RESULTS-BASED FINANCING IN MALAWI

BRIEF 1: THE EFFECT OF RBF4MNH ON HEALTH SERVICE UTILIZATION AND HEALTH-SEEKING BEHAVIOR

OBJECTIVE

Utilization of critical maternal and neonatal services is considered essential to meet internationally agreed-upon maternal and child health objectives set forth in the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs), and the Every Women Every Child Action Movement's Global Strategy.

This brief summarizes the effect of the RBF4MNH Initiative on two of its primary aims:

1. To increase utilization of health services that were directly targeted (including delivery and early neonatal care), and
2. To increase quality health services that were directly targeted (including delivery and early neonatal care).

This brief also aims to provide insights into how the RBF4MNH program affected care-seeking patterns and duration of stay following childbirth across facilities in the participating districts. In addition to incentives for healthcare workers, RBF4MNH included cash incentives for pregnant women, conditional upon seeking a facility-based delivery.

THE RBF4MNH INITIATIVE

The Results-Based Financing for Maternal and Neonatal Health (RBF4MNH) Initiative was designed to increase uptake and improve quality of care during childbirth in Malawi. Implemented in 18 facilities in 2013 and expanded to 28 facilities in 2014 across Balaka, Dedza, Mchinji and Ntcheu districts, RBF4MNH entailed investments in infrastructure and equipment; the provision of financial incentives (based on achievement of pre-defined targets) for health providers in RBF facilities; and conditional cash transfers to pregnant women residing in catchment areas of intervention facilities for recovery of expenses directly related to accessing and staying at target facilities during and at least 48 hours after childbirth.

This series of briefs is meant to serve as a resource for decision makers as they craft results-based financing programs and policies in Malawi and similar settings. The briefs stem from a two-year impact evaluation conducted jointly by Heidelberg University in Germany and the College of Medicine in Malawi.

July 2016

This study was funded by the United States Agency for International Development under Translating Research into Action, Cooperative Agreement No. GHS-A-00-09-00015-00, and by the Norwegian Agency for Development Cooperation (NORAD) and the Royal Norwegian Embassy in Malawi. The project team includes prime recipient, University Research Co., LLC (URC), Harvard University School of Public Health (HSPH), and sub-recipient research organizations.

POLICY RECOMMENDATIONS

In light of the findings presented in this brief, the research team recommends the following when devising or modifying RBF programs in this and similar contexts:

1. A thorough understanding of baseline utilization rates for maternal and neonatal health services is essential. This information will help to ensure that performance incentives target specific services for which utilization is low, especially in contexts like Malawi, where utilization at baseline was high for most maternal and neonatal services.
2. Consider the limited value of linking conditional cash transfers (CCT) to a service for which utilization is already very high. To produce meaningful behavioral change, cash transfers should be tied to a service or set of services for which utilization rates are sub-optimal, such as completing at least four antenatal care visits and/or seeking antenatal care within the first trimester of pregnancy.
3. Ensure that incentives promote adequate and appropriate referral across levels of care.
4. Consider scaling up the intervention to all Emergency Obstetric Care (EmOC) facilities in the participating districts to avoid potentially overburdening Comprehensive Emergency Obstetric Care (CEmOC) facilities with a large influx of patients from non-RBF4MNH Basic Emergency Obstetric Care (BEmOC) facilities.
5. In the context of generalized poverty, RBF approaches should favor an equitable approach to social health protection schemes like CCT programs, rather than targeting particular socioeconomic strata.
6. When revising the CCT component in Malawi's RBF4MNH, and in the design of conditional or any cash-transfer programs in general:
   - Ensure efficiency in the registration process: find a more efficient alternative to verification by health surveillance assistants (HSAs).
   - Consider incentivizing facility staff to improve registration and disbursement of cash transfers.
   - Develop tighter controls on both the registration and the disbursement procedure to avoid fraud and selective discrimination.
   - Consider the placement of a CCT-focused staff member in each facility in order to promote a more seamless transfer of funds.
   - Invest in communication and education activities to counteract the false understanding that cash transfers could divert attention from family planning efforts.

SUMMARY OF METHODS

Findings presented in this brief are based on quantitative results from three rounds of approximately 1,800 household surveys, and complemented by qualitative research approaches (24 in-depth interviews with providers from 12 facilities, 36 in-depth interviews and 29 focus group discussions with women across the four intervention districts); the findings presented are representative of providers' and women's opinions.

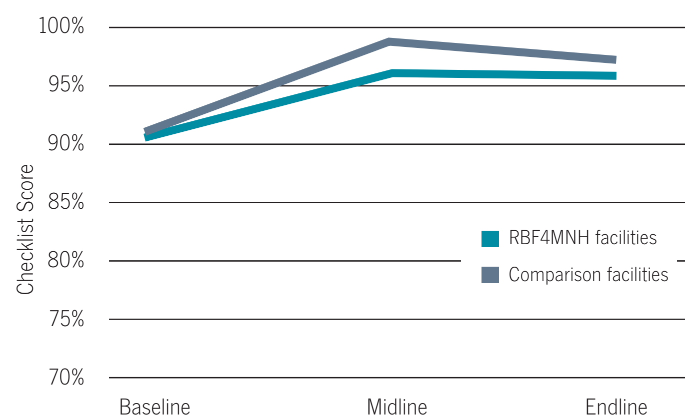
FINDINGS

THE RBF4MNH INITIATIVE DID NOT LEAD TO INCREASES IN HEALTH SERVICE UTILIZATION

In terms of maternal and early neonatal service utilization, the evaluation detected no impact from the RBF4MNH initiative on the use of delivery and early neonatal healthcare services. Likewise, the evaluation found no effect of the initiative on antenatal (ANC) or postnatal (PNC) care seeking.

One reason the evaluation found no difference in health service utilization between RBF4MNH and comparison facilities could be due to high rates of care-seeking for delivery and early neonatal care services prior to the launch of RBF4MNH. When the initiative

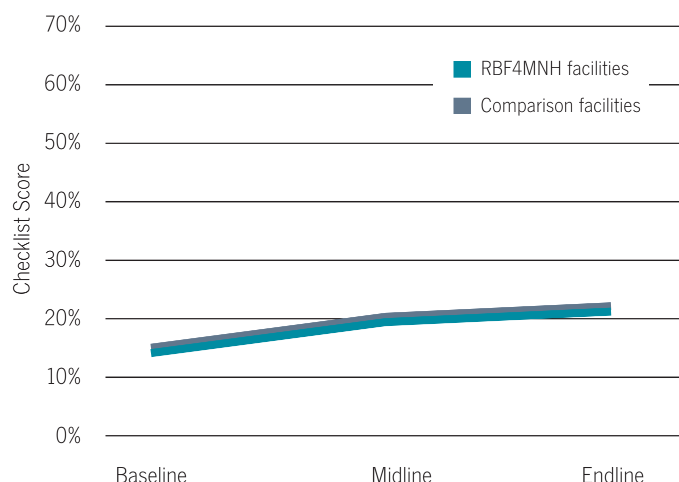
Figure 1: Percentage of women reporting having delivered their last child in a health facility



was launched in 2013, utilization rates for delivery and early neonatal services were upwards of 90%. While increases in service utilization were observed between 2013 and 2015, these changes were similar across all facilities, regardless of intervention status. By 2015, the percentage of women who reported delivering in a facility was approximately 95% (see Figure 1). Similarly, the RBF4MNH initiative did not increase the percent of women seeking PNC. Again, this could be due to the high rate of PNC service utilization prior to the launch of RBF4MNH.

The RBF4MNH initiative did not improve the timing or frequency of ANC care seeking, despite low baseline levels with much room for improvement. While there were slight improvements in the timing and frequency of ANC care-seeking, levels remained low and the improvements were not found to be a result of the initiative. After two years of implementation, only 20% of women sought an ANC visit within the first trimester of pregnancy (see Figure 2) and only about 50% of women completed at least four ANC visits during pregnancy. While these levels are consistent with national and regional trends, ample room for improvement remains in Malawi. With slight adjustments to the CCT component of the initiative, RBF4MNH has an opportunity to affect the timing and frequency of ANC visits.

Figure 2: Percentage of women reporting having attended their first antenatal care clinic during the first trimester of their most recent pregnancy



THE RBF4MNH INITIATIVE DID NOT LEAD TO IMPROVEMENTS IN TERMS OF EQUITY

The RBF4MNH initiative did not have any effect on the equitable utilization of services between women of different income/wealth levels, nor among women living different distances from the healthcare facility. Utilization of health services increased in similar proportions across all socio-economic strata, irrespective of intervention or control status, so that the utilization gap between poor and least poor (which was relatively small) remained unchanged over time. The absence of meaningful differences at this level indicates that RBF4MNH did not benefit the women who were less poor or those living closest to the facilities more than others, as is often the case when interventions are implemented without defined targeting strategies. This could also be due to the fact that women in these communities are all poor, so differences across wealth quintiles are actually negligible.

The RBF4MNH initiative is currently implemented in four districts in Malawi: Balaka, Dedza, Mchinji, and Ntcheu.

Health provider with clients at Golomati Health Center, Malawi.
Photo credit: Uchembere Wangwiro Program

THE RBF4MNH INITIATIVE PRODUCED CHANGES IN DEMAND PATTERNS

An increasing number of women from control catchment areas were referred to intervention facilities to receive delivery services. Between 2013 and 2015, the percentage of women from control areas who migrated to intervention facilities to deliver increased from 15% to 20%, after a peak of 25% in 2014 (before the intervention was scaled up to an additional ten facilities). This increase can largely be attributed to changes in referral rates among providers working in control facilities. Referral rates remained stable at 15% in intervention communities, while they increased to 21% in control communities. Interviews with both women and healthcare workers indicated that this shift in demand was largely induced by a change in healthcare workers' referral patterns. Specifically, women reported—and healthcare workers confirmed—a greater propensity to refer women away from control Basic Emergency Obstetric Care (BEmOC) facilities towards Comprehensive Emergency Obstetric Care (CEmOC) facilities (all district CEmOC facilities were RBF4MNH facilities) to ensure that more women (hopefully those potentially more at risk) could receive better care at delivery. By end-term, the proportion of women with complications being referred from BEmOC to CEmOC facilities was 38% and 43% in intervention and in control communities respectively.

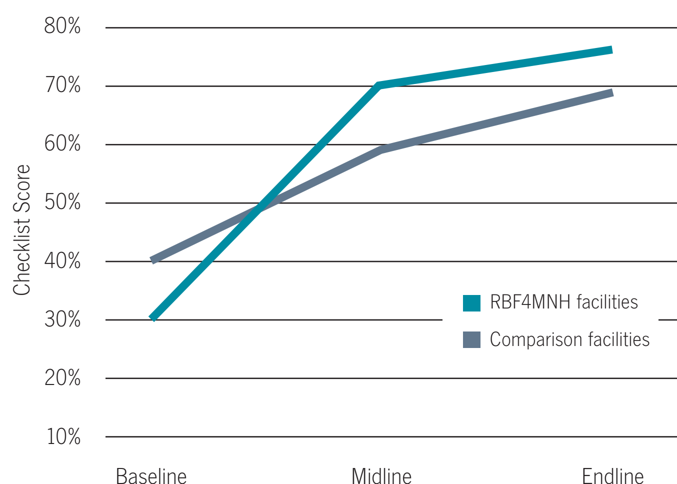
The RBF4MNH initiative was not intended to promote shifts from BEmOC toward CEmOC facilities, but rather to improve care at the BEmOC level and to reduce workload at the CEmOC level. Therefore, the increase in referral rates observed in control areas was an unexpected consequence. Changes over time in referrals from control BEmOC to (intervention) CEmOC facilities varied by district. Ntcheu saw an increase over time, while Dedza saw a decrease over time. In Balaka, the proportion remained relatively stable over the three years, while Mchinji experienced a small increase. These marked differences indicate different understandings and different implementation patterns across districts. A desirable outcome was observed in Dedza, where the intervention appears to have limited demand at CEmOC level and retained more women at BEmOC level.

THE RBF4MNH INITIATIVE INCREASED THE DURATION OF POST-DELIVERY STAY AT INTERVENTION FACILITIES

While the proportion of women who stayed at a facility at least 48 hours after delivery[1] increased in both groups, the evaluation found that RBF4MNH facilities saw a significantly larger increase than comparison facilities (see Figure 3). The indicator

1 This is the national target, which was set so that women could be monitored for the onset of delivery-related complications for 48 hours post-delivery.

Figure 3: Percentage of women reporting having stayed at the health facility for at least 48 hours after childbirth



increased in RBF4MNH facilities nearly 30 percent more than in comparison facilities.

Qualitative findings indicate that this change is mostly attributable to conditional cash transfers, which women described as giving them the means to afford the cost of post-delivery stays (primarily the cost of food, but also to purchase clothing for their babies). It was also reported that district supervision teams reinforced the importance of keeping women for at least 48 hours across all (intervention and control) facilities, which may have supported the increase observed in both groups of facilities. Despite these facilitators that assisted more women to stay for monitoring, one quarter of women in intervention facilities left earlier than 48 hours after delivery.

The evaluation also detected a tendency for women from control areas to leave the health facility significantly earlier (i.e. within 24 hours of delivery) than women from intervention areas even when delivering at a RBF4MHF facility. This difference was particularly pronounced at end-term. It is likely that this difference is motivated by the potential of the CCT (conditional on the 48-hrs post-partum stay) to retain intervention women in facilities. This finding provides evidence that the removal of geographical targeting for the CCT could result in longer length of stay for all women, thereby expanding the health benefits of the program.

THE CONDITIONAL CASH TRANSFER WITHIN THE RBF4MNH INITIATIVE

The RBF4MNH initiative included a CCT component, intended to motivate women to deliver in a healthcare facility by offering financial incentives and financial protection. The transfers included a flat lump sum and an adjustable sum, depending on distance from the health facility and duration of stay. Among women who received the transfer, the average sum received was 4500 Malawian Kwacha (approximately USD 7.15/EUR 6.53).

THE INTERVENTION DID NOT AFFECT PATTERNS OF OUT-OF-POCKET SPENDING FOR DELIVERY SERVICES

The evaluation did not detect any difference in the amount paid by women to cover direct costs (transport, minor medical expenses, food, supplies for mother and baby) associated with

A health care worker in Malawi prepares to see a patient
Photo credit: SC4CCM/JSI

delivery at a health facility. The average out-of-pocket spending increased homogeneously across intervention and control facilities, from 2300 MKW in 2013 to 3500 MKW in 2015. The increase is likely to be due to inflation and to the decreasing purchasing power of the local currency. The fact that the evaluation did not detect an effect of the intervention on total out-of-pocket spending indicates that healthcare providers did not take advantage of intervention women (for example, through the imposition of informal charges) in light of the fact that they knew these women would be receiving a CCT. Women who received the CCT received on average 4500 MKW, suggesting that on average, they were amply able to recover the direct costs incurred due to the facility-based delivery. This suggests there is potential for the CCT to act as an instrument of financial protection. In addition, women receiving the CCT were found to rely less heavily on a family member accompanying them and remaining with them at the facility for the entire duration of the pre- and post-partum phase. This implies that the costs of care may be lower among women receiving the CCT due to lower productivity losses among caregivers

THE CCT PROGRAM DID NOT REACH ALL ELIGIBLE WOMEN AS INTENDED

Out of all eligible women (i.e., women residing in the catchment areas of the RBF4MNH facilities), just above 50% were registered in the cash transfer program. Of those, only two-thirds reported having received the cash transfer upon delivering in the healthcare facility. Registration rates appeared to be highest in Balaka (70% of all eligible women registered) and lowest in Dedza (40% of all eligible women registered). Dedza also displayed the lowest percentage of women receiving the transfer once registered (55%), while Ntcheu displayed the highest percentage of women receiving the transfer once registered (84%). Beyond the differences across districts, registration did follow an equity-oriented pattern, with rural and least wealthy women being the most likely to be registered in the program.

NON-REGISTRATION IF LATE TO INITIATE ANTENATAL CARE

"They gave cards to women who started antenatal clinic at four months, but the cards were not given for those women who started antenatal at six or seven months."

— Focus Group Discussion

Providers and women said a major barrier to registration was that patients were not allowed to register for cash transfers if they visited facilities too late during the antenatal period; women who made their first visit during their third trimester were generally not registered (See Box: Non-Registration if Late to Initiate Antenatal Care). In some cases, however, women who made their first visit during the fifth month of pregnancy were also considered ineligible for the CCT. The Initiative has since changed registration procedures so that all eligible women are registered regardless of the timing of the first antenatal care visit. Some women expressed suspicion that providers discriminated against certain women when deciding who would receive transfers, or showed nepotism towards clients whom they knew. Providers and women also reported challenges related to the CCT, including:

- An absence of available funds at the time of discharge after delivery
- A woman's inability to produce evidence of her earlier registration (i.e., a registration card missing both at the facility and among the paperwork that women keep in their possession)
- An inability among women to prove the distance travelled between their villages and the facility and uneven documentation by HSAs to verify distance travelled
- Overall, poor quality and late submission by HSAs of verification cards
- Cumbersome process of multiple disbursements weighed on overworked providers
- Ineffective timing of disbursements to clients, hindering ability to purchase necessary items

CASH TRANSFERS DID NOT MEASURABLY ALTER CARE-SEEKING BEHAVIORS AMONG WOMEN, BUT WOMEN REPORTED THAT THE CASH DID ENABLE THEIR CARE SEEKING

Given the joint implementation of demand-side and supply-side incentives, the evaluation could not detect the specific effect of CCT on utilization of maternal care services. Among women with self-reported complications, the evaluation detected a significant reduction in time to care (the time elapsed between onset of symptoms and the decision to seek professional care) attributable to the CCT. Through qualitative interviews, women generally described the cash in a positive light, referring to it as "helpful" (see Box: Cash Transfers as Helpful). Women reported the cash payments positively influenced their decision to:

A health provider cares for mother and newborn at a health center in Dedza District.
Photo credit: Uchembere Wangwiro Program

- Stay longer in facilities, given that they had money for food and baby supplies
- Arrive earlier during labor, for the same reason

Providers observed that among women who received the cash transfer (and the sensitization that accompanied it), women's empowerment and awareness of patient rights during maternity care was stronger, especially among the poor.

CASH TRANSFERS AS HELPFUL

"I feel the money is very helpful because sometimes you may find that you have been referred to the district hospital and your husband doesn't have any money, the situation becomes bearable because of the money."

— Focus Group Discussion

WOMEN USED THE CASH RECEIVED TO PURCHASE FOOD AND BABY SUPPLIES

Women described using the funds to purchase food and items related to caring for the baby, such as clothing, baby soap, and an umbrella. In two instances (reported in one facility each in Ntcheu and Mchinji districts), women described being pressured to purchase items directly from providers. Another point of concern related to reports from women in one facility, who felt pressured to pay for services that were once provided free of charge, such as baby weighing, as providers remarked that they knew women had enough funds to pay a small fee, given the recent receipt of a cash transfer.

CONCERNS THAT CASH TRANSFERS WOULD INCENTIVIZE WOMEN TO BECOME PREGNANT WERE NOT WARRANTED

At the outset of the program, all stakeholders expressed concern that providing cash transfers to women may incentivize them to become pregnant. In follow-up interviews one year into the program, stakeholders highlighted that these fears were unwarranted, as women were not viewing pregnancy as a

mechanism to access cash. Stakeholders said there were two reasons their fears did not come to fruition. First, the amount of funds available for cash transfers was too low to compel pregnancy. Second, as the broader RBF4MNH program was rolled out, it was adapted to include family planning components. No woman described cash transfers as a factor that compelled her to become pregnant.

Study Contact:
Dr. Manuela De Allegri, Principal Investigator of the RBF4MNH Evaluation
manuela.de.allegri@urz.uni-heidelberg.de

TRACTION PROJECT OVERVIEW

The Translating Research Into Action (TRAction) Project, funded by the U.S. Agency for International Development, focuses on implementation and delivery science—which seeks to develop, test, and compare approaches to more effectively deliver health interventions, increase utilization, achieve coverage, and scale-up evidence-based interventions. TRAction supports implementation research to provide critically-needed evidence to program implementers and policy-makers addressing maternal and child health issues.

For more information on the TRAction Project:
www.tractionproject.org ▶ tracinfo@urc-chs.com

RBF4MNH IMPLEMENTING PARTNERS

RBF4MNH is implemented by the Malawian Ministry of Health with funding from the Governments of Germany and Norway through KfW. Technical assistance to the Ministry of Health is provided through Options Consultancy Ltd. Additional information on the program can be found at:

www.options.co.uk