Value for Money – Qualitative Analysis

Number of the assignment (750-391)

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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1</strong></td>
<td></td>
</tr>
<tr>
<td>Title Page</td>
<td>1</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>2</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Abbreviations and Acronyms</td>
<td>4</td>
</tr>
<tr>
<td><strong>Section 2</strong></td>
<td></td>
</tr>
<tr>
<td>Executive Summary (summary of findings and recommendations)</td>
<td>6</td>
</tr>
<tr>
<td><strong>Section 3</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Background &amp; Introduction</td>
<td>8</td>
</tr>
<tr>
<td>3.2 Objective of the Assignment</td>
<td>8</td>
</tr>
<tr>
<td>3.3 Approach and Methodology</td>
<td>8</td>
</tr>
<tr>
<td>3.4 Findings and Analysis</td>
<td>8</td>
</tr>
<tr>
<td>3.4.1 Overall Approach</td>
<td>8</td>
</tr>
<tr>
<td>3.4.2 Community Engagement</td>
<td>10</td>
</tr>
<tr>
<td>3.4.3 Other Value for Money Approaches &amp; Examples</td>
<td>14</td>
</tr>
<tr>
<td>3.5 Conclusions</td>
<td>16</td>
</tr>
<tr>
<td>3.6 Recommendations and Next Steps</td>
<td>17</td>
</tr>
<tr>
<td><strong>Section 4</strong></td>
<td></td>
</tr>
<tr>
<td>Annexes:</td>
<td></td>
</tr>
<tr>
<td>Annex 1 Terms of Reference</td>
<td>19</td>
</tr>
<tr>
<td>Annex 2 List of persons consulted</td>
<td>22</td>
</tr>
<tr>
<td>Annex 3 Consultant’s bio data</td>
<td>23</td>
</tr>
<tr>
<td>Annex 4 Value for money concepts</td>
<td>24</td>
</tr>
<tr>
<td>Annex 5 Facility Refurbishment</td>
<td>27</td>
</tr>
<tr>
<td>Annex 6 CE Replication costs</td>
<td>29</td>
</tr>
<tr>
<td>Annex 7 CE scale up a VfM approach</td>
<td>33</td>
</tr>
<tr>
<td>Annex 8 PRRINN-MNCH and Sustainability</td>
<td>39</td>
</tr>
</tbody>
</table>
Acknowledgements

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<table>
<thead>
<tr>
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</tbody>
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The contents of this report are the sole responsibility of its authors and do not necessarily reflect the views of Health Partners International, Save the Children UK, GRID Consulting or the UK Department for International Development.
Abbreviations and Acronyms

ANC: Antenatal Care
BEOC: Basic Emergency Obstetric Care
CBOs: Community Based Organizations
CDC: Centre for Disease Control
CEOC: Comprehensive Emergency Obstetric Care
CHEW: Community Health Extension Worker
DfID: Department for International Development
EMC: Emergency Maternal Care
EOC: Emergency Obstetric Care
EPG: Eminent Persons Group
ERC: Expert Review Committee
ETS: Emergency Transport Scheme
FHD: Family Health Department
FMoH: Federal Ministry of Health
GAVI: Global Alliance Vaccine Initiative
GHSB: Gunduma Health System Board
HDSS: Health Demographic Surveillance System (or Site)
HDCC: Health Data Consultative Committee
HMH: Honourable Minister of Health
HMIS: Health Management Information System
HPO: Health Promotion Officer
HRCC: Human Resource Coordinating Committee
HRH: Human Resources for Health
HRIS: Human Resource Information System
HSR: Health Sector Reform
HSSP: Health Sector Reform Programme
IPD: Immunization Plus Days
IMCI: Integrated Management of Childhood Illnesses
LEC: Local Engagement Consultant
LG/LGA: Local Government/Local Government Area (or Authority)
LGC: Local Government Chairmen
LLGA: Learning LGA
M&E: Monitoring and Evaluation
MDGs: Millennium Development Goals
MoH: Ministry of Health
MNCH: Maternal Neonatal and Child Health
MOU: Memorandum of Understanding
MSP: Minimum Service Package
MSS: Midwives’ Service Scheme
MTSS: Medium Term Sector Strategy
NAS: Nigeria Academy of Science
NGO: Non-Governmental Organization
NHIS: National Health Insurance Scheme
NICS: National Immunisation Coverage Survey
NIA: National Immunisation Advisor
NPHCD: National Primary Health Care Development Agency
NPI: National Program on Immunization
OR: Operations Research
OP: Operational Plan (for the Health Sector)
OPV: Oral Polio Vaccine
OPR: Output to Purpose Review (DfID Annual Review)
PATHS: Partnership for Transforming Health Systems
PEI: Polio Eradication Initiative
PHC: Primary Health Care
PHCUOR: Primary Health Care Under One Roof
PMS: Programme monitoring system (or site)
PPP: Public private partnership
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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPRHAA</td>
<td>Peer and Participatory Rapid Health Appraisal for Action</td>
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<td>RAR</td>
<td>Rapid Awareness Raising</td>
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<td>REW</td>
<td>Reaching every ward</td>
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<td>RI</td>
<td>Routine Immunisation</td>
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<td>RR</td>
<td>Reality Radio</td>
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<td>Road to Health (Cards)</td>
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<td>SBA</td>
<td>Skilled birth attendant</td>
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<td>SCH</td>
<td>State Council on Health</td>
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<td>SDADS</td>
<td>Service Delivery at Door Step</td>
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<td>SDP</td>
<td>State Development Plan</td>
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<td>SEEDS</td>
<td>State Empowerment and Economic Development Strategy</td>
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<td>SSHDP</td>
<td>State Strategic Health Development Plan</td>
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<td>SHDP</td>
<td>Strategic Health Development Plan</td>
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<td>SHF</td>
<td>Secondary Health Facility</td>
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<td>SIACC</td>
<td>State Inter-Agency Coordinating Committee</td>
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<td>State Lead Program</td>
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<td>State Ministry of Health</td>
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<td>SM</td>
<td>Safe Motherhood</td>
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<td>State Operational Plan</td>
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<td>SDSS</td>
<td>Sustainable Drug Supply System</td>
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<td>State social mobilization officer</td>
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<td>SSP</td>
<td>State Strategic Plan (for the Health Sector)</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of reference</td>
</tr>
<tr>
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<td>Training of trainers</td>
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<td>United Nations Children’s Fund</td>
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<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
SECTION 2 - EXECUTIVE SUMMARY
This qualitative analysis is one of two value for money (VfM) reports commissioned for PRRINN-MNCH’s 2012 Output to Purpose review. It highlights aspects of PRRINN-MNCH’s management and design that illustrate the programme is about far more than achieving ‘quick wins’. PRRINN-MNCH aims to engender sustainable and equitable change in health systems offering opportunities to maximise the potential long-term benefits of DFID’s investment. The report thus focuses on elements of PRRINN-MNCH that appear to be enhancing value for money in terms of sustainability and equity, with relevant examples.

2.1 CONCLUSIONS
- PRRINN-MNCH’s design and management approach is implicitly informed by VfM consciousness. It is seeking economy and efficiencies using means that encourage continuous assessment of progress against milestones, learning and adaptation. The programme seeks to increase the scale and sustainability of impact.
- Although its accounting system is reasonably well structured and allows cost tracking and understanding of cost drivers, with the benefit of hindsight and more focus on VfM, staff feel that this could be further improved.
- PRRINN-MNCH’s ways of working and collaborating appear to offer opportunities to increase the efficiency of aid resource use over the long term, as well as economies of scale. The rolling out of PHCUOR across 15 states is a remarkable VfM achievement.
- The community engagement approach, particularly the community mobilisation component, appears both efficient and effective and is starting to produce cost benefit data that demonstrates it is affordable to government. The data has utility for influencing policy as well as contributing to practitioner debates and learning about VfM benchmarks. Assessing sustainability will be important in the future.
- PRRINN-MNCH is pursuing some potentially efficient approaches that address complex equity issues. There are some important CE outcomes in terms of women’s empowerment and social cohesion that do not appear in the logical framework and might be overlooked in standard VfM analysis.
- In the stakeholder contribution data in Annex 8, government and donor contributions indicate that PRRINN-MNCH has been successful in leveraging resources and that its services are valued.
- Despite considerable challenges, PRRINN-MNCH seems to be generating political commitment at some levels and contributing to health reforms, as well as increases in the governance, management and delivery capacity of PHCs that enhance prospects for maximising VfM in the given context.

2.2 RECOMMENDATIONS AND NEXT STEPS
- Discuss and develop VfM indicators, and develop a holistic approach to VfM assessment.
- Have further discussions with DFID and OPR team about if and how (qualitative) sustainability analysis could best complement quantitative VfM analysis.
- Share emerging cost benefit data that may be of interest to others to encourage critique and progress towards consensus on assessment methodologies.
- Enrich value for money debates by sharing thoughts and reflections about the importance of setting up cost structures and accounting systems to facilitate easy and appropriate cost efficiency, effectiveness and VfM analysis.
Select a sample of communities where the community exit strategy has been implemented and monitor levels of volunteer activity and other effects after PRRINN-MNCH’s ‘exit’.

Consider the potential benefits of integrating a social return on investment analysis that considers issues of equity in selected CE sites to generate a more complete picture of PRRINN-MNCH’s value from the perspectives of community members.

Develop a short case study to document experience and lessons from the stakeholder contribution analysis that might include implications for other actors interested in using similar metrics for VfM analysis.

Use the community engagement analysis to encourage the development of other short case studies relating to the VfM of various ‘supply side’ components of the programme for ongoing qualitative analysis and learning.
SECTION 3 – MAIN REPORT

3.1 BACKGROUND AND INTRODUCTION
Developing proportionate and contextually appropriate ways to assess and deliver value for money (VfM) is one of the most pressing challenges facing development practitioners and donors today. The quantitative and qualitative VfM reports commissioned for the PRRINN-MNCH Output to Purpose Review (OPR) are evidence of its proactive and increasingly systematic response. This report - the qualitative component - illustrates how PRRINN-MNCH’s design and management approach aims to enhance VfM with reference to ‘qualitative’ examples.

3.2 OBJECTIVES
The objectives of the report are:
- To identify qualitative evidence of PRRINN-MNCH’s design, management approach and implementation that appear likely to enhance the VfM achieved by DFID’s investment;
- To identify potential lessons related to the assessment and delivery of VfM generated by PRRINN-MNCH of potential interest to other practitioners;
- To make recommendations to inform the more systematic VfM assessment approach being developed by the consultant working on the quantitative approach.

3.3 APPROACH
- PRRINN-MNCH aims to increase progress towards MDGs 4 and 5. Its design and management are driven by a political economy and evidence based approach that demonstrates commitment to contributing to the development of locally owned, resilient and sustainable health systems (Annex 8).
- The approach to the qualitative VfM analysis is informed by an understanding of VfM as a management tool and way of working to enhance impact (outlined in Annex 4). It reflects PRRINN-MNCH’s sustainability aims (above), including the importance of contributing to changes in accountability relationships, which are consistent with DFID’s concerns about maximising the potential benefits of its investments.
- To address concerns that an emphasis on VfM could discourage investments in programmes benefiting the most vulnerable people, whom are often expensive to reach, the report reflects the Independent Commission Aid Impact (ICAI’s) addition of equity as a VfM consideration.¹
- The qualitative analysis is based on a desk-based review of key programme documents, mostly related to the community engagement (CE) approach, complemented by a few discussions with key programme staff and the VfM specialist working on the quantitative analysis.

3.4 FINDINGS AND ANALYSIS

3.4.1 VfM of Overall Approach
- **Emphasis on sustainability, accountability and local ownership:** PRRINN-MNCH aims to avoid the pitfalls of technical short-term donor led service delivery programmes that can appear efficient but have proved unsustainable.² Achieving sustainability through enabling communities to

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² This interpretation is based on reading HPI position papers and recent political economy analyses in three of the states.
mobilise resources to ensure they can access services and empowering them to demand accountability from health service providers, as well as aligning rather than replacing government systems are key principles. The latter involves securing political commitment; building capacity to manage health systems and deliver services; leveraging resources; and working holistically with others (For a fuller explanation of the strategy refer to Annex -8).

- PRRINN-MNCH’s ways of working and collaborating offer opportunities to increase the efficiency of aid resource use over the long term, as well as economies of scale. The government’s decision to roll out the PHCUOR, a policy tried and tested in PRRINN-MNCH states, across 15 other states, using funds from other donors is a particularly important example of the potential benefits of this approach that will be further analysed in the future. Other examples are identified below.

- **Management approaches that encourage VfM** Despite not having developed approaches to quantitatively assess VfM, programme documents - including many prepared in preparation for the review - demonstrate that PRRINN-MNCH staff constantly challenge themselves to reflect on whether initiatives are economic, efficient and effective and seek ways to improve. This has not always been easy. Even though PRRINN-MNCH has established systems that allow fairly good cost tracking and understanding of cost drivers, with the benefit of hindsight there is realisation that this is an area that could be improved and needs further discussion in debates about value for money methodologies (Annex 5).

### February 2011 VfM Report

- In addition to identifying rigorous procurement processes and cost savings, the VfM report outlines key management processes the team uses to regularly assess financial and programmatic progress and make resource allocation decisions. These include quarterly reviews, bi-annual work plan reviews, budget meetings and annual review processes that provide opportunities to take stock of performance in key areas against milestones; identify new areas for research; or feed results from evaluation and research back into plans.

- The 2011 report included examples of cost savings; reductions in consultant and staff per diems; reductions in costs per person attending training courses. Costs for the rehabilitation of CEOC and BEOC facilities in 2010 were respectively 8% and 18% less than PATHS1/HCP. These costs offered potential benchmarks for other health programmes in Nigeria. As a result of standards, procurement policies and supervision as well as increasing contributions from stakeholders and communities, costs incurred by PRRINN-MNCH for refurbishing BEOC and 24/7 facilities in 2011 have decreased even more dramatically (Annex 5).

- PRRINN-MNCH also tackles instances of malpractice head on. In 2010 research to identify the significance of the costs of ghost workers attending in training activities in Yobe led to more effective focusing of training and significant cost savings.

- **Real-time learning and adaptation to enhance VfM.** PRRINN-MNCH’s design incorporates systems thinking and adaptive management approaches that emerging evidence suggests may be best practice for programmes aiming to scale up quickly to increase progress towards the MDGs.4

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3 February 2011 Value for Money Report, PRRINN-MNCH
4 Ligia Paina and David H Peters, 2011 Understanding pathways for scaling up health services through the lens of complex adaptive systems, Health Planning and policy. Paina and Peters argue there is mounting evidence that blueprint models for strengthening health systems, which revolve around linear, predictable processes do not work. They recommend a move to models informed by adaptive systems thinking that embraces uncertainty, non-linear processes, the uniqueness of local
Progress reports indicate PRRINN-MNCH has fostered a culture of experimentation and learning that enhances VfM. It carefully monitors progress against milestones to identify successful approaches that can be scaled up, as well as unsuccessful approaches that risk wasting resources, which are discontinued. For example the piloting of mobile phone use for HMIS reporting was dropped due to the lack of 24-hour server availability at state HMIS offices and difficulty in supervision.

PRRINN-MNCH's operational research approach can be considered a VfM engine. It enables piloting of innovative approaches in small cluster areas that are monitored to assess the costs and benefits of scaling up. The CE approach is a good example.

3.4.2 ANALYSIS OF THE DEMAND SIDE - CE APPROACH

PRRINN-MNCH’s measures the costs and benefits of the CE Approach (Annex 7). Although it may be subject to methodological debate concerning accuracy of estimates, producing data to demonstrate that the costs of replicating the community engagement approach could be as low as £340, and that the community level costs of potentially saving a life are < £20, has enormous utility. On the one hand it contributes to debates about potential benchmarks among practitioners concerned with enhancing VfM. Establishing such figures is also vital for generating political commitment essential for sustainability.

Community mobilisation approach is cost efficient and effective. PRRINN-MNCH’s CE approach is cost efficient as it relies on developing relationships with key leaders, rapidly raising awareness and selecting volunteers who are key actors in mobilising community resources.

Community Engagement Assessed to be Good Value for Money
In March 2011 PRRINN-MNCH commissioned a Study of the Community Engagement approach. The study used a Commonwealth VfM framework well suited to the nature and values of the programme. It explored the following dimensions: fitness for purpose, flexibility, cost, resource use and long-term capacity development. Based on intuitive and qualitative analysis, the study concluded that the community engagement component offered good value for money in all 5 areas. The authors also identified a set of recommendations about how this value could be further enhanced and prospects for equity and sustainability be improved. In keeping with the programme’s commitment to learn and adapt in light of evidence generated through research, PRRINN-MNCH elected to take up these recommendations, which have subsequently been implemented.

Cost efficiency of DFID’s investment is increased by investments from community members. Since the programme start, over 26,000 volunteers have been trained and play vital roles in raising awareness. They mobilise community members to come together in solidarity to enable pregnant women, many of whom are very poor, to access medical services. Assistance includes cheap community organised transport – much of it delivered by ETS trained drivers - funded by community savings, as well as potentially life saving blood donations. Since the start of the programme community members have mobilised over 12 million Naira. Though the expansion of the programme makes it hard to analyse trends, in Katsina an attempt to undertake a like-for-like analysis

context and emergent characteristics
5 Analysis of Data from the Community Monitoring System Report February 2012 prepared by Cathy Green
6 Data relates to the period up to December 2011.
reveals that community members value the scheme. 82% of the 2011 increase in Katsina savings happened before the expansion.

- 1,478 (42%) of those reporting maternal complications availed of grants or loans over the period January 2010-December 2011. In some states it is hard to interpret why the numbers availing appear relatively low. PRRINN-MNCH is pursuing research to explore why a relatively large number of women have not availed of the scheme in Katsina and what this might mean for equity concerns.

- **The community mobilisation approach appears to be cost effective.** Despite disappointing results for output 6 in the quantitative VfM analysis, recent community level research suggests community mobilisation components are effective.

- PRRINN-MNCH encourages caution in terms of attribution, however it appears that maternal deaths as a proportion of live births fell in 2011 compared with 2010 in Katsina and Zamfara. Although there are several possible reasons, evidence suggests PRRINN-MNCH is likely to have contributed to the reduction:
  - Over 90% of maternal complications (approximately 3,334 women) used emergency transport scheme drivers between 2010 and 2011.\(^7\)
  - The KAP 2011 survey found significant increases in knowledge about maternal danger signs and increases in birth preparedness plans (Annex 7) that could be linked to PRRINN-MNCH. Community volunteers were the most widely cited source of information (79.5%), followed by CE discussion (67.2%) and health worker home visits (61%). There was a three-fold increase in the mention of Mallams preaching and Islamiyya schools (31%).

Examples of cost efficient approaches to awareness raising

- Data on increases in immunization following RI DVD sensitizations and viewing suggest it is an effective means to stimulate behaviour change. A prototype budget suggests the average cost per person for DVD shows in one LGA was Naira 74 (GBP 0.32) per head.

- The above is cheaper than rapid awareness raising facilitated by local health visitors estimated in 2010 to cost £0.83 per person.

- Cheaper still is engagement with religious leaders. A snowballing approach initiated by 42 scholars passing on key messages to almost 1600 people is estimated to have reached up to 2.4 million.

- **Low cost replication for efficient scale up.** An additional efficiency feature of the CE design is its incorporation of community led replication by volunteers – what PRRINN-MNCH describes as a CE light approach. Current estimates suggest that the average cost of replication, not including outlays for international consultants or master trainers, is approximately £340 per community (Annex 6).

- 2011 saw a huge increase in total communities served by CE from 338\(^8\) to 2141 and 71% of the increase (1560) are community light sites compared

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\(^7\) The number quoted here is slightly lower than that in the community monitoring report source to allow for the author’s acknowledgement that the figures might include some transfers of women without complications

\(^8\) This figure comes from figures included in the 2011 progress report increased number of CE sites from 300 by end of 2010 to 581 for CE complete in 2011 and from 38 to 1,560 for CE light.
with only 11% in 2010. Based on these achievements PRRINN-MNCH estimates it will be possible to quadruple communities reached from 1,250 to 5,000 at minimal cost.

- **Low cost replication appears cost effective.** The recent KAP survey found knowledge of maternal danger signs in Katsina and Zamfara community light sites and community complete sites were similar - over 92%. (Results in community light sites were not quite as good in Yobe). In all three states the number of women with birth preparedness plans averaged 63% in community light compared with 68% in community complete sites – a significant increase from the baseline (36%). This indicates the effectiveness of the CE light approach - results were comparable in community light and complete sites.

- **Realisation of potential economies of scale will depend on context.** Close correlation between immunisation status in community light and complete sites in Katsina, where progress was slow, suggests this is likely to be a problem related to strategy and context rather than the community light approach.

**Consistent with DFID’s aims to increase efficiency in the use of aid resources, PRRINN-MNCH has developed relationships, leveraged programme resources and worked with other programmes to increase the scale of impact of the CE approach. Recent collaboration with the DFID funded Girl Hub will enable expansion of intervention sites with community response systems to MNCH barriers from 487 to 3000.**

- **Value perceived by communities bodes well for sustainability.** The rapid increase in community light sites in 2011 reflects increased confidence of community volunteers who receive little financial incentive. They are motivated by recognition and personal empowerment and the chance to share information they know can make a real difference to people’s lives.

“The Local Community Volunteers also provide key points of contact and useful communication channels between the community and the programme and the LGA teams. In addition they are key players in any follow-up training and further training in new topics and are a crucial mechanism for ensuring sustainability of the programme”  March 2011 Community Engagement Report

- The March 2011 CE study found overwhelming community level appreciation for an initiative they felt made a real difference to maternal and child health as well as having other benefits. This enthusiasm; low volunteer attrition rates; simple training materials; entertaining social occasions used to increase awareness; and involvement of influential religious leaders are likely to encourage sustainability.

- As a result of the 2011 study, PRRINN-MNCH implemented measures to increase prospects of sustaining benefits. They included: the development of an exit plan that has trained over 16,000 people; allocating resources to increase saturation in larger communities; and investing more in the development of lead volunteers to reduce recurrent costs for LGAs, who are to be responsible for continued outreach when PRRINN-MNCH ‘exits’.

- **Mixed levels of LGA support suggest the CE approach may be more sustainable in some places than others.** The sustainability of CE success not only relies on community members’ investment and enthusiasm, but also political, financial and technical support from state level actors and LGAs. These factors may be influenced by the length of time DFID has been
supporting governance work related to PRRINN-MNCH, which differs across states.

- The nature and degree of stakeholder contributions to the community engagement approach suggests it is valued and thought to be cost effective. Funds for 80% of the CE scaling up plan have been leveraged within Jigawa; LGAs in other states have released funds for the LGA coaching team; some have included CE activities in the budgets of Primary Health Care Boards/agency, MoLGA, MoWA and MoRA; In Katsina 6 LGAs contributed to routine immunisation and the SPHCD has conducted DVD shows and the NURTW purchased buses to enable the ETS.

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**Evidence of cost effectiveness motivates LGA support**

After challenges in Katsina, improvements in health indices and opinions that the programme is cost effective influenced State Primary Health Care Development agency interest in rolling the CE out in as many communities as possible. They aim to roll it out to cover 80% of the population in the next 2 years. This is reflected in the 5-year strategic plan.

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- Despite the above achievements, LGAs’ abilities and willingness to lead community engagement are mixed. In Yobe and Jigawa progress appears good, but weaker performance in Katsina and Zamfara may reduce potential VfM and economies of scale. Dialogue focused on leveraging funds for CE through the state health basket fund is ongoing.

- **Increased importance of FHCs.** During 2011 the number of FHCs; women’s engagement in them; and their level of activity in resource mobilisation, general facility maintenance and advocacy increased. PRRINN-MNCH’s pilot of a systematic space for engagement between FHCs and LGA leaders has led to some encouraging ‘wins’. The agreement of several LGAs to provide additional resources for facilities and pay midwives full allowances could be considered an example of shifts in accountability relationships that have important implications for VfM (For further discussion see Annex 4).

- **PRRINN-MNCH uses a potentially cost efficient approach to increase equity.** Although representing a relatively small proportion of the overall budget, PRRINN-MNCH has devoted considerable intellectual effort to ensuring the programme benefits the most vulnerable.

- **Gender equity:** The goals of the programme explicitly speak to gender equity concerns, but attempts to gender mainstream HR policies, increase incentives for female workers and successfully influence HMIS systems to collect data disaggregated by sex promise to achieve much more.

- Again, engaging religious leaders in efforts to mobilise government officials and legislators, as well as parents and husbands to encourage girls to enter professional training institutions and engage with the programme appears an efficient approach.

- CE research suggests that the efficient approach to community mobilization is contributing to substantial shifts in gender relations. Increases in standing permission are leading women to feel empowered and exercise more control over decisions. They have also become more active in FHCs and there has been a rise in saving by women’s only savings groups.

- **Social inclusion and equity in service access:** PRRINN-MNCH’s choice of communities in cluster one; the emergency transport system; blood donation services; and savings and loans schemes all aimed to increase equitable access to services. After identifying poor roads as a challenge to remote communities enjoying the benefits of the EMC and ETS, PRRINN-MNCH
invested more in training volunteers to mitigate risks of low LGA support after the programme’s exit. It also planned a Performance Based Financing approach in Katsina to improve community level health services in underserved communities. Unfortunately this has experienced some challenges in implementation.

- Findings from 2010 research that identified relationships between high levels of child deaths and women who lacked respect and social support led to efforts to advocate for social issues to be included in PHC models. At the end of 2011 social safety net policies had been designed and implemented in Zamfara and Yobe and were being piloted in Katsina and Jigawa. These policies could have substantial impacts on the most vulnerable women and families.

- In the future PRRINN-MNCH will use the results of the study to implement a strategy that targets particularly vulnerable young women who are neglected isolated or depressed. By nurturing the formation of Young Women Support Groups it will aim to empower these particularly vulnerable young women so that they can access the support and services that they need to look after their own and their children’s health.

- PRRINN-MNCH has also invested in a range of measures to increase health worker capacity to respond to needs of the most vulnerable and to encourage community level emergency systems to pay more attention to social inclusion. Mobilisation of religious leaders to communicate messages encouraging social support and inclusion could prove particularly cost efficient. Evidence that some FHCs are reaching out to hard to reach facility catchment areas and supporting the poor and the vulnerable to access health services by paying for the cost of their treatment is an encouraging sign.

- Although too early to assess effectiveness, PRRINN-MNCH’s proposed research to explore the subsequent experiences of the most vulnerable women and families accessing immunization and MNCH level services could provide useful value for money data for others interested in finding cost effective means to benefit these hard to reach groups.

- **Added Value of DFID’s investment in CE not captured in the log frame.** A number of other benefits resulting from PRRINN-MNCH include:
  - *Economic benefits* to (some) citizens in communities. The March 2011 community engagement study included anecdotal mention of families of immunized children reporting they were spending less on medicine. The 2011 KAP survey reported that across three states savings related to transport, drugs and treatment costs previously incurred when dealing with a maternal complication were on average at least N10,000. It is not clear from the KAP survey how much of this is a ‘real saving’ in terms of cheaper transport and drugs and/or a contribution to increased equity through redistribution of funds in the form of grants due to the saving scheme.
  - *Women’s empowerment:* PRRINN-MNCH appears to be implementing a cost efficient approach to contributing to gradual but important social change that will increase gender equity. The effects of this are likely to be of increased interest as a result of its relationship with Girl Hub and their M&E and VfM priorities.
  - *Individual empowerment.* The March 2011 qualitative study identified that community volunteers and ETS drivers were given more status

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9 A summary can be found in the PRRINN-MNCH 2010 Annual report.
and respect from other community members. This was particularly important for female CVs.

- **Social benefits.** The 2011 CE qualitative study notes impact on social cohesion and empowerment and community capacity to organize and take action. If sustained this could have important implications for demanding change in state accountability behaviours in the longer term.

### 3.4.3 Other Value for Money approaches and examples.

- As emphasised earlier, PRRINN-MNCH aims to avoid the pitfalls of technical short-term donor led service delivery programmes. Although not yet analysed in as much depth as the community engagement ‘demand side’ approach, the following section highlights some particularly relevant ‘supply side’ examples that could be explored in more depth at a later date.

**Output 1 - State and LGA governance of PHC systems geared to RI and MNCH**

- **Generating political commitment.** The programme’s nuanced political economy analysis has had significant success in securing political commitment in Jigawa. During 2011 sustained advocacy and networking resulted in winning vital political support in Katsina. This is likely to lead to improvements in state level VfM performance in the future. Gaining presidential support for the Health Bill remains a considerable challenge.

- **Increased capacity for health systems planning** was illustrated by the conduct of performance reviews and the adoption of a national strategic health development planning and M&E framework to track plan implementation. One achievement that increases prospects for sustainability is the incorporation of health plans, including costs of minimum service package and free MNCH services that reflect PRRINN-MNCH 2010 project data, in state development plans.

- **Leveraging funding:** Securing fund release from the National Health Insurance Scheme and GAVI remains a significant challenge and concern for achieving outcomes as well as sustainability. However, PRRINN-MNCH has continued to enjoy success leveraging resources from key partners for activity implementation (e.g. UNICEF, NHIS, ACF, Pathfinders etc). All states have been able to access new federally managed health funds and given the associated difficulties (above), accessing additional funds from GAVI is an important achievement.

- **Building capacity to address governance and financial management issues:** Progress appears to have been good in terms of state level expenditure review meetings and submission of financial reports to GAVI/NPHCGA. Although all LGAs in Zamfara Yobe and Katsina made financial data available, performance in terms of LGAs budget review meetings was below target. Transparency and accountability remains an issue challenging sustainability and the joint management and auditing of the basket fund for PHC in Zamfara is viewed as an important development.

- **Setting up advocacy coalitions** in each state offers potential value for money gains not only by combining partner financial resources but also by strengthening advocacy alliances. However, mobilising and advocacy at LGA level remains a challenge both in terms of capacity and political will.

- Increased collaboration with SAVI and SPARC who share offices with PRRINN-MNCH in Yobe and Zamfara States offers efficiencies through cost sharing, and easier harmonisation of approaches.
Output 2 – Improved human resource policies for and practices for PHC.

- Building technical local capacity to plan, fund, manage and deliver services at the beginning of the programme has not only increased prospects for sustainability, but also led to economy and efficiency identified in the quantitative VfM analysis. The state human resource and coordinating committees play a particularly important role in value for money achievements.
- PRRINN-MNCH has continued to seek efficiencies by setting up and using training venues in local institutions/training schools instead of hotels for in-service training of MNCH workers.
- A training of trainers approach has increased economies of scale as the need for support from national consultants and state programme officers has declined.
- A review of output 2 milestones suggest that achievements in activities within PRRINN-MNCH’s control such as trainings have been better than those in other areas. Considerable external constraints outside of PRRINN-MNCH’s control, e.g. strikes, insecurity, increases in minimum salary rates are likely to have had negative effects on the value for money achieved under this output component.

Output 3 – Improved delivery of MNCH and RI services by the PHC system

- Achievements in health sector reform have contributed to significant improvements in health care delivery. For instance immunization coverage has increased dramatically (e.g. from 15% to 76% in Jigawa between 2006 and 2010\(^\text{10}\), a greater improvement than in any other State)
- The increased use of local health professionals to provide training and supervision instead of programme staff and national advisors is reducing costs incurred by PRRINN-MNCH.
- The Katsina State Government’s purchase of SDSS drugs for cluster 1 worth N23 million, 75% of which are to be distributed in the target cluster facilities, is viewed as a particularly important VfM achievement.
- The under resourcing of the transport system and frequent vaccine stock outs is likely to have had a negative impact on the value for money delivered by PRRINN-MNCH.

Output 4 – Operational research for stewardship of PHC and RI and MNCH policy.

- Performance against milestones is impressive and the use of information in state plans (output 1) as well as increase in stakeholder contributions and management by national staff suggests this component is more cost efficient and effective than the quantitative VfM analysis suggests. Reasons for differences need investigation.
- The contribution of stakeholders to capital expenditure and secondment of staff indicates ownership and willingness to invest in the HDSS and LLGA setup and bodes well for future sustainability of OR in all states.
- Increased capacity of national staff is resulting in significant cost reductions. The cost of implementing the mid-term MNCH household survey was half the price of the baseline.

Output 5 - Information generation and use in policy and planning

- Apart from the documentation of success stories and technical briefs, performance in this component against milestones is good.

\(^{10}\) NPHCDA: *Nigeria 2010 National Immunization Coverage Survey*
• The particular value of the extremely ambitious monitoring and evaluation system that is starting to facilitate VfM analysis deserves special mention. Lessons relating to the costs of developing and maintaining such an ambitious system, particularly the community based monitoring system as well as the stakeholder contribution analysis is likely to be of interest to other practitioners trying to assess the costs of demonstrating VfM.11
• Despite some disruption because of the strike, the fact that submission rates of MNCH and RI data to the HMIS are higher than planned is a promising sustainability development, although performance in Katsina and Zamfara was better than Jigawa and Yobe.

Output 7 – Federal level capacity to support LGA MNCH and RI
• Ultimately prospects for sustainable change in health systems and effective delivery of services rest not only on changes in accountability behaviours of LGA’s but also federal level and national level policy commitments.
• Despite substantial political challenges and relatively low levels of resources that have made it impossible to respond to all of the federal level demands for its services PRRINN-MNCH is actively involved in influencing national policy.
• As mentioned earlier a significant achievement that offers the potential to dramatically increase the impact of DFID’s investment is the roll out of the PHC under one roof approach, successfully piloted in 4 PRRINN-MNCH states, across 15 other states.
• The unpredictability of the relationship between inputs and outputs under this output that is highly dependent on, and sensitive to the political environment means it may not be well suited to standard value for money analysis.

3.5 CONCLUSIONS
• PRRINN-MNCH’s design and management approach is implicitly informed by VfM consciousness. It is seeking economy and efficiencies using means that encourage continuous assessment of progress against milestones, learning and adaptation. The programme seeks to increase the scale and sustainability of impact.
• Although its accounting system is reasonably well structured and allows cost tracking and understanding of cost drivers, with the benefit of hindsight and more focus on VfM, staff feel that this could be further improved.
• PRRINN-MNCH’s ways of working and collaborating appear to offer opportunities to increase the efficiency of aid resource use over the long term, as well as economies of scale. The rolling out of PHC-UOR across 15 states is a remarkable VfM achievement that is hard to quantify.
• The community engagement approach, particularly the community mobilisation component, appears both efficient and effective and is starting to produce cost benefit data that demonstrates it is affordable to government. The data has utility for influencing policy as well as contributing to practitioner debates and learning about VfM benchmarks. Assessing sustainability will be important in the future.
• PRRINN-MNCH is pursuing some potentially efficient approaches that address complex equity issues. There are some important CE outcomes in terms of women’s empowerment and social cohesion that do not appear in the logical framework and might be overlooked in standard VfM analysis.

11 Comic relief has commissioned work to look at the costs of assessing effectiveness – it aims to look at particular issues related to collecting community level information stakeholder contributions.
In the stakeholder contribution data, (annex 8) government and donor contributions indicate that PRRINN-MNCH has been successful in leveraging resources and that its services are valued. (However, given the high levels of dependency on donor funds in two states identified in the contribution analysis discussed in the quantitative report, it is difficult to assess what this means for local ownership and sustainability in the longer term.)

Despite considerable challenges, PRRINN-MNCH seems to be generating political commitment at some levels and contributing to health reforms, as well as increases in the governance, management and delivery capacity of PHCs that enhance prospects for maximising VfM in the given context.

3.6 RECOMMENDATIONS AND NEXT STEPS

- Discuss and develop VfM indicators, and develop a holistic approach to VfM assessment. Consider if and how the quantitative VfM analysis tool used for the review could best incorporate any lags between expenditure and outputs.
- Have further discussions with DFID and OPR team about if and how (qualitative) sustainability analysis could best complement quantitative VfM analysis, e.g. by the identification of 3 or 4 key sustainability and equity indicators that should include data on community mobilisation and the outcomes of FHC activities.
- Share emerging cost benefit data that may be of interest to others to encourage critique and progress towards consensus on assessment methodologies.
- Enrich value for money debates by sharing reflections about the importance of setting up cost structures and accounting systems to facilitate easy and appropriate cost efficiency, effectiveness and VfM analysis. This could be particularly relevant for understanding of programmatic and management cost drivers.
- Select a sample of communities (perhaps purposively according to different levels of LGA support) where the community exit strategy has been implemented and monitor levels of volunteer activity and other effects after PRRINN-MNCH’s ‘exit’.
- Consider the potential benefits of integrating a social return on investment analysis in selected CE sites to generate a more complete picture of PRRINN-MNCH’s value from the perspectives of community members. Such an approach could also seek to explore issues related to the relative efficiency and effectiveness of efforts to increase equity.
- Develop a short case study to document experience and lessons from the stakeholder contribution analysis that might include implications for other actors interested in using similar metrics for VfM analysis.
- Use the community engagement analysis above as an example to encourage the development of other nuanced short case studies relating to the VfM of various ‘supply side’ components of the programme for ongoing qualitative analysis and learning. PRRINN-MNCH could usefully illustrate the limitations of technical approaches to assessing the value for money of health programmes operating in highly sensitive and complex political and cultural contexts.
ANNEX 1 – TERMS of REFERENCE

TERMS OF REFERENCE FOR DOCUMENTATION OF PROGRAMME EXPERIENCE ON VALUE FOR MONEY

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<td><strong>Decision Date: ASAP</strong></td>
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<td><strong>Responsible Persons: Solomon Mengiste</strong></td>
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Background
PRRINN-MNCH is a UK-DFID and Norwegian Government funded program with the overarching goal of reviving routine immunization, strengthening MNCH services and primary health care in the four Northern Nigerian states of Jigawa, Katsina, Yobe and Zamfara. PRRINN aims to achieve this in partnership with the state governments through the development and implementation of health policies; strengthening immunization, MNCH and PHC systems; increasing community participation in the demand for and supply of routine PHC services; and carrying out research to inform these activities.

2009 was the first year in which the Partnership for Reviving Routine Immunization in Northern Nigeria (PRRINN) and Northern States Maternal, Newborn and Child Health Initiative (MNCH) were implemented as a comprehensive and fully integrated programme called PRRINN-MNCH. During the first half of 2009, activities that were initiated under PRRINN relating to governance, PHC systems development and demand side continued being rolled out in the states. In October 2010, the programme has scaled up its cluster approach in the programme states doubling the target population and extending the programme life up to end of December 2013.

PRRINN-MNCH is a comprehensive and integrated programme. The programme, while results oriented, encompasses a health system strengthening approach, founded on a political economy strategy as a basis for addressing political, organisational, and technical impediments to taking evidence based pilot services to scale. The approach also focuses on: Measuring Results achieved; monitoring and evaluating (including an operations research platform for institutionalising the
adoption of new approaches and practices); Financial Management; Capacity Building and Stakeholder Engagement and Contribution/ local participation and ownership.

The programme recognises that DFID and the state department of the Norwegian government want to achieve, and demonstrate, greater value for money in its programmes. This technical assistance is aimed at documenting the programme experience on approaches to address value for money.

Rationale
PRRINN-MNCH is a comprehensive programme designed with key deliverable results to offer and guided and monitored with robust monitoring and evaluation framework. Expansion and extension of the programme was approved when value for money was high on the agenda of donors and international communities. It is very crucial for the programme to document experiences on approaches that address value for money, both quantitative and qualitative experiences, and disseminate the knowledge nationally and internationally.

Purpose of Assignment
The purpose of the assignment is to document lessons learned and best practices in addressing value for money, quantitative and qualitative, in relation to the key principles; economy, efficiency, effectiveness as well as equity and sustainability.

Specific tasks
- Discuss with the programme management and technical staff both at national and states level
- Review PRRINN and MNCH logframes and the combined M&E frameworks, key deliverable results to offer
- Critically review programme experiences (operations, management, finance etc) in addressing VFM
- Review programme inputs, process, outputs, outcomes and impacts with comparative analysis against similar programmes in Nigeria or elsewhere.
- Document programme experiences in addressing equity and sustainability (ownership).

Expected Output
By the end of the assignment the following outputs will be expected:
- An in-depth report (qualitative and quantitative)
- Mission report on the assignment with 3 page executive summary

Type of Consultants Required
Two international consultants (quantitative and qualitative experts), who are familiar with DFID health programmes, and with health economics and development background. Consultants who have experiences on similar assignments are recommended.

Cathy Shutt (10days) and David Toomey (15days) are recommended for this assignment because of their expertise in the VFM area. Further to this, David is a health economist, who has previously undertaken a VFM assignment on a large health systems strengthening programme in Nigeria.

Timing of Consultancy
The documentation will start in January and end in February 2012.
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<thead>
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<th>Band A – Catherine Shutt (qualitative)</th>
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<tr>
<td>Jenna Treen</td>
<td>PRRINN-MNCH UK Programme Support Manager</td>
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<tr>
<td>Solomon Mengiste</td>
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<td>Cathy Green</td>
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<tr>
<td>Anthony Klouda</td>
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<tr>
<td>Bryan Haddon</td>
<td>Health Partners International</td>
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ANNEX-3 CONSULTANT BIODATA

SUMMARY

Cathy Shutt is an independent consultant and university tutor with over 18 years’ experience of research and practice within the international aid system, previously she worked in the voluntary and private sector in the UK.

Key thematic areas of interest/experience: power; civil society; Big INGOs; aid relationships; evaluation methodologies; the sociology of money, accounting and corruption, non-profit financial management and value for money; organisational learning and change; youth participation, governance and accountability; gender inequality and women’s empowerment.

Her most recent work has focused on developing monitoring and evaluation systems and tools as well as undertaking evaluations for DFID funded governance - particularly voice and accountability programmes - many with a focus on empowering women and related value for money work.

Cathy has a PhD in Development Studies, an MSc in Agricultural Economics and a BSc in Money Banking and Finance.
WHAT IS VALUE FOR MONEY?
Value for money is a management approach understood to improve the impacts of investments. DFID’s recent guidance defined value for money as being about maximising the “the impact of each pound spent to improve poor people’s lives.”

The National Audit Office’s conceptualisation of value for money highlights aspects of economy - spending less, efficiency - spending well and effectiveness - spending wisely. These concepts are now the generally accepted starting point for VfM considerations:

- **Economy** accounts for the cost of inputs used to deliver development programmes and is managed through procurement policies and identification and monitoring of unit costs.
- **Efficiency** describes the relationship between inputs and outputs. It is often referred to as a measure of productivity that can be greatly enhanced by the quality of relationships between different actors. The relative efficiency of achieving outputs can vary over time and thus the timing of efficiency assessments is important.

Effectiveness is concerned with whether outputs are the best means to achieve outcomes
- Evaluating effectiveness requires identifying appropriate indicators to continually assess assumptions about whether outputs are necessary and/or sufficient to achieve desired outcomes. In practice cost effectiveness is measured in terms of relationships between the costs of cash (and sometimes non-cash) inputs and outcomes.

DFID has recommended that VfM analysis frameworks include 3 other dimensions:
- **Additionality** - ensuring VfM analysis of DFID programmes only considers the incremental change that would not have taken place without DFID funds.
- **Sustainability** - a dimension of effectiveness that conveys VfM is about more than immediate programme outcomes. Sustainability requires considering how programme approaches contribute to long-term transformational change for recipient countries. It is about improving technical capacity and engendering the political will - including finance - to mainstream and maintain initiatives and outcomes without external support. There is often a trade off between efficiency and sustainability.
- **Equity** is about ensuring that effectiveness analysis considers whether the most marginalised are participating and benefiting equally from programme processes and outcomes. It inevitably makes interventions more expensive and requires adding a power lens to planning, monitoring and evaluation.

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12 From ‘DFID’s Approach to Value for Money (VfM)’, July 2011
Although seldom stressed in the articulations above, aid principles articulated in the Paris and Busan Declarations suggest that reducing fiduciary risk through encouraging transparency, accountability and local ownership of aid are also crucial for achieving VfM. Despite a weak evidence base, many practitioners hope that empowering citizens to demand transparency and hold government actors and donors to account will increase VfM. Enabling local citizens and government actors to have a voice in defining what should be valued and how is also an important VfM consideration.

Recent emphasis on transparency, accountability, sustainability and equity illustrates that achieving VfM is not a technical profit maximisation problem. It is not merely about designing the cheapest or most efficient interventions. Delivering VfM is about designing and managing programmes in ways that strike the right balance between economy, efficiency, effectiveness, transparency, accountability, sustainability and equity considerations, given the values and theories of change of implementers and the dynamics of the contexts in which they operate.

**ASSESSING AND MEASURING VFM**

When DFID first started emphasising VfM it was commonly assumed to require the use of economic approaches such as cost benefit or cost effectiveness analysis, which rely on the ability to measure and quantify outcomes, (but not necessarily impacts. The parameters of the 3e model above define cost effectiveness in terms of outcomes). Debates about the methodological challenges associated with measuring outcomes such as empowerment have illustrated the potential utility of applying complexity science and systems thinking to determine whether it is possible to quantify the VfM of different development and social change initiatives. Ramalingham’s framework (below)\(^\text{13}\) illustrates linear results based management thinking and associated econometric VfM assessment techniques may have limited utility for complex initiatives, such as the GHE.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{vfm-framework.png}
\caption{The nature of the development / humanitarian intervention}
\end{figure}

Results based management techniques and economic analysis work well for ‘simple’ service delivery interventions with established programme theories being implemented in stable environments e.g. vaccination programmes. However, they are difficult to apply to initiatives involving more complex relationships and unpredictable change processes, such as empowering and transforming societal attitudes towards girls. Such programmes require adaptive management techniques - experimentation, monitoring and evaluation of progress, and learning to enable

\(^{13}\) Source http://aidontheedge.info/2011/06/30/results-2-0-towards-a-portfolio-based-approach
adaptation in order to enhance VfM. GHE’s innovative monitoring and learning framework is an apposite example of a complexity informed M&L system designed to support an adaptive management approach.

Although links between complexity thinking and VfM are not yet explicit in DFID’s VfM and M&E guidance notes, DFID’s advice for governance and security advisors includes similar concepts. It recommends that VfM analysis include:

- **Modifiers** that take account of context and risk – the inherently political nature of development work (that implies change will not be linear)
- **Contribution** analysis that recognises DFID is one of many actors facilitating good change (or stopping situations getting worse)
- **Confidence** analysis - consideration of how reliable data is for making VfM determinations or comparisons.

Recognising that many DFID funded programmes will not be able to apply traditional economic analysis to measuring their VfM, and even those that can may not be able to until *ex post* impact assessment studies, alternative approaches have been identified. Some of these highlight the benefits of using VfM analysis as a management and learning tool during implementation. A table in DFID’s advice to governance advisors usefully maps out possible approaches to assessing VfM along a continuum. **Management approaches** that focus on using monitoring and context analysis to generate insights that can inform resource allocations to enhance the probability of delivering VfM are well suited to complex initiatives in difficult environments where quantitative outcome data may be weak. **Measurement approaches** using cost benefit analysis are better suited to simple programmes implemented in stable contexts with easily quantifiable outcomes. Value for money approaches that suit programmes with different degrees of complexity can be summarised as follows:

- **Very complex/chaotic:** Adaptive management techniques that demonstrate reasonable efforts to be accountable and achieve reasonable unit costs. Continuous, but pluralist efforts to interrogate assumptions and theories of change and use resulting learning to inform resource allocation, given the knowledge available at the time.
- **Complex:** Encompasses adaptive management techniques above, but might also include the development of VfM indicators that can be scored, e.g. with a scoring card methodology over time to inform value for money judgements
- **Complicated:** Encompasses the above, but might also include trend analysis e.g. efficiency of a certain product over time as the basis for scoring, as well as some ‘ad hoc’ cost effectiveness analysis for discrete bounded aspects of programmes that lend themselves to measurement, and/or occasionally comparison with metrics from other programmes. Discrete econometric analysis might be undertaken to develop benchmarks and or metrics for sharing with the development community.
- **Simple/stable:** Measurement and economic analysis of the whole programme using established methods and VfM metrics, such as disability adjusted life years (DALY’s).

What has not yet received adequate attention in the VfM debate is treatment of costs. A recent review of social marketing approaches to changing attitudes to gender based violence illustrates how cost efficiency calculations can vary according to treatment of management costs. If the objective of VfM analysis is to go beyond simply enabling the determination of whether a programme did or did not deliver...
value for money, and also generate benchmarks that are valid standards for comparison, there needs to be more discussion about cost classifications. Again, this is not merely a technical consideration. Costs classifications tend to be influenced by accounting cultures in different organisations and also political pressures to try and achieve certain industry standards in order to appear efficient.
ANNEX 5  VFM: Rehabilitation

Initiative

Rehabilitation costs for CEOC and BEOC facilities

VFM

The rehabilitation initiative of PRRINN-MNCH demonstrates both the economic and efficiency aspects of VFM.

1. Unit costs

The unit costs below are for the PRRINN-MNCH programme and the PATHS1 programme:

<table>
<thead>
<tr>
<th>Costs to rehabilitate and equip MNCH facilities</th>
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<td></td>
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<td></td>
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<td>Rehabilitate a 24/7 PHC facility</td>
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<tr>
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<tr>
<td>Equip a 24/7 PHC facility</td>
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</table>

The unit costs shows that PRRINN-MNCH rehabilitation costs for CEOC and BEOC facilities in 2010 are respectively 8% and 18% less than PATHS1/HCP (which was completed >2 years ago)

2011 Costs to rehabilitate MNCH facilities

<table>
<thead>
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<tr>
<td>Equip a 24/7 PHC facility</td>
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</table>

PRRINN-MNCH lowered it’s costs even further in 2011.

How was this achieved?

1.) Established infrastructure standards was basis for rehabilitation, stringent procurement policies, regular monitoring and strick supervision. These
ensured that the programme purchased *inputs* of the appropriate quality at the best price.

2.) In all programme states, the programme’s robust engagement process with State, LGA and communities was able to leverage additional resources to carry out rehabilitation work beyond the program’s financial inputs.

3.) In Katsina State for example, the LGAs rehabilitated Maska PHC and constructed a bore hole at Daudawa PHC saving the program funds earmarked for that purpose.

4.) Greater community participation in all aspects of rehabilitation.
ANNEX-6

PRRINN-MNCH COMMUNITY ENGAGEMENT APPROACH:
REPLICATION COSTS

1. INTRODUCTION

Two major challenges faced by Ministries of Health when trying to improve the health of the population are how to integrate their systems with existing community-based systems, and how to work with other efforts on the wide variety of factors that impact on health, especially social determinants. PRRINN-MNCH has developed a model that places community-based and other development efforts alongside health services and health systems strengthening inputs and views these as equally important components of an integrated and holistic strategy for improving health. This approach is different to the WHO model of a functioning health system, which is primarily supply-side focused.

The PRRINN-MNCH community engagement approach utilises a highly effective training methodology, appropriate to a low literate audience, to train community volunteers. The volunteers saturate communities with new information and ideas on MNCH, and on the social factors that result in poor health outcomes, by facilitating cycles of community discussion groups. Communities are supported to put in place systems that address the main barriers that prevent timely use of MNCH services. These usually include: community emergency savings funds; emergency transport schemes; blood donor groups; and a system of mother’s helpers. At household level families are also supported to develop individual plans for safe pregnancy and delivery. These community mobilisation activities comprise the core of the community engagement approach.

Additional activities are being piloted in a small number of communities. These include Women’s Support Groups, which identify and support particularly vulnerable women so that they are better able to look after their own and their children’s health. They also include Facility Health Committees, which are being strengthened so that they act as the ‘institutional home’ for community engagement efforts, and as the interface between the community and health services. The programme is also piloting the delivery of door-step health services.

Emerging evidence suggests that the PRRINN-MNCH community engagement approach is effective: that maternal complications are being identified earlier and women are being transferred to health facilities with fewer delays; that demand for institutional deliveries is increasing; that immunization uptake is improving; and that communities are proactively identifying and supporting vulnerable women so that they are in a better position to look after their own and their children’s health.

A strategy of ‘local dissemination’, where community volunteers share what they know with neighbouring communities, has allowed LGA partners to quickly scale up activities by 400% at minimal cost. Moreover, the community engagement approach has many elements that promote sustainability – from a highly effective training approach, which results in high levels of volunteer motivation and retention, to a focused strategy of building government and CSO institutional capacity to lead the community engagement work.
However, in order to scale up health or health-related interventions to cover large populations, intervention strategies have to be affordable to government. PRRINN-MNCH’s experience is that the core components of the community engagement model are relatively low cost and hence affordable to government.

Sections 2 and 3 below look at the costs incurred in the cluster one intervention sites and at the cost of replicating basic elements of the PRRINN-MNCH community engagement approach.

2. IMPLEMENTATION COSTS

The cost of intervening in 552 intervention sites in the first cluster LGAs in Katsina, Yobe and Zamfara states (total LGA population of 325,000) was slightly less than N47 million or £188,000 (Table 1). These costs cover the two core components of the PRRINN-MNCH community engagement approach: community mobilisation and ETS. A summary of what is included in these costings can be found in Box 1.

Table 1: Costs of Implementing Community Mobilisation and ETS in Cluster 1

<table>
<thead>
<tr>
<th>Item</th>
<th>Naira</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total costs (community mobilisation)</td>
<td>36,835,000</td>
<td>147,340</td>
</tr>
<tr>
<td>Total costs (community mobilisation + ETS)</td>
<td>46,940,333</td>
<td>187,761</td>
</tr>
</tbody>
</table>

Box 1: What The Costs Cover

Community Mobilisation Process
- Initial Community Forum
- Maternal health training of community volunteers (lead and ordinary)
- Newborn health and routine immunization training of community volunteers
- Initial weekly intensive coaching and mentoring support visits by LGA teams
- Ongoing monthly monitoring visits by LGA teams

Emergency Transport Scheme
- Driver selection
- Initial driver training
- Ongoing coaching and mentoring support to ETS drivers

The costs associated with implementing other components of the community engagement strategy such as Facility Health Committees and Women’s Support Groups (both being implemented in a small number of sites) are not included in the calculations. Investment costs such as provision of technical advisory support and training of core (master) trainers are also not included since these are one-off costs.
3. REPLICATION COSTS

The cost to government of replicating the PRRINN-MNCH-supported community mobilisation approach in a single community is N66,730 or £267. If the costs associated with establishing an emergency transport scheme are added, replication costs per community increase to N85,037 or £340 (Table 2).

Table 2: Summary of Replication Costs - Community Mobilisation Plus ETS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Replication Costs Per Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Naira</td>
</tr>
<tr>
<td>Community Mobilisation</td>
<td>66,730</td>
</tr>
<tr>
<td>Emergency Transport Scheme</td>
<td>18,291</td>
</tr>
<tr>
<td>Community Mobilisation Plus ETS</td>
<td>85,037</td>
</tr>
</tbody>
</table>

These costs per community are very low and are therefore affordable to government.

Note that the figures in Table 1 are based on the cost of intervening in both ‘CE Complete’ and ‘CE Light’ intervention sites (costs have been averaged over all sites). As the number of ‘CE Light’ intervention sites increases, average implementation costs per community fall. Hence, within the PRRINN-MNCH approach overall costs depend on the scale at which communities can successfully disseminate what they know to neighbouring communities.

In the first cluster LGAs each CE Complete site supported an average of four CE Light sites, which is probably the maximum number of sites that can be supported by a single community without compromising the quality of outcomes.\(^{15}\)

4. COST OF AVERTING A MATERNAL DEATH

Community mobilisation efforts in the PRRINN-MNCH support intervention sites are expected to lead to the following: better home-based care of pregnant women and newborns; higher utilisation of ANC and post-natal care services; higher rate of institutional deliveries; and timely utilisation of emergency maternal and newborn care services. In relation to the latter, the transfer of a pregnant woman with a complication to a health facility by an emergency maternal health transport scheme can be used as a proxy indicator for a potential maternal death averted.

Table 3 below compares known health outcomes from the community mobilisation and ETS interventions with the cost of intervening. The cost of averting a potential maternal death was equivalent to N4,500 (£18) in Zamfara, N3,250 (£13) in Yobe and N2,500 (£10) in Katsina. These modest investments therefore provide excellent ‘returns’. Put another way, there should be a strong policy impetus to invest in community-based systems in order to improve health since the investment costs are low compared to the very substantial benefits to be derived from the investment.

\(^{15}\) However, this needs to be tested.
Table 3: Costing Health Outcomes

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>Cost</th>
</tr>
</thead>
</table>
| **Katsina State**  
Between December 2009-July 2011 988 women in 30 community engagement complete sites in the first cluster were transferred to a health facility with an obstetric emergency. This equates to 988 potential maternal deaths averted. | The average cost per community of supporting a demand-side response to MNCH barriers is £340. An investment of £10,200 equates to 988 potential deaths averted, which is equivalent to just over £10 per life saved. |
| **Zamfara State**  
845 women with a maternal complication were transferred by ETS from 45 community engagement complete sites over the period January 2010-July 2011. | Based on an average cost per community of supporting a demand-side response to MNCH barriers of £340, an investment of £15,300 equates to 845 potential maternal deaths averted (equivalent to £18 per life saved). |
| **Yobe State**  
822 women with a maternal complication were transferred from 31 community engagement complete sites to health facilities by ETS from between December 2009-December 2011. | This equates to an investment of £10,540, which is equivalent to just under £13 per life saved. |
1. SUMMARY

PRRINN-MNCH recognised at an early stage of implementation the benefits of scaling up into new intervention sites using a strategy of 'local dissemination'. This is where health volunteers in communities supported by the programme share what they know, and provide on-going encouragement and support to neighbouring communities, with minimal external support. This is an innovative approach, which, if effective, could provide a way to scale up demand creation efforts to reach large LGA populations.

The 'local dissemination' strategy represents value for money. Over the lifetime of the programme it is estimated that the strategy will allow the number of intervention sites to be quadrupled (from around 1,250 to 5,000 sites) at minimal cost to the programme and its partners. Early evidence suggests that the strategy is working, and that this is a cost-effective and sustainable way to scale up demand-side MNCH activities.

2. BACKGROUND

PRRINN-MNCH supported community engagement (CE) activities are being implemented in three different types of intervention site:

- ‘CE Complete’ Communities: In these communities health volunteers are being supported to facilitate discussion groups on safe motherhood, newborn care and routine immunization, and to support the establishment of community systems that address the main barriers to timely use of emergency MNCH services. The volunteers also go door-to-door to encourage a high level of preparedness for safe delivery and utilisation of routine health services among key target groups. In order to create an enabling environment for changes in social norms and behaviour, traditional, religious and other opinion leaders are involved in and are encouraged to become advocates for community mobilisation efforts.

- ‘CE Complete Plus’ Communities: Like the CE Complete communities, these communities have been supported to implement cycles of community discussions on MNCH issues. Some communities have also established Facility Health Committees as a way of strengthening the interface between communities, health facilities and policy makers. Other communities in this category are participating in a Community Based Service Delivery (CBSD) initiative, which is bringing health services ‘to the doorstep’; others still have established women’s support groups, which aim to identify and support vulnerable women in the community. Some of these ‘add-on’ initiatives came on stream relatively late in the implementation timeframe. Hence this paper groups CE Complete and CE Complete Plus communities together for the purposes of analysis.

16 In the cluster one intervention sites the local dissemination strategy allowed the programme to increase the number of intervention sites from 106 to 552 – a 421% increase in sites.
‘CE Light’ Communities: These are communities that are benefitting from the dissemination of information from, and sharing of emergency maternal care systems with the CE Plus and CE Complete communities. Very little PRRINN-MNCH support has been given to these communities. Mobilization efforts are supported by concerned and motivated community health volunteers from neighbouring communities.

Table 1 below provides data on the number of complete and light community engagement sites in each of the three MNCH states.

Table 1: Number of Complete and Light CE Sites in Cluster One Communities by State

<table>
<thead>
<tr>
<th>State</th>
<th># LGAs</th>
<th># CE Complete Sites</th>
<th># CE Light Sites</th>
<th>Total CE Sites</th>
<th>Average # Light Sites per Complete Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katsina</td>
<td>3</td>
<td>30</td>
<td>43</td>
<td>73</td>
<td>1.4</td>
</tr>
<tr>
<td>Yobe</td>
<td>3</td>
<td>31</td>
<td>71</td>
<td>102</td>
<td>2.3</td>
</tr>
<tr>
<td>Zamfara</td>
<td>3</td>
<td>45</td>
<td>332</td>
<td>377</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>106</td>
<td>446</td>
<td>552</td>
<td>-</td>
</tr>
</tbody>
</table>

For the local dissemination strategy to work, community volunteers in the sites supported by PRRINN-MNCH and its partners need to feel well-supported, and to be convinced that their activities are making a difference. In the CE Complete and CE Complete Plus sites, a coaching and mentoring support strategy involving regular, supportive visits to communities by government stakeholders and programme staff, combined with community efforts to recognise and reward the work of the volunteers, have had a positive impact on volunteers’ motivation. Seeing the results of their efforts first hand, as fewer women and babies lose their lives during pregnancy and childbirth, is also highly motivating for the volunteers. Community records of pregnant or newly delivered women assisted by the community emergency transport scheme, by emergency maternal care funds, and by community blood donors, provide the hard evidence that the community response is working. This is often enough to inspire highly motivated volunteers to make contact with neighbouring communities.

A key question for PRRINN-MNCH and its government partners is whether outcomes and impact in the CE Light communities are in any way comparable to those in the sites that are receiving much more intensive support from the programme. Evidence so far suggests that the strategy is working, and hence that this is a cost-effective way to scale up.

2. RESULTS

A Knowledge, Attitudes and Practices endline survey (KAP) undertaken in early 2011 found that although the CE Light sites scored slightly less well than the CE Complete sites, this difference was not, in general, dramatic. Selected results from the endline KAP survey are presented below.

Knowledge of Maternal Danger Signs

17 Communities in the Zamfara intervention areas are surrounded by small settlements. Hence there are more light communities in this state.
Differences in knowledge of at least four maternal danger signs between the Complete and Light communities were marginal in Katsina and Zamfara at endline. Both states had made considerable progress in both types of site compared to baseline.

In Yobe 16% of respondents knew at least four maternal danger signs at baseline. This increased to 68% of respondents in the CE Light sites and to 91% of respondents in the CE Complete sites at endline. Although the endline results in the CE Light communities in Yobe were not as good as the other two states, they were still very positive (Figure 1).

Preparedness for a Safe Pregnancy

Across the three states, preparedness for a maternal emergency increased between baseline and endline from 36% to 66% of respondents. At endline 68% of respondents in the CE Complete sites said that they had prepared for a possible maternal emergency compared to 63% in the CE Light communities. The difference between the two types of site is therefore negligible (Figure 2).
Immunization Status

In Yobe 22% of respondents reported that their child had received at least one type of vaccination at baseline. This had increased to 76% in the CE Complete sites and to 62% in the CE Light sites by endline. Progress was even better in Zamfara. The baseline figure was 20% and this had increased to 81% of respondents in the CE Light sites and 87% of respondents in the CE Complete sites by endline (Figure 3).

The results for Katsina are poor, however, with little progress made in immunization status between baseline and endline in the CE Complete sites, and an apparent fall in children with one immunization in the CE Light sites. It is not clear why the CE Light sites fared worse on average than at baseline.

What these results imply is that performance in the CE Light sites is inherently linked to performance in the CE Complete sites, and therefore getting the strategy right in these core sites is essential if economies of scale are to be realised.

In relation to children with the complete set of vaccinations, the CE Complete sites in all three states did better than the CE Light sites, although performance in the latter was still very good. All three sites had results that were substantially better than the baseline situation (Figure 4).
Again, the factor that seems to have the most bearing on the results in the CE Light sites is not the strategy of local dissemination itself, but the quality of the work in the CE Complete sites.

3. DISCUSSION

Although the CE Light communities fared slightly less well than those that had received intensive support from PRRINN-MNCH, the difference was generally not substantial, and considering the minimal external investments made, it can be argued that the results were obtained in a highly cost-effective way.

Performance in the CE Light communities tended to mirror closely that of the CE Complete communities, as was seen with the vaccination results in Katsina. Hence getting the strategy right in the core communities (or minimising the impact of external factors that are affecting progress, for example vaccine stock-outs) is essential if positive spin-offs from these initial investments are to be maximised.

Since the results obtained in the CE Light sites were derived from communities’ own investments, a core principle underpinning the concept of value for money – additionality – was achieved. A further VFM consideration is whether a financial investment leads to sustainable change. The fact that communities are driving the process of local dissemination, choosing where and when to support neighbouring communities, bodes well for long-term sustainable change. In a context where social capital is generally weak as a result of widespread economic pressures and insecurity, the efforts by communities to reach out to and support neighbouring communities also point to improved prospects for greater social support and cohesion across communities.

Value for money is also derived from investments that drive equitable change. The emphasis on social inclusion within the PRRINN-MNCH supported community engagement approach, which has been mainstreamed throughout key demand-side activities, is expected to have a positive impact on equity of access to information.

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and services. In 2013 the Output 6 team is planning to give considerable emphasis to verifying whether equitable change is indeed taking place at community level. Early feedback from communities, however, suggests a greater emphasis on inclusiveness at community level, with many positive examples of how communities have reached out to and supported vulnerable women.

Based on current plans, the strategy of local dissemination will enable PRRINN-MNCH and its partners to work in an estimated 5,000 communities in a total of 49 LGAs. In the absence of the strategy, it would be feasible to work in only a quarter of these sites. The emphasis on local dissemination has therefore allowed considerable scaling up at minimal cost.

PRRINN-MNCH’s experience of scaling up using a strategy based on local dissemination raises interesting questions about the minimum investments required to achieve results that are ‘good enough’. These are questions that the programme and its partners will continue to reflect on as it moves forward.

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18 The population of intervention communities in the first 19 LGAs is 657,669 persons. The population of intervention sites in the remaining 30 LGAs is unknown at this stage, but is likely to be over a million people.

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Annex 8: PRRINN-MNCH sustainable approach: Good governance and partnerships with stakeholders

Executive Summary

Sustainability describes how resources are utilised through an approach that will be viable over the longer term, therefore enhancing the value for money achieved by the initial investment.

By employing a sustainable implementation approach PRRINN-MNCH aims to achieve sustainable delivery and lasting health impacts, rather than just ‘quick win’ results. This approach is consistent with DFID’s concerns about maximising the potential benefits of its investments.

One aspect of the PRRINN-MNCH that aims to achieve sustainable results is its emphasis on good governance and partnerships with stakeholders. The emphasis on good governance and partnerships aims to get sustainable results by aligning with and strengthening existing systems, creating ownership, leveraging resources, creating political commitment, increasing local technical capacity and working holistically with other programmes.

The programme results and spend relating to governance and stakeholder partnerships have been analysed to show how the PRRINN-MNCH programme is achieving results, with minimal cost inputs; in these areas which contribute to the sustainability of the programme inputs and therefore reflect value for money;

- Governance

The programme output 1 is the governance output. The results are being monitored against milestones on the PRRINN-MNCH monitoring and evaluation framework. The following results have been achieved

- Output 1 achieved 17 out of 23 of its 2011 indicator milestones. £283,395 was spent which equates to 8% of the 2011 budget.
- PHCUOR was adopted as national policy with minimal budgetary input, which demonstrates results in strengthening of existing systems
- 49 LGAs/Gundumas that are implementing at least 5 MNCH & RI activities in line with their annual operational plan (milestone 36) which demonstrates results in ownership
- SiACC have been set up in all states and (or state equivalent) provide significant support for RI through PHC system in all states, demonstrating results in working holistically with other programmes
- Financial data was obtained from all LGAs in Zamfara, Yobe and Katsina States.
- 4 federally managed health funds accessed by each state

- Partnership with stakeholders

Increases in Stakeholder Contributions to PRRINN-MNCH activities shows that the partnership with stakeholders approach encourages growth toward sustainability by leveraging inputs from stakeholders and partners in programme activities.
- The correlation between the PRRINN-MNCH management strategy to encourage stakeholder contributions, and the resulting escalating trend, is notable.

The PRRINN-MNCH Programme is funded & supported by the UK Department for International Development (DFID) and the State Department of the Norwegian Government. The programme is managed Health Partners International (HPI), Save the Children UK and GRID Consulting, Nigeria.
- The number and volume of stakeholders and partners contributing is growing in all states annually, thus strengthening the acceptance of the programme in the relevant state is increasing in annually and in all states.
- By the end of 2010, stakeholders had already contributed to 46 out of 62 core activities (or 74%) in the PRRINN-MNCH activity planning framework.

- Significant improvements in health care delivery.
The approach has resulted in significant improvements in health care delivery.
- Immunization coverage has increased dramatically (e.g. from 15% to 76% in Jigawa between 2006 and 2010\textsuperscript{19}, a greater improvement than in any other State)
- Household survey findings by Columbia University indicate a large drop in Infant Mortality Rates and increase in SBA rate.

The aim of the approach is to create sustainable healthcare delivery results rather than quick wins.

1.) **Sustainability Approach**

Sustainability can be linked to the aid effectiveness agenda. Ownership and alignment are essential building blocks for long term sustainability.

By employing a sustainable implementation approach PRRINN-MNCH aims to achieve sustainable delivery and lasting health impacts, rather than just ‘quick win’ results. This approach is consistent with DFID’s concerns about maximising the potential benefits of its investments.

One aspect of the PRRINN-MNCH that aims to achieve sustainable results is it’s emphasis on good governance and partnerships.

The emphasis on good governance and partnerships aims to get sustainable results by aligning with and strengthen existing systems, creating ownership, leveraging resources, creating political commitment, increasing local technical capacity and working holistically with other programmes.

The approach is in line with the principles underlining the Paris Declaration on Aid Effectiveness in 2005, as well as the IHP+ which puts these principles into practice in the health sector by encouraging wide support for a single national health strategy or plan, a single monitoring and evaluation framework, and a strong emphasis on partners holding each other to account.

The governance results show that the programme is achieving results with regards to strengthening existing systems, creating ownership and political commitment increasing local technical capacity and working holistically with other programmes.

The stakeholder contribution analysis demonstrates that the programme is leveraging funds from stakeholders.

PRRINN-MNCH’s approach is based on core principles and strategies for: engagement with key stakeholders and communities, ensuring ongoing political

\textsuperscript{19} NPHCDA: Nigeria 2010 National Immunization Coverage Survey
and managerial ownership and commitment at all levels: strengthening core systems of management, information, monitoring and evaluation; ensuring that changes improve the quality of service delivery; and ensuring that changes achieve tangible improvements and that disruption is minimized during the change management process.

Working together with governments to achieve effective reform in public health systems is at the heart of our programme’s work. This involves effective collaboration and engagement with leadership, management and staff at all levels, as well as with communities and other stakeholders, such as front-line supervisors and labor organizations.

Of particular significance has been the comprehensive and effective engagement with key stakeholders at Federal, State, local government and community levels. The PRRINN-MNCH programme is very careful in supporting the work and development of governments and service providers rather than directly delivering healthcare itself. As a result thorny governance issues such as financial management and fragmentation of the health system have been directly and substantively addressed in close partnership with government, in order to build on and not duplicate existing structures. A key working principle for PRRINN-MNCH has been to ‘complement and strengthen’ rather than ‘replace’ government.

2.) Governance results to demonstrate sustainability

The following results relate to output 1 of the PRRINN-MNCH programme which is ‘Strengthened state and LGA governance of PHC systems’. The results are the broken down into initiatives and core activities. The results are taken from the PRRINN-MNCH monitoring and evaluation framework.

Output 1 is the main governance outputs of the PRRINN-MNCH programme. The below outlines the initiatives and core activities for output 1 and 7. It shows the 2011 results achieved against each core activity as well as the amount and % of budget spent.

Output 1 ‘Strengthened State and LGA governance of PHC systems geared to RI and MNCH’

Output 1 achieved 17 out of 23 of its 2011 indicator milestones. £283,395 was spent which equate to 8% of the 2011 budget.

Initiative 1.1 Support State and LGA planning and policy development

Initiative 1.1 achieved 7 out of 9 of its 2011 indicator milestones. £121,593 was spent which equates to 3% of the 2011 budget. The results related to PHCUOR demonstrate the cost effectiveness of these inputs as well as highlighting the sustainability impact of the approach. See box 1.

Box 1: PHCUOR

The “PHC Under One Roof” approach was developed by the programme to address the fragmentation of PHC services. The NPHCDA was supported by PRRINN-MNCH to develop the “PHC Under One Roof” concept note, policy brief, and implementation guide.

Due to the programme’s effective governance and engagement approach, the
Core activity 1.1.1 Support annual State health sector review and operational planning

£38,185 was spent on Core activity 1.1.1 in 2011 which equates to 1% of the budget billed. The following results were achieved:

- State government staff lead annual review and health planning process in all states
- All states with their State Health Plan incorporated into their State Development Plan
- All state health plans reflect project data from 2010. Each state has at least five examples of evidence based planning in their state plans
- 49 LGAs/Gundumas that are implementing at least 5 MNCH & RI activities in line with their annual operational plan (milestone 36)
- Two quarterly performance reviews at state level conducted in each state in 2011
- All states have adopted the national Strategic Health Development Planning M&E Framework to track state health plan implementation

Core activity 1.1.2 Facilitate state health policy analysis, development and implementation (including PHCUOR)

£56,387 was spent on Core activity 1.1.2 in 2011 which equates to 2% of the budget billed. The following results were achieved:

- “PHC Under One Roof” concept was adopted as national policy.
- 3 states SPHCDA/B established

Core activity 1.1.3 Facilitate the development of a costed State minimum service package and free MNCH services

£27,021 was spent on Core activity 1.1.3 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

- All States with costed MSP reflected in State Plans (including SEEDS)
- All States with costed free MNCH services reflected in State Plans (including SEEDS)

Initiative 1.2 Facilitate coordination and harmonisation of stakeholders and partners at State and LGA levels

Initiative 1.2 achieved 2 out of 5 of its 2011 indicator milestones. £42,716 was spent which equates to 1% of the 2011 budget. (£33,000 of the spend was for the promotion of the improvement in efficacy and efficiency of IPDs)

Core Activity 1.2.1 Support inter-agency co-ordination and harmonization

£5,068 was spent on Core activity 1.2.1 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

- All states have at least 3 donor PHC programmes reflected in State and LGA annual health plans.

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- SIACC have been set up in all states and (or state equivalent) provide significant support for RI through PHC system in all states.
- One donor field mission and review done jointly.

**Core Activity 1.2.2 Facilitate co-ordination with State and LGA stakeholders**

£4,592 was spent on Core activity 1.2.2 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

- 3 out of a milestone of 4 MOU/change matrix agreements signed between PRRINN-MNCH and states
- 8 out of a milestone of 38 MOU/change matrix agreements signed between PRRINN-MNCH and LGAs in CEOC clusters

**Initiative 1.3 Promote coordinated advocacy, institutional change and change management**

Initiative 1.3 achieved 2 out of 2 of its 2011 indicator milestones. £51,253 was spent which equates to 1% of the 2011 budget.

**Core Activity 1.3.1 Support co-ordinated advocacy for increased PHC resources and institutional change and Core Activity 1.3.2 Support change management and Agents of Change**

- State advocacy plans formulated in each state
- HERFON chapters supported to establish Eminent Persons Groups in each state
- State Programme Advocacy Committees set up in each state

**Initiative 1.4: Support health financing, budgeting and public financial management for PHC**

Initiative 1.4 achieved 6 out of 7 of its 2011 indicator milestones. £67,833 was spent which equates to 2% of the 2011 budget.

**Core Activity 1.4.1 Facilitate improvement of budgeting and public financial management**

£29,101 was spent on Core activity 1.4.1 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

- Financial data was obtained from all LGAs in Zamfara, Yobe and Katsina States.
- Annual expenditure reports available in targeted LGAs/Gundumas
- All states and LGAs in cluster 1 were supported to prepare 2012 annual health plans and budgets.

**Core Activity 1.4.2 Facilitate mobilization of federal government resources by States & LGAs for PHC**

£10,061 was spent on Core activity 1.4.2 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

- All states successfully access new Federally managed health funds.
- 4 federally managed health funds accessed by each state
- All states have applied and received additional funds from GAVI
- 14 timely state financial reports sent to GAVI/NPHCDA

**Core Activity 1.4.3 Facilitate regular finance and budget performance reviews**

£28,672 was spent on Core activity 1.4.3 in 2011 which equates to less than 1% of the budget billed. The following results were achieved:

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- 2 State level expenditure review meetings held between SMOH and MOPB to review plans, release of funds and budgets in all states
- 25 LGA/Gunduma expenditure review meetings in each targeted LGA/Gunduma to review plans, release of funds and budgets

3.) Partnership with stakeholders

The ‘Technical brief on PFM’ outlines the health sector financial performance in each state. (see Technical Brief on Public Financial Management Activities in 2011). This technical brief outline PRINN-MNCH’s work in PFM and achievements.

However the programme also wanted to see what specific contribution stakeholders and partners had made to PRINN-MNCH activities. The programme undertook a rapid survey of stakeholder and partner contributions to PRINN-MNCH activities. Stakeholder and partner contributions in each of the four states were tracked using a comprehensive template of all core activities in the PRINN-MNCH activity planning framework. There is increasing buy-in by state stakeholders and partners to the PRINN-MNCH activity plans and MNCH related funding by stakeholders and partners is significant compared to PRINN-MNCH contribution and increasing. The range of activities supported by stakeholders/partners illustrates the effectiveness of PRINN-MNCH engagement process with stakeholders and partners. High levels of Stakeholder/Partner funding in PRINN-MNCH states make it impossible to attribute of key results solely to PRINN-MNCH.

Increases in Stakeholder Contributions to PRINN-MNCH activities shows that the partnership with stakeholders approach encourages growth toward sustainability by leveraging inputs from stakeholders and partners in programme activities.

PRINN-MNCH Stakeholder Contribution VFM Methodology

a. Financial and operational reports from PRINN-MNCH were reviewed.
b. We analyzed the comparative state spend on health services with the budget in the four PRINN-MNCH states. We then linked the actual state spend to the stakeholder spend and looked for trends.
c. We reviewed total stakeholder spend by year, state and Output
d. We recalculated the % of partner spend as a percentage of total spend on an output (rather than as a % of the programme spend) to give a more accurate indication of the impact of partner spend. The prior calculation provided by PRINN-MNCH made the partner contribution appear as a greater % of total spend, and the impact of the partner contribution then appeared to be less.
Results
Table 2, 3, 4 and 5 following show strong stakeholder and partner contributions.

<table>
<thead>
<tr>
<th>Jigawa State Stakeholder Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jigawa State</strong></td>
</tr>
<tr>
<td># of stakeholders/partners</td>
</tr>
<tr>
<td># of activities funded</td>
</tr>
<tr>
<td>Total contributions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Katsina State Stakeholder Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Katsina State</strong></td>
</tr>
<tr>
<td># of stakeholders/partners</td>
</tr>
<tr>
<td># of activities funded</td>
</tr>
<tr>
<td>Total contributions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yobe State Stakeholder Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yobe State</strong></td>
</tr>
<tr>
<td># of stakeholders/partners</td>
</tr>
<tr>
<td># of activities funded</td>
</tr>
<tr>
<td>Total contributions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Zamfara State Stakeholder Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zamfara State</strong></td>
</tr>
<tr>
<td># of stakeholders/partners</td>
</tr>
<tr>
<td># of activities funded</td>
</tr>
<tr>
<td>Total contributions</td>
</tr>
</tbody>
</table>

Analysis
- The correlation between the PRRINN-MNCH management strategy to encourage stakeholder contributions, and the resulting escalating trend, is notable.
- The number and volume of stakeholders and partners contributing is growing in all states annually, thus strengthening the acceptance of the programme in the relevant state is increasing in annually and in all states.
- By the end of 2010, stakeholders had already contributed to 46 out of 62 core activities (or 74%) in the PRRINN-MNCH activity planning framework.
- Stakeholders/partners are channelling significant resources to a wide variety of activities that include both demand and supply side for immunisation and MNCH activities, governance and service delivery activities and even operations research.