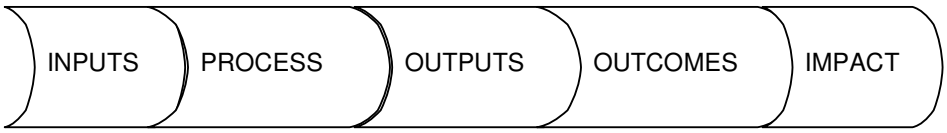
Value for Money (VfM) - the PRRINN-MNCH experience

The VfM approach is a different way of looking at monitoring and evaluation (M&E). Traditionally M&E uses a set of indicators and targets that assess progress against an implementation plan in five areas:



Each of the five areas will have a set of indicators and targets, and managers (or evaluators) will measure whether the targets have been met and if not try to understand why not and implement (or suggest) remedial measures.

The VfM approach asks us to look at M&E through another lens:

"***We maximise the impact of each pound spent to improve poor people's lives***"[1]

Essentially, we are being asked to take the traditional five indicator areas and apply a set of principles to see whether we are getting the 'maximum bang for our buck'. The six principles include:[2]

- **Economy** is about purchasing *inputs* of the appropriate quality at the best price
- **Efficiency** is about strengthening *processes* to best utilise inputs to maximize the *outputs*.

Even though a programme might be economical and efficient, the outputs produced might not lead to the envisioned outcomes and impact, essentially because of the disjuncture between the inputs/processes/outputs and the outcomes/impact.

- **Effectiveness** is about whether the inputs, processes and outputs lead to the planned *outcomes* and *impact* as described in the plan.

The first three principles are classic economic principles. However, recently three more principles have been added to address the concerns in the definition captured above. These apply to development partner assistance but equally should apply to locally funded and driven programmes.

- **Additionality** indicates whether the resources are non-duplicative, supplementary and will produce additional outputs and outcomes beyond what is possible with existing resources.
- **Sustainability** describes how resources are utilised through an approach that will be viable over the longer term with progressively decreasing external assistance.
- **Equity** describes the ability to target those most at need or most marginalised.

It is only when all these components are strong that a programme represents good VfM.

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[1] From 'DFID's Approach to Value for Money (VfM)', July 2011

[2] There is no defined set of principles, this is an amalgam from a number of resources – the DFID note mentioned above, the Global Fund to fight AIDS, TB and Malaria (GFATM) note on VfM and the Makana VfM Index®

How does the PRRINN-MNCH programme measure up to VfM? Below is a set of examples to illustrate the six VfM principles.

a) Economy

Economy is about purchasing *inputs* of the appropriate quality at the best price

PRRINN-MNCH employs a range of measures to increase economy, which include the use of stringent procurement policies, monitoring and evaluation of unit costs and rigorous selection and contracting procedures for technical assistance.

i) Stringent procurement policies and regular monitoring and evaluation of unit costs

This ensures the programme reduces costs without effecting quality. For example, this has resulted in reduced costs for facility rehabilitation. The PRRINN-MNCH rehabilitation costs for CEOC and BEOC facilities are respectively 8% and 18% less than PATHS1/HCP[3] (Partnership for Transforming Health Systems, Health Commodities Programme).

ii) Rigorous selection and contracting procedures for technical assistance

This ensures that the programme uses appropriately experienced consultants at the best price. This combined with the programme's capacity building approach has resulted in:

- A shift from using international technical assistance to national technical assistance (55% international in 2006 to an estimated 10% in 2013).
- Increased use of local (indigenes of the state) consultants (LECs or LEOs) who are employed on a long-term and full-time basis (none in 2006 to 67 in 2012).
- Shift from using external technical assistance to internal programme staff (decreased use of technical advisors by 24% and of programme management board members by 46% over the lifetime of the programme).
- Low average fee rates.

Other examples of economy resulting in the programme achieving low costs are:

iii) Use of practical sites for in-service training

In Katsina and Zamfara the SMOH has dedicated 4 classrooms in the School of Nursing to the program as a training site. This was estimated to be saving the program over N1.5m on venue and other hotel logistics per training.

iv) In-service training

The days and the costs of training have been reduced without affecting the quality of the training. For example:

- Modified competency training from 21 days to 3 days with associated savings
- The average cost per participant was £941 which is significantly cheaper than FMOH designed programmes.

b) Efficiency

Efficiency is about strengthening *processes* to best utilise inputs to maximize the *outputs*. It is also about maximising the productivity of resources.

[3] Members of the same consortium were involved in the PATHS1 programme which ended in 2008

To ensure productivity is higher PRRINN-MNCH employs efficient management structures, including an emphasis on decentralised management. Detailed monitoring of inputs versus outputs ensures that the productivity of the programme resources are maximised. Cost efficiency analyses are also undertaken to establish benchmarks or unit costs.

Overall, efficient inputs and processes have ensured that the programme has best utilised it's budget to maximize the outputs. This has resulted in the PRRINN- MNCH programme being able to double it's target population from 4.5 million to 9 million with the budget extension of only 46%.

The decentralized management approach has led to an integrated, unitary structure with single lines of accountability for all staff and managers up to the funding organisation. For example, in 2011, 100% of programme activities implemented at the state level were planned and budgeted for by the PRRINN-MNCH state team managers.

Other examples of the efficiency of the programme include:

i) **Minimising Routine Immunisation (RI) missed opportunities**
In Jigawa, secondary health facilities and busy PHC facilities have, from 2009, provided more regular RI services. To date 48 facilities are providing either daily or twice weekly RI services.

ii) **Community Engagement (CE) 'light' sites**
The Community Engagement strategy included CE 'light' sites, which are community engagement sites where limited direct support was provided by PRRINN-MNCH. In these sites the emphasis was on encouraging communities supported by the programme to disseminate new ideas to and share systems with neighboring communities.

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.

iii) **Strong partnerships established with religious leaders**
The strong partnerships established with religious leaders has enabled the programme to achieve increased promotion of MNCH services at minimal cost. For example, this resulted in 2.4 million people being reached by religious leaders during Ramadan Tafsir, through mosque preaching sessions, radio jingles and TV programmes.

iv) **Budget performance and expenditure review**
Budget performance is a weak area in Nigeria often due to poor fiscal projections and over enthusiastic budgeting. PRRINN-MNCH has worked steadily on these issues. For example, in Jigawa, a budget performance and expenditure review conducted at Gunduma Council and Board levels in 2011 showed that 50% of the Gunduma Councils have reached 75% budget performance ranking score while the Board's 2010 budget performance was 95%.

c) Effectiveness

Effectiveness is about whether the inputs, processes and outputs lead to the planned *outcomes* and *impact* as described in the plan.

The programme uses specific, evidence based, cost-effective and targeted health interventions. This is achieved by delivering healthcare in CEOC clusters inclusive of the

programme's community engagement approach. New ideas for interventions are also tested out through a learning and research approach to ensure they are effective before they are employed

i) CEOC clusters

By delivering healthcare in CEOC clusters whereby women in labour and with emergencies can be easily referred and transferred to higher level facilities with more resources for saving women's and neonatal lives.

ii) Community Engagement

A participatory community mobilisation approach saturates communities with new ideas and supports community members to turn their awareness into action in support of women's and children's health.

iii) Learning LGAs and piloting approach

The implementation research approach pilots innovations on a small scale, learns from the process, and then expands and ultimately scales up successful (feasible and effective) activities. This ensures that funds are not dissipated on non-feasible and non-effective approaches or strategies.

iv) Utilising a Political economy approach

This ensures that policy and strategy choices are more likely to gain traction and also suggests areas where traction can be found and/or leverage applied.

The programme also has an extensive logframe and Monitoring and Evaluation (M&E) framework which it uses to ensure the programme is having the desired outcomes and impacts. In relation to MNCH indicators, the programme has exceeded the 2011 annual milestones in 14 of 17 cases (82%), has already achieved 3 end-of-programme targets for 2013 (18%) and is within 10% of end-of-programme targets for 5 indicators (29%). This following key results have been achieved:

Progress on achievement of key annual results

Indicators for Key Results	Baseline	Milestone 2011	Progress 2011	Target 2013
Improved human resources				
Number of accredited training institutions	2	4	2	8
Number of PHC facilities (PHC and BEOC) with midwives	0	36	66	72
Number of midwives working in programme-supported facilities	12	184	194	310
Expanded access to emergency obstetric care				
Number of facilities providing comprehensive emergency obstetric care	2	9	12	18
Number of PHC facilities (PHC and BEOC) providing deliveries 24 hours a day by trained staff	NA	58	139	144
Number of deliveries per year attended by skilled birth attendants	8,172	65,520	99,537	150,000
Number of maternal complications transferred to health facility via emergency safe motherhood transport scheme	0	1000	2,361	>2,000
Number of Caesarean section conducted	NA	3,780	4,611	5,670
Number of postnatal visits in targeted PHC facilities	2,488	12,852	30,577	37,800
Expanded access to antenatal care				
Number of 1st ANC visits per year	14,524	95,760	181,021	200,000
Expanded access to family planning				
Number of PHC facilities providing contraceptives	NA	50	139	144
Number of women used modern family planning	NA	45,126	23,231	86,526

Indicators for Key Results	Baseline	Milestone 2011	Progress 2011	Target 2013
services				
Contraceptive prevalence rate	NA	2.20%	NA	4.20%
Expanded uptake of immunisation services				
Number of health facilities providing immunisation on a weekly basis	89	312	442	468
Number of <1 year old receiving measles immunisation per year	126,439	403,556	590,200	544,710
Number of <1 year old that have received DPT3	59,611	144,978	413,101	256,793
Expanded access to essential child health services				
Number of health facilities providing IMCI & growth monitoring	0	117	214	234

Other examples include:
Using available data from within the programme and from federal surveys, the following results in comparison with the baseline data[4] illustrate the effectiveness of the programme:

- 314% increase or an additional 222,141 children fully immunised children per annum in the four PRRINN-MNCH states.
- 431% increase or an additional 360,072 pregnant women appropriately immunised against tetanus per annum in the four PRRINN-MNCH states.
- 270% increase or an additional 24,748 women per annum attending antenatal care (ANC) first visits in targeted facilities in the CEOC first clusters in the four PRRINN-MNCH states.
- 271% increase or an additional 13,998 women being delivered by skilled birth attendants (SBAs) per annum in targeted facilities in the CEOC first clusters in the four PRRINN-MNCH states.

d) Additionality

Additionality indicates whether the resources are non-duplicative, supplementary and will produce additional outputs and outcomes beyond what is possible with existing resources.

Examples include

i) Learning LGAs and piloting approach
The second round Operational Research (OR) protocols will be funded almost entirely by the state OR budgets. However, PRRINN-MNCH will still provide technical assistance.

ii) GAVI financial management system tools
Currently in use by all the states and NPHCDA for reporting on use of GAVI funds. The development and piloting was done in the four states by PRRINN-MNCH, but use by NPHCDA and roll out to other states was funded by NPHCDA and other partners.

e) Sustainability

Sustainability describes how resources are utilised through an approach that will be viable over the longer term with progressively decreasing external assistance.

Thus, the programme ensures that its inputs strengthen and are aligned with existing local systems; and avoids vertical interventions which are independent of local systems.

[4] Extracted from the 2010 Annual Report

i) Alignment with local systems

All activities are internally led and aligned with existing local systems. Examples include:

- All four states have their State Health Plan incorporated into their State Development Plan
- The CE costs are low and affordable to state government and LGAs, evidenced by the fact that to date government is funding 38% of community engagement sites, either wholly or partially, across the four states.

ii) Ownership

All activities aim for political commitment and ownership:

- The 'PHC under one Roof' approach was developed to address the fragmentation of PHC services. The approach was adopted by the National PHC Development Agency (NPHCDA) Board and the National Council for Health (NCH) as national policy.
- PHC under One Roof is now being rolled out to 15 other states with funding from other partners.
- In Jigawa, the Gunduma Board has scaled up the community engagement approach to 21 wards in the Gunduma councils and allocated their own budget in 2010 and 2011.

iii) Capacity Building

Technical capacity, required to continue implementing program activities over time with decreasing external support, is being strengthened across all activities

iv) 'Stakeholder engagement' process.

The process of engagement is seen as a key element of sustainability. For example, the PRRINN-MNCH programme has worked with stakeholders at both federal and state levels to develop and implement systems for accessing, utilising and retiring Global Alliance for Vaccines and Immunisation (GAVI) funds.

Stakeholder and partner contributions to PRRINN-MNCH activities

There is increasing buy-in by state stakeholders and partners to the PRRINN-MNCH activity plans and MNCH related funding by stakeholders and partners is significant compared to PRRINN-MNCH contribution and increasing.

Key findings of the survey of stakeholder and partners contributions to RI and MNCH are:

- Stakeholder contributions amount to 29% and 44% of total programme contributions in 2009 and 2010 respectively.
- Stakeholder contributions increased by £ 931,247 (or 80%) from 2009 to 2010.
- 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.

In addition

- Partners contributed to setting up Operational Research capacity in learning local government areas (LLGAs) - 58% of expenditure contributed by partners; and in the health demographic surveillance system (HDSS) site - 38% of expenditure contributed.

The range of activities supported by stakeholders/partners illustrates the effectiveness of PRRINN-MNCH stakeholder engagement process. It also demonstrates political commitment and ownership of program activities that suggests the benefits of the proposed investments and activities will be continued after external financing ends

The examples on the pooled fund, minimising RI missed opportunities, budget performance and the CE scale up mentioned earlier are all examples of sustainability.

f) Equity

Equity describes the ability to target those most at need or most marginalised. The programme seeks to identify those most at need or most marginalised through surveys and studies.

Example of studies and interventions include:

- The clustering of health problems study[5] provided data showing that 20% of women account for 80% of child deaths in communities. This study informed the design of programme interventions to target these families.
- First and second delays in accessing EOC have been addressed through innovative approaches that have included emergency transport schemes (ETS) with the National Union of Road Transport Workers (NURTW) and emergency loan schemes (ELS). These have had considerable success in hard-to-reach areas.
- The Young Women Support Group Initiative targets vulnerable, excluded, and neglected young women.
- The work on the Minimum Service Package (MSP) and free MNCH services is targeted to reach those most marginalized.

[5] Described in the 2010 annual report