EVALUATION OF MALAWI'S SUPPORT FOR SERVICE DELIVERY INTEGRATION PBI INTERVENTION

BRIEF 2: FACILITATORS AND BARRIERS OF IMPLEMENTATION

THE CHALLENGE

The implementation of complex health interventions presents challenges that are multifaceted, and tied to acceptability, feasibility, adaptability, affordability and ownership. Programs must gain and sustain "buy-in" across a spectrum of stakeholders- from officials at ministry and regional levels, to district health staff, facility-based providers and community leaders. An added layer of complexity is inherent to programs that are new or novel; under these circumstances an extra dose of sensitization and knowledge dissemination is needed.

The design of the Support for Service Delivery Integration-Performance Based Incentives (SSDI-PBI) program began in 2012, and implementation started in September 2014. The evaluation of the program drew on a mixed-methods approach using quantitative and qualitative methods, and primary as well as secondary data. Information for this brief drew from 54 in-depth interviews with program implementers, Ministry of Health (MOH) officials, and providers (including District Health Officers) at hospitals and health centers, as well as 17 focus group discussions with community leaders including traditional chiefs, religious leaders and members of Health Advisory Committees. Focusing on the implementation period, this brief outlines factors that emerged as highly salient in interviews or focus groups in terms of barriers or facilitators to implementation. The aim of the brief is to inform program modification in the event that the program continues or is scaled up in Malawi or a similar context.

THE SSDI-PBI INITIATIVE & IMPACT EVALUATION

The SSDI-PBI program aims to increase access, utilization, and quality of essential health services by linking rewards to service utilization and quality indicators across a range of conditions and services. Implemented by the Ministry of Health with funding from USAID and technical support from Jhpiego and Abt Associates, the program operates in 17 facilities across Chitipa, Nkhotakota, and Mangochi districts. SSDI-PBI entailed rewards paid to facilities and destined exclusively for facility improvements, and the procurement of goods and equipment via implementers rather than facilities directly.

This series of briefs is meant to serve as a resource for decision makers as they craft performance-based financing programs and policies in Malawi and similar settings. The briefs stem from a 1-year evaluation led by Heidelberg University in Germany and the College of Medicine in Malawi. While the design SSDI-PBI began in 2012 and will be implemented through September 2016, data for the evaluation represents the period up to and including December 2015.

VIEWS OF THE SSDI-PBI PROGRAM

In an overarching sense, a majority of respondents within each respondent group are conversant with the program, and could critically reflect on its strengths and weaknesses. On

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the whole, views of the program are positive. The sharpest criticism of the program is that it is too heavily concentrated within the implementing team. Community members, district level health staff, and representatives within the Ministry of Health described how the program is not instilling a sense of meaningful ownership. Yet in the same conversations where this critique is leveled, respondents appear equally inclined to say that their dissatisfaction is linked to high expectations, intimate knowledge of the program, a desire to see the program continue and a longing to feel more engaged in that continuation. As one Ministry of Health official said, "You can't really discuss flaws of a stranger, but you can find them in a friend."

Table 1 outlines factors that facilitated, challenged or served to both facilitate and challenge the SSDI-Program in its implementation phase (2014-2016). While the full array of factors is more extensive, those listed in the table are most salient either because they represent a finding that was triangulated across several respondent groups, or because they were described with more frequency, depth, nuance or conviction within any one respondent group. The left column divides findings into three domains: facilitating factors, factors that could simultaneously facilitate or challenge the program, and barriers. The right column presents an illustrative quote for each example. A broader, textual description of each domain is presented after Table 1.

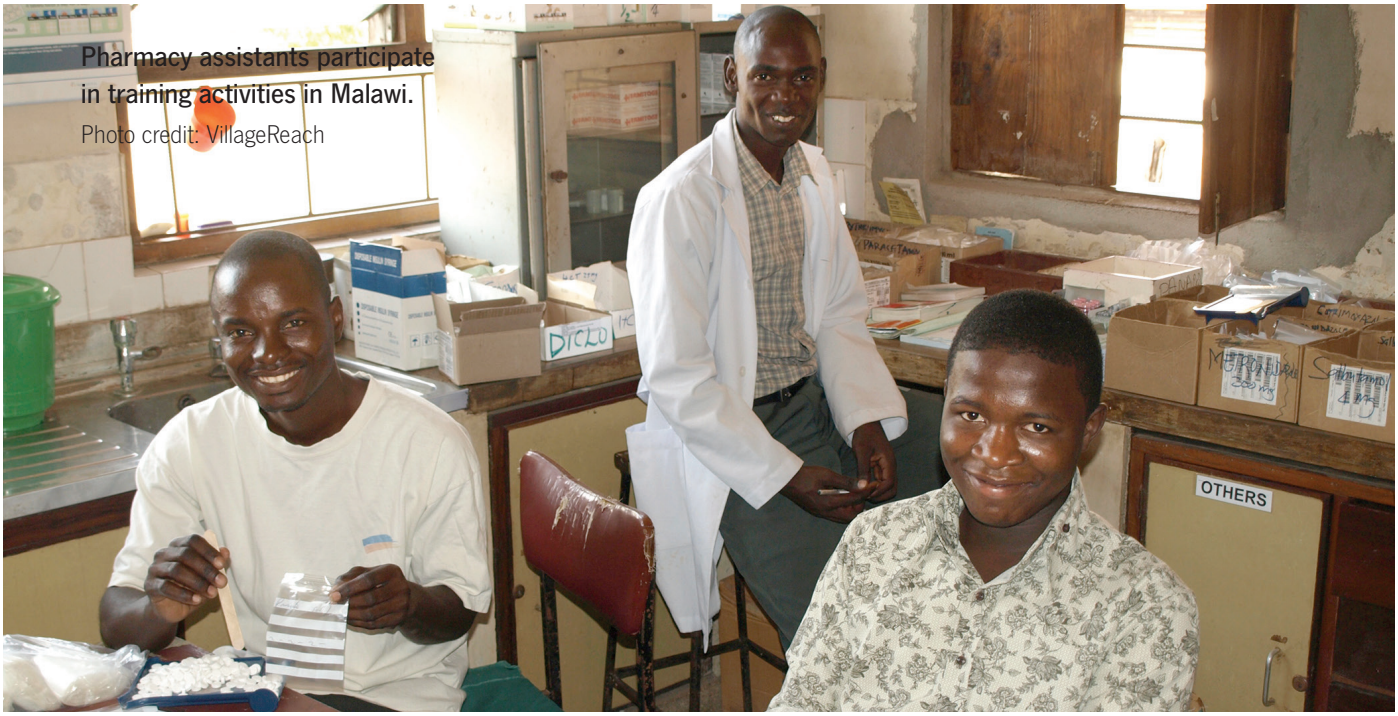
FACILITATORS OF PROGRAM IMPLEMENTATION

Factors mentioned most often as underscoring success within the SSDI-PBI program are largely rooted in the successful execution of essential PBI program ingredients. In this sense, the program fostered changes in attitudes and behaviors and then benefited from those changes. For example, SSDI-PBI fostered—in some cases initiated—improved relationships between the community and facility. Community members consistently described feeling surprised by the sight of facility-based providers conducting outreach clinics to undertake antenatal services, HIV counseling and testing, and knowledge dissemination. One leader described how she had "never in (her) lifetime" imagined seeing a truck full of health providers arriving in her village. Both providers and community members described how community-facility meetings chaired or guided by SSDI-PBI were often tense and awkward at the outset of the program as community members were not familiar with the concept of voicing their opinions, and providers felt that they were under attack. As the

Table 1. Overview of Factors that Affected Implementation

FACILITATORS	ILLUSTRATIVE QUOTES
Strong **community engagement**, community is responsive to roles assigned to them and feels compelled to achieve targets	*"The program said we cannot improve our health if our facility lacks materials. We mobilized...we were the first to contribute. We started on a fence... we got the Anglican organization to buy screens, razor blades, soap, mats."* – FGD Community
Enhanced **community-facility understanding**; community senses that providers are more responsive; providers feel more attentive to community concerns	*"The program created a platform to talk. We had never talked to one another. The community would have never brought up issues with the facility that they brought up.... we have opened a discussion and formed a way forward."* – District level provider
Inter and intra facility collaboration and communication via reward meetings, goal setting, ad hoc facility-facility visits to share experiences and troubleshoot issues	*"I would say even when we have review meetings for PBI facilities, this has formed a certain grouping where we see how we are alike... there is that cohesion. Wherever we meet, the interaction is unlike in the past because they have something in common – PBI. We even made a Whatsapp-PBI."* – Health Center Provider
Goal setting and goal tracking fosters collective momentum	*"To me, these numbers show me if I'm improving. It means I'm doing something. How can you know if you're improving if you're never told?"* – Health Center Provider
Receipt of goods as outlined in business plans enhances program buy-in	*"I did not have a desktop.... We didn't have a scanner ... lawn mowers, proper curtains ... stationary. We are seeing the fruits of the program."* – District level provider

FACILITATORS & BARRIERS	ILLUSTRATIVE QUOTES
Financial management/planning skills represent a steep learning curve for providers at outset, but later described by providers as an invaluable skill	*"At first (providers) really struggled. Planning is not a skill that is passed on to lower levels. This initiative gave them a feel of what it means to plan... to not wait for the higher level to decide something and just be on the receiving end."* – Program Implementer
Some feelings of program **ownership** (particularly via business plans) at facility level, but also a sense in facilities and communities that the program is controlled by "the people in Lilongwe" too much. Lack of meaningful (financial) ownership of the program by MOH and administrators at district level	*"When we ask providers, they say the budget is controlled in Lilongwe where the headquarters is, but we were wondering how can they budget and know our problems in Lilongwe? Our problems are not similar to those of Lilongwe. We are disappointed."* – Community FGD *"How do you say this program is for and by the Ministry of Health when all the files are sitting with Jhpiego?"* – MOH official
Knowledge of a **similar ongoing, finance program** that rewards providers with cash sparks envy within SSDI-PBI facilities; knowledge that the education sector employs a rewards-based finance program fostered buy-in	*"People thought cash would go to the providers because of the Balaka program that does some kind of 80/20 split with 80% cash for providers."* – District level provider
Dealing with data initially problematic and unclear, but later a recognition of value of data	*"Most people were not aware of what was happening in the facilities in terms of data, but the became interested ... to know what statistics are and how they were being used."* – District level provider
BARRIERS	**ILLUSTRATIVE QUOTES**
Indicators beyond reach due to national stock-outs of drugs or inability to find enough HIV-positive patients	*"The Central Medical Store does not have folic acid and sulfate. ... If we don't have this, we can't meet one of our PBI indicators."* – District level provider *"We are being penalized on things that we have no control over."* – Nurse
Lack of transparency and ease in **procurement** (goods arrive late or are of substandard quality). Facilities are penalized (in terms of score) when goods or funds that have been ordered arrive late	*"The materials that they buy most of the times are not of good quality and they are very expensive, so in the end only a few materials are bought."* – Medical Assistant *"We're not procurement specialists. We didn't even have a procurement officer dedicated to PBI. ... We did not foresee how big this would turn out to be—that we'd need a special unit. Now we have an engineer and procurement person just for PBI."* – Program Implementer
Lack of transparency and ease following the **flow of funds** (including the issuing of receipts), which undermines business plan development.	*"Munayiwonapo ng'ombe kumwa mkaka wake (Have you seen a cow drinking her own milk)? This is what is happening. ... It is not true to buy those items for those prices ... They are eating our money instead of using it here."* – Community FGD *"We are not given any receipt on any item procured [...] which (would) enable us to follow how much money is remaining with us."* – Medical assistant
Contextual issues such fuel shortages, political strife and currency inflation.	*"This program has been designed and implemented at a time that Malawi experienced the highest political and economic volatility in its history. You can see this by the currency inflation, the international relations, the scandal of Cashgate, the change of three governments in three years."* – Program Implementer



Pharmacy assistants participate in training activities in Malawi.
Photo credit: VillageReach

program progressed however, both sides grew more comfortable with the notion of evaluation and appraisal. Community members across each district described feeling heartened by the manner in which providers were trying to be more responsive, which in turn compelled community members to deliver on their end of the agreement by, for example, encouraging more pregnant women to visit facilities or by being more available to undertake sweat equity such as fence building. Providers described how they benefited from this strong community buy-in, which helped them attain indicators. In one positively extreme case, the community organized to electrify the facility, was in the process of building an incinerator and toilets, and was making plans to purchase an ambulance for the facility.

In two instances, the data collection team encountered facilities that were in the midst of inter-facility knowledge exchanges wherein providers (often accompanied by community leaders) would visit other facilities to share and compare PBI experiences. These ad hoc exchanges were not an explicit component or target of the SSDI-PBI program and were not initiated, coordinated or led by the implementing agency. Nevertheless, providers viewed the exchanges as a means to galvanize buy-in and to support struggling facilities to better understand the purpose and process of PBI. In interviews and focus groups, providers and community members described how the creation of forums and exchanges allowed them to better grasp their performance in relation to others and made them feel that they were "part of something" important and promising. In terms of intra-facility sharing, providers described how they posted PBI targets on the walls of different departments and colleagues would tease, berate or encourage one another to be more conscious of their respective quality targets. Facilities also described creating PBI Whatsapp groups and gathering to create, clarify and refine business plans, which fostered a sense of collective engagement.

Respondents in communities and facilities consistently recited their "PBI percentage" (the score received on a given indicator) without being explicitly probed for this during data collection. Respondents often knew how they scored in relation to themselves (in a previous round), and how they scored in relation to other facilities in the district. In this sense ranking and goal setting fostered competition with oneself and also with others.

Finally, while the receipt of goods was often delayed, providers described their happiness at having received items, in particular, uniforms. Uniforms were described as something that set providers apart and announced their status to visitors. One provider described how she had not received a new uniform since she began her career in the 1980s. Along with uniforms, facility-based staff would often insist that interviewers take a tour of the facility wherein the provider would point out items in rooms and corridors and describe when each item was "purchased by PBI" (items most often highlighted were: curtains, blood pressure machines and shoes). A few providers described how the receipt of apparel represented a form of payment.

FACTORS THAT BOTH FACILITATED AND CHALLENGED PROGRAM IMPLEMENTATION

Several factors were described as both a barrier and facilitator. The clearest example of these program facets that entailed a steep learning curve were learning how to devise and develop finance skills, switching mindsets to be more output-based rather than input-based, underscoring the rationale behind collecting and analyzing data, and cultivating the ability to forecast which supplies and equipment would be essential at later periods. Each of these skills was described (particularly by district level health staff) as an essential tool to have in one's repertoire, but not something that has ever been a part of clinical providers' training. One DHO said this was among his favorite aspects of the SSDI-PBI program: "This program could leave tomorrow, but the providers in the PBI facilities now have a skill that they didn't have before. They can think critically in a way that they were never before trained to do".

While providers in facilities often described the way in which business plan development made them feel like "owners" of the PBI program, district health officers and community members were more skeptical of true program ownership. Due to delays in procurement and the rigidity in terms of setting indicators, many respondents felt that SSDI-PBI was owned by "the people in Lilongwe". Ministry officials often described feeling involved in the sense that they were intimately involved during the programs design process and they accompanied implementers on supervisory visits during implementation, ministry staff were also disgruntled by the feeling that their inclusion was, by turns, cursory or superficial.

Because Malawi has another performance-based program ongoing within the health sector (albeit in different districts) and because the education sector uses a version of performance-based rewarding, several respondents within facilities and communities highlighted a passing knowledge of the concept of PBI. This proved beneficial, but also problematic. In general, providers who knew of another health program (and knew that it entailed cash rewards to providers) reported being de-motivated by SSDI-PBI's lack of salary top-ups. At the same time, community leaders, who were the main respondent group that highlighted the existence of a system akin to PBI implemented in schools, described how that program allowed schools to serve as cost centers. Unfortunately, the nature of this program was not adequately probed in interviews. Furthermore, the manner in which the education sector's program appears to be functional and also more so decentralized seems to have compelled community members to expect that the SSDI-PBI program implement or adopt a similar structure.

BARRIERS TO PROGRAM IMPLEMENTATION

Implementation barriers within SSDI-PBI largely center on a sense that the program cannot be modified or adapted to be more sensitive to on-the-ground priorities and realities. This sentiment was described by nearly all involved in the program (including implementers), and perhaps best encapsulated by one district-level provider who said, "... let me tell you, I wanted them to bring us a skeleton. A skeleton and then together we would put on some flesh. Build something together. But they came from Lilongwe and brought their prince. He could not be touched, nothing could be changed or altered". Implementers described how their hands were often tied due to regulations and standard-operating procedures of their organization or of the funder, USAID. Providers described how the nature of indicators and measurement of performance could be unrealistic or inappropriate when essential medical supplies (such as pregnancy tests) were out of stock, or when the indicators themselves were devised without updated input or using "old, bad data". Several providers also described how quality indicators were too rigidly interpreted or enforced. A District Health Officer described how it was raining on the day of a quality inspection yet the facility was penalized for standing water. Another provider described how the maternity ward was missing bed sheets on one bed during an inspection (the sheets were drying on a clothes line), but because each bed was not covered, the facility was penalized. "It feels like... there is no flexibility," said a provider, "... No understanding. If I'm at home, and I want to make a meal I need water, a pot, some fire and some food. These are the major things. This program is penalizing us because we don't have salt. The meal is there but that salt is missing. ... I don't need salt to eat a meal."

Providers and community members were also displeased with a sense that the program did not entail an adequate amount of autonomy, which was most clearly pronounced in relation to the procurement of rewards. Respondents described how goods would arrive late, be of substandard quality or not meet required specifications, which was frustrating in itself but was more so problematic because facilities were penalized for goods that were not present – yet had been included in their earliest business plan. Similarly, cash for outreach and meetings as stipulated in the business plans were described as arriving late

Participants of a Community Advisory Group (CAG) during training and discussions in Malawi.
Photo credit: JHUCCP/Malawi

at the facility, preventing providers from proceeding with planned activities. The experience of being penalized because an ordered item or cash had not been delivered (and facilities could do nothing to expedite the process) is among the most problematic facets of the SSDI-PBI program according to respondents. The situation was described as undermining facility and community motivation, and breeding resentment and distrust. Implementers and Ministry officials are intimately aware of this problem, but consistently maintained that facilities could not be rewarded for goods that were not present during inspection.

Facilities and communities would also like to have a better understanding of the flow of funds in PBI. Providers said that community members hold a mistaken understanding that SSDI-PBI distributes funds directly to providers or that providers may be unfairly benefitting at the community's expense as described by one medical assistant: "The relationship between the community and the facility, of course has improved, but with some negatives because if staff members procured an item, for example a bicycle, the community would assume that the facility is using the community's resources." This finding was not triangulated in focus group discussions with communities. Providers also described not receiving receipts and lacking oversight of their SSDI account balance, and therefore making "blind" decisions regarding how to modify their business plans in later cycles, a finding that was triangulated by community members. Community members and providers also presented examples of costs that were conveyed to them by the program, but which they found outlandishly high (2.5 million Kwacha (~3,533.00 USD)) for a motorbike; 70,000 Kwacha (~98.95 USD)) for a mop etc.). The issue of monetary transparency is perhaps especially acute in this context at this moment because of Cashgate, a 2014 political scandal wherein public funds were misappropriated by government officials.

Aside from Cashgate (and its aftershocks, including a heavy turnover of government staff), broader political and economic issues did not foment an altogether solid program foundation. Namely, at the time of program rollout, the country was in the midst of or rebounding from fuel shortages and currency inflation. Inflation presented a particular problem in terms of procurement and construction as the timing between seeking bids, awarding a tender and starting construction was long and initial prices could have escalated dramatically in the interim.

LOOKING AHEAD

Moving forward, most respondents agree that it would be beneficial for the program to bolster procurement autonomy for facilities, or to drastically reduce the amount of time between procurement of a good and arrival of the good to a facility. If the possibility of facility-based, direct procurement for items and equipment is not possible, other measures to foster autonomy must be considered and reductions (or removal) of penalties levied against facilities that have ordered though not received goods or cash merits consideration.

While facility and district level providers said the program sensitized communities on what the program entailed, moving forward communities need more information on procurement and compensation in order to quell concerns regarding how facilities are using funds. Community members echoed a desire to be more regularly sensitized.

Implementers at the district level suggested that the PBI program do more to engage local and district level government officials, who would not only appreciate the tangible benefits of the program but could also provide added credence to the program and potentially bolster its profile. Ministry members described a need for higher-ranking staff within the ministry to be better sensitized on the program as a means to reinforce program sustainability and better navigate how, where and how much to "push for the program to continue".

Roughly half of respondents at facility, district, implementer and ministry levels highlighted that it would be beneficial to financially compensate providers directly. Ministry staff clarified that this particular adjustment would not be sustainable in the long-term.

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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:
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