How rewards improve health practice in Malawi

Learnings from a Maternal and Newborn Health Initiative

A publication in the German Health Practice Collection
The German Health Practice Collection (GHPC) is a joint initiative of the German Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing agencies, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Development Bank (KfW). Established in 2004, the Collection is built around a series of case studies which identify and document insights generated during the implementation of German-supported health and social protection programmes. Since 2017, it also includes evidence briefs which synthesise current knowledge about specific questions of relevance to German development cooperation in the areas of health and social protection.

**Case studies: A collaborative approach to learning from implementation**

The GHPC case studies identify, document and share knowledge generated in the course of implementing German-supported development interventions.

In response to an annual call for proposals, GIZ and KfW staff from around the world submit proposals of implementation experiences they consider worthy of documentation. The proposals are commented upon and ranked by GIZ and KfW peers to ensure that they reflect issues of broader technical and political relevance. Guided by their assessment, BMZ decides which proposals should be developed into case studies.

A GHPC researcher/writer assigned to develop the case study reviews available documentation and visits the programme site to get first-hand impressions of implementation and to interview programme staff, partners, beneficiaries and other stakeholders. In an ongoing critical and reflective exchange with the staff of the German-supported programme and their partner institutions, he or she analyses and documents how they approached a specific development challenge, how they dealt with difficulties and adapted their approaches accordingly, and what they learned in this process about effective implementation.

Prior to publication, independent peer reviewers who are international experts in their fields review the case studies and assess whether the documented insights are worth sharing with an international audience. A summary of their reviews is included at the end of each case study.

**Evidence briefs: Research syntheses to guide policy and programming**

The Collection also includes evidence briefs which summarise the current state of knowledge on specific development-related questions, including areas of emerging interest for German development cooperation. Each brief’s concept and guiding questions are developed in consultation with BMZ and with GIZ and/or KfW colleagues working in the given topic area. An independent researcher or team of researchers develops the evidence brief on the basis of literature reviews, interviews and data analysis, including a review of German-supported programmes in the field. The evidence briefs are intended to contribute to international debates and to inform decision-making about development interventions and programmes.

**Front cover photo:** Health provider attending mother and baby in Dedza District Hospital, Malawi.
## Executive Summary

**Executive Summary**

**Welcoming New Life in Golomoti Health Centre**

**Mothers’ and Newborns’ Health in the ‘Warm Heart of Africa’**

**RBF4MNH: An Initiative with a Strategic Approach**

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### Acronyms and abbreviations

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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Ante Natal Care</td>
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<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
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<td>BMZ</td>
<td>Federal Ministry for Economic Cooperation and Development, Germany</td>
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<td>CCT</td>
<td>Conditional Cash Transfer</td>
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<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
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<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSSP2</td>
<td>Health Sector Strategic Plan 2017-2022</td>
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<td>IDR</td>
<td>Institutional Delivery Rate</td>
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<td>KfW</td>
<td>KfW Development Bank</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MNH</td>
<td>Maternal and Newborn Health</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NORAD</td>
<td>Norwegian Agency for Development Cooperation</td>
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<td>PBF</td>
<td>Performance-Based Financing</td>
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<td>PMTCT</td>
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<td>RBF</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TRAction</td>
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Executive Summary

BOX 1. KEY LEARNINGS

Implementing the intervention as a shared learning experience enables adaptation and ownership. Adopting an action-research approach, together with the partners, in which strategies are tested and adapted in the course of implementation, ensures continued relevance of the project despite a changing context.

Results-Based Financing (RBF) can empower health worker teams to improve their own working conditions and the quality of care they provide. Rewarding the performance of the health facility as a whole fosters teamwork, and reserving part of the cash reward as a ‘facility portion’ to be spent at the team’s discretion improves quality of care and fosters staff’s self-efficacy.

Compared to investments in infrastructure and equipment, investments in staff motivation make a greater difference. Incentivising quality of care led to rapid and sustained improvement, well before reception of the Initiative’s equipment and infrastructure component.

Regular review and adaptation of payment indicators are important and should be participatory. Incentivising quality of care indicators allows a direct link with health-care provision. Indicators can be targeted at specific areas of weakness and must be verifiable by an external team. To be motivating, rewards must relate closely to performance, reward cycles must be short and feedback of results prompt.

It remains a challenge to ensure careful monitoring of performance indicators while keeping a lid on staff workload. Keeping up with reward indicator monitoring in addition to routine administration and reporting is time-consuming and often perceived by staff members as reducing their availability to provide quality care. RBF interventions need to carefully assess the time ratio between performance and accounting for the performance in order to find a realistic balance.

Associating supply-side and demand-side interventions can lead to improved maternal-newborn outcomes. Health-promoting behaviours such as pregnant mothers’ early arrival and prolonged stay after delivery can be supported by a Conditional Cash Transfer (CCT) that defrays their costs for transport, delivery items and food while away from home, while health personnel are rewarded for regularly checking newborns’ vital signs during the crucial 48 hours after birth.

At district level RBF can facilitate effective health service decentralisation. Anchoring the intervention at district level and rewarding the District Health Management Teams’ supportive supervision has improved these teams’ management capacities, their resource allocation and their responsiveness to feedback – not just for the intervention facilities but for their districts as a whole. Evidence-based results on district level can in turn feed into national health policy and strategy.
This case study explores learnings generated during the implementation of the Results-Based Financing for Maternal and Newborn Health (RBF4MNH) Initiative in Malawi, a process which has been led by the Reproductive Health Directorate of the Malawian Ministry of Health (MoH), with support from German Development Cooperation through KfW Development Bank and other international partners.

THE CHALLENGE: PERSISTENT HIGH MATERNAL AND NEONATAL MORTALITY

Despite a greatly improved Institutional Delivery Rate (IDR) of nearly 90%, Malawi’s rates of maternal and newborn mortality remain high at 439/100,000 and 27/1000 live births respectively. Factors include on the one hand sub-optimal quality of care in maternity services, reflecting insufficient human, financial and material resources in the health sector, and on the other hand late arrival and early departure after delivery by mothers, many of whom cannot afford to be away from home for long.

THE RESPONSE: INCENTIVISING IMPROVED HEALTH PRACTICE AND SUPPORTING MOTHERS’ STAY IN THE HEALTH FACILITY

RBF4MNH aims to improve quality and accessibility of selected Emergency Obstetric and Newborn Care (EmONC) facilities in four rural districts since 2012 via three main components:

- **Supply-side incentives** – health facilities and District Health Management Teams (DHMT) earn monetary rewards by fulfilling indicators related to quality of care and health system improvements, of which 40% – the ‘facility portion’ – is to be reinvested by the team to improve their working conditions.
- **Demand-side payments** – to make it more affordable for mothers to come early and stay longer after delivery. Conditional Cash Transfers (CCT) assist pregnant women to defray costs for transport between home and the health facility, for delivery-related items and expenses during their stay in the health facility.
- **Investment in equipment and infrastructure** was designed as a preliminary measure to bring the intervention EmONCs up to a minimum standard for ensuring emergency obstetric care.

Taking a highly participatory action-research approach, with a major accent on communication and collaboration with traditional chiefs, the Initiative team and its partners on district, community and central level have fine-tuned their strategies in the course of implementation, accompanied by an external impact evaluation conducted by Heidelberg University’s Institute of Public Health and Malawi’s College of Medicine (in the following text referred to as ‘Heidelberg-College of Medicine impact evaluation’). Adaptations of the Initiative design have included definition and monitoring of reward indicators, management of incentives, enabling health facility staff to manage the cash for the CCTs and the ‘facility portion’, and adjusting targeting of CCT beneficiary mothers from an inefficient administrative approach to one which involves the communities in determining women’s eligibility.

WHAT HAS BEEN ACHIEVED

RBF4MNH has largely succeeded in achieving its goal ‘Women deliver increasingly in targeted health facilities, where maternal and neonatal services of good quality are offered.’ All 33 of the currently supported EmONCs fulfil 100% of the MoH’s quality criteria, and the majority of women delivering in these facilities benefit from the CCT. With the new community-based approach, all poor women residing in the district are eligible for CCT. RBF-supported EmONCs attract an estimated 10% more women than before the intervention. Eighty-seven per cent of women stay 48 hours after delivery, and the proportion of maternal and neonatal deaths appears to be decreasing.

Incentivising District Health Management Teams’ management and supportive supervision of all health facilities – not just the RBF EmONCs – has led to overall improvement in quality of care in each district.

HOW THIS CASE STUDY WAS DEVELOPED

In 2016, a GHPC researcher/writer studied all available reports and other documentation about the Initiative and then travelled to Malawi to get a first-hand impression of the RBF approach. Here she interviewed programme staff, health workers, representatives of the Ministry of Health and other stakeholders. In accordance with this Collection’s new focus on learning from implementation, the case study was then prepared in close consultation with the programme team through a process of critical reflection on the implementation process, the challenges that arose during implementation, and the insights generated in addressing these challenges.

Correspondingly, the case study starts with an overview of the background and context of the RBF4MNH Initiative, followed by an exploration of the approach taken and the challenges encountered on the way. After a summary of the results achieved to date, the focus is on the insights generated in the course of implementation. The study wraps up with a peer review by two independent experts in the domain of Results-Based Financing.
In the rolling hills of Malawi, a half-day’s drive from the capital Lilongwe, lies the village of Golomoti. At the end of a dusty road is the scrupulously clean health centre. Golomoti is not an ordinary health centre, but one of eight facilities in the Central Region’s Dedza District selected by Malawi’s Ministry of Health (MoH) to offer Basic Emergency Obstetric and Newborn Care (BEmONC) with support from German Development Cooperation through KfW Development Bank. The Results-Based Financing for Maternal and Newborn Health (RBF4MNH) Initiative applies an innovative approach to reward improved health service delivery while supporting poor women’s access to professional obstetric care.

With a catchment area of 68 villages and Malawi’s average of nearly five children per woman in rural areas (NSO and ICF International, 2016), Golomoti is a very busy BEmONC, delivering babies night and day. Highly pregnant women, some accompanied by a female friend or family member, stroll in the courtyard or soak up the sun’s rays perched on a colourful spread-out chitenje (cotton wrapper). It is May and with the approaching southern hemisphere winter, there is already a chill in the air. The post-natal ward, enlarged with support from the Initiative, is practically overflowing with mothers resting with their newborns.
In the narrow delivery room all five beds are occupied by women at different stages of labour. Esther Chirwa, nurse-midwife and RBF4MNH Desk Officer at Golomoti Health Centre, takes a break from filling out the partograph following the progress of a young woman giving birth for the first time. Pouring herself a cup of coffee, she observes, ‘The RBF4MNH Initiative has brought great improvements, starting with the infrastructure and equipment component to bring our service up to a minimum standard. Getting regular supervision from the District Health Management Team is also really helpful.’

‘I must say though,’ Esther adds with a twinkle in her eye, ‘the financial rewards that we take home every three months based on the performance of our health facility are what we staff members personally find most motivating. We are proud that Golomoti and our district have recently been among the highest rated by the verification team!’

‘Then there is the “facility portion” of our reward,’ she continues. ‘The facility portion is very important to us, since our team decides together how to use these funds to improve our working environment. For instance, we bought this coffee maker’ – here Esther holds up her cup – ‘and we often buy drugs and medical supplies, as well as antisepsics and soap, to make up for what the Ministry can’t provide us.’ Gesturing towards the delivery room, she adds, ‘Those plastic curtains between the beds to provide privacy to the patients – those we also bought with the facility portion.’

‘On the other hand,’ she adds, ‘it’s true that in many ways our workload has increased: people see the improvements and now women are even coming from outside our catchment area to deliver here.’

‘The big problem,’ says Esther, ‘is that we’re only four technical staff – nurse-midwives and medical assistants – to deal with all these deliveries, not to mention all the other services like vaccination and treating sick patients. Salaries are low here in Malawi, and many of our colleagues have even left the country to find jobs elsewhere.’

The break is over, and a foot-weary Esther returns to the side of her young patient.

RESULTS-BASED FINANCING FOR MATER- NAL AND NEWBORN HEALTH IN MALAWI

With persistently high rates of maternal and newborn mortality (see next chapter), Malawi has failed to reach its Millennium Development Goal (MDG) targets on mother and neonatal health. Facing severe financial, material and human resources deficits, the Malawian health system is struggling to rise to this challenge. The Ministry’s Reproductive Health Directorate sees promise in an approach which is gaining an increasing number of adherents worldwide: Results-Based Financing (RBF), which uses financial incentives to promote positive behaviour change and improved quality of care (see next chapter).

Since 2012, Malawi’s RBF4MNH Initiative, with support from the German Federal Ministry for Economic Cooperation and Development (BMZ) through KfW Development Bank, has been applying this approach to motivate improved quality of care and performance by providers and increased utilisation of maternal and newborn health (MNH) services by clients in four rural districts.

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In 2016, a researcher/writer with the German Health Practice Collection studied all available reports and other documentation about the Initiative and then travelled to Malawi to get a first-hand impression of the RBF approach. Here she interviewed programme staff, health workers, representatives of the Ministry of Health and other stakeholders. In accordance with this Collection’s new focus on learning from implementation, the case study was then prepared in close consultation with the programme team through a process of critical reflection on the implementation process, the challenges that arose during implementation, and the insights generated in addressing these challenges.

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Malawi is nicknamed ‘the warm heart of Africa’, reflecting the unspoiled beauty of its natural environment, its orderly cities adorned with floral sculptures, and the courteous welcome of its largely rural inhabitants. Contrasting with many African countries, Malawi embraces the legacy of its diverse ethnic groups, whose traditional chiefs continue to play a major role in running day-to-day affairs, in complementary partnership with the national and local government. English is the language of administration, but the national language Chichewa is understood and written by most Malawians.

Beyond this impression of a ‘land that time forgot’ is a nation of 17 million squeezed into the southernmost tip of Africa’s Great Rift Valley, where most inhabitants live on less than a dollar a day (World Bank, 2015). The former British protectorate, now a parliamentary democracy, has few mineral resources and little industry. Eighty-five per cent of the population is rural, mainly engaged in subsistence farming of maize, Malawians’ staple food, in addition to some cash crops such as tobacco, macadamia nuts, tea and coffee. Ranked 170th out of 188 nations on the United Nations’ Human Development Index in 2015, the country has in recent years suffered a series of droughts and natural disasters that have undermined its agricultural exports and its capacity to feed its growing population. Approximately 40% of children under five are stunted 1, reflecting chronic malnutrition (NSO and ICF International, 2016). With a prevalence of over 10% and as first cause of mortality in adults (WHO, 2015), HIV takes a tremendous toll on Malawians’ economic and social well-being and continues to thin the ranks of the education and health sectors in particular.

1 Too short for their age.
Malawi’s public services are hard put to keep pace with an annual population growth of 3.1% (World Bank, 2015). Forty-five per cent of the population is under age 15, and elementary school classes of 100 to 200 pupils are not uncommon. The country, which is heavily dependent on external funding, was dealt a major blow in 2013 by the funds mismanagement scandal known as ‘Cashgate’. This led to a sharp reduction in foreign aid, including in the health sector.

Despite significant progress toward gender equality – Malawi has recently attained parity in primary school enrolment of girls and boys, and raised the age of marriage from 15 to 18 years – women and girls remain particularly affected by poverty, HIV and AIDS (both as patients and as caretakers) and other manifestations of disempowerment. Some, such as conjugal violence or early sexual initiation and pregnancy, can be linked to local norms and traditions (OECD, 2015). At present, nearly a third (29%) of girls aged 15-19 have begun childbearing (NSO and ICF International, 2016), a rate which has barely declined since 1992 (34.7%).

REPRODUCTIVE HEALTH: AIMING FOR THE MDGS AND SDGS

Malawi was focused on achieving its MDG targets by 2015 and made some impressive gains (Ibid.) These results are all the more remarkable in light of the profound challenges faced by Malawi’s underfunded and understaffed health services (see below).

- **Fertility** has been reduced from 6.7 births per woman in 1992 to 5.7 in 2010, and down to 4.4 in 2015-2016.
- **Contraceptive use** by married women has increased dramatically from 13% in 1992 to 46% in 2010 and a remarkable 59% in 2016.
- **Delivery in a health facility** has increased from 55% in 1992 to 73% in 2010 and an exemplary 91% in 2016.
- **Mortality of children under five** was halved from 1992 (234/1000) to 2010 (112), and halved again by 2016 (64).

Despite these impressive successes, two indicators have stubbornly resisted efforts to reduce their numbers:

- **Maternal mortality** has greatly diminished since the year 2000 from 1123 maternal deaths per 100,000 live births \(^2\) to 439/100,000 in 2016 (National Statistical Office, 2014; HSSP2). Nonetheless, Malawi is far from reaching its target for MDG 5A \(^2\), which was set in 1992 together with the World Health Organization (WHO) at 155/100,000 live births.
- **Neonatal mortality.** Although Malawi, with its strong decrease in child mortality, attained MDG 4 in 2013, the newborn death rate \(^4\) has remained at a constant and high ratio of 27/1000 for the past 15 years (NSO and ICF International, 2016). This indicates that at present nearly half of Malawi’s under-five mortality (64/1000) occurs during the first month of life.

The MDGs have now been succeeded by newly formulated Sustainable Development Goals, to be achieved by 2030. Maternal and child health are the first two targets of Goal 3 aiming for universal health coverage (WHO, 2016):

- **Target 3.1.** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- **Target 3.2.** By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to a maximum of 12 per 1000 live births and under-five mortality to no more than 25 per 1000 live births.

Malawi’s Ministry of Health is confronted with a dramatic lack of resources – financial, material and human – to ensure functioning of the health system. Malawi’s second Health Sector Strategic Plan (HSSP2) 2017-2022 identifies fundamental problems in quality and accessibility of basic health-care services. Quality of care and access to services have been hampered by a lack of resources to build, renovate and equip health facilities. Inefficiencies in the health system have compounded this problem, including a centralised distribution of drugs and supplies, of which over half ‘leak’ out of the public health services (Sivertsen, 2013). Most critical is a persistent deficit in technical staff, running as high as 60% for nurses and midwives (Vidal, 2015).

\(^2\) Maternal mortality is calculated as the ratio of maternal deaths per 100,000 live births.

\(^4\) For the 95 countries with a maternal mortality rate over 100, this goal was formulated as ‘to reduce maternal mortality by 75% between 1990 and 2015.’ In 1992 Malawi’s maternal mortality rate was estimated at 620/100,000.
Malawi’s ongoing decentralisation reform, progressively transferring decision-making powers to district councils, has positive repercussions on the health system. District Health Management Teams, under the leadership of the District Health Officer, who is a medical doctor, are increasingly taking responsibility for improved functioning of the local health facilities.

To expand coverage, since 2004 the Ministry has been subsidising the provision of maternal and newborn health services by selected facilities of the Christian Health Association of Malawi (CHAM), whose network represents over a quarter of health facilities in the country, mainly in rural areas where there is no alternative provision.

Particularly problematic have been access to and quality of maternal and newborn health (MNH) services. Well into the new millennium, nearly half of Malawian women were giving birth at home with Traditional Birth Attendants (TBAs). To encourage institutional delivery, in 2007 the Ministry of Health redefined the roles of TBAs, preventing them from conducting deliveries and requiring them to refer women to health facilities for skilled attendance at birth. Chiefs set by-laws imposing heavy fines (e.g. cash or a goat) both on the woman and the TBA assisting her (Butrick et al., 2014). This measure, although highly contentious with regard to its effect on poor families, was enforced by the network of traditional chiefs and appears to have contributed to raising the rate of births assisted by a skilled health provider from 56% in 2004 to 71% in 2010 and to 91% in 2016 (NSO and ICF International, 2016).

Although institutional deliveries were rising, the maternal and newborn mortality rates in Malawi were nonetheless stagnating at unacceptably high levels, with persistently low quality of health services. In 2010, in the wake of the international ‘Muskoka Initiative on Maternal, Newborn and Child Health’, where the planet’s eight richest nations pledged $US 5 billion to help countries attain MDGs 4 and 5, the German and Norwegian governments proposed their support to Malawi for the design of an innovative results-based financing intervention to improve quality and accessibility of maternal and newborn health care.

RESULTS-BASED FINANCING: A PROMISING APPROACH FOR IMPROVED MNH?

In contrast to more traditional forms of financing for development assistance, where payments are made for ‘inputs’ such as salaries or staff training, buildings, equipment or consumables, Results-Based Financing (RBF) links payments directly to performance or results. In developing countries, variants of RBF are increasingly common across many sectors including education, utilities, climate change and, of course, the health sector, where the approach has rapidly gained in popularity over the past 15 years. In the health sector, RBF has been described as a cash payment or non-monetary transfer made to a national or subnational government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. (http://www.rbfhealth.org)

In other words, RBF means paying for work done.

These predefined results may be stated as outputs (i.e. the number of children immunised or number of women who have received a cash payment), or outcomes such as the quality of the services provided.

RBF is the umbrella term which encompasses a range of approaches and can operate on both the supply side and the demand side. The unifying characteristic of all RBF approaches is the provision of an incentive or reward in return for a desired change in behaviour – in the health sector this means more services provided, better quality services, improved access for certain beneficiary groups and changes in health-seeking behaviours.

Financial rewards and incentives have long been used to motivate health-care providers and managers to meet volume and quality targets in countries such as the United Kingdom, Sweden and the United States (Savedoff, 2010). In developing countries, the focus on results also goes hand in hand with rising pressure to demonstrate impact and success of the huge sums invested in development assistance.

1 Related terms are Performance-Based Incentives (PBI) and Performance-Based Financing (PBF). A good summary of different RBF approaches can be found in the recently published Performance-Based Financing Toolkit of the World Bank (Fritsche et al., 2014, pp. 8 and 9).
Within the health sector, MNH services have been a major area for the application of the RBF approach, with incentives directed at the demand for and provision of family planning, prevention and management of sexually transmitted infections, antenatal care, skilled normal delivery, referral of complicated delivery, neonatal and postnatal care, and child care (Gorter, Ir and Meessen, 2013).

Many RBF practitioners would say that it is much more than simply paying for results – it is a health systems approach. Advocates of Performance-Based Financing (PBF) in particular highlight the separation of functions (purchasing and providing services), enhanced autonomy of health-care facilities and the empowering of communities (cf. Oranje, 2017). Overcoming entrenched barriers to accessing care is also an important feature of most RBF interventions.

In practice, most RBF projects include some level of investment in inputs, often to shore up dilapidated infrastructure and to ensure a minimum level of functionality of service providers selected to participate in the programme. This is particularly important for maternal and newborn health interventions, where poor quality care can lead to death and disability of the mother and her newborn. Input-based investments in maternal health RBF programmes are often directed towards ensuring readiness to provide emergency obstetric care. However, this can also make it difficult to evaluate the relative contributions of the different components – input- and output-based (Keijzer and Janus, 2015).

The results-based approach is based on a contractual relationship between a principal (who rewards) and an agent (whose changed behaviour is rewarded). The agents range from governments, ministries and public sector agencies, through private sector organisations, to individual service providers – and include potential users of services. The dynamic of the principal-agent relationship in RBF can give rise to unintended effects, such as the overproduction of rewarded results or ‘gaming’ of data to earn increased rewards. Financial incentives may also divert attention and resources away from other non-incentivised but equally important tasks and services (Savedoff, 2010). Critics of the approach also point to possible ‘crowding out’ of intrinsic motivation, whereby health-care providers lose some of their natural inclination to do good work once they start to receive financial rewards.

RBF programmes usually encompass measures to mitigate these challenges: Regular reviews of performance indicators can mitigate either over- or under-production of services. To prevent ‘gaming’, payments are made only after results have been externally verified.

RBF in health has attracted increasing attention from development partners, including from Germany (cf. Gorter, Ir and Meessen, 2013) and, more recently, from the United States Agency for International Development (USAID) and Norway, who with the World Bank and the UK are committed to jointly documenting and evaluating the rapidly multiplying number of experiences in this sector. 4 The Malawi RBF Initiative described in this case study was the object of an independent impact evaluation under USAID’s Translating Research into Action (TRAction) project with co-financing from Norway (see p. 14), and has made an important contribution to the knowledge base of RBF in maternal and newborn health.

GERMAN DEVELOPMENT COOPERATION: A LONG-TIME PARTNER FOR HEALTH IN MALAWI

Malawi has been a partner of Germany since 1964, and in recent years has attained the status of ‘priority partner’. In 2015 BMZ pledged over €100 million support to Malawi over the next few years in the domains of basic education, rural development and health.

Germany’s support is channelled through two main organisations with complementary roles: financial cooperation via KfW Development Bank, and technical cooperation via the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. In Malawi both organisations and their respective interventions are associated in the overarching Malawi-German Programme of Support to the Health Sector. The focus on both sides is on promoting rights-based reproductive health within the framework of Malawi’s Health Sector Strategic Plans 2011-2016 and 2017-2022: GIZ among others through support to quality assurance, training measures and improvement of the health management information system, and KfW – in addition to the RBF Initiative – through investment in health infrastructure, equipment and supplies including vaccines and contraceptives, as well as contributions to joint funding of the health sector. 5 Both GIZ and KfW support the public-private partnership with CHAM.

RBF4MNH is exemplary of the close partnership between Malawi and Germany. The next chapters will take a closer look at the evolution of an innovative approach in response to a broad range of challenges.

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4 Cf. the website of the Health Results Innovation Trust Fund at http://www.rbfhealth.org/mission and the Translating Research into Action (TRAction) project at http://www.tractionproject.org

5 Germany contributed to the basket fund of the health Sector-Wide Approach until 2012. In the aftermath of the Cashgate scandal, it was decided that no further funds would be committed to pool-funding mechanisms in Malawi. Since 2016, Germany supports the Health Services Joint Fund, a common funding mechanism to support the Malawian health sector, with more stringent oversight measures.
RBF4MNH is an initiative of the Ministry of Health’s Reproductive Health Directorate. Focusing on the core problem of high maternal and newborn mortality in Malawi, the Initiative’s goal is formulated as follows:

Women deliver increasingly in targeted health facilities, where maternal and neonatal services of good quality are offered.

Mothers and their newborns – particularly the poorest – and health professionals at the district and facility level are important beneficiaries of the RBF4MNH Initiative.

Following a preparation phase, the RBF4MNH Initiative has been implemented since October 2012 in the districts of Balaka, Dedza, Mchinji and Ntcheu in Malawi’s Central and Southern Regions, totalling approximately two million inhabitants.

RBF4MNH has evolved in the course of two overlapping phases: the first (10/2012-12/2016) was jointly funded by Norway and Germany for a total of US$10 million, while the second (9/2014-12/2017) is funded by BMZ alone with €10 million for consolidating the Initiative.

The RBF Initiative cooperates with the GIZ-supported part of the Malawi-German health programme, which intervenes in the same four districts. GIZ supports the health management information system, quality management structures at district and health facility levels, and capacity development for maternal-neonatal health providers. To monitor progress, RBF4MNH and GIZ carry out annual Joint Quality Assessments of the supported health facilities.

**BOX 2. SIGNAL FUNCTIONS OF BEmONCs AND CEmONCs (WHO et al., 2009)**

<table>
<thead>
<tr>
<th>BASIC SERVICES</th>
<th>COMPREHENSIVE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administer parenteral antibiotics</td>
<td>Perform signal functions 1-7, plus:</td>
</tr>
<tr>
<td>2. Administer uterotonic drugs (i.e. parenteral oxytocin)</td>
<td>8. Perform surgery (e.g. caesarean section)</td>
</tr>
<tr>
<td>3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (i.e. magnesium sulfate).</td>
<td>9. Perform blood transfusion</td>
</tr>
<tr>
<td>4. Manually remove the placenta</td>
<td></td>
</tr>
<tr>
<td>5. Remove retained products (e.g. manual vacuum extraction, dilation and curettage)</td>
<td></td>
</tr>
<tr>
<td>6. Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery)</td>
<td></td>
</tr>
<tr>
<td>7. Perform basic neonatal resuscitation (e.g. with bag and mask)</td>
<td></td>
</tr>
</tbody>
</table>

A BEmONC is one in which all functions 1-7 are performed. A CEmONC is one in which all functions 1-9 are performed.

1. Injection or intravenous infusion.
2. Uterotonic drugs are administered both to prevent and to treat postpartum haemorrhage.
**FROM 18 TO 33 COOPERATING FACILITIES**

RBF4MNH aims to improve quality and accessibility of selected Emergency Obstetric and Newborn Care (EmONC) facilities in the four rural districts where it works. As outlined in Box 2, there are two levels of EmONC: Basic EmONCs (BEmONC) are health centres that have been upgraded to provide seven life-saving medical interventions or ‘signal functions’, while a Comprehensive EmONC (CEmONC) – a district or community hospital – offers in addition surgery and blood transfusion. The Ministry of Health strives to follow WHO’s guideline on EmONC coverage: ‘There are at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500,000 population’ (WHO et al., 2009).  

To participate in the RBF4MNH Initiative, the health facilities need to fulfil additional criteria, including the presence of at least four staff members skilled in providing delivery care to ensure 24-hour service.

In the course of its two phases the Initiative has progressively extended its intervention from 18 health facilities to the current total of 33, representing by WHO standards a more than adequate coverage of the four districts with EmONCs. Out of these, 26 are BEmONCs and seven – the four district hospitals plus three community hospitals managed by CHAM – are CEmONCs.

**RBF4MNH IS ONE OF THE MINISTRY OF HEALTH’S MAJOR ONGOING INITIATIVES**

To provide technical accompaniment to the Reproductive Health Directorate in planning and implementing RBF4MNH, the Ministry of Health, with funding from BMZ provided through KfW, contracted London-based Options Consultancy Services with their consortium partner Broad Branch Associates.  

From the start the Initiative has been conceived as a totally integrated and participatory intervention. Options’ small local team works out of a modest, glass-partitioned office space on the second floor of the Reproductive Health Directorate. One of the glass cubicles houses a senior official of the Directorate, who devotes over half her time as a member of the RBF4MNH team. The Ministry’s strategic positioning of the Initiative within the Reproductive Health Directorate enables communication and learning on RBF4MNH among the Ministry’s high-level decision-makers, even though the Initiative’s activities take place well outside the capital city. The Minister of Health and all Ministry Directors, as well as Members of Parliament, have visited the RBF facilities many times.

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8 What is different in Malawi’s system is that a BEmONC’s coverage coincides with the catchment area of the health centre in which it is located: thus BEmONCs do not function as reference centres for neighbouring non-BEmONC health facilities.

9 Including 5 CHAM facilities, added in Phase 2.

10 In line with standard KfW procedures, a tender agent supported the Ministry in the tendering process.
In the intervention districts, the four District Health Management Teams are the motor of RBF4MNH. In each district, day-to-day Initiative activities are supported by a District RBF Coordinator, a health professional working for the district. The four District Councils are close partners of the Initiative, and the District Commissioners supervise it four times a year on their own budget.

During the preparation phase, a participatory approach was used, involving village heads, traditional chiefs and first-line health facilities as well as district-level decision-makers in developing a concept adapted to local realities. Traditional authorities continue to play a major role in outreach to their rural constituents (pp.16 and 23-26).

As an initiative designed to test an innovative approach to inform Malawi’s health policy, with the possibility of being scaled up nationwide, RBF4MNH has a strong focus on monitoring and evaluation, as well as on learning from experience. In a participatory process, the team and its partners have adopted what could be described as a pragmatic, action-research approach, proactively adapting their model in response to internal, external and contextual challenges as these arise.

In addition to the core RBF4MNH team, government partners on all levels, as well as community structures and traditional leaders, actively participate in the learning process. Twice-yearly visits of Options’ technical advisors to the Initiative and an annual planning process which looks back as well as forward serve as mechanisms for joint reflection and review. With government and implementing partners, the main coordination mechanisms are quarterly meetings where representatives from all the districts (including implementers at different levels, district parliamentarians/councillors and technical assistants) gather to discuss progress and report back on the intervention. These are supplemented by ad hoc meetings in the districts to address specific challenges or issues – which can then also lead to changes in implementation.

In addition, the TRAction-funded independent impact evaluation by a research consortium including Malawi’s College of Medicine, and led by Germany’s Heidelberg University’s Institute of Public Health, followed the Initiative from its launch until 2015 with three rounds of data collection (Brenner, De Allegri et al., 2016).11 The Initiative team’s action-research approach also informed the impact evaluation’s ‘difference-in-difference’ research design12, which was able to cope with the changes and adaptations as Initiative roll-out continued (Corinne Grainger, personal communication).

### AN INNOVATIVE DESIGN COMBINING SUPPLY-SIDE, DEMAND-SIDE AND INVESTMENT COMPONENTS

The Initiative has three major components which together aim to increase quality and accessibility of MNH services.

#### Supply-side incentives

Supply-side incentives aim to optimise the effectiveness of the human resources engaged in MNH. The basis for the provision of incentives are Quality & Performance Agreements with the health facilities and with the District Health Management Teams, which are signed by the Director of Reproductive Health and the respective District Commissioner. These agreements set out a list of quality and performance indicators whose achievement is rewarded by RBF4MNH. Beneficiaries are situated on two levels:

- **Health facilities** receive monetary rewards13 for fulfilling indicators related to quality of care and health system improvements, of which 40% is given to the whole facility team for investment in the facility, and 60% provided in the form of individual bonus payments for both service providers and auxiliary staff. The facility teams decide themselves how the individual bonus payments are to be shared. The staff also decide as a team how to spend the ‘facility portion’ on useful purchases (e.g. hygiene products, drugs or, in some cases, even equipment or infrastructure) to improve their working conditions. Capacity development of EmONC staff is promoted by a system of supportive supervision, which strengthens technical aspects of service delivery, but also includes additional requirements of RBF approaches (recording and reporting data, monitoring, etc.) and interpreting performance and quality information.

- **District Health Management Teams** are rewarded for their effective management of the district as a whole, and not just with regard to RBF participating facilities. Emphasis is laid on their responsibility for supportive supervision and follow-up in all health facilities. The District Health Management Team’s reward, as in the health facilities, is divided between a ‘staff portion’ and a ‘facility portion’, the latter typically allocated to support district supervision and functioning.

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11 This study was funded by USAID under TRAction Cooperative Agreement No. GHS-A-00-09-00015-00 and by the Royal Norwegian Embassy in Lilongwe and NORAD. The contents of this study are the sole responsibility of its authors and do not necessarily reflect the views of USAID, the United States Government, the Royal Norwegian Embassy in Lilongwe or of NORAD.

12 Difference-in-difference estimation models calculate the effect of an intervention on an outcome by comparing the average change over time in the outcome variable for the intervention group to the average change over time for the comparison (control) group (Brenner, De Allegri et al., 2016).

13 CEmONCs are eligible for a larger amount than BEmONCs.
Performance management and verification are essential to all RBF interventions (see p. 11). The data provided by the EmONCs, once verified and confirmed, provide the basis for RBF reward payments to the facilities and District Health Management Teams. Participating health facilities submit monthly reports using data drawn from their registers. Data requested in monthly reports is mostly the same as presented through Malawi’s health management information system (HMIS). Supported health facilities also carry out self-assessments of Quality of Care and Infection Prevention based on a checklist, as well as client exit interviews with a minimum number of women. To avoid influencing women’s responses, exit interviews are carried out by community members rather than service providers. These procedures are meant to identify quality deficits and women’s perception of services provided, and findings are incorporated into quarterly facility plans for Quality of Care Improvement. All of this documentation provides the basis for a periodic external verification (see p. 20), including visits to each supported structure, which determines the amounts of rewards subsequently paid out by the Initiative. If fraud or errors are detected, the facilities where these occurred are sanctioned. The reward cycle is completed by a feedback meeting with health facility staff, members of the District Health Management Team and representatives of the District Council.

**Demand-side payments**

Conditional Cash Transfers (CCT) seek to assist pregnant women to defray costs for transport between home and the health facility, for delivery-related items, and for expenses during their stay in the health facility. To enable the new mothers and babies to remain under professional surveillance during the crucial hours following delivery, an additional sum is paid after 24 hours, and again after 48 hours in the health facility. The maximum payment per woman is approximately €7. The Initiative’s strategy for targeting CCT beneficiaries has evolved in the course of implementation to include poverty criteria (see p. 23).

Although in Malawi delivering in a public health facility is free of charge, KfW (2016) estimates the cost borne by a poor family – between transportation, board and accommodation away from home and opportunity costs for lost days of women’s work – as the equivalent of ‘50 working days, making it too expensive for any poor family.’ The Initiative team emphasises that the CCT paid to new mothers should not be seen as an incentive but rather from the perspective of Universal Health Coverage, as a preventive measure against precipitating a poor family into deeper poverty.

14 The results of the exit interviews are discussed by the facility team, who greatly value them as an instrument to improve quality based on the needs of clients. The focus for this tool is on the local level and the questionnaires are not shared with either the RBF4MNH office in Lilongwe or the district teams.

15 This perspective on CCT to combat poverty is shared with another KfW programme, which supports the Malawian Government’s Social Cash Transfer Sub-Programme targeting 10% of extremely poor households in seven other districts (German Embassy, 2016).
**Investment in equipment and infrastructure**

This was designed to be a preliminary measure to bring the intervention EmONCs up to a minimum standard for ensuring emergency obstetric care. All facilities have received delivery and hospital beds and other essential furniture, examination and sterilisation material, and life-saving equipment such as forceps and neonatal oxygen masks. CEmONCs have received in addition equipment to make operating theatres more functional. Infrastructure improvements have included, among others, electricity and water supply, enlarged delivery and post-partum wards, construction or renovation of maternal waiting hostels, and in the district hospitals construction of labour suites, additional operating theatres for Caesarean sections, and High Dependence Units for stabilising emergency cases. To ensure continuing functionality of the newly installed equipment, electric and water systems, the Initiative has also provided support to the four district maintenance teams.

Another major facet of the Initiative’s communication approach has been its alliance with the hierarchy of traditional chiefs. The influence of this powerful network of traditional authorities extends well beyond its respective cultural communities to encompass all levels of government and society. The RBF Advocacy Team, consisting of high-ranking traditional chiefs representing the four districts under the leadership of Paramount Chief Gomani V of the Ngoni Maseko ethnic group, was launched by the Initiative through the District Councils in 2015 and has reinforced the ties between the Initiative and local communities (see pp. 23-26).

This constellation of components in an RBF health project is exceptional, associating as it does a supply-side with a demand-side component, complemented by investment and cross-cutting communications and advocacy work. How has this innovative design been translated into reality and which challenges did it encounter on the way?

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**STRATEGIC COMMUNICATION ACCOMPANIES THE INITIATIVE AT ALL LEVELS**

This dimension of RBF4MNH is cross-cutting and accompanies the three components at all levels. The Initiative team brings creativity and diplomacy to the tasks of lobbying, networking with strategic partners and decision-makers and forging strong bonds with decentralised structures and stakeholders. Culturally sensitive awareness-raising campaigns and a judicious interplay with the written and audio-visual media keep the population in the target districts and the wider public informed about the Initiative’s objectives, activities and achievements. Thanks to its regular media exposure, the Initiative has gained a high and positive profile in Malawi, which enhances its credibility within the Ministry and with other key partners.
The flexibility and creative problem-solving of the Initiative team have come to the fore in dealing with a multitude of greater and smaller challenges encountered during implementation. This chapter focuses on the more important ones and how these led to continuous adaptations and improvements in the RBF4MNH approach.

EMBRACING AN ACTION-RESEARCH APPROACH FOR CONTINUOUS LEARNING

The RBF4MNH team’s flexible implementation approach was strategically developed in discussions with KfW and the Norwegian Agency for Development Cooperation (NORAD). Since RBF was relatively new to Malawi, for partner mastery and ownership it was considered more promising to make introduction of the approach a shared learning process. The intervention design was therefore somewhat open-ended, rather than being fine-tuned before embarking on implementation. As a consequence, the fine-tuning of the strategy took place during implementation itself, whenever planning confronted an unexpected or changing reality. This situation fostered great agility and cohesion on the part of the Initiative team and its partners, who were systematically associated in the reflection and decision-making process. A plus has been the exceptional stability of the RBF4MNH team, whose Malawian members including the Directorate’s RBF Liaison Officer have been with the Initiative since its design phase.

A pattern emerges in which the team’s pragmatic approach repeatedly transforms constraints and setbacks to the Initiative’s advantage, sometimes in unexpected ways. One of RBF4MNH’s greatest strengths – its embedding on district level – was considerably enhanced by the team’s proactive adaptation to two unforeseen challenges:

- The lack of a budget to hire District RBF Coordinators, who were initially planned to be employed by the Initiative. This problem was solved by transferring to the District Health Management Team the responsibility for assigning a member of their personnel as District RBF Coordinator, ensuring ownership and integration of the Initiative within the district health system.

- The Initiative had established strong working relationships with the four District Commissioners. But in May 2014 there was a sudden change in District Council organisation, with newly elected District Councillors taking on a decision-making role. The team rose to the challenge of broadening the palette of their district-level interlocutors. They promptly organised RBF4MNH orientation sessions for all the new councillors from different sectors and walks of life. This diversity further reinforced the Initiative’s decentralised presence, with each District Council creating a dynamic RBF sub-committee (Berk, 2015).

FINE-TUNING INDICATORS TO ENHANCE STAFF PERFORMANCE

Managing incentives to enhance performance of health staff is at the heart of the RBF4MNH Initiative. Over the two phases, there has been a progressive refinement of the reward indicators and their definitions. The team and its partners analyse performance against every indicator – reviewing progress by the different facilities/teams, looking at whether the definition remains appropriate, and whether to make changes.
The principle is that formulating an indicator with its respective weighting (what percentage of the reward payment does it represent?) will focus staff attention on the targeted behaviour. For instance, measuring (and rewarding an increase in) the number of women who stay in the facility 48 hours after delivery led to a rapid rise from 0 to 87% on this indicator, well before introduction of the CCT that facilitates women’s stay. Indicators focussing on functioning equipment and water supply were added to enhance attention to maintenance issues, and an indicator on keeping stock cards up to date has been successful at improving management of drugs and commodities.

Conversely, an indicator can be removed for activities that no longer need to be incentivised: to focus increased attention on surveillance of newborns, the indicator on providing Vitamin A was replaced by one on checking newborns’ vital signs twice daily for 48 hours. Similarly, since the indicator on administration of a uterotonic in third stage labour was constantly fully achieved, this indicator was removed.

As a small operational research to see whether the performance would drop, the team continued to monitor this indicator after removing the link to reward payments: performance did not alter in the year following removal.

BOX 3. INDICATORS (SUMMARISED) AS CURRENTLY APPLIED IN RBF4MNH FOR DISTRICT HEALTH MANAGEMENT TEAMS, BEmONCs AND CEmONCs

District Health Management Teams

1. Total number of facility-based deliveries recorded across the district remains stable or increases.
2. Percentage of all EmONcs having a minimum of one month’s supply of essential MNH medicines and commodities on day of verification.
3. Essential equipment is in operating condition in all government-owned RBF-supported EmONCs.
4. Percentage of HMIS 15 reports from the health facilities that are submitted on time to the district health office.
5. Percentage of HMIS 15 reports that are complete and accurate submitted to the district health office.
6. Running water in all government-owned RBF-supported EmONCs on day of verification.
7. Functional electricity in all government-owned health facilities on day of verification.
8. All health facilities must have received supportive supervision by District Health Management Team during the quarter, with at least two actions taken by District Health Management Team.

BEmONCs and CEmONCs

1. Increase in facility-based deliveries by 2.5% compared to the same quarter of the previous year (only for BEmONCs with under 85% IDR).
2. Partographs completely and appropriately filled out.
4. Newborn deaths properly audited.
5. HIV testing – and if necessary PMTCT treatment – of expectant mothers with unknown HIV status.
6. Women with signs of pre-eclampsia treated with Methyldopa.
7. Women with signs of eclampsia treated with Magnesium Sulphate.
8. Newborns checked twice daily for 48 hours after birth.
9. Total number of users of modern family planning methods increased by 1% compared to the previous verification period.
10. Stock cards of essential MNH medicines and commodities up to date and complete.
11. HMIS reports submitted on time to the district health office.
12. HMIS reports are complete and accurate.
13. RBF reports submitted on time to the district health office.
14. RBF reports are complete and accurate.
15. Water problems in maternity ward repaired within 7 days after loss of function.
16. Broken maternity equipment repaired within 7 days after loss of function.
17. Use of Infection Prevention and Delivery Quality Checklist (filled out and two actions taken).
18. Use of Client Exit Questionnaire (20 filled out and two actions taken).
19. Percentage of newborn babies with asphyxia resuscitated during the month of reporting.

16 Prevention of Mother To Child Transmission of HIV.
17 This indicator does not apply to CHAM facilities, which do not offer family planning.
A striking case of indicator adjustment concerned the Institutional Delivery Rate (IDR). At the time of planning the Initiative in 2010, IDR stood at a low 71%, and increasing IDR was formulated as a priority for the future intervention. Thus, in the first Quality and Performance Agreements, the prime indicator (representing 55% of the reward) applied to all BEmONCs was to increase facility deliveries by 5% every year. This turned out to be unrealistic, since in the meantime Malawi’s IDR had gone up to practically 90% – a rate almost impossible to top in sub-Saharan Africa. This situation rapidly led the Initiative team to nuance its approach: since most of the supported facilities had an IDR of 90% or above, they continued to apply the indicator on increasing IDR only for those health facilities that had an IDR of less than 85%.

Given the poor performance results of the first verification cycles, which led to some discouragement on the part of health workers, the District Health Management Teams and the Ministry advocated for changes to be made in the way indicator attainment was rewarded. Following discussion among partners, the evaluation approach was then changed from ‘target-based’ (all-or-nothing achievement) to ‘performance-based’, which rewards progress made. This more flexible approach ensures that effort is rewarded and thus reduces frustration.

**ADJUSTING REWARDS TO MAXIMISE MOTIVATION, LEARNING AND TEAMWORK**

The Initiative’s continuous learning from implementation has also been reflected in its gradual adjustments of the monetary incentives paid to facility staff. Based on a review of RBF designs in other countries, the maximum individual rewards were calculated to represent approximately 15–25% of the staff member’s take-home pay – an attractive but not disproportionate motivation to fulfil the performance and quality criteria. When confronted by the inflation of the Malawian currency and rising costs, the Initiative significantly raised the reward amounts for each structure, both to maintain individual motivation and to enable the purchase of more expensive items with the facility portion of the reward.

The internal composition of rewards has likewise been adjusted. For the BEmONCs, the facility portion – which plays an important role in promoting teamwork and ensuring minimal functioning (see below p. 21) – has been increased from 30% to 40% of the reward. Although this reduced the staff portion from 70% to 60%, the individual bonus has actually risen somewhat due to the increase in the total envelope for the health facility.

CEmONCs’ rewards now apply these same proportions, with the facility portion going only to the CEmONC team rather than – as previously – to the district hospital as a whole. This change allows the CEmONC team to invest in quality improvements relevant specifically for the maternity department, while the rest of the district hospital is still supported by the overall operating budget received from the Ministry.

The fact that the reward is attributed to the EmONC as a whole, rather than on the basis of individuals’ performances, has promoted teamwork. Improved collaboration is incentivised by enabling the whole team (including support personnel) to benefit from the reward payments, which are perceived to be the result of a team effort. In discussions with facility team members, including lower-level personnel, the external evaluation determined that teamwork is the aspect most often cited by them as a direct result of the intervention (Brenner, De Allegri et al., 2016).

Nonetheless, especially toward the beginning of the Initiative, sharing of personnel bonuses has sometimes led to conflict (Ibid., Progress Report 7-12/2015). This problem has been particularly complex to manage in district hospitals, where not only maternity personnel but also personnel from other departments contribute to safe deliveries.

This situation was improved when the Initiative team together with the Directorate developed non-binding guidelines for sharing rewards, which are appended to the Performance Agreements. Each health facility team was instructed to prepare and apply its own Reward-Sharing Scheme reflecting the proportionate contribution of each category of staff, to be approved and monitored at the district level. Experience has shown that facilities can work out systems for sharing the reward payments which function well and with time become embedded in practice.

After the first three six-month reward cycles, perceived as too long by the beneficiaries, the Initiative reduced the verification cycle to every three months to keep up motivation by more closely linking performance and reward.

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18 The IDR refers to the proportion of deliveries – out of all deliveries expected in the catchment area of a given health facility – that take place in this health facility. The estimate of expected deliveries is based on the annual population growth – 3.1% for Malawi – and the Crude Birth Rate, estimated at 50 births per 1000 inhabitants per year (MoH, 2015).

19 It is possible that this high IDR might be somewhat overestimated, since often births on the way to the health facility are recorded as births in the health facility (Corinne Grainger, personal communication).

20 In early 2016 the Initiative’s total reward envelope (in the national currency) was raised by 58% (Progress Report 1-6/2016).

21 The Ntcheu RBF Coordinator mentions an incident where an ophthalmologist at the district hospital refused to consult a newborn because he was not among personnel benefitting from the RBF bonus.
CONTROLLING FOR POTENTIAL NEGATIVE EFFECTS OF INCENTIVES

In addition to their positive impacts, incentive systems are also at risk of creating distortions: these are the phenomena of ‘gaming’ – when stakeholders seek to manipulate the system to their own advantage – and of ‘crowding out’, when people neglect non-incentivised activities (cf. p. 11). The concern is that incentives might weaken intrinsic motivation (e.g. helping the client, quality service, learning) in favour of extrinsic motivation (performing the minimum to obtain a reward).

To monitor the risk of crowding out, the Initiative analysed data on non-incentivised services: immunisation of children under one year and the proportion of pregnant women receiving malaria prophylaxis. The data showed that 'the staff did not prioritise delivery care to the detriment of other services' and that immunisation coverage actually increased (Progress Report 1-6/2016).

The verifications and supervisions have found no incidents of fraud to date, and relatively few cases of ‘gaming’ – dishonest reporting in an attempt to manipulate the system. As stipulated by the Quality Performance Agreements, when such incidents are discovered, the facility as a whole is punished by removing that indicator from the calculation of its reward. Legal action is also mentioned as an option in the Performance Agreements but has never been invoked. Furthermore, the culprits are publicly ‘named and shamed’ in reward feedback meetings with the District Health Management Team. This aims to encourage collective responsibility of the facility team for ensuring honesty and improvement.

The main example of gaming encountered by the verification team has been filling out partographs after the women delivered in order to meet the partograph indicator. When the verification team goes out to verify the reported results for the previous cycle, they now also randomly select partographs from the current period (including the day of the visit). If the documents cannot be found or if it is clear that the partographs were filled out after the birth (the verification team includes members with medical training) then the scores for that facility are adjusted down and a lower reward is earned. However, the programme team also then work with the facility team to address this problem and support them to improve the indicator.

The findings of the Heidelberg-College of Medicine impact evaluation suggest that RBF4MNH did not lead to crowding out of intrinsic motivation among health workers (Brenner, De Allegri et al., 2016). The impact evaluation describes a situation of ‘increased extrinsic motivation while intrinsic motivation remains unchanged.’

OPTIMISING PERFORMANCE VERIFICATION TO ENSURE ACCOUNTABILITY AND MAINTAIN TRUST

Regular, effective and impartial verification of performance is essential to ensure trust and maintain motivation on the part of beneficiary partners. Between April 2013 and March 2017 there have been 13 reward cycles, whose results have been disseminated within the four intervention districts.

For the first three cycles, the verification was carried out as a reciprocal process among the four districts: ‘peer review’ teams of nurses and clinicians from two RBF4MNH districts verified the other two districts and vice-versa. This had the advantage of being timely, cost-effective and capacity-building for the Malawians in the peer review team.

The objectivity and acceptability of the peer review approach were, however, criticised by the personnel being verified – the health workers found it difficult to accept each others’ judgments.

As a consequence, the verification system was changed from the peer review approach to an external audit – an assignment that was tendered out internationally and won by a Ugandan firm. Although this approach is more expensive and logistically complex (every three months two auditors arrive from Uganda and hire 12 Malawians to carry out the physical verification in the districts, including in a sample of non-RBF facilities and in the communities), it is better accepted by the health personnel. Now there are hardly any complaints of unfair notation: in such cases, the results are re-verified by the Initiative team and the District Health Management Team, and they are generally found to be close to the original assessment.

ADDRESSING SCARCITY AND HIGH TURNOVER OF PROFESSIONAL STAFF

Scarcity and high turnover of professional staff are fundamental problems in Malawi’s health sector, both in health facilities and on district management level. This challenge strongly affects the Initiative: rapid turnover dilutes the effect of capacity-building measures, and RBF institutional memory is constantly being lost. New personnel repeatedly need initiation, increasing costs for supportive supervision, coaching and refresher courses.

To address the problems related to high staff turnover, the Initiative team has focused on capacity development for teams as a whole rather than for selected individuals. One of the most effective ways in which the Initiative addresses this is to train RBF District Coordinators and health personnel to set up training teams as a whole rather than for selected individuals. This approach was successful in the first three cycles, when the District Health Management Team was responsible for setting up training teams. However, the approach was not as successful in the next four cycles, when the Initiative team was responsible for setting up training teams. This highlights the importance of involving the District Health Management Team in the capacity development process.

Personal communication, RBF4MNH Evaluation Officer Mabvuto Mndau.

For instance, in the first six months of 2016 one District Commissioner, two District Health Officers and three District Medical Officers were replaced in RBF4MNH’s intervention districts. (Progress report, 1-6/2016).
facility RBF Desk Officers to train and orient new staff, with the support of the Initiative team from Lilongwe.

Training for EmONC personnel, e.g. on managing cash in the health facility (see below p. 23), is provided simultaneously to all members of staff, and the Initiative team has involved and trained the entire District Health Management Team in each district to maximise continued familiarity with the approach.

To counter the very real risk of insufficient skilled staff to ensure 24-hour delivery assistance, the Initiative conditions its support on the presence of at least four such skilled birth attendants in each intervention health facility. The initial agreements with the District Health Management Teams reduced their rewards by 10% for each EmONC that dropped out of the programme for not fulfilling these admissibility criteria, and in some cases districts have shifted personnel from non-targeted health facilities to RBF facilities.

The measures introduced by RBF4MNH to improve performance - monetary incentives, supportive supervision and collaborative planning of the ‘facility portion’ – also aim to increase motivation and job satisfaction on the part of health personnel, a dimension that is regularly monitored by the Initiative (see below p. 30). The hope is that increased health worker satisfaction will lead to less turnover.

**EMPOWERING FACILITY TEAMS TO IMPROVE AND MAINTAIN THEIR WORKING ENVIRONMENT**

Equipment and infrastructure are only useful if they are in working order, and keeping them so has been a general challenge for Malawi’s health services, due to both financial and organisational factors. Similarly, health care can only be provided if the necessary drugs and commodities are on hand. Accustomed to depending on the limited inputs trickling down from the Ministry hierarchy, health facility staff were in the habit of ‘making do’ with what was available – or not. Their situation did not encourage them to proactively attempt to improve their environment.

This changed with the arrival of the Initiative. While waiting for its investment component to raise the standard of care in the targeted health facilities, the Initiative introduced an equally important measure to respond to the urgent need for essential inputs to ensure functioning of basic health services. This was a special one-time start-up grant, equivalent to 30% of the maximum yearly reward, paid out to each health facility upon first signing of their Quality and Performance Agreement. This grant was to be managed similarly to the facility portion.

This was the staff’s first experience of working together to analyse the needs of their health service and to decide how to spend a large sum of money to improve the functioning of the facility. The fact that the facility team have their own budget empowers them and instils in them a sense of responsibility and entrepreneurial spirit, so that they begin to come up with their own solutions to infrastructure and equipment problems.

Individual health facilities’ directly managing cash is completely new in Malawi. Although there is close oversight by MoH and District Health Management Team on how the funds are spent, there are no bureaucratic constraints preventing health facility teams from using the total amount of their facility portions as they themselves choose, to improve their working conditions.

Staff are now used to using the facility portion of their reward to ensure that they have the material means to get the job done. Some CHAM facilities have been particularly successful at saving part of their rewards in order to invest in larger-scale projects such as building new staff housing. One health facility was able to fund the construction of a maternity waiting home by saving several cycles of their facility portion. Others have used their facility portion to repair broken equipment or to improve quality of care from the women’s perspective by, for instance, buying curtains for privacy and improving hygiene.

From the start, the Initiative has placed emphasis on the importance of repair and maintenance and on a direct connection between the health facilities and the district’s Maintenance Officer. Prompt reporting and repair of defective installations and equipment are included among reward indicators.

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24 So far there has been only one case where a BEmONC was temporarily removed from the programme.
BOX 4. DISTRICT STAKEHOLDERS SEE ‘TREMENDOUS ADVANTAGES’ IN RBF4MNH

It is Monday morning, time for the Dedza District Health Management Team to plan their weekly activities. In the district hospital’s small meeting room, Dr Solomon Jere, District Health Officer, is joined by several District Health Management Team members.

‘RBF’s investments in equipment and infrastructure have brought our District Hospital up to standard,’ says Dr Jere. ‘And functioning is helped by the facility portion: it is even used to buy fuel for the ambulance and the operating theatre’s generator.’ Dr Jere continues, ‘But where the contract with RBF has been most beneficial is supportive supervision. Now we supervise each health facility in the district once per quarter using the RBF checklist and we agree with the staff on an action plan. We then leave both documents in the facility for the external verification. RBF has ensured that our supervision is more consistent, and now it is always carried out – thanks to the resources of the facility portion of our reward.’

Zenaida Phiri, whose lacy white cap identifies her as the District Nursing Officer, chimes in. ‘The evaluators give us the true picture of how we perform. The rewards motivate staff members to check on each other to ensure that their health facility gets a high bonus.’ She proudly adds, ‘In the most recent cycle, Dedza District was number one among the four districts, and our District Health Management Team was number two.’

Goodmore Nyirenda, District RBF Coordinator, interjects, ‘What is also important is our stronger relationship with the community. Through the revitalised Health Facility Advisory Committees, community representatives check on drug management to avoid pilferage in the health facilities. Since our District Health Management Team is closely linked to the District Council, even the District Commissioner was involved in training communities on our new CCT approach.’

James Jones Kanyangalazi and Auzious John Chidobvu, respectively District Commissioner and Chair of the Dedza District Council, see ‘tremendous advantages’ in the RBF4MNH approach. ‘We appreciate that when new district councillors were elected in 2014, we were all trained by the Initiative on the CCT approach,’ explains Mr Auzious. ‘District and ward councillors were involved in sensitisation on RBF, and we work hand in hand with the traditional chiefs. Women are now attracted to deliver in health facilities, because of improved quality.’

The District Commissioner adds, ‘There were standards, but they were not being followed. We see the positive impact of the indicators and the constant evaluation. Our only concern is about the selection of the BEmONCs: our population complains that there are too few. Because of the mountainous barriers in Dedza District, over the past three years the Initiative has increased the supported health facilities from four to seven and now to 11 including two CHAM facilities. Still our population wants more, and we as government can’t tell them that there will be no further expansion.’
ENABLING HEALTH FACILITY STAFF TO MANAGE CASH

Keeping cash in a health facility was unheard of in Malawi. But when administrative restrictions made it impossible to set up bank accounts for the RBF health facilities, this became necessary – to manage both the facility portion and the payments of the CCT to eligible women.

Initially planned to start at the same time as the Quality Performance Agreements, the demand-side component was finally launched after the end of the first reward cycle in September 2013. This delay was mainly due to the difficulty of putting in place a system to allow health facilities to keep and manage cash.

In each EmONC a safe and burglar bars had to be installed, and the staff needed to master the standard operating procedures for managing the funds. The Initiative team invested in this learning process through intensive coaching, training, supervision and audits. In each health facility one staff member is designated as RBF Desk Officer, responsible for managing the cash, but all staff are trained and involved in checking on the funds and their use. This ensures collective monitoring of the funds as well as continuity if the RBF Desk Officer is absent or moves away.

Prior to the intervention, health facilities in Malawi were not accustomed to having funds on hand and deciding how to use them. The increased autonomy of the facility teams to decide both how to divide the individual bonus payments and how to invest the facility portion of the reward supports Malawi’s ongoing decentralisation process.

OVERCOMING FEARS AND MISCONCEPTIONS ABOUT PAYMENTS FOR DELIVERIES

Even before the launch of the demand-side component, the Ministry’s Family Planning Programme expressed concern that ‘paying women who deliver in health facilities’ would counteract the effect of its Family Planning campaigns, which with an estimated 59% contraceptive coverage in 2015 (NSO and ICF International, 2016) were finally raising hopes of reining in Malawi’s rapid population growth.

In response to these expressed worries, the Initiative team reviewed the situation and determined that there is no evidence to show that CCTs for institutional delivery lead to increased fertility. A key breakthrough was helping the Family Planning Programme to understand that RBF-4MNH is not ‘paying for deliveries,’ but making a small contribution towards the costs incurred in getting to and staying at the facility. This is quite a different perspective. At a later stage the Heidelberg-College of Medicine impact evaluation (Brenner, De Allegri et al., 2016) confirmed that the CCT amount (approximately €7) is rightly perceived by the beneficiaries as too small to be an incentive to fall pregnant.

In order to further convince the critical voices that this concern about motivating women to become pregnant has been addressed, the family planning indicator (‘Increase in total number of users of modern family planning methods’ – see Box 3) was added, creating an incentive to EmONC personnel to encourage this important measure for maternal and child health.

On the community level, the cash transfers were initially met with a great deal of suspicion. Doubting that money would be given without expecting something in return, speculation and rumours arose, e.g. that CCT is ‘devil’s money’, that it is to ‘buy the placenta’, or that women ‘get more money for a son’. To reassure the potential beneficiaries and their communities, the Initiative team turned not only to the health and administrative officials, but also to the most effective intermediaries with the population: their traditional chiefs. This was the start of a close and productive association, including the creation of the Advocacy Team (see p. 16), and ever since, new interventions are systematically preceded by community mobilisation.

Although traditional chiefs and community representatives had been consulted since the design phase of RBF4MNH, it was in responding to the concrete problem of confidence raised by communities in reaction to the CCT that they themselves became part of the Initiative’s design.

REACHING OUT EFFECTIVELY TO POOR EXPECTANT MOTHERS

The demand-side payment (CCT) was an integral part of the original Initiative design. The objective was to work on both the demand and supply sides to improve the quantity and quality of safe motherhood services – countering the factors that contribute to sustained high maternal and neonatal mortality despite Malawi’s IDR of nearly 90%. Prior to the intervention, women were arriving very late for delivery – often with complications – and were leaving the facility immediately after delivery.
The CCT was designed to overcome financial barriers (the intervention districts are all rural and poor) to enable women – in line with MoH standards – to come on time for delivery and to remain for 48 hours, a critical time for the health of the mother and baby. The separate parts of the payment target the different factors contributing to a positive outcome:

- Access to the EmONC: contribution to transport cost
- Early arrival: initial payment for delivery supplies and stay in waiting home
- Stay for 24 and 48 hours after delivery: the two post-natal payments.

Until October 2015, the CCT targeted all pregnant women residing in the catchment areas of RBF facilities without specific poverty targeting. As the external evaluation observed, poverty is deep and fairly uniform in Malawi, particularly in rural areas, so nearly all clients can be expected to be poor.

Because of the delay in setting up cash management in the health facilities (see p. 23), the CCT was introduced in September 2013, six months after the supply-side measures. Once the CCT was up and running, it emerged that too few women were actually receiving the cash contributions. Despite the extension to 33 RBF facilities, the Initiative team calculated that only 72% of women in the four districts were within their catchment areas. And of these eligible women, only about half were able to benefit from the CCT because their place of residence needed first to be confirmed through a lengthy and inefficient verification process by the EmONCs’ Health Surveillance Assistants, auxiliary staff members who work in the community.

At the community level, the initial lack of poverty targeting for CCT attribution was perceived as an inconsistency: it was seen as only fair that women with a steady income (such as a teacher) or with the means to hire labour be excluded from the CCT.
Analysis of these different problems led the Initiative team to rethink the CCT approach as a **community-based strategy**. In collaboration with a working group of community members under the leadership of Paramount Chief Gomani V, and with support of an external demand-side financing specialist, the Initiative developed new eligibility criteria to identify poor women.

In the new approach, women are eligible for CCT independently of their place of residence as long as they are Malawian citizens from the district and deliver in an RBF-supported EmONC. The woman’s poverty status is assessed by the Village Health Committee following specific poverty criteria (in order to benefit from the CCT, women only have to meet one of the below-mentioned criteria):

- Neither she nor her husband is employed and/or has a viable business.
- She is single, not employed and has no viable business.
- She has a generally food-insecure household most of the period in a year.
- She has a high dependency ratio of more than five dependents.
- She has physical disabilities that hinder her productivity.

Given that the majority of people in rural areas are subsistence farmers, these criteria apply to nearly everyone. Since the village chief’s stamp on the woman’s CCT card indicates her place of residence (within the district), verification by Health Surveillance Assistants is no longer necessary.

The idea is not that the CCT is targeted at the very poorest. The idea for the restructured CCT is to exclude only those who can easily pay the costs associated with an institutional delivery, while not being overly concerned with inclusion errors. The most important aspect of the new approach is its systematic implication of the communities and their traditional chiefs, ensuring local ownership. In this new approach women are encouraged to inform their Village Health Committee as early as possible of their pregnancy, confiding for instance in a ‘secret mother’ (often a former Traditional Birth Attendant) who will be their intermediary with the committee and the traditional authority. If the woman meets the poverty criteria, they send her to an RBF-supported EmONC, where her pregnancy will be confirmed, she will register for the CCT and start her antenatal consultations. Independent verification of the women’s poverty status has been entrusted to local community-based organisations who verify a sample of the women.

Initiative partners are confident that with this approach many more poor women will be able to benefit from the CCT, while the traditional chiefs are confirmed in their leadership role.

The restructuring of the CCT has been the Initiative’s opportunity to engage with the community, its structures and leaders, bringing them into the network of actors enthusiastic about improving quality and accessibility in their local MNH facility. This has been reflected in a revitalisation of the Health Facility Advisory Committees, which are largely composed of community members, one of them taking on the role of ombudsman to mediate complaints, conflicts and suggestions on the part of health facility users.

The new CCT approach was introduced starting in January 2016. Accompanied by a lively community awareness campaign, including distribution of brochures, posters, T-shirts and bright green chitenjes decorated with the Initiative logo, thousands of members of Village and Area Development Committees and group leaders, as well as health personnel, were oriented on the new approach, which is now uniformly applied throughout the four districts.

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25 Extending access to the BEmONC service beyond the catchment area of the health centre moves closer to the WHO model of the BEmONC as a reference centre accessible to the population of non-EmONC health facilities.

26 The RBF4MNH Advocacy Team now targets ‘secret mothers’ with appropriate training (Progress Report 1-6/2016).
BOX 5. TRADITIONAL CHIEFS – KEY PARTNERS FOR COMMUNITY MOBILISATION

The five-member RBF Advocacy Team, entirely composed of traditional chiefs, encourages behaviour conducive to reproductive health among their constituents in the four districts. The president and vice-president of this unique team share their perspective on their mission.

Senior Chief Kachindamoto 7, vice-chair of the Advocacy Team, is in charge of 551 villages in Dedza District. A colourful personality, she has founded her own Kachindamoto Band with hand-made musical instruments to animate sensitisation events. Gathered in a shady grove in the Senior Chief’s village of Ntakataka, different community groups speak out in favour of antenatal care and delivering in a health facility, encouraged by traditional ‘secret mothers’ and ‘secret fathers’. Senior Chief is a strong advocate for girls’ education. Young girls sing songs in Chichewa against early marriage and girls’ dropping out of school. The Initiative’s Chichewa name – *Uchembere wa ngwiro* – comes up frequently, emphasising reproductive health.

Senior Chief praises RBF4MNH: ‘The Initiative helps rural people who have nothing – so many women have only one chitenje. When they come to deliver, they find soap on the table, and with the CCT they buy a clean wrapper and things for the baby, and pay for bike transport to the maternity.’

‘Our Advocacy Team spreads the word that women should deliver in a health facility. We insist that people uphold the Government’s law against marriage before age 18. We go around to all four districts, visit hospitals, and sit with doctors and nurses and pregnant mothers. We have also talked with Members of Parliament: I am in touch with the chair of their health committee, who is a registered nurse.’

The chair of the Advocacy Team is a soft-spoken, yet resolute, 20-year-old university student. At age 14, on the death of his father, he became Paramount Chief Gomani V of the Ngoni Maseko, a major ethnic group extending from Malawi into Mozambique and Zambia. One of his goals is to uniformise bylaws within the Ngoni area, e.g. fines for getting a girl pregnant. Studying to become a teacher and to work with young people, he uses Facebook to reach youth. He points out, ‘Sixty-five per cent of our population is under 25. Youth know what is right and wrong, but sometimes the choice is hard.’ Gomani V advocates for patients’ rights: ‘People should report to the ombudsman of their health facility if health workers have a bad attitude.’

What is the essence of the strong link between traditional chiefs and their constituents? Says Paramount Chief Gomani V, ‘Your people are the most important thing to have around you. You can hate your government, but not your chief.’
What did RBF4MNH achieve?

The RBF4MNH Initiative’s overall objective ‘Women deliver increasingly in targeted health facilities, where maternal and neonatal services of good quality are offered’ is to be attained through improvements in the output areas of access, quality, and staff motivation. This chapter will summarise the Initiative’s results in these three domains, citing findings from complementary sources:

- **The internal monitoring of the RBF4MNH Initiative including the annual Joint Quality Assessments conducted with the GIZ health programme.** The RBF internal monitoring follows a limited number of specific output indicators in addition to the different reward indicators (cf. Box 3). A constraint is the uneven quality of the reporting on the part of the health facilities (Progress report 1-6/2016).

- **National statistics such as the Demographic and Health Survey 2015 and the EmONC Needs Assessment 2014.** Such statistics can provide valuable benchmarks against which to assess progress and effects of a particular project or region. They are, however, rarely detailed (or recent) enough to reflect impact of a given project in a specific zone or district.

- **The impact evaluation by the Heidelberg-College of Medicine consortium.** This long-term assessment followed the Initiative from 2013 to 2016 through baseline, midline and end-line studies of the 18 first-phase RBF EmONCs in comparison with unsupported control EmONCs in the same districts (Brenner, De Allegri et al., 2016).


ALL POOR WOMEN CAN HAVE ACCESS TO QUALITY MATERNAL AND NEONATAL CARE, INCLUDING TO CARE FOR DELIVERY-RELATED EMERGENCIES

With the extension to 33 RBF facilities realised by 2016, 72% of women in the four districts live in the catchment area of an EmONC offering quality maternal and neonatal care. Since in reality women can deliver in any facility that they choose, the RBF facilities’ services are, in principle, accessible to all of them. With the new CCT approach introduced in 2016, the financial barrier has been reduced for 100% of poor women residing in the district.

By December 2016, a total of 77,103 women had benefited from the CCT. In the first semester of 2016, 64% of the women who delivered in the RBF EmONCs were CCT recipients.

All 33 RBF EmONCs provide the requisite number of MNH signal functions (seven for BEmONCs, nine for CEmONCs – cf. Box 2) allowing their personnel to deal with delivery-related emergencies. This is an important accomplishment: the 2014 country-wide EmONC Needs Assessment (Ministry of Health, 2015) recognised only 45 out of 87 hospitals (52%) as CEmONCs and only 19 of 464 health centres (4%) as BEmONCs.

Since 2014 100% of deliveries in RBF-supported EmONCs are attended by skilled health providers.

THE DISTRICTS’ AVERAGE IDR REMAINS STABLE AROUND 90% BUT MANY MORE WOMEN DELIVER AT RBF FACILITIES

While at the time of the Initiative’s planning (2010) Malawi’s IDR was at a low 71%, by the time it started its activities a variety of measures had helped boost it to 90% (NSO and ICF International, 2016).
In individual BEmONCs and CEmONCs supported by RBF, the IDR can rise even above 100%, reflecting increased attractiveness of the health facility as well as an influx of women coming to deliver from Zambia and Mozambique, which border three of the four intervention districts. In the first semester of 2016, women from outside Malawi represented about 5.3% of the 27,154 deliveries that took place in RBF facilities (Progress Report 1-6/2016).

Although it has not been possible to increase overall IDR significantly beyond the already very high level of 90%, the Heidelberg-College of Medicine impact evaluation found several indications of an impact of the improved quality of RBF facilities on service utilisation:

- During the impact evaluation study period, non-RBF BEmONCs (control facilities) increased their referrals of expectant mothers on average from 15% to 22% between 2013 and 2015 to the district hospitals, which participate in the RBF4MNH as CEmONCs. Referring staff explained that their patients would receive better service in the RBF-supported CEmONC. This finding was confirmed by women in focus group discussions, reporting increased referral patterns. (Brenner, De Allegri et al., 2016).

- By contrast, RBF-supported BEmONCs maintained a referral rate of only 15%, indicating an improved capacity in these BEmONCs to handle complications related to delivery (Ibid.).

- Women noticing a disturbing symptom during pregnancy were swifter (by several days) to seek care in RBF EmONCs than in control facilities (Dr. Jobiba Chinkhumba, personal communication).

Preliminary findings of the impact evaluation indicate that with sustained high utilisation rates of RBF-supported EmONC facilities, the RBF4MNH Initiative appears to have produced a positive change of about 10% over the two-year observation period. This means that in intervention areas, about 10% more women had access to an EmONC delivery of satisfactory quality – an unusually high improvement in outcome in just two years (personal communication, Manuela De Allegri).

28 What did RBF4MNH achieve?

29 As a consequence, the CEmONCs, where 21% of all institutional deliveries take place in Malawi (MoH, 2015), had to handle a significantly larger number of deliveries.
EIGHTY-SEVEN PER CENT OF WOMEN STAY THE FULL TWO DAYS AFTER THEY HAVE DELIVERED AT THE FACILITIES

The Initiative encourages and enables mothers who have delivered to stay for 48 hours at the facility to permit resting and follow-up of mother and newborn during the crucial hours after birth when most complications occur. From a baseline of zero at the start of the Initiative, the proportion of women who follow this recommendation immediately shot up and since 2013 has remained stable at around 87%.

THE PROPORTION OF MATERNAL AND NEONATAL DEATHS APPEARS TO BE DECREASING AND THOSE WHICH OCCUR ARE AUDITED

During the first six months of 2016 a total of 27,412 live births took place in RBF facilities. Fifty-two mothers and 298 newborns did not survive. Regrettably as these deaths are, these facility-based case fatality ratios of respectively 193/100,000 and 11/1000 would represent just a fraction of Malawi’s current national mortality figures of 439/100,000 and 27/1000. Although these figures are but a ‘snapshot’ from one semester, they support the conviction held by many partners of RBF4MNH that the Initiative is reducing delivery-related deaths.

Analysing deaths that occur in health facilities is a powerful learning tool enabling personnel to understand and, if possible, improve factors that led to this tragic outcome. In the supported facilities 95% of neonatal deaths and 100% of maternal deaths were properly audited during the first six months of 2016 (Progress report 1-6/2016). It was 0% at the start of the Initiative.

FOLLOWING STEADY IMPROVEMENTS DURING THE FIRST 18 MONTHS, THE RBF FACILITIES’ OVERALL SERVICE QUALITY IS STABLE AT A RELATIVELY HIGH LEVEL

The 18 RBF reward indicators (see Box 3) can be seen as a proxy for quality of care: the increased amount paid out in rewards to the facility staff is correlated with improved service quality, as well as adjustments to the reward envelope to respond to inflation.

The ascending curve in Figure 3 reflects both rapid learning by BEmONC, CEmONC and District Health Management Team staff of the actions required to earn the rewards, and the changes in how the rewards were calculated, from an all-or-nothing approach in the earliest cycles to rewarding progress proportionately (cf. p. 19).

30 Although such specific facility-based fatality ratios (based on a small sample of 100% of women delivering in a health facility) are not directly comparable to national population-based mortality figures, the fact that in Malawi nationwide 90% of deliveries take place in a health facility reduces the discrepancy.
Since 2015 the health facilities have been maintaining their performance between 70% and 80% indicator attainment. According to the 2016 first half-year progress report, in the RBF facilities 88% of newborns are regularly checked during their first 48 hours of life, and 97% of babies in difficulty are resuscitated. One hundred per cent of cases of pre-eclampsia are treated, and 100% of women coming for delivery with unknown HIV status are tested and managed accordingly – a dramatic increase from only 23% before launch of the Initiative. Stock-outs of drugs have decreased and 90% of stock cards were up to date when most recently verified, while 100% of water systems, drainage and equipment were in a good state of repair, or if broken had been repaired within seven days.

Another approach to measuring service quality is the yearly Joint Quality Assessment with the GIZ health programme which is carried out in all RBF facilities. The Quality Assessment Score is one of the output indicators of the Initiative and it presents, overall, a positive evolution: Starting from a baseline score of 35.3% in 2014, it rose to 66% in 2015 and descended slightly to 64% in 2016, which the RBF4MNH team attributes to the acute lack of resources in the health sector in that year.

Across the board the Phase 2 facilities have been scoring higher than did the Phase 1 facilities at the same time after joining the project. The RBF team attribute this to the fact that the Phase 2 facilities were already informed about the Initiative and highly motivated to join, whereas in Phase 1 the project was new.

THE EXTERNAL IMPACT EVALUATION FOUND EVIDENCE OF IMPROVED SERVICE DELIVERY – IN BOTH SUPPORTED AND NON-SUPPORTED EMONCs

Through qualitative research methods the Heidelberg University-College of Medicine consortium determined that stakeholders in general – managers, partners, health staff and clients – perceive the Initiative as having a positive impact on quality of care (Wilhelm et al., 2016; Brenner, De Allegri et al., 2016).

Objective measurements of service delivery improvements that can be linked to incentives are more difficult to observe. The research team carried out systematic before and after comparison of selected elements in both the supported and non-supported facilities. They discovered greater availability of functional equipment and essential drugs in the intervention facilities, an effect which could be attributed to the incentive scheme applied on facility level.

On the other hand, in both the supported and the unsupported EmONCs, drug procurement, clinical care activities and birth attendants’ adherence to clinical protocols improved over the two-year period.

How can this improvement in non-supported EmONCs be explained? The external research team sees here an overall positive effect of RBF4MNH on service delivery within the district (Brenner et al., 2017). They attribute this mainly to a reinforcement of District Health Management Teams’ performance fostered by the incentives for supportive supervision, equitable resource allocation, and attention to functioning and maintenance targeting all health facilities in the district (see Box 3). An additional factor could be the emulation effect mentioned at the end of the previous section. The personnel of the non-supported facilities are well-informed about Initiative activities and hope by their good performance to be selected for support in future.

WHILE RBF4MNH INCREASES HEALTH WORKERS’ OVERALL JOB SATISFACTION, THEIR INCREASED WORKLOAD, LACK OF RESOURCES AND LOW SALARIES ARE STILL TAKING A TOLL

The Heidelberg-College of Medicine impact evaluation found a strong increase in health providers’ perception of a supportive work environment and overall job satisfaction in the RBF facilities compared to the control facilities (Brenner, De Allegri et al., 2016). A very positive finding of this evaluation was that health providers’ intrinsic motivation (cf. p. 11) was not reduced: although they appreciated the extra income, the incentives did not ‘crowd out’ staff’s motivation to do their job properly for its own sake.

The impact evaluation observed a high degree of stakeholder commitment to RBF4MNH, including among health staff. This is reflected in examples of health providers’ going above and beyond their regular duties to find creative solutions to ensure women’s access to CCT (Progress Report 1-6/2016):

- When pregnant women were unable to register for CCT during their first antenatal care visit because the health facilities had run out of cards, staff members sent the Health Surveillance Assistants to track all the women and have them registered at community level, so that by their second visit they got their card – and their registration was already confirmed.

- In other facilities, when confronted by a lack of CCT funds to pay new mothers, staff used the facility portion of their incentive (which they recuperated later) to ensure that no eligible woman was denied payment.

Individual interviews and Focus Group Discussions.
According to the Initiative’s annual satisfaction survey among the personnel of the supported EmONCs, overall staff satisfaction had risen from 57% in 2015 to 66% in May 2016 with differences between Phase 1 and Phase 2 facilities: in 2015, personnel in Phase 1 facilities declared only 49% satisfaction, while the Phase 2 ‘newcomers’, whose better performance seems linked to stronger motivation (see above), expressed 71% satisfaction. This led the team to observe, ‘The survey results show an upward trend on joining the Initiative which later declines.’ (Progress Report 1-6/2016)

These figures indicate that despite the positive effects of the incentives, the improved working environment and the strong commitment of many staff members, the difficult working conditions in Malawi’s health-care system do take their toll on staff motivation: ‘Some of the health workers were not satisfied due to high workload, inadequate resources, lack of resources and low salaries.’ (Progress Report 1-6/2016)

COST-EFFECTIVENESS OF THE INITIATIVE

As an initiative intended to inform national health policy and strategy, the different elements discussed above need to be analysed not only from the perspective of their effectiveness, but particularly of their efficiency. Currently, a cost-benefit study by the University of Bergen (Norway), funded by NORAD, and a costing study by an independent consulting firm commissioned by KfW are in progress. This information will be important to guide the Ministry and the development partners in selecting and/or adapting measures that have the best prospect of being sustainable long-term and giving value for money.

BOX 6. THE INITIATIVE TEAM REFLECTS ON WHAT HAS BEEN ACCOMPLISHED

Twambilire Phiri, the Reproductive Health Directorate’s RBF Liaison Officer, launches the discussion: ‘I think capacity development of health providers has had an important impact: supportive supervision, training, adherence to protocols and guidelines. All this has brought great improvement in managing obstetrical complications.’

Chief Accountant Angel Msukwa confides, ‘In supervising funds management I have seen another side of capacity improvement. With the facility portion, decision-making on critical requirements not provided by the government leads to empowerment of staff. They realise: “What we need to make this work, we can do on our own with these funds.”’ He continues, ‘Mothers come to deliver in a safe and healthy place, and are discharged home with healthy babies.’

For RBF Communication Officer Charity Roka, ‘Incentives contribute to quality of care for clients, because they motivate a hard-working spirit in staff.’ She adds, ‘Traditional leaders have played an important role in community ownership of the RBF4MNH programme, passing relevant bylaws and enhancing mindsets on MNH measures.’

Evaluation Officer Mabvuto Mndau emphasises the Initiative’s adaptability: ‘Wherever our team has seen room for improvement, we don’t hesitate. Based on feedback, we fundamentally modified the incentive system, and now that we saw the health facility catchment area is a barrier, we have introduced a more equitable approach for ensuring that poor women benefit from the CCT. The measures we have introduced encourage teamwork both on facility and District Health Management Team level, and RBF facilitates adherence to Ministry policies and procedures.’

Reagan Kaluluma, Deputy Director of the RBF4MNH team, sees the Initiative’s integration into government structures on all levels as its main strength: ‘Government has good policies and structures, but maybe it lacks mechanisms to implement them. The RBF concepts are shaped and implemented together with central, district and local authorities, and the Initiative develops their existing community structures as multipliers on MNH. This approach contributes both to government ownership and to sustainability.’ He adds, ‘Change of key partners remains a challenge: for instance, when their District Health Officer was replaced, there was a sharp reduction in Balaka District’s results. With new Ministry partners as well, it takes time to familiarise them with the Initiative and develop a relationship.’
Key learnings from the Initiative

The Initiative team believe that it is too early to highlight best practices resulting from the Malawi RBF4MNH. Nonetheless, a number of key learning points have emerged that could have relevance for other RBF and even broader health projects.

IMPLEMENTING THE INTERVENTION AS A SHARED LEARNING EXPERIENCE ENSURES FLEXIBILITY, ADAPTIVENESS AND OWNERSHIP

From the outset, the approach has been to learn by implementation and to continually adjust the design based on feedback and experience (action-research approach). This contrasts with projects that undergo a longer design phase in order to fine-tune the design before sign-off for implementation, after which the design (in theory) is not supposed to be changed. The in-built flexibility of RBF4MNH has made it possible, as we have seen, to fine-tune the intervention as an ongoing process in the course of implementation, to respond to contextual changes (e.g. inflation of the local currency, Malawi’s decentralisation reform), issues arising (e.g. the need for secure conditions for keeping cash in health facilities, the concern that the CCT might encourage increased fertility), and to strengthen coherence of the Initiative design itself. This reflective approach has been enhanced by scientific research, particularly the external impact evaluation, but also a considerable number of academic theses on specific topics.

The power of this approach is multiplied because the reflective and decision-making process is not limited to the core RBF4MNH team, but is rather a shared learning experience in which government partners on all levels, as well as community structures and traditional leaders, actively participate. Members of the Initiative team describe this as an ‘organic process’ growing out of the original commitment to work in a highly participatory way. Embedding the Initiative within government structures and systems (including situating the RBF4MNH office within the Reproductive Health Directorate of the MoH) has enabled a high degree of ownership. This has been very important for the design of tools and processes in line with MoH structures and systems, for the day-to-day management of the Initiative, as well as for facilitating collaboration and coordination between the different programmes and activities of the Directorate.

RBF CAN EMPOWER HEALTH WORKER TEAMS TO IMPROVE THEIR OWN WORKING CONDITIONS AND THE QUALITY OF CARE THEY PROVIDE

Overall, RBF4MNH has shown that incentivising performance has a strong motivating effect, reinforcing already high levels of professional responsibility and making personnel feel that they are empowered to provide quality services to their patients. Whereas in the past they had no way of doing anything about the gaps and challenges, RBF has provided a degree of autonomy to address problems, which is highly motivating.

The individual portion of the rewards, which is paid on the basis of the whole facility’s performance, provides a strong motivation to work as a team to fulfil the reward indicators. The facility portion, where co-workers together decide how to use 40% of their facility’s reward payment, is particularly effective. According to Berk (2015), it ensures that health workers ‘gained skills and knowledge how to solve their delivery challenges themselves or with the support of the next authority. Thereby, they have experienced and learned that their own actions, behaviour and attitudes directly impact the quality of care. Now, the teamwork at the facilities has improved and they see themselves increasingly as drivers of change.’

The facility portion, by delegating to individual health facility teams the means to plan and themselves directly procure the material inputs they judge necessary to complement what is provided by the MoH, also liberates the Initiative team (and to some extent the MoH) of the burden of large-scale procurement – with its attendant risks of late or incomplete arrival, or quality perceived as unsatisfactory by the users (cf. the issues encountered with the Initiative’s equipment and infrastructure component).
Developments at the Lizulu Health Centre in Ntcheu District are just one illustration of the way in which RBF can improve living and working conditions for staff and quality of care for patients: With its facility portion, the team installed toilets in the five staff houses, bought new mattresses for the maternity, fixed 17 broken beds, and procured soap, drugs, gumboots and chlorine to prevent patient infections. As a result of these visible quality inputs, the IDR at Lizulu increased dramatically.

**COMPARSED TO INVESTMENTS IN INFRASTRUCTURE AND EQUIPMENT, INVESTMENTS IN STAFF MOTIVATION MAKE A GREATER DIFFERENCE**

It was strategically effective on the part of the Initiative to start with equipment and infrastructure improvements, not only to ensure essential physical viability of the health facilities, but for the credibility of the forthcoming Initiative. Interestingly, however, quality of care started to improve in the targeted facilities even before the equipment was delivered and the infrastructure improvements completed. This improvement was even more marked in the second phase facilities, where activities and improvement started even before the equipment and infrastructure contracts were tendered out.

It can be hypothesised that the Initiative’s investment in human motivation, as consigned in the Quality Performance Agreements, had an even greater effect on quality improvement than the material investments. The combination of teamwork to win a collective reward for quality performance, and the empowering experience of decentralised management of the modest facility portion, has brought about a fundamental change in approach and attitude on the part of health workers. The increasing proactivity of the health facility teams and sense of responsibility of the District Health Management Teams will make all the difference in maintaining the quality of health care and, in principle, the long-term functioning of the Initiative’s costly investments in equipment and infrastructure.

**REGULAR REVIEW AND ADAPTATION OF PAYMENT INDICATORS IS IMPORTANT AND SHOULD BE A PARTICIPATORY EXERCISE**

The Malawi RBF4MNH is unusual in directly incentivising quality of care indicators rather than using a quality assessment tool either to augment or deflate a core reward payment. This has both advantages and disadvantages. The link between the provision of quality of care and the reward is immediate and the quality of care indicators can be targeted at specific areas of weakness. However, indicators must also be able to be objectively verified by an external team, which makes indicator selection difficult in some areas (e.g. infection prevention). Some lessons emerged regarding the selection of indicators:

- Incentivise processes of care (e.g. Active Management of Third Stage Labour) and not just components of a process.
- Choose indicators which are achievable and feasible, taking into consideration contextual features such as human resource shortages or administrative complications and delays.
- Indicators should be directly linked to national quality protocols and standards.
- Rewards must relate closely to performance: shorter reward cycles and prompt feedback of results are most effective.
- In some areas (e.g. Respectful Maternal Care) it can be difficult to select indicators for rewards – in these cases other supply-side interventions may be needed to complement RBF.
- Incentives which reward progress made, rather than achievement of absolute targets, are more motivating.

Payment must be high enough to make a difference and must be adjusted for inflation (an issue in Malawi). There is no ‘one fits all’ design – the design must be flexible, dynamic and adjusted to the local context.

**ENSURING CAREFUL MONITORING OF PERFORMANCE INDICATORS WHILE KEEPING A LID ON STAFF WORKLOAD REMAINS A CHALLENGE**

The RBF4MNH Initiative, in reinvigorating health services – including obliging personnel to adhere to Ministry standards that were often neglected in the past – is confronted with a dilemma. While continuous documentation of performance is an indispensable element of RBF (and in many cases an official Ministry requirement), it also leads in practice to a marked increase in the number and volume of administrative tasks for individual caregivers. In addition to the increase in the number of...
deliveries they have to perform and their new responsibility to manage CCTs, RBF facility staff need to fill in over 20 different types of reports, registers, protocols, checklists and other documents each month.

The Heidelberg-College of Medicine impact evaluation points to this increased workload as a factor reducing staff’s availability to improve service delivery: ‘Improvements in staff levels and resources could not match overwhelming increase in workload’ (De Allegri et al., 2016b).

ASSOCIATING SUPPLY-SIDE AND DEMAND-SIDE INTERVENTIONS CAN LEAD TO IMPROVED MATERNAL-NEWBORN OUTCOMES

The Initiative’s original hypothesis that associating supply-side and demand-side measures would lead to improved health outcomes appears to be substantiated by the concrete achievements reviewed in the preceding chapter, including improved IDR and apparently reduced mortality.

The synergy between supply side and demand side can be seen in their reciprocal reinforcement of health-promoting behaviours such as pregnant mothers’ early arrival and prolonged stay after delivery: these are supported on the demand side by the CCT that defrays women’s costs for transport, delivery items and food while away from home, while on the supply side health personnel are rewarded for regularly checking newborns’ vital signs during the crucial 48 hours after birth, reinforcing the same message to mothers.

AT DISTRICT HEALTH MANAGEMENT TEAM LEVEL RBF CAN FACILITATE EFFECTIVE HEALTH SERVICE DECENTRALISATION

Contrasting with the habitual, top-down project approach, RBF4MNH from the start focussed its planning, activities and partnerships on the district level. Coinciding with administrative decentralisation, working with district-level stakeholders also facilitated access to the community level via the traditional authorities. District authorities, oriented and familiar with RBF, were able to facilitate its introduction to new facilities and continuously support implementation. With their help, a broad range of existing and traditional structures (e.g. District Commissioners and Councils, Village Development Committees, Area Development Committees) could be enlisted as vectors for the Initiative’s messages and activities.

Even though they did not formally evaluate the incentives for the District Health Management Teams, members of the impact evaluation team consider them a crucial component of RBF4MNH and highly effective in promoting decentralisation and health system reform (S. Brenner, personal communication). It is their conviction that rewarding the DHMT’s ‘supportive supervision’ – and through their facility portion providing resources to enable this support – has greatly contributed to quality improvement in health services across the four districts.

Going a step further, Brenner et al. (2017) observe that ‘local adoption [of the RBF approach] has led to further decision-making by managers about resource allocation to extend beyond the initiative’ – i.e. the Initiative has had a broader impact on management habits of the District Health Management Teams. Regular quarterly review meetings on district level to address concerns arising in the course of Initiative implementation and establishment of feedback loops between them and the health facilities turned out to be important mechanisms for consolidating a functioning district system. As with the health staff mentioned above (p. 30), these ‘stakeholders took on functions not directly incentivised by the intervention, suggesting that they turned adoption into actual ownership’ (Wilhelm et al., 2016).

Embedding the intervention at district level and moving out from there to the community and to the national level supports Malawi’s decentralisation process. Production of evidence and results for the effectiveness of RBF on the operational level has led to central-level support and fed into the Ministry’s planning of health policy and strategy.

‘The great advantage of the integration of RBF4MNH in the Ministry structures is that there is no handover, because the Ministry has been implementing the Initiative all along.’

Reagan Kaluluma, Deputy Director, RBF4MNH Team
Future outlook

With its current phase ending in December 2017, the RBF4MNH Initiative has an opportunity to influence health policy development in Malawi in the longer term, through lessons learned in the course of implementation. Having attained broad support and high-level recognition for its achievements all the way up to the President’s office, RBF4MNH is greatly appreciated in the upper echelons of the Ministry of Health.

STRATEGIC DISCUSSIONS ON SCALING UP THE RBF APPROACH

In May 2016, the Ministry organised an international workshop in Lilongwe to discuss the RBF approach and reflect on the options for scaling it up. This was the opportunity to share the observations of the Heidelberg-College of Medicine impact evaluation of RBF4MNH as well as the perspective of the Initiative’s technical and traditional partners.

Other RBF approaches were also shared at the workshop, including that of the USAID-funded Performance-Based Incentives (PBI) programme, which is being piloted by the Ministry of Health in three other districts of Malawi and has also been evaluated as part of the TRAction project.

In the wake of the workshop, a task force was delegated to work on integrating RBF elements into national policy, taking into account the limited human, material and financial resources of the Ministry of Health.

The new Health Sector Strategic Plan 2017-2022 presents ‘Performance Based Budgeting’ as an objective that is ‘being rolled out but is still some way from being properly implemented’ (p. 33). In the same paragraph the plan points out the disadvantages of the current ‘input-based payment system which provides limited incentive to pay attention to health outcomes and patient satisfaction’ and deplores that health facilities ‘are not designated as cost centres and hence not explicitly allocated financial resources’ (p. 33). The two existing PBF initiatives – RBF and PBI – are presented together as ‘strategic purchasing arrangements that can enhance performance as opposed to line budget and salary payments, while also indicating CCTs can improve demand for health care’ (p. 29).

This vision is concretely anchored in the planning matrix of this five-year plan, under Objective 8: ‘Increase health sector financial resources and improve efficiency in resource allocation and utilization’. Specifically, the Strategy ‘Institutionalize Performance Based Financing’ and the following activities (p. 96) appear to be inspired by the RBF approach:

- ‘Pilot a Purchaser-Provider Split within the health sector
- Finalize designing of and operationalise Programme Based Budgeting (PBB)
- Design and implement performance based financing options e.g. Result Based Financing
- Make peripheral health facilities (e.g. community hospitals, health centres, dispensaries) cost centers and provide them with direct funding allocation
- Introduce formula for allocation of funds to peripheral health facilities.’

CONTINUED GERMAN SUPPORT

In February 2017, in an official communication to the German Embassy in Lilongwe, the Ministry of Health requested the German government to consider providing additional funding for results-based financing as part of its support to the health sector in Malawi beyond 2017.

Currently, the stakeholders involved in the RBF4MNH Initiative are waiting for the results of the independent cost-benefit analysis and the costing study (see p. 31). The outcomes of these studies are expected to be finalised in the third quarter of 2017.

32 This concern seems a reaction to the positive experience of decentralised management of the facility portion.
Subject to these results, the German government intends to further support RBF activities. Funds are provisionally earmarked for this purpose within the Health Services Joint Fund, a funding modality put in place in December 2015 to channel pooled development partners’ financial contributions to address priority health constraints in Malawi. The scope, components and geographical coverage of a potential future RBF model will be defined and agreed upon between the Ministry of Health and KfW Development Bank, in accordance with the priorities and strategies outlined in the 2017-2022 Health Sector Strategic Plan.

**BOX 7. TOP MINISTRY OFFICIALS SEE GREAT PROMISE IN RBF4MNH**

Ms Chimwemwe Gloria Banda, Chief Director of the Ministry of Health, is brimming over with enthusiasm. ‘I have just come back from visiting an RBF health facility in Mchinji District that was having some problems with record-keeping. But you can see they are wisely using their “facility portion”: Staff are in uniform, they have gloves and pain-killers, and the centre is clean, mopped with detergent three times a day! In the waiting home expectant mothers have soap and clean wrappers, and staff teach them about hand-washing, having a toilet at home, and healthy eating. They even have planted a small vegetable garden. The Initiative’s approach of working with District Health Management Teams under the auspices of the District Councils and local government has brought positive results.’

Mr Samuel Chembe, Deputy Director of Planning and Policy Development, agrees: ‘RBF4MNH has been very successful in mobilising district councillors and community leaders. It was a milestone to involve the District Commissioners: since they can mobilise the means, they are the real gatekeepers of the health facilities. This is an effective strategy to improve mother and newborn health, and the incentives create a positive competition among districts. The lobbying towards Members of Parliament was very effective: after visiting the Initiative, they asked the Ministry to scale up.’

Mr Chembe does express concern about sustainability of the approach: ‘The results are wonderful! But how can our Government finance these activities after the donors have pulled out?’

Ms Banda is, however, optimistic that the necessary means for scaling up the RBF approach will be found. ‘We must continue lobbying: convince the Ministries of Finance and of Local Government to budget the scale-up; put in budget requests to our technical and financial partners. The political and technical will are there: the First Lady is patron of Safe Motherhood, which is a presidential initiative. As a former journalist, I know the media – TV, radio, newspapers – are friendly and can be enlisted for active support. This Initiative is really saving lives!’

36 • Future outlook
Prior to publication each case study in the German Health Practice Collection is reviewed by two independent peer reviewers. The reviewers, who are internationally recognised experts in their fields, are requested to comment on whether the case study has generated new insights into the implementation of the given approach and the development challenge it addresses. In line with the Collection’s new focus on learning from implementation, the peer reviewers no longer align their assessment on specific criteria correlated with ‘best practice’, but are free to discuss – and question – any and all aspects of the case study which they find significant for a deeper understanding of the implementation. In the present case, the insightful queries posed by the two peer reviewers have led the writer to present certain topics in more detail. Here we summarise the peer reviewers’ main observations on the present case study.

Both experts praise as highly useful and ‘far too rare’ the reflective approach used in this case study, focussed on lessons that can be gleaned from implementation challenges. They emphasise the novelty of this type of study compared to simply showcasing ‘successes’. This confirms the relevance for development practitioners of the new orientation recently adopted by the German Health Practice Collection. As one of the reviewers puts it, ‘The reflective approach should be central to public health intervention research….It is important that this type of document collection persists and even spreads because development actors sometimes hide their failures (and sometimes even their successes) or, unfortunately, embellish their achievements.’

Both reviewers recommend this case study for publication and find that it contributes in a meaningful way to the current RBF debate. One appreciates that the document ‘manages to explain difficult concepts of health financing and RBF in a way that is accessible to a broad readership of health practitioners.’

Both experts particularly appreciate the design and evolution of the Initiative as a self-reflective ‘learning organisation’. One observes, ‘That the project maintained a flexible and open approach to the design and implementation of RBF, iteratively adapting the standard practices to the context… has proven a key asset for the success of the project and is something that has been shown to somewhat lack in other RBF schemes.’ The other remarks, ‘One is pleasantly surprised by the adaptability of the project and the donors (which is very rare in development) to the necessarily shifting context, the reactions of the actors and the results produced.’

Nonetheless, one peer reviewer would have liked more ‘transparency’ on the mechanisms by which the learnings were generated within the core team: ‘What are the context-specific elements that explain a given outcome? What are the conditions for the lessons learned from this intervention to be applicable and transferable to another context?’ Remarking that ‘writings on these processes in Africa are too rare,’ this reviewer’s concern is that the reflective approach be ‘serious and rigorous’ – in contrast to ‘tacit, local knowledge or beliefs’.33

The other reviewer gives the Initiative team more credit for ‘rigorous analysis and self-reflection… [which] generated key insights which are well documented in the report,’ concerning both ‘technical challenges and lessons linked to RBF and broader challenges and lessons applicable to a wider set of issues in public health.’ Nonetheless, this reviewer, too, regrets that the case study in some cases ‘falls short of going into a higher analytical level on the functioning/effects of the project’ and recommends including a list of additional readings, particularly from the external impact evaluation, for readers wishing to delve more deeply into the topic (see Box 8).

This reviewer regrets that ‘overall less emphasis was given to longer-term, wider (health system) issues and unintended effects, such as the risk of “verticalisation” in the implementation of RBF. The potential for RBF to create

33 Here the reviewer evokes the prejudice that CCT will encourage increased fertility and points out that it has been scientifically disproved.
parallel systems and structures within the health system and the possibility of generating an internal brain drain from MoH to project, and from non-RBF supported facilities to RBF-supported ones are mentioned in the report, but it is not clear how the initiative had dealt with them.

The other reviewer expresses special appreciation for the CCT as contributing to universal health coverage by promoting ‘equity and access to care for the poorest’. On the other hand, this reviewer questions the absence of scientifically objective poverty criteria for beneficiary targeting as well as the Initiative’s relatively late shift to community-based CCT, pointing out that ‘scientific evidence of the community’s relevance is well-known’.

Among specific measures adopted by the Initiative, one peer reviewer points out that the ‘facility portion’ concept and the external verification are not original to the Malawi RBF4MNH. On the other hand, this reviewer highlights the Initiative’s engagement with traditional leaders and includes among ‘interesting new approaches’ the definition of indicators and reward levels, as well as practical measures such as organising secured cash management in health facilities, indicating that such ‘insights… are often overlooked by the academic literature, which tends to focus on technical or theoretical aspects.’ Other practical examples appreciated by this reviewer include the core team’s workplace organisation within the Reproductive Health Directorate as ‘a practical and relevant example of how personal relationships and networks for learning are encouraged to ensure regular exchange, tackle daily challenges, and enhance the potential of the project.’

The overall assessment is summed up in the words of one reviewer: ‘The experience of the RBF4MNH Initiative in Malawi seems well worth sharing to a large audience of health practitioners, both because of its relevance in terms of showing an approach which allows RBF’s design and implementation to be adapted to the specificities of a context (which has been identified in the literature as deserving more attention), and also because of the number of interesting approaches that were adopted, which can be relevant beyond RBF’.

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**BOX 8. FURTHER READINGS ON RBF4MNH**

**The external impact evaluation:**


**Policy briefs:**


The German Federal Ministry for Economic Cooperation and Development (BMZ) would like to thank the many individuals and organisations who have contributed to the present case study on the RBF4MNH Initiative in Malawi.

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References


German Embassy in Malawi (2016). Fact sheet on German support to health and social protection in Malawi. Lilongwe: German Embassy in Malawi. Available at: http://m.lilongwe.diplo.de/contentblob/4566270/Daten/6816278/health.pdf


Wilhelm DJ et al (2016). A qualitative study assessing the acceptability and adoption of implementing a results based financing intervention to improve maternal and neonatal health in Malawi. BMC Health Services Research. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4989348/


