Partner Coordination and Implementation of Health Interventions:
Results from Mid-Term Evaluation of USAID/Malawi Support for Service Delivery Integration Project (SSD-I)

Dr. Swati Sadaphal MD MHS, Director, Global Health Practice

International Business & Technical Consultants, Inc. (IBTCI)

BACKGROUND

USAID/Malawi supports Government of Malawi (GOM) through its **Support for Service Delivery Integration Project (SSD-I),** to improve the effectiveness of the Essential Health Package (EHP) and efficiency in the management of integrated services delivery in fifteen districts. SSD-I consists of three **5-year** inter-related sector activities:

- ***Health Services Activity :*** A $65 million integrated service delivery program to expand and improve quality of selected EHP services: maternal, newborn & child health, nutrition, family planning, reproductive health, HIV/AIDS, TB, and Malaria.
- ***Communications Activity:*** A $24 million program to strengthen national and targeted district level social behavior change communication (SBCC) planning and coordination; develop SBCC packages for a multi-level, multi-media campaign; build capacity of national and district level partners; and identify best practices.
- ***Health Systems Strengthening Activity:*** A $10 million collaborative effort designed to provide technical assistance to the Ministry of Health (MOH) to improve policies, management, and leadership, and strengthen Malawi's health care system.

SSD-I was designed as a program implemented by three separate implementing partners (IPs). We conducted a mid-term evaluation to understand the effect of joint coordination and implementation under SSD-I on achievement of sector-specific objectives.

OBJECTIVES

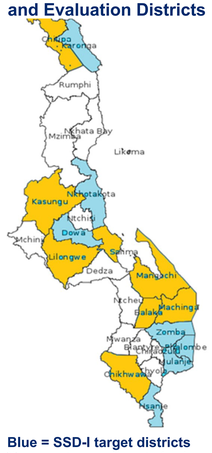
Evaluation Questions:

1. To what extent has SSD-I's approach improved the delivery of quality EHP services and health indicators at SSD-I supported service delivery points?
2. To what extent has SSD-I's health system strengthening (HSS) and capacity building approach (at central, zonal, and district levels) responded to specific bottlenecks that impact service delivery?
3. What effect has joint coordination and implementation of interventions across SSD-I had on the achievement of sector-specific and USAID's health objectives?
4. To what extent has SSD-I's approach responded to client needs and supported families in adopting improved preventative and health-seeking behaviors?
5. What elements of SSD-I's approach have either enabled or limited its ability to improve government capacity in: health service delivery, fiscal responsibility, management and leadership, SBCC, and use of data for decision-making; and what recommendations can be made for overcoming bottlenecks?

METHODOLOGY

- **Site selection:**
- 8 of 15 SSD-I intervention districts selected based on:
  - ◊ Timeframe and coverage of project activities
  - ◊ Geographic and population representation
  - ◊ Availability of baseline and comparative data
- Within each district, a district hospital, urban health center, and rural health center. Facility selection based on:
  - ◊ Time and scope of SSD-I project interventions
  - ◊ Geographic situation (urban/rural)
  - ◊ Population representation
- Two communities (urban and rural) within catchment areas of health centers for three focus group discussions (FGDs) per community:
  - ◊ Beneficiary women
  - ◊ Beneficiary men
  - ◊ Community volunteers

SSD-I Target Districts and Evaluation Districts



Blue = SSD-I target districts
Yellow = Evaluation districts

Key Data Sources

Stakeholders	KIIs
USAID Agreement Officer Representatives (AORs) and Health Population Nutrition (HPN) management	6
MOH staff, central level	23
SSD-I staff, central level	10
Donors and implementing partners (IPs)	4
MOH zonal staff and DHMTs	24
SSD-I zonal and district staff	26
Facility Level	**Mini-Survey**
District hospital (8 total)	19
Urban health center (8 total)	21
Rural health center (8 total)	23
Beneficiaries and Volunteers	**FGDs**
Urban communities (24 total)	195
Rural communities (24 total)	198
Total, all activities	549

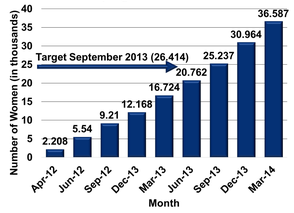
FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

SSDI – SERVICES

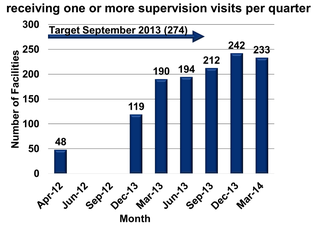
Findings - Achievements

- Achieved or exceeded 5 of 10 targets for key outcome indicators by Year 3.
- Initially strengthened delivery of 15 interventions, later increased to 30 interventions at MOH request. However, lack of Sector-Wide Approach (SWAp) financing caused activity to be stretched too thin.

Number of HIV+ pregnant women initiated on ART

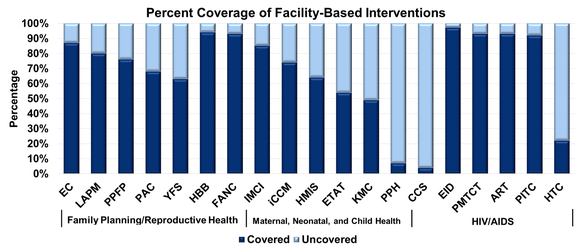


Number of health facilities in SSD-I districts receiving one or more supervision visits per quarter

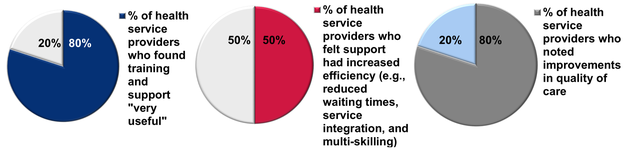


- SSDI-Services supported health service delivery training of >18,000 health workers.

Percent Coverage of Facility-Based Interventions



Mini-survey to Assess Usefulness of SSDI-Services Trainings



Challenges

- Imbalance between technical capacity vs. inputs (infrastructure, supplies, materials)
- Year 1: collaboration started with decentralized, bottom-up approach, but Year 2 -3: became increasingly centralized / top-down → led to less communication, collaboration, and District Health Management Team (DHMT) involvement.
- Pressure to implement broad range of interventions, show results in limited timeframe, shortage of DHMT staff and resources → SSDI-Services has to implement independently of MOH compromising country ownership and sustainability.

Conclusions

- Significant progress in service delivery capacity: district, facility, community level.
- Efficiency, access, quality, and utilization of key EHP services increased.
- Lack of MOH ownership, institutionalization, and sustainability due to design flaws, increasing demands and expansion of coverage.
- Activity handover to MOH not achievable within life of the project (~ 5 years).

Recommendations

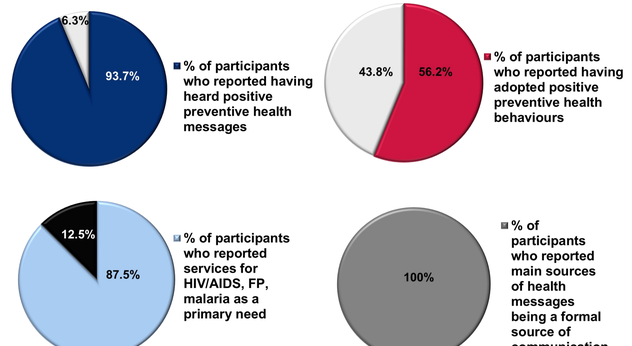
- Focus on high-impact, priority interventions in final two years: follow best practices and areas in which the project has already made significant progress.
- Community mobilization interventions should continue as planned, but project should work to ensure that efforts are closely aligned with availability of services.
- Document progress, best practices, and lessons learned for each intervention for an in-depth assessment for improved planning in the future.
- Adopt flexible, decentralized approach with district teams, which institutes structures to support district level planning, support, and logistics.

SSDI – COMMUNICATIONS

Findings - Achievements

- Strengthened MOH Health Education Unit (HEU) capacity to finalize National Communications Policy and develop communications strategies for all EHP areas.
- Trained HEU staff, journalists, and private media partners at National Level.
- Developed a "Moyo ndi Mpamba" (Life is Precious) platform: disseminated positive, preventive health messages via multi-media and inter-personal channels. Reached:
  - ◊ 2 million individuals through 8,124 radio spots;
  - ◊ 88,357 individuals through community theater;
  - ◊ 1 million individuals through print materials, including posters
- Community perspectives from focus group discussions (FGDs)
  - ◊ Health-seeking behavior has improved due to increased health messages *however* demand has increased where services are not consistently available.
  - ◊ BCC and mobilization efforts to improve awareness and support for women's health issues has also led to more open communication between couples, support for women regarding family planning and autonomous health decision-making, and reduced gender-based violence.

Focus Group Discussion Results



Challenges

- From Year 1 to Year 2, USAID decided that SSDI-Communications sub-grantees should remain under SSDI-Services so SSDI-Communications now only has limited and indirect influence over community mobilization activities:
  - ◊ Led to a delayed launch of community mobilization activities for more than a year – limits its ability to measure impact of BCC activities.
  - ◊ Limited communications between Services and Communications- prevents SSDI-Communications from providing ongoing technical support and/or from revising and targeting trainings, messages, and materials in the final two years.

Conclusions

- Built private sector and MOH's SBCC capacity at central, district, community levels.
- Developed SBCC policies, strategies, and tool kits to support future SBCC activities.
- Constrained by insufficient funding leading to discontinuation of community mobilization activities.

Recommendations

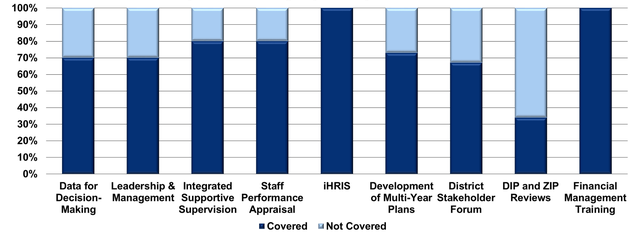
- Increase coordination of M&E between SSDI- Services and Communications for better gains from BCC efforts.
- Focus BCC efforts on same 15 interventions as recommended to Services.
- Carefully coordinate and integrate increasing demand for services only where services are accessible and available. Also consider gender equality issues.

SSDI – SYSTEMS

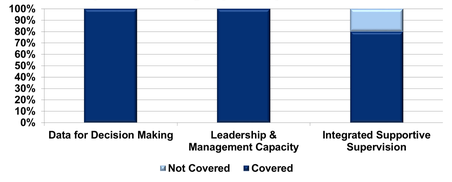
Findings - Achievements

- **Central Level**: Strengthened MOH institutional capacity to:
  - ◊ Coordinate and develop evidence-based health policies by establishing Policy Development Unit: 6 of 10 policies were in development process by August 2014
  - ◊ Provide strategic leadership and management to strengthen decentralized health services through training, integrated supportive supervision, and mentorship
  - ◊ Revitalize plans and implement GOM Performance Management System
  - ◊ Track health expenditure and develop health-financing tools for resource generation
  - ◊ Improve district planning and financial management in all 15 districts
- Upgrade District Health Information System
- **District level**: trained, coached, and mentored DHMTs in leadership and management; and scaled up training on Human Resources Information System (iHRIS).
- **Zonal level**: trained Zonal Health Officers and Coordinators in integrated support supervision; performance management system; and supported stakeholder groups for improved coordination.

SSD-I-Systems Coverage by Activity at the District Level



SSD-I-Systems Coverage by Activity at the Zonal Level



Challenges

- Systems-related bottlenecks at district and facility levels that require regular follow-up.
- Delayed initiating policy development activities due to diverging and competing demands from technical teams at USAID and MOH.
- Optimal use of smartphones for support supervision activities is hampered due to lack of appropriate training.
- Minimal participation of stakeholder groups at district level: no engagement of key civil society organizations in policy development and analysis process.

Conclusions

- There is progress towards achieving targets but final approval of policies and systems lies with MOH/GOM; so full achievement of targets is beyond USAID or IP control.
- Unlikely that the activity will be able to scale up interventions in all 15 districts and build adequate MOH capacity to institutionalize and sustain HSS interventions within life of the project (~ five years).

Recommendations

- Align all partners at quarterly district and zonal performance reviews (DIP and ZIP) to strengthen stakeholder coordination at all levels to improve collaboration, leverage resources, and increase partner synergy.
- Generate district plans with DHMT to promote ownership and institutionalization.
- Provide focused training in districts that are already using smartphones for integrated supervision and monitor their use before further scale-up.
- Complete HSS pilot activities and disseminate best practices and lessons learned.