directed at senior officials. Has the IC case approach been ‘built in” to the normal government processes? Has there been a skill transfer to local analysts etc. In which parts of the government apparatus is the IC ideas embedded? 
Documentation related to the number of people with training/ experience in applying IC approaches. |
| (G) Has the IC approach strengthened the power of key actors engaged in MNCH&N at national or sub-national levels? For example increasing their visibility, credibility, coordination, collective action, leadership, or available resources? | • Who are the actors in MNCH+N at national and sub-national levels?  
<p>|                       | • What is the extent of their power and influence? | Local investigators will be asked to describe the political economy of MNCH+N ‘sector’ in the country. Key influencers will be questioned in regard to the impact on them and their influence on the IC. For example, where applicable, has the IC activity strengthened the position for NGOs supporting women’s rights? |</p>
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Data sources and methods</th>
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<tbody>
<tr>
<td></td>
<td>• How has the IC impacted on their power and influence?</td>
<td></td>
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<tr>
<td></td>
<td>• How has it changed their ideas re importance of improving MNCH from Public Health, development, equity, and Human Rights perspectives?</td>
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<tr>
<td></td>
<td>• Has IC enabled actors to take advantage of “political windows” of opportunity?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What “political windows” have occurred?</td>
<td></td>
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<tr>
<td></td>
<td>• Were the IC products used to advantage?</td>
<td></td>
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<tr>
<td></td>
<td>• How has this changed since IC introduction?</td>
<td></td>
</tr>
<tr>
<td>3. Document the current use being made of the IC in four countries.</td>
<td>(A) What is the nature and intensity of IC activities at the time of evaluation?</td>
<td>Questions directed at IPs.</td>
</tr>
<tr>
<td></td>
<td>• How have lessons from previous ICs been used to inform the current methodological approach?</td>
<td></td>
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<tr>
<td></td>
<td>(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?</td>
<td>Questions directed at AusAID, UQ, and UNICEF at regional and global levels as well as donor coordination mechanisms (SWAPs).</td>
</tr>
<tr>
<td></td>
<td>• What are the other costing and planning tools being promoted?</td>
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<tr>
<td></td>
<td>• Is there a consensus amongst stakeholders, including DPs, about the use of costing and planning tools?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(C) What is the role of the IC methodology vis-a-vis other planning and implementation activities?</td>
<td>Questions directed at senior country officials, and other development partners at the country level.</td>
</tr>
<tr>
<td></td>
<td>• What is the relationship between IC and other planning tools?</td>
<td>In the first instance seek an interview with the Health lead agency in any SWAP/ country coordinating mechanism.</td>
</tr>
<tr>
<td>Evaluation objectives</td>
<td>Evaluation questions</td>
<td>Data sources and methods</td>
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</tbody>
</table>
|                        | • How easily is the IC process incorporated into broader planning devices, e.g., the WHO-promoted One-Health tool?  
• How should IC processes be coordinated with other major exercises (e.g. Global Fund allocations, GAVI HSS, etc.) not only within the health sector but also related to other health related MDGs (e.g. nutrition, WASH, HIV/AIDS - i.e. e-MTCT tool for costing HIV/AIDS/ PMTCT))  
• How has the IC activities influenced the policy and funding choices of other development partners? | Questions directed at AusAID, UQ, and UNICEF at regional and global levels. |
| 4. Compare the IC process between the countries, and put forward lessons learned and recommendations | | The answers to this section will be extrapolated from the answers to the questions above. |
Methodology for the development of the approach to this evaluation

The approach to this evaluation has been developed using a number of tools and sources of information. The initial development took place using the information provided in the TOR for this evaluation and in initial discussions with the key contact people (see appendix) during country visits to Bangladesh, Nepal, Indonesia, Philippines. These visits enabled an initial contact to be made with national stakeholders (UNICEF, Government Officials, DPs, and NRIs). In Indonesia, we were able to visit the provincial office and meet with provincial level officials and used the opportunity to collect information, discuss expectations and processes for the project.

Mapping the evaluation

The design summary (above) is based on the evaluation objectives specified in the TOR for the IC evaluation. For each objective, a set of relevant questions has been prepared, building on those supplied in the TOR by the steering group. Known and potential data sources were identified, and gaps in information that will require either further investigation, and/or the development of proxy indicators. The balance of qualitative and quantitative information was considered for each objective. The resulting matrix forms the basis of the evaluation design.

In addition, the RUFDATA framework has been used to identify the critical questions and decisions in this project. RUFDATA is an acronym for the following:

- What are the Reasons and purposes for this evaluation?
- What will be the Uses for our evaluation?
- What will be the Foci of our evaluation?
- What will be the Data and evidence for our evaluation?
- Who will be the Audience?
- What will be the Timing for the evaluation?
- Who should be the Agency conducting the evaluation?

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

Programme models

The first step in any evaluation is to define what those implementing the project expect to happen because of project activities. Programme logic or theory has been identified as a key tool to use in the evaluation. Programme logic often begins with a model that “identifies and links programme outcomes with interventions and processes and the theory and assumptions or principles underlying the programme. The model provides a map for the programme, illustrating how it is expected to work, what activities need to come before others, and how desired outcomes are achieved”.

The logic model starts with the assumptions that were made when the programme was first being formulated. It then identifies the resources that a programme needs to accomplish a

xxv This final question is applicable to agencies that are considering whether to commission an evaluation so is not relevant at this stage.
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 has been further explored at the country level, and the different country contexts have been incorporated as noted above.

A logic model framework can be presented as describing the relationships between, resources/inputs, activities, outputs, and outcomes, in that order. Descriptions of all these factors will include assumptions, in particular assumptions about how the component parts of the programme will come together to achieve the desired impact. In addition, there are factors influencing the relationship of the component parts, some of which are within the control of the programme and its stakeholders, and some which are not. The process of developing a logic model makes these assumptions and mediating factors explicit, and therefore creates a shared, clearly understood description of the programme, its component parts, and the assumptions that underpin it.

For the IC which is ongoing, the model can identify successes and barriers, and the factors that will need to be addressed to achieve the best possible outcome. The logic model itself can become a tool for improving the understanding of a programme.

A project pathway map was developed in 2009 to describe a strategic conceptual framework under which the IC is to be implemented in each country (see Appendix 1). This is understandably high level and strategic, and the evaluation intends to develop this further with country level stakeholders to describe the logic applicable in the particular country context. This will form a part of the baseline assessment for each country. One outcome of the evaluation will be to further develop the logical frame for future Investment case related activities.

Data and information sources

This evaluation will rely on a range of data and information sources, including primary and secondary data, process and outcome data. Country consultants will play a key role in identifying existing country relevant data, from the grey and published literature. The main emphasis on new data collection will be on qualitative data collected during interviews that will be conducted during the two country visits.

Project framework and methods of work

This section briefly sets out the structural parts of the project which will determine how the project works with the lead evaluator, country level evaluators, the steering committee, and the other project stakeholders.

The steering committee has established the terms of reference for the evaluation. The evaluation team consists of the lead evaluator and independent evaluators based in each country. The lead evaluator will be responsible for the design and for the majority of the interviews. Local evaluators will collect relevant information, advice on the contextual and political economy of the recipients MCH sector in the different countries. They will also support the lead investigator to describe specific country issues.

The implementation partners will be engaged in the formative aspects of the evaluation, sharing experiences and reflecting on the evaluation findings as they evolve. The recipient
countries will be engaged in the formative aspects of the evaluation, and participate in country level workshop/s to reflect on findings as they evolve.

UNICEF will provide facilitation and logistic support for the evaluation.

**Communications**

Communication of the progress of the evaluation will be in the form of a brief email newsletter every two months to stakeholders. This will include a section on the progress being made in each country.

It is the intention to publish the findings as they relate to specific countries at the completion of the evaluation.

**Ethics approval**

Advice to date is that ethical approval is not required for this evaluation as it does not involve direct contact with patients. Further exploration of the ethical issues in each country will be discussed with the country level consultants.

**Limitations**

<table>
<thead>
<tr>
<th>Potential limitations</th>
<th>Mitigating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of institutional memory of IC activity</td>
<td>Focus of evaluation is on new/ recently introduced IC activities.</td>
</tr>
<tr>
<td>Outcomes and impact take years to eventuate</td>
<td>Focus of evaluation on more immediate outputs and outcomes.</td>
</tr>
<tr>
<td>Data quality</td>
<td>Triangulate qualitative/quantitative/and local expert (country consultant) knowledge.</td>
</tr>
<tr>
<td>Experiences and impacts very different in different countries due to different contexts</td>
<td>Logic developed for each country specifically as part of baseline survey.</td>
</tr>
<tr>
<td>IC impacts confounded by other related events occurring simultaneously</td>
<td>Attribution especially to IC only applied to specific discrete outcomes. (e.g. Investment in specified bottlenecks) Accept limitations of attribution for wider system improvements.</td>
</tr>
<tr>
<td>Between country comparisons will be difficult.</td>
<td>Framing of programme intention to improve evidence based planning and budgeting will assist higher level between country comparisons.</td>
</tr>
</tbody>
</table>

There are limitations of programme logic or programme theory approaches, including the risk of over-simplifying and de-contextualising programmes. In complex systems there are programme logics, rather than a single logic. Programmes also evolve, so what might have been a sound theory at the start of a programme may have little relevance at later stages. Nevertheless, in such an activity-rich environment, the programme logic approach will help to bring focus as to what it is that is being evaluated.
Furthermore, the programme is still being implemented and the evaluation’s focus using the programme logic approach has the potential to help programme staff to identify gaps or inconsistencies in the programme logic (e.g., in activities). The staff are therefore able to make immediate changes to programme implementation to address these. The evaluation promotes a common explicit model that helps programme staff to keep focused on the most important aspects of the programme (ie prioritising). It can help staff cooperate across staff and across agencies and focus the evaluation process at the most important aspects of the programme. The evaluation can also help to identify any timely adjustments to the programme (which may be particularly important given that the ultimate outcomes of the programme are long-term).

**Strengths of this design**

This proposed evaluation design has the following strengths:

- It will provide a level of context-rich country and district specific information, currently missing from the monitoring IC progress.
- It will analyse the effects of the IC over time to enable an estimate of the value-added by IC activities
- It will test some key assumptions underpinning IC and provide an evidence based planning and budgeting programme theory to inform future policy in this area;
- By taking a formative approach, it will be responsive to the needs of those responsible for implementing IC activities, and will produce real-time findings that can be used to support improvements to implementation processes;
- The districts/ cities will provide rich ‘stories’ about the impact of IC activity at a subnational level.
- The approach will take account of different contexts, recognising that there were things happening before IC and that governments were at different starting points in terms of the MNCH agenda.
Appendix 1: Project Pathway Map

ASSUMPTIONS

A. Priority MNCH interventions are effective at reducing maternal, newborn and child mortality.
B. Implemented plans have correctly identified the most effective MNCH interventions and best strategies for scaling-up equitable coverage in the local context.
C. Implemented plans are sustainable in the short-medium term.
D. Effective and functioning public sector financing mechanisms are in place to plan and fund MNCH.
E. There is enough fiscal space (government and donor contributions) to implement MNCH plans.
F. Evidence produced (in a timely manner) is used in government plans.
G. Polynomials few in more costly a “bottom-up” analysis that takes into account local diversity and is grounded in the local context.
H. Development partners (such as World bank) can influence government sectors outside health.
I. This IC complements rather than competes with DF strategy/agenda for MNCH.
J. The political will to implement, support and finance plans exists.
K. Data is available for the equity and Scale-up analysis.
L. Government officials can make time commitment to strategy development for this IC.
M. Government officials and development partners see the benefit of this IC in addition to any activities already ongoing in country.
N. National research partner has contacts/links with key government officials/development partners in country.
O. Indicates factors beyond the control of the project.

ACTIVITIES

1. Consult with local research partners to undertake project activities in-country.
2. Consult with government and development partners in-country.
3. Identify and align project activities with key government budgeting and planning milestones for MNCH.
4. Identify major constraints to scaled-up priority interventions.
5. Establish strategies to the short-mid-term to address major constraints and estimate the associated outlays and impact.
6. Dissemination of results.
Appendix 2: People consulted

Australia:

AusAID: Joanne Greenfield, Kelly Vuanivono
UQc: Allan Lopez, Eliana Jimenez Soto, Alison Morgan, Sonja Firth, Kim Mulholland (T)
Steering Group: Ian Anderson

Bangladesh:

UNICEF: Pascal Villeneuve, Isa Achoba, Lianne Kuppens, Shukhrat Rakhimdjano
Government: Dr Musa, Dr Altaf, Dr Osmani
Consultant: Afeef Mahmood (E)

Indonesia:

UNICEF CO: Robin Nandy, Deswanto Marbun, Dr Budhi Setiawan, Lukman Laksmono
UNICEF Papua Office: Margaret Sheehan, Sudhir Chandra, Ratih Woelanda Roe
Prov Govt: Agnes Ang
NRI: Prof Laksono Trisnantoro (T). Tiara Marthias, Harbianto Deni, Faozi Kurniawan, Digna Niken, Purwaningrum, Shita Dewi, Melkior Tappy, Marike Yosetina-Watofa

Nepal:

UNICEF CO: Hanaa Singer, Hendrikus Raaijmakers, Asha Pun, Dr Kishori Mahat
Government: Dr Mingmar Sherpa, Dr Raj Upreti, Dr Shilu
NRI: Badri Pande, Dr Bhandari, Yogenra Prasai
Consultant: Dr Tirtha Rana, Dr YV Pradhan
UNICEF Regional Office: Genevieve Begkoyian, Nuzhat Rafique

Philippines:

UNICEF: Tomoo Hozumi, Willibald Zeck, Hammad Masood, Mariella Castillo
NRI: Bernadina Aldava
Consultant: Sylvia Divina

New York:

UNICEF HQ: Kumanan Rasanathan

Bangkok:

UNICEF Regional Office: Basil Rodrigues (T), Kyaw Myint Aung
Appendix 3: List of abbreviations

ADB  Asian Development Bank
AusAID Australian Agency for International Development
DP Development partner
GAVI GAVI Alliance
GF Global Fund to Fight AIDS, Tuberculosis and Malaria
HSS Health system strengthening
HIS Health Information Systems
IC Investment case for maternal, newborn and child health
ICT Information and communications technology
ICTOR Investment case evaluation terms of reference
IP Implementation partners
mHealth Mobile health use to collect and transmit health information
MBB Marginal budgeting for bottlenecks
MDG Millennium Development Goal
MNCH&N Maternal, newborn, and child health (and nutrition)
NRI National Research Institute
OTSUS Special Autonomy Law for Indonesia
PMNCH The Partnership for Maternal, Newborn & Child Health
PMTCT Preventing Mother to Child Transmission (HIV)
SWAP Sector wide approach
TOR Terms of reference
UNICEF United Nations Children’s Fund
UQc The University of Queensland consortium
USAID United States Agency for International Development
WASH Water, sanitation and hygiene
WHO World Health Organization
References


