The Technical Resource Facility and related initiatives (TRF+)

Policy brief

September 2019

Improving delivery of MNCH and nutrition services using better data: progress and implications in Pakistan

The Provincial Health and Nutrition Programme (PHNP) began in 2013 to address the poor state of maternal and child health (MCH) in Punjab and Khyber Pakhtunkhwa (KP) provinces. TRF+, managed by Mott MacDonald, provided targeted technical support to improve service delivery by strengthening systems and capacities in areas such as governance, financial management, procurement and monitoring and evaluation (M&E).

A central premise was that better production and use of data would support governance and enable evidence-based decision making. This brief looks at how this was achieved and its implications going forward.

TRF+ has been funded by the UK's Department for International Development (DFID) and managed by Mott MacDonald

TRF+

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The Challenge

At the programme's inception, there was an acute awareness that Pakistan was lagging behind some of its regional neighbours in its progress against key RMNCH indicators. This sparked the attention of the Chief Minister of Punjab who was particularly concerned that Indian Punjab, just across the border, was performing significantly better. This set the tone, creating an appetite for more comprehensive, robust and timely data to measure how each district in the province was faring and whether Pakistan's Punjab could catch up. Awareness in KP that the province was lagging much behind the MDG targets triggered a similar response under the leadership of the KP Health Minister.

Progress and Achievements

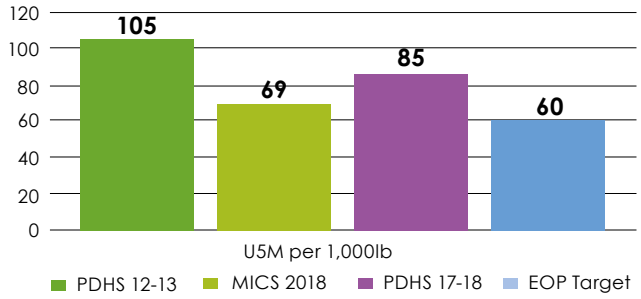
TRF+ was implemented for five years from 2014-2019. The Pakistan Demographic & Health Survey (PDHS) of 2017-18 recorded substantial improvements in maternal and child health indicators compared with the PDHS of 2012-13, as follows:

- Under-five mortality has fallen in Punjab from 105/1,000 live births to 85/1,000 and in KP from 70 to 64/1,000.
- Both provinces have shown a very significant increase in skilled birth attendance (SBA), increasing from 53% to 71% in Punjab and from 48% to 67% in KP.
- Punjab saw a 14 percentage point increase in complete immunisation coverage from 66% to 80%. For KP the change was from 53% to 55%.

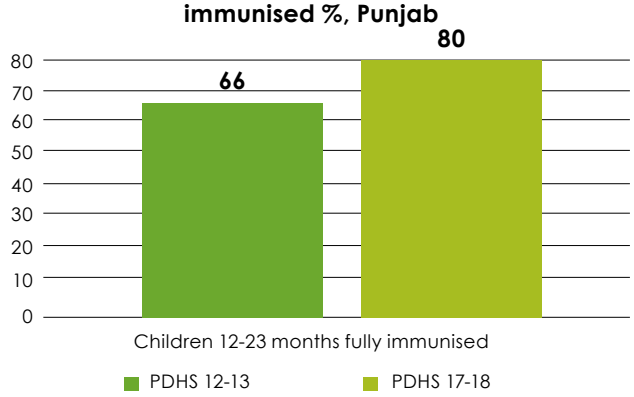
Analysis of government MIS showed that public sector utilisation, coverage and quality also saw positive trajectories. Facility Utilisation Rate (FUR) in Punjab increased from 38% to 53% between 2014-17, while in KP it increased from 34% to 41%, showing increased confidence of people in using these facilities. Notably, births in a public sector facility rose most markedly for the lowest three wealth quintiles in Punjab. This progress may have also benefited from coinciding with a period when the Pakistan economy was relatively stable, with steadily increasing GDP growth rates between 4 and 6%, as opposed to the previous boom and bust fluctuations.

In the following sections we describe the initiatives put in place to achieve these results. Our work was made up of three complementary elements – supporting the effective use of DFID's financial aid to the governments of Punjab and KP; a Roadmap approach implemented by our partner, Acasus; and TA support for strengthening systems and building government's capacity. This 'three-pronged approach' proved increasingly successful over the 5 years as relationships evolved and monitoring feedback loops helped partners to adapt strategies to achieve the targets.

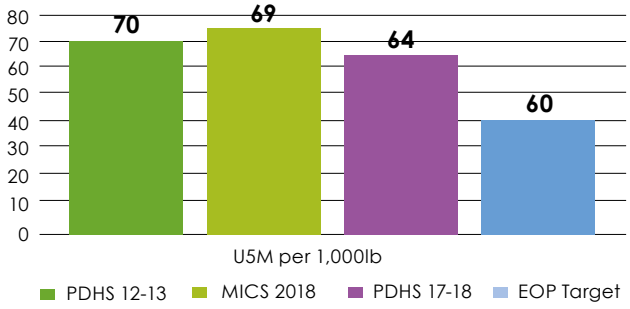
Under 5 mortality, Punjab (per 1,000 LB)



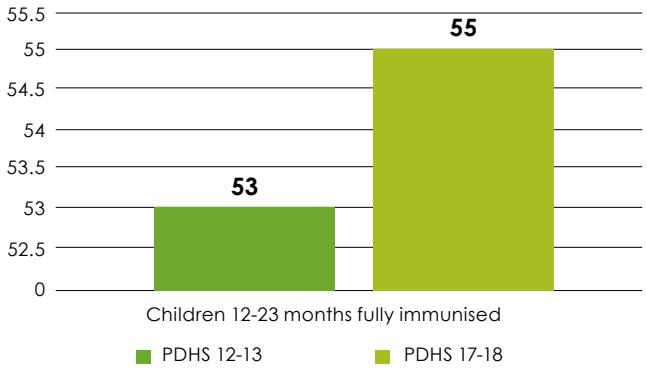
Children 12-23 months fully immunised %, Punjab



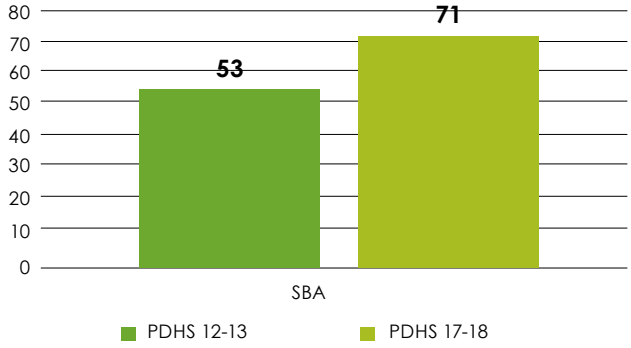
Under 5 mortality, KP (per 1,000 LB)



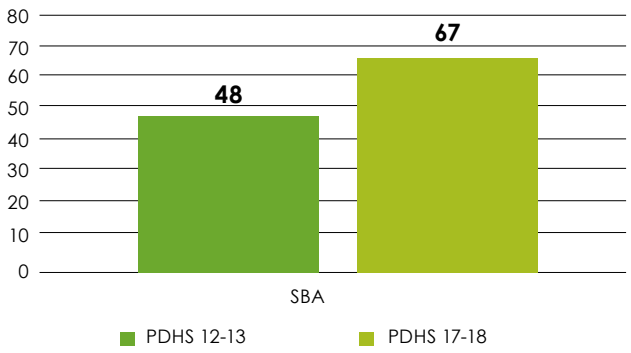
Children 12-23 months fully immunised %, KP



SBA (%), Punjab



SBA (%), KP



Supporting the effective use of financial aid

DFID's financial aid has been invested in improving RMNCH services with incremental targets set each year relating to services by LHWs, basic and comprehensive emergencency obstetric care (BEmONC and CEmONC) and nutrition curative services. Annual disbursement linked indicators (DLIs) were linked to achievement of these targets, and assessed by TRF+ using robust field surveys. In Punjab, a separate financing instrument or "Business Plan" was introduced for using DFID financial aid in support of the reforms, while in KP the Integrated Programme's PC-1 was revised to reflect financing needs of priority reforms.

In the last year of the programme all DLI targets were met in both provinces. Contraceptive availability targets were achieved for the first time in 2019, and district and tehsil level hospitals tasked with providing CEmONC services also met their targets. In Punjab, three successfully achieved DLIs - provision of adequate supplies, filling of service providers' posts, and fully implementing Minimum Service Delivery Standards - all contributed towards compliance with BEmONC requirements. In KP, DLIs aimed at designated health facilities meeting BEmONC criteria were achieved in 2018/19. DLI assessments enabled data to be used for accountability.

In one particular quarterly meeting in KP, when the government had missed the target on contraceptive stock-outs by LHWs, participants suggested DFID might soften the target and approve the full disbursement regardless. This was cut short by the Secretary who asked, "Do the women of KP deserve to be served by LHWs without stockouts?". When the assembled officials agreed they did, the Secretary declared that they would forego the money until they had reached the proper target. This example nicely illustrates accountability in action – when stark data is presented to those in authority in a public forum.

The Roadmap

Alongside this the Roadmap focused on priority primary health areas with significant public health impact related to the MDGs, including increasing safe deliveries and immunisation coverage. The approach entailed regular monitoring of key indicators for each district of the province, with data presented in quarterly stocktake meetings chaired by the Chief Minister in Punjab and by the Health Minister in KP. Data on input and output indicators relating to availability of staff, medicines, supplies and equipment and skilled birth attendance rates at facilities were generated through specially designed monitoring systems – Monitoring and Evaluation Assistants (MEAs) in Punjab and by an Independent Monitoring Unit (IMU) in KP. Data on coverage by vaccinators was collected through an innovative mobile application, usng GIS technology, e-VACCS.

Follow up meetings with district health managers, which took place after the stocktakes and were chaired by the Secretary of Health, focussed on districts which were falling behind targets. Bottlenecks and barriers were identified at these meetings with a view to quick decision-making to unblock the hindrances.

The use of accurate data and consistent engagement of department officials through the Roadmap process was instrumental in rapidly implementing a number of priority and ambitious reforms:

- In Punjab over 1,000 Basic Health Units were converted to 24/7 facilities for provision of SBA services. Related staffing and infrastucture improvements were carried out. In addition, a rural ambulance service was introduced for pregnant women to avail 24/7 BHU services and for referral of complicated cases. The service had handled 80,700 life saving emergencies and 456,800 routine transfers up until the end of 2018.
- In KP, the Roadmap and the TRF+ technical team joined hands in providing similar support to upgrade selected Rural Health Centres (RHCs) into 24/7 facilities for provision of SBA services.

The improvements were more pronounced in Punjab where the Chief Minister was himself steering the Roadmap process. This typically ensured the presence of the heads of all relevant departments in the stocktake, including Finance, Planning and Development and Population Welfare. The Chief Secretary's participation ensured that instructions of the Chief Minister were implemented by the departments concerned. In this way, the stocktake was an effective governance tool where all concered could be held accountable. This model of governance could not be replicated in KP, where only the Health Department and its related offices and organisations were present in the stocktake, chaired by the Health Minister. This meant that issues relating to other departments, e.g. delays in release of funds, could not be taken up with concerned departments on the spot which somewhat diluted the process.

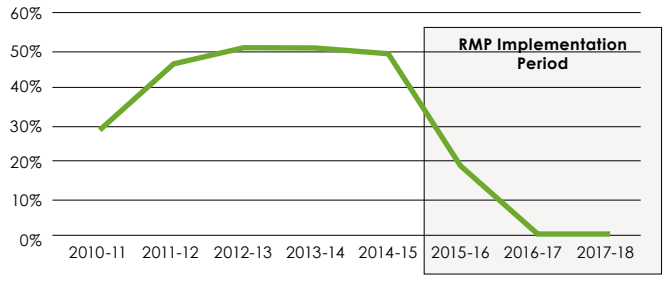
In both provinces there has been strong evidence of government's capacity and focus to continue the Roadmap approach. The facility based monitoring by MEAs in Punjab and by the Indepentent Monitoring Unit (IMU) in KP and e-VACCS in both provinces continue and stocktakes have been maintained, though now are led by the Health Minister in both provinces. The Roadmap had sustainability built into its approach, embedding routines and processes and hard-wirng changes into the system so they become the norm rather than exception; and developing increased expectations from the public.

Technical Assistance

The Roadmap process was accompanied by a large and diverse range of TA aimed at strengthening systems and capacity building, which ultimately contributed to service delivery improvements benefitting women and children. The TA, both short- and long-term, improved public financial management (PFM), procurements, monitoring and reporting, and some outreach programmes.

Improving PFM in both KP and Punjab involved ensuring rational budget allocations so that funds were available for the reforms under the Roadmap as well as in the broader health system, in addition to meeting the routine expenses of the department. In KP, TRF+ supported the Health Department to take ownership of the budgetary process, which led to the department preparing its own needs-based budget for the first time in a decade. Prior to that, the Finance department prepared budgets simply adding a percentage increase on the previous year's budget, that largely remained unchanged year after year. With the budgets reflecting real needs, this avoided the requirement for re-alloactions during the financial year – which previously wasted precious time and impacted on service delivery.

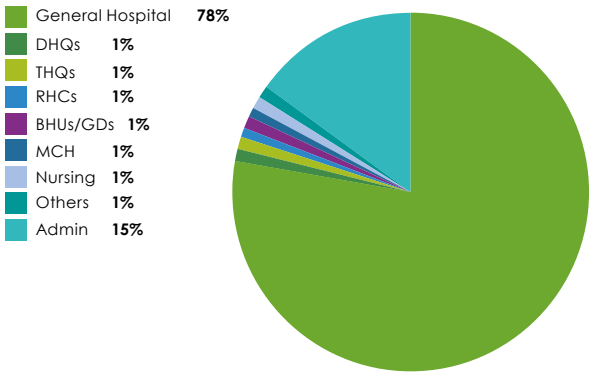
Block allocations as (%) of total health development budget



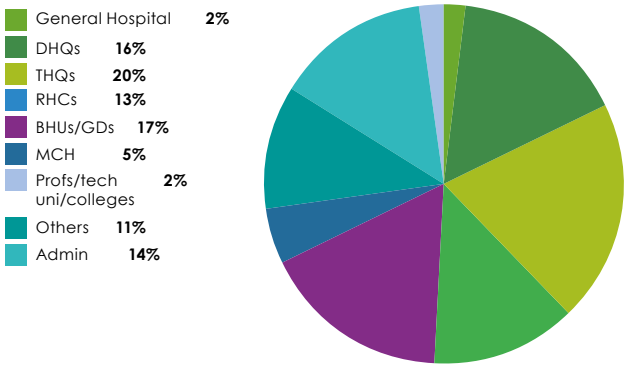
Budget classification was made more meaningful to provide disaggregated information on important spending units such as BHUs and RHCs, rather than lumped together under one budgetary head. In both provinces budgetary expenditure analysis was conducted on a quarterly basis and reviewed by senior officials to ensure expenditures were on track and funds were directed where needed.

In KP, the authorisation to spend relevant budgets was decentralised from district to sub-district (Tehsil) level to expedite expenditures in support of service delivery. To implement these reforms Health Departments in both provinces were supported in establishing a Financial Managament Cell staffed with specific expertise.

Before implementation of new functional classification



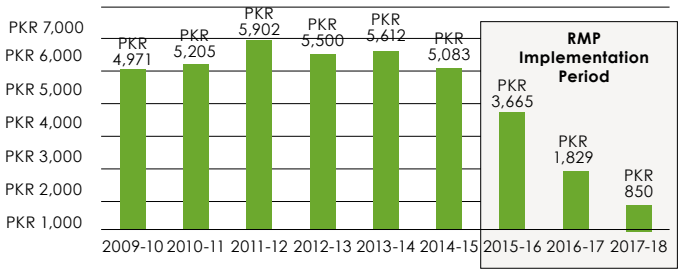
After implementation of new functional classification



The capacity building support also extended to district and sub-district financial units that worked with FMC to implement the reforms. After the successful implementaion of PFM reforms, the FMCs were made a regular part of the government establishment, and now have robust capacity to take the reforms forward.

A comparison of pre and post TRF+ intervention to improve the PFM systems clearly shows that in both Punjab and KP, staff and processes are much stronger now to deliver. This is validated by the evidence on reduction in appropriations, supplementary grants, improved budget utilisation rates, and easily accessible data on allocation and expenditures. Between 2014-15 and 2017-18 there was an 83% reduction in re-appropriations and supplementary grants and budget utilisation rates improved from 78% to 87%.

Reduction in supplementary grants (PKR in million)



Besides supporting the data collection systems for the Roadmap, the TA improved the routine M&E systems and programme management information systems (MIS). The data collection and reporting systems for the IMU, which collected data for the Roadmap, were developed by TRF+ and its staff trained. The e-VACCS system for vaccinators earlier developed in Punjab was adapted for KP and the vaccinators and programme staff trained in its use. A comprehensive M&E system was develped for the Extended Programme on Immunisation (EPI) in KP that not only monitored vaccination coverage but also the performance of supervisors and the whole supply chain for vaccines. Both Community Midwives' (CMW) and Lady Health Workers' (LHW) MIS's and the District Health Information System were upgraded to include additional fields on nutrition and maternal health and were converted into on-line systems with dashboards providing meaningful information. All of these revamped systems are now funtioning smoothly, informing managers on the status of service delivery and highlighting areas needing attention.

To strengthen service delivery – particularly access to and quality of MNCH services - TRF+ worked to improve targeting of the Community Midwife (CMW) programme in KP. CMW policies were rationalised to favour areas with highest needs, resulting in a 42% increase in deliveries in KP, and a 47% improvement in data accuracy.

Intensive TA provided by TRF+ also served to expand and sustain therapeutic nutrition services at outpatient therapeutic programmes (OTPs) in KP and Punjab. The TA led to an improvement in functionality of OTP centres from 26% to 64% in KP. Quality improvements were also made, such as monitoring adherence to the protocol of administering ready to use therapeutic food (RUTF) according to the weight of the child. The TA led to significant improvements in cure rates and reduced default rates of children with Severe Acute Malnutrition (SAM).

Value for Money

TRF+ also helped government and DFID to review if their investment priorities presented the best policy options for achieiving PHNP goals and if the results due to these investments provided value for money. For instance, DFID funds were used by Punjab government for establishing 24/7 BHUs - that represented the most important initiative for improving SBA rates. The government sought further investment of DFID funds to expand the network of 24/7 BHUs from 700 to 1,200. DFID agreed to the request after a study by TRF+ showed 24/7 BHUs to be highly cost-effective. The cost per DALY averted was twelve times lower than Pakistan's GDP per capita, and the cost to benefit ratio represented a return of PKR 12 for every PKR 1 invested. From an equity perspective the use of 24/7 BHUs reduced out of pocket expenditure for the poorest quintile by approximately PKR 5,000 for each delivery (the expenditure could be as high PKR 20,000). This suggested that potentially catastrophic health expenditure was averted. making a very tangible difference in the lives of the poorest people.
In fact deliveries at 24/7 BHUs were more cost effective than the deliveries by CMWs in Punjab, which suggested that CMWs should preferablly be deployed only in areas not covered by 24/7 BHUs.

Similarly, the value for money assessment of PFM reforms in Punjab showed that as re-appropriations between the budget heads declined by 54% and supplementary grants were reduced by 28% over two financial years, procurement of medicines, supplies and equipment could be done more rapidly, giving a significant boost to service delivery. Even the most conservative estimate of the cost to benefit ratio showed a return of PKR 72 for every PKR 1 invested in capacity building of FMC, which led the process for PFM reforms. Among others, the PFM reforms under FMC were pivotal in ensuring adequate financing for the Roadmap initiative.

An end of project assessment found the wider PHNP programme to be highly cost effective. High synergies between PHNP and the two provincial governments' reform priorities contributed to this result. A estimated 37,800 maternal and children under-five lives were saved due to PHNP, which translates into nearly 340 lives saved for every GBP 1 million invested. The return on investment was found to be high at £19 for every £1 invested.

Lessons Learned

As outlined, the approach of this programme led to significant improvements in key indicators such as under five mortality, skilled birth attendance and immunisation coverage, making a vital improvement to the lives of the intended beneficiaries. A number of important lessons can be drawn from the experience across the 5 years:

- Overarching provincial health sector strategic plans – which TRF+ began supporting at the end of the programme - provide significant added value in terms of an integrated and aligned approach. They would provide the framework for future Roadmaps, financing frameworks and facilitate further engagement on a range of issues such as quality of care, and public private partnerships.
- When financial aid is provided in this context, conditionalities are beneficial for all parties, including a requirement for counterpart funding, minimum utilisation thresholds and DLIs to be met. As much as possible, DLIs should align with programme targets, provincial Roadmaps and sector plans.
- It is important to agree on a VFM framework early on and use this as a tool for informing decisions on investment of financial aid. DFID was able to make better choices based on the VFM framework when it came to approving government proposed investments.
- The value of the Roadmap and its data driven approach to drive progress from the top down has been well established. So as not to lose momentum - and to ensure longer term sustainability and ultimate transfer to government – such initatives need to be maintained without short-term funding gaps.
- Building on the success of the Roadmap and health surveys undertaken by TRF+, future interventions should maintain the focus on information systems and use of data. Support should be provided to improve integration of health information systems (using the DHIS) and expand into data validation and data quality. Embedding team members within department teams to transfer skills and institutionalise processes is very effective. This was one of the critical factors for success achieved through the PFM reforms and the Roadmap process. This longer term support was highly valued and created strong relationships of trust and strengthened capacity from within. Therefore, an essential mix of long and short-term technical assistance should be considered well in future programmes.

Conclusion

There is evidence of strengthened government systems and capacity as a result of PHNP – ranging from HR and supply chain policies needed to support functional 24 hour BHU and RHCs, better use of data to improve immunisation coverage, referral systems and ambulance services, increased reporting into MIS databases, improved budget preparation methodologies with clearly disaggregated data, and some inroads on regulatory functions such as facility licensing. Helping decision-makers access the right data at the right time has been a common theme throughout the reform process.

The combination of mutually reinforcing financial aid, Roadmap and technical assistance is effective when used to achieve clear common objectives. Financial aid, with its associated DLIs, provides an enabling environment for demand-led TA, increasing influence with government. And TA helps mitigate the risks that come with financial aid and strengthen its overall use. Along with the Roadmap approach, with its ability to catalyse change through strengthening governance and accountability, the TA has enabled sustainable reforms, delivered results and helped to maximise government's own resources. The sustainability of any future intervention needs a sound understanding and commitment from government in the constrained fiscal space that Pakistan currently finds itself.

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This Policy Brief was prepared by the TRF+ Mott MacDonald core team

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