



Impact Evaluation Agenda

Motivation for Impact Evaluation

Intervention Context: *Despite years of human and financial investment in the Nigerian health sector, the country may not achieve the health-related millennium development goals (MDGs) by 2015. Innovative approaches are needed to accelerate the country's progress towards achieving the health-related MDGs. Results-based financing is one such innovative approach that has shown great promise for improving performance in the health sector by providing financial incentives to States, Local Government Agencies (LGA), and selected health facilities based on results achieved. To that end, with resources from the Health Results Innovation Trust Fund (HRITF), the government of Nigeria is in the process of preparing a results-based financing (RBF) project in three pilot states in order to reduce both the mortality of children under the age of five and maternal mortality (MDG 4 and MDG 5). If the intervention is demonstrated to be successful in the pilot states, the program will be scaled up to the national level.*

Evaluation Context: *Given the innovative nature of the proposed project, the Government of Nigeria has incorporated a rigorous impact evaluation in the project. The primary goal of the evaluation of the RBF project in Nigeria is to determine if providing financial incentives linked directly to performance increases the quantity and quality of maternal and child health (MCH) services. The evidence will be used to inform programmatic changes, scale-up, and fund allocation decisions.*

Key Messages:

- *When arguing for an increase in health budget allocations from Ministries of Finance and/or applying for grants, policy-makers, heads of implementing agencies and program managers need to answer basic questions such as which intervention is effective, cost-effective, and equitable. Since health sector budgets are often constrained and official development assistance (ODA) has been decreased because of the recent economic crisis, evaluation has become more important and more prominent as it provides critical evidence for policy-making and program design. In order to mobilize additional resources for new programs we need to demonstrate that the programs work and that they are good investments.*
- *Evaluation is especially relevant for innovative programs, where we need to test operational alternatives, learn during the implementation, and show that the intervention makes a significant difference over just additional resources before scaling up.*

- *Evaluation is resource intensive, but when it is combined with capacity building, technical assistance, and a systematic approach within agencies and in the health sector, evaluation can be conducted in a cost-effective manner.*
- *Making the link from micro data to aggregate level may help with arguments during budget negotiations and allocations, but it requires thorough design, robust methods, and an ambition to go beyond the pure health arguments and see health as an input into productivity and, possibly, as a determinant of growth.*

Interview with Dr. Muhammad Pate, Minister of State for Health, Federal Ministry of Health, Government of Nigeria

WB: *Honorable Minister, your country became a beneficiary of the Health Results-based Innovation Trust Fund (HRITF). This trust fund requires robust program, and where feasible, impact evaluation to help policymakers and practitioners in client countries and donors learn whether the piloted innovative interventions work, and if yes what mechanisms drive success and how to scale programs up. Well before entering the negotiations with the HRITF you have been pushing the frontiers in Nigeria to generate more evidence for programmatic decisions. What motivated your drive for evaluation?*

Dr. Pate: In my previous office, as Executive Director of the National Primary Health Care Development Agency (NPHCDA) –which is a federal parastatal agency responsible for primary care delivery across all 36 states in Nigeria– it was clear that more resources and innovation will be required to put the health MDG targets back on track in a country that has a population of close to 150 million people and has some of the worst MCH indicators. Since the NPHCDA is mandated to provide coverage to everyone for all essential care and the health MDG targets are heavily driven by the strength of the primary delivery system, we knew that innovations, which would lead us to more effective care and efficient use of resources were needed to propel the country toward better maternal and child health outcomes. However, no matter if we sought support for increased domestic budget allocations to the primary sector or sought funding from development agencies, we faced the same questions – *Could we show results? Could we show impact? Could we prove that we were getting good value for the money, whether it is from a domestic or international source?* We soon realized that we needed credible results for government budget allocations and official development assistance, which included loans and grants. The need for solid evidence and results has increased for both governments and donor agencies because of budget pressures and fiscal strains during the economic crisis.

WB: *How did his increased need for results and evidence affect the approach at the NPHCDA?*

Dr. Pate: It is estimated that Nigeria, which constitutes just 1% of the world’s population, accounts for 10% of the world’s maternal and under-5 mortality rates. A woman’s chance of dying from

pregnancy and childbirth in Nigeria is 1 in 13, compared to 1 in 5000 in developed nations, and only about 40% of deliveries are attended by skilled birth attendants. To change these outcomes, in the face of constrained resource, we have designed innovative interventions that need to be piloted and assessed before they can be scaled up. One such program is the Midwives Service Scheme (MSS) – which is a federally funded program and includes support from the President’s MDG Office – seeks to provide an emergency stop-gap to the shortage of skilled birth attendants at the primary health care level. Since 2009, the MSS has been rolled out in two phases, and has reached approximately 1,000 primary health facilities and related referral sites. Since the goal of the nationwide MSS project is to fast track the country’s progress towards the health MDG targets, the project team wanted to implement a robust program evaluation to determine from the first phase of the intervention whether the innovation affects PHC performance and, specifically, whether the additional midwives have positive effects on maternal and child health care utilization and outcomes.

WB: *How did the MSS team get started with the evaluation? Did you have experts on the team or you contracted in technical advisors to help with the design and implementation of the IE?*

Dr. Pate: We had a very agile team, who had a genuine curiosity to learn more from the evaluation of the program’s implementation and impact. However, funding for evaluation was limited. Thus, the original program evaluation design only focused on the intervention area and had no comparison facilities and households. While the NPHCDA has a database of primary facilities, which is updated every other year, the project team saw a need to implement household surveys in the catchment areas in order to assess health care utilization and MCH outcomes. The team has senior program officers and evaluation members, who both have ample experience in operations, monitoring and evaluation (M&E), and field work. Yet, there are no staff members at NPHCDA who has had formal training or experience in rigorous program evaluation. Therefore, we actively sought opportunities to build the staffs capacity for evaluation. Pushing the frontiers required investments in staff and resources devoted to novel methods. From the World Bank, we received an invitation to the *IE Workshop Building Evidence on Results Based Financing for Health*, which was held in Cape Town, South Africa in 2009. This training was timely since it equipped the staff from the NPHCDA with advanced technical knowledge on how to design and implement robust evaluations, taught them to think more critically and also creatively about evaluation and how it could be integrated into daily operations, enabled rich exchanges with other countries, and connected not only the MSS team but also the NPHCDA to the Development Impact Evaluation Initiative (DIME) and the Results Based Financing (RBF) teams of the Bank, from which our staff benefited from their insights and technical assistance with respect to both operational and evaluation design. The team found that introducing more strategic and prospective operational research and integrating it into the project cycle was a practical way to establish the causal impact of development policies and programs and identify mechanisms to improve outcomes.

WB: *Beyond the general technical capacity building and connecting to a community of practice,*

what are some of the concrete benefits of interactions with the Bank's evaluation experts?

Dr. Pate: When the team returned from the training, they were inspired and were equipped with practical ideas. The IE design clinics at the workshop and the technical assistance that we received following the workshop improved the design of our evaluation. For example, a control group was added, which is important in measuring the causal effect of the program. The team also got expert advice on sampling, instrument design and implementation aspects, which included staffing. As a result the MSS team hired a local coordinator dedicated to the IE. The technical capacity building and exchanges led to changes that made our evaluation more robust, more cost-effective, and more manageable on a daily basis. Beyond these immediate benefits, the training was an important catalyst for introducing more systematic approach to evaluation, which included rethinking the organizational structure of the agency to support the integration of evaluation and improvements of evaluation capacity and quality over time. Indeed, we have requested more support from the World Bank to advance our evaluation agenda. These exchanges have also lead to more fundraising opportunities, specifically for evaluation, but that also benefited operations in this area, such as the HRITF.

WB: *What has been your vision for the evaluation agenda at the NPHCDA?*

Dr. Pate: In my view, integrating evaluation into operations, especially when we wanted to test innovative designs, has been critical in allowing us to base more of our decisions on facts and improving accountability across the board. Yet, applying evaluations to our programs required a new way of thinking, early planning, and more funds. At the NPHCDA we started to call for a more cohesive framework to manage programs and guide development decisions on the basis of solid evidence. The MSS team and other departments, such as the Disease Control and Immunization (DCI) Division have benefited from training in evaluation and related technical assistance. The benefits of such evidence-based program management approach goes beyond the individual programs. This agency-wide approach helps us to adjust interventions to improve impact and cost-effectiveness as programs evolve, and applying more systematic evaluations across the board has helped us identify the interventions which are most likely to succeed and deliver sustainable results when scaled up. Evaluation has informed resource allocation decisions within and across programs.

WB: *During your time at the NPHCDA, what were the main constraints to carrying out evaluation?*

Dr. Pate: The challenge has not been a lack of interest or motivation. Our staff soon realized the benefits of implementing evaluation: the ability to receive timely information and evidence in order to decide between operational alternatives, prioritize both within and across programs, and scale up or down interventions when needed. The primary challenges have been funding and organizational constraints. Although the benefits are clear, financial and human resource allocations often do not match implementation needs. With respect to funding, operational costs are often stretched and leveraging evaluation resources requires additional effort and time. Regarding human resources,

building a professional team that can also manage evaluations requires investment, and maintaining the initial momentum requires incentives. We have been fortunate to receive some public funds that have supported our evaluation efforts. However, these have not sufficient for scaled and robust evaluations, and the NPHCDA has had to seek funding from bilateral and multilateral development partners. Currently, a number of activities have benefited from exchanges with the Bank, including the publicly funded MSS project, which covers all 36 states; the donor-financed HRITF evaluation, which covers 3 states; and most recently, the Disease Control and Immunization Division, which has started the design of evaluations, hopefully with support from donors and technical assistance from the Bank. The expansion of evaluations across states and technical areas is important as it helps us understand how programs and populations behave in different contexts and how different programs benefit their target populations. These parallel activities can be complementary in terms of the value of information and can also improve external validity of the findings.

WB: *Beyond the pioneering work at the NPHCDA, how does evaluation fit in health sector programs in Nigeria? Do you have a vision for IE in the health sector?*

Dr. Pate: Beyond the NPHCDA, a number of federal-level agencies, such as the National Malaria Control Program (NMCP) and the National Health Insurance Scheme (NHIS) have been engaging in evaluation activities. These evaluations have been arising from the need for greater links between operations, policy-making, budget decisions, and development work in the health sector, and both agencies have been benefiting from technical assistance in IE from the World Bank. There have also been a number of evaluations undertaken by local university teams, academic teams from the US and Europe, and other development agencies/partners. Thus, we currently have a diversity of views, disciplines, and competition in the evaluation market, which is expected to generate both more and richer information for sectoral decision-making. In December 2011, I presented on the policy panel at the research conference *“Innovations in Financing and Service Delivery: Making Malaria Treatment Available”* hosted by the DIME’s Malaria Impact Evaluation Program (MIEP)² This event showcased recent impact evaluation work on novel methods of decreasing financial and other access barriers to effective malaria treatment (ACTs). A number of issues discussed at this event were relevant for health sector evaluation, including discussions on the right level and granularity of data to ensure that policy decisions are well informed. Specifically, these discussions have addressed how evaluations inform federal, state, or local level decisions; whether there is evidence on effectiveness, and whether there is adequate data to take into account cost and cost effectiveness. Since evaluation is costly, a major issue is determining whether the implementation of evaluations can be done more cost effectively, for example by better coordination across agencies, surveys, harnessing ongoing nationwide household surveys (e.g. the Harmonized National Living Standard Survey), and connecting these to advanced mapping technologies, such as Google Maps to learn more about communities, facilities and so forth. Using more standardized metrics, when possible, and standardized reporting would help us to increase comparability, link information, and improve policy and budget decisions in order to make the most of evaluation efforts. Yet, we need to realize that

human resources in the health sector and even the standard M&E platforms are often over-stretched. Thus mainstreaming the evaluation agenda, building capacity for its implementation, and standardizing approaches and platforms will require serious investments, sustained technical support, and time. We have already made progress in changing mindsets, and we seek further opportunities to accelerate this change.

WB: *How can improvements in the health sector link to the macro level, to economic productivity and growth? Can you share any evidence from recent program or impact evaluations so far that have been shaping policy decisions?*

Dr. Pate: Indeed, arguments beyond improvements in health outcomes, such as productivity and growth have value-added when it comes to budget allocations or investment in health interventions. Establishing a causal path from micro evidence to macro effects is not easy, but a few recent studies and results have helped us establish connections. As an example of the productivity effect of health care in Nigeria, a recent study³ that analyzed the effects of malaria testing and treatment with a first-line drug on sugarcane cutters' earnings, labor supply, and productivity found that both labor supply and productivity increased and accounted for a 26 percent increase in earnings. Such gains could translate into macroeconomic growth and poverty reduction at the national level. This implies that improving access to basic care can be a key component of improving agricultural productivity and Nigeria's poverty reduction strategy. Results from the RBF program on MCH outcomes are not available yet, but both the federal level pilots with MSS and state level pilot programs, such as Abiye (Safe Motherhood) in Ondo state, have started to show results in ante-natal care, skilled delivery, and post-natal care utilization. Improved maternal and child health indicators, coupled with reductions in the fertility rate are important triggers for a demographic transition that results in a faster growth in the number of workers in the population, making it possible to boost economic growth. Yet, today Nigeria is only in an early stage of this process, and thus we can only make projections regarding the aggregate and longer term effects of a possible 'demographic dividend.' We continue to encourage evaluation and economic analyses to help us understand whether programs and policies will lead to more effectiveness, cost-effectiveness, and equitable access, and to assess changes over time in order to better connect micro level evidence with macro outcomes over time. This is an ambitious agenda, which requires a step-by-step, practical approach.

Notes:

¹ Adamawa, Nasarawa, and Ondo

² The event was organized in conjunction with the Affordable Medicines Facility – malaria (AMFm) at the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the Center for Disease Dynamics, Economics, and Policy (CDDEP); and the Clinton Health Access Initiative (CHAI).

³ Dillon, Friedman, and Serneels (2010)