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VOUCHERS FOR HEALTH: INCREASING UTILIZATION OF FACILITY-BASED FAMILY PLANNING AND SAFE MOTHERHOOD SERVICES IN KENYA

Ben Bellows, Matthew Hamilton, and Francis Kundu

Inside

About the P4P Case Studies Series	2
Acronyms	2
Introduction	3
Background	5
Program Structure and Management	9
Program Impact	17
Summary	22
Acknowledgments	26
References	27

This case study describes a Kenyan demand- and supply- side pay-for-performance (P4P) scheme that uses vouchers as a means to reduce maternal and child mortality. Subsidized vouchers are targeted to poor women, enabling increased access to a range of safe motherhood and family planning services. Accredited public and private health service providers are reimbursed for voucher-supported services provided. Findings show that uptake of safe motherhood vouchers was very successful; however uptake of family planning vouchers proved more complex. This case study provides an example of a Government-led program to increase service utilization and offers lessons for countries considering implementing similar voucher-driven schemes.

P4P Case Studies



ABOUT THE P4P CASE STUDIES SERIES

Pay-for-performance (P4P) is a strategy that links payment to results. Health sector stakeholders, from international donors to government and health system policymakers, program managers, and health care providers increasingly see P4P as an important complement to investing in inputs such as buildings, drugs, and training when working to strengthen health systems and achieve the Millennium Development Goals (MDGs) and other targets that represent better health status for people. By providing financial incentives that encourage work toward agreed-upon results, P4P helps solve challenges such as increasing the quality of, as well as access to and use of health services.

Many developing countries are piloting or scaling up P4P programs to meet MDGs and other health indicators. Each country's experience with P4P is different, but by sharing approaches and lessons learned, all stakeholders will better understand the processes and challenges involved in P4P program design, implementation, evaluation, and scale-up.

This Health System 20/20 case study series, which profiles maternal and child health-oriented P4P programs in countries in Africa, Asia, and the Americas, is intended to help those countries and donors already engaged in P4P to fine-tune their programs and those that are contemplating P4P to adopt such a program as part of their efforts to strengthen their health system and improve health outcomes.

Annexed to each case study are tools that the country used in its P4P program. The annexes appear in the electronic versions (CD-ROM and Health Systems 20/20 web site) of the case study.

Rena Eichler, Ph.D
Technical Advisor, Pay for Performance
Health Systems 20/20 Project

ACRONYMS

ANC	Antenatal Care
BTL	Bilateral Tubal Ligation
FBO	Faith-based Organization
FP	Family Planning
GVR	Gender-based Violence Recovery
IGES	Institut für Gesundheits und Sozialforschung GmbH (Institute for Health and Social Research, Ltd.)
IUCD	Intrauterine Contraceptive Device
KDHS	Kenya Demographic and Health Survey
KfW	German Development Bank
KMET	Kenya Medical and Educational Trust
MOH	Kenya Ministry of Health
MTR	Midterm Review
NCAPD	National Coordinating Agency for Population and Development
NGO	Nongovernmental Organization
NHIF	National Hospital Insurance Fund
OBA	Output-based Approach
PNC	Postnatal Care
PwC	PricewaterhouseCoopers
SDP	Service Delivery Point
SM	Safe Motherhood
TFR	Total Fertility Rate
VMA	Voucher Management Agency
VSP	Voucher Service Provider



INTRODUCTION

This case study documents a novel health finance intervention in Kenya that uses vouchers and direct reimbursement to restructure incentives among patients and health care providers. The voucher gives patients a large, portable economic subsidy that they can take to any accredited facility for perinatal services, including facility-based deliveries and long-term family planning (FP) products. Providers are reimbursed for treating voucher-bearing patients according to a contractually agreed standard of care. In the first two years of the program (June 2006–October 2008), more than 60,000 women delivered using the Safe Motherhood (SM) voucher and the proportion of emergency obstetric surgeries increased dramatically at contracted facilities. More than 10,000 women used the FP voucher to access long-term methods (mostly intrauterine contraceptive devices and tubal ligations) from qualified medical professionals.

The voucher program was launched in June 2006 with 54 contracted public, private, and non-profit providers. The initial program targeted three rural districts and two urban slums representing a total population



A man brings his newborn to a clinic to receive postnatal care services offered through the Safe Motherhood Voucher (SM).

of more than 3 million. By October 2008, the program had treated more than 60,000 expectant mothers and 10,000 individuals seeking long-term FP methods. A second phase is planned to begin in 2010 with an expanded package of services and additional providers in the same pilot areas.

Three separate vouchers were developed to offer: 1) antenatal care, facility-based deliveries, and postnatal care; 2) modern methods of long term FP; and 3) gender-based violence recovery (GVR) care. Although a population impact evaluation was not conducted in Phase I (a comprehensive evaluation is being carried out in Phase II), voucher claims data and facilities' monthly utilization figures provide some insight into patient volume during the initial project period. The Kenya voucher program was successful in increasing facility utilization, particularly with respect to the SM program. However, given the national need for FP, increasing utilization of the FP services in Phase II will be a significant goal of the voucher management team.

This case study of the Kenya voucher program is based on published reports, personal communications, and internal documents made available to the authors. Previous documents provided useful background and insights into the origins of the program and were written by experts in the Kenya Ministry of Health (MOH); the National Coordinating Agency for Population and Development (NCAPD) at the Ministry of Planning and National Development; consultants from the German Institute for Health and Social Research Ltd. (*Institut für Gesundheits und Sozialforschung GmbH, IGES*); the Bill & Melinda Gates Foundation; Family Health International and the Population Council.

The SM Voucher allowed this mother to seek proper pre- and post- natal care.






BACKGROUND

MATERNAL MORTALITY AND FAMILY PLANNING IN KENYA

The Kenyan health care system is in a sustained crisis, evident in poor population health outcomes and underutilization of existing facilities. Reproductive health services are a barometer of health system performance and are a significant first point of contact for the majority of adult women in the country. Although a high percentage (more than 80 percent) of pregnant women seek antenatal care (ANC), fewer than half deliver in a health facility, many because they cannot afford the costs of service or transport, or are discouraged by the low service quality.

Kenya saw a sustained and relatively impressive fall in the total fertility rate (TFR) from 8.1 (1975–78) to 4.7 (1995–97); however, according to the 2003 Kenya Demographic and Health Survey (KDHS), the increases in contraceptive prevalence stalled at 39 percent (1998–2003) and the TFR rose to 4.9 in 2003 (Central Bureau of Statistics et al. 2004). These percentages are significant in a growing population, and Kenya's population grew roughly 25 percent between 2000 and 2008. At present, there are approximately 8 million women age 15–49 years, and this number will grow to 10.5 million or more by 2015. The 2003 KDHS estimated the median age at first marriage to be 17 years for women with no education, and 19 years for women with a primary education. Forty-four percent of currently married women want no more children and 79 percent of women with six or more children want no more.



Yet the prevalence of voluntary sterilization, intrauterine contraceptive device (IUCD), and oral contraceptive use is falling, while the use of long-acting hormonal methods has risen slightly, keeping overall prevalence of modern FP use constant at 31 percent.

Data on maternal health indicators in Kenya are poor. Recent national surveys have estimated that 414 women die from childbirth-related causes per 100,000 live births (KDHS 2003). Unattended delivery is one of the greatest risk factors for maternal mortality and morbidity (Gill et al. 2007). Of births reported in the 2003 KDHS, only 40 percent were delivered in a health facility. The lack of trained medical assistance during delivery jeopardizes the lives of both mother and newborn. UNICEF estimated that there are 80 infant deaths (under 1 year old) per 1,000 live births and 121 deaths of children under 5 years of age per 1,000 live births (UNICEF 2007). Low contraceptive use and the correlated high TFR results in inadequate birth spacing, which contributes to maternal mortality and lost productivity as young women are pulled away from educational opportunities and economic activity at an early age.

Given the rapid growth in the number of fertile women and the rise in the TFR, it is possible that unless new strategies are adopted, more Kenyan women will die from pregnancy, childbirth, and unsafe abortion in the coming decade than in any prior 10-year period in the history of the country. For every woman who dies in childbirth, up to 20 women suffer morbidities, often with severe medical and social consequences. Without access to surgical repair, a nonfatal fistula can leave a woman incontinent, which sometimes results in abandonment by her husband and family (Velez et al., 2007). Infertility can have similar consequences.

Gender-based violence against women also is a significant problem in Kenya. The 2003 KDHS found high proportions of married women and divorced or separated women experienced different forms of violence by their current or last husbands. The most common form of spousal violence was slapping or arm twisting, which had been experienced by one-third of women. The KDHS found that 23 percent of ever-married women had ever been pushed, shaken, or thrown by a husband; 17 percent had been punched; and 11 percent had been kicked or dragged. The KDHS concluded that marital rape appeared to be common, with 15 percent of married women and separated or divorced women reporting having experienced forced sexual intercourse; 12 percent reported this experience in the 12 months preceding the survey (KDHS 2003).

DEVELOPMENT AND LAUNCH OF THE VOUCHER PROGRAM

To address these maternal health and gender violence priorities, the German Development Bank (KfW) provided support for a voucher program to subsidize safe motherhood, FP, and GVR services. Planning the voucher services took several years from concept to program launch. Initial consultations took place in late 2003. A technical assistance mission to Kenya in early 2004 brought together partners from the government of Kenya, donors, nongovernmental organizations (NGOs), and faith-based organizations (FBOs) in a workshop where the voucher concept was introduced and discussed. Active stakeholders in the voucher program conceptualization included KfW, the African Population and Health Research Center, the Kenyan Government Division of Reproductive Health, the NCAPD, the Kenya Medical and Educational Trust, the MOH, the National Hospital Insurance Fund (NHIF), the Population Council, PricewaterhouseCoopers (PwC), and service providers.

Through the FP Voucher, women can receive FP counseling and services at local providers participating in the voucher scheme.



The results of the 2004 technical mission were presented in a feasibility report to the donors and NCAPD that presented options and recommendations for the design, costs, and organizational structure of the proposed voucher program (Griffith et al. 2004). The report also presented recommendations on investments in information systems, financial systems, capacity development, marketing strategies, and evaluation capabilities. Cost estimates were also included, but modified as plans were clarified in 2005 and 2006.

Events within Kenya at the time helped to drive the voucher agenda. Parliament was considering legislation to create a national social health insurance fund and the voucher concept was viewed by some Kenyan policymakers as a useful model for contracted services and provider reimbursement. The Ministry of Planning and National Development, through the NCAPD, also stood to gain significant experience given its key role in the design and implementation of the voucher program.

In 2005, the government of Kenya embarked on a performance-based reproductive health program

to incentivize access to women's reproductive health care. The government determined that one potentially effective means to improve reproductive health outcomes was to empower patients with a voucher to access care from approved providers who would be reimbursed on a per-patient basis. It developed a single program with separate vouchers for FP and SM services, the latter of which included antenatal care and access to a qualified health worker during delivery. A third voucher allowed clients to access GVR services initially from Nairobi Women's Hospital; later this was extended to other accredited hospitals in the project areas. The voucher services were launched in June 2006 by the NCAPD in the rural districts of Kisumu, Kitui, and Kiambu, as well as the Nairobi informal settlements of Viwandani and Korogocho. Together, these areas have a total population of approximately 3 million.

During the planning stage, aspects of program design and voucher patient populations underwent significant changes. Initial potential program beneficiaries ranged across several high-priority populations – from expectant mothers to men and women seeking FP services to individuals seeking HIV counseling and testing. The decision to provide contracted SM services to low-income women was made after reviewing epidemiologic data to identify unmet need and after consulting stakeholders to determine if the combination of vouchers and contracts would be a useful lever to reduce maternal morbidity and mortality.

The SM voucher as finally implemented entitles the user to four ANC visits, a delivery visit, and postnatal care (PNC) within six weeks after delivery at any contracted facility. Complicated deliveries, that for example treat excessive blood loss or provide surgery, are reimbursed at about four times the rate for normal deliveries (\$292 versus \$70). PNC does not currently include malaria prophylaxis, but does involve basic vaccination for the infant. The FP voucher entitles the user to any of several modern contraceptive methods: bilateral tubal ligation (BTL), vasectomy, hormone-based implants, and IUCDs. The GVR voucher entitles the user to medical examination, treatment, and counseling. The SM and FP vouchers are available from contracted voucher distributors operating in designated public venues. The GVR voucher is distributed only at contracted facilities rather than at third-party distributors, due to the unpredictability of the event.

Facilities were selected to participate in the voucher scheme as voucher service providers if they could demonstrate that their staff was qualified and competent in the delivery of healthcare services.



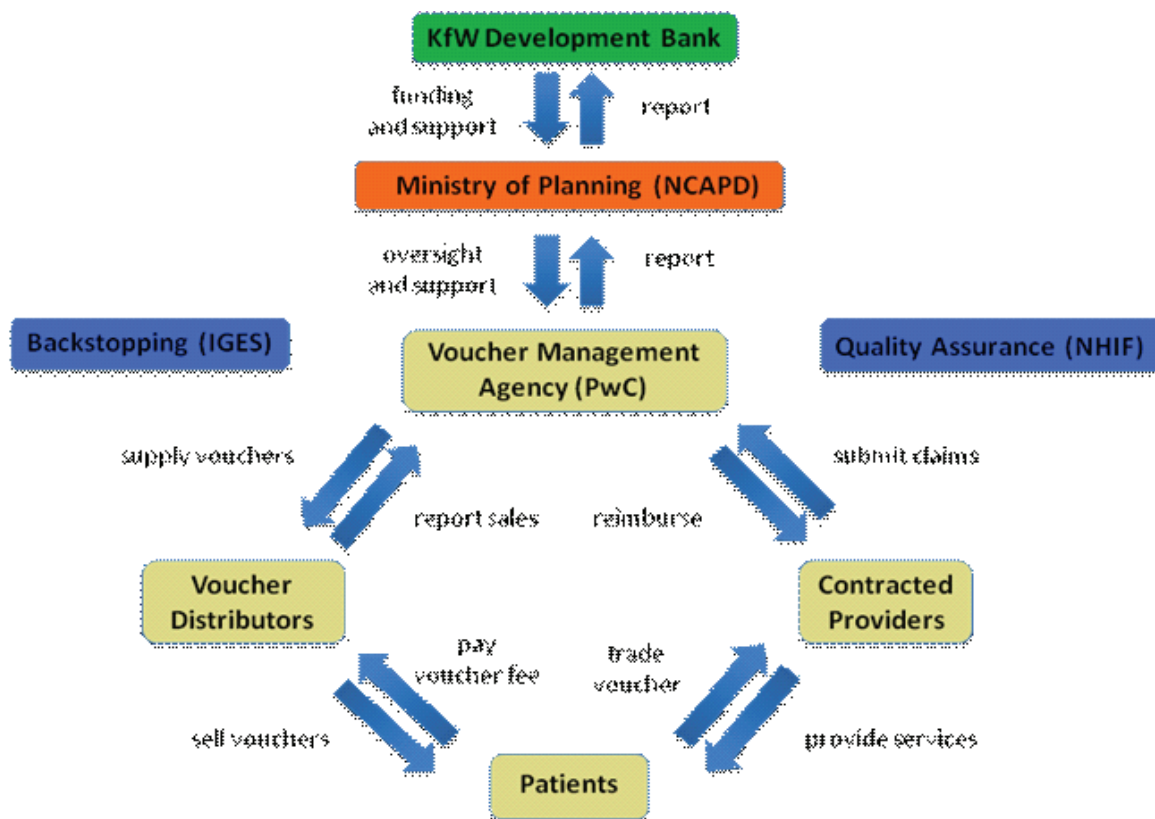


PROGRAM STRUCTURE AND MANAGEMENT

PROGRAM MANAGEMENT

Figure 1 describes the organizational structure of the voucher program in terms of major functions and the actors responsible. As its name implies, the voucher management agency (VMA) is the organization responsible for managing the voucher program overall. In Kenya, VMA functions were initially divided between the financial services company PwC and the non-profit Population Council, which works internationally on issues around population and reproductive health. The NHIF was chosen to play a role providing accreditation and quality assurance services, which would contribute to the monitoring and evaluation done by PwC.

FIGURE 1: ORGANIZATIONAL CHART OF THE VOUCHER PROGRAM, FIRST PHASE (2006–08)



The Population Council produced the manual on the standard of care in 2006 (Warren et al. 2006), but then was excluded from further program quality assessment; PwC eventually assumed all the major VMA functions of claims management and reimbursement, voucher marketing, and internal monitoring. The NHIF was contracted to perform quality assurance and provider accreditation. In this first phase, IGES performed backstopping functions for all the three services.

PROVIDER SELECTION AND ACCREDITATION

Fifty-four health facilities were contracted as voucher service providers (VSPs), and the NGO Marie Stopes Kenya provided outreach FP services in all the project sites. Facility participation varied by region and type of provider (Table 1). Less than 40 percent of the VSPs were government facilities.

TABLE 1: DISTRIBUTION OF CONTRACTED FACILITIES BY LOCATION AND TYPE OF PROVIDER, OCTOBER 2007

Site	Public	Private	FBO	NGO	Total
Kisumu	7	6	3	2	18
Kiambu	11	3	3	0	17
Kitui	1	2	4	0	7
Nairobi	2	8	0	2	12
Total	21	19	10	4	54

The NHIF managed VSP accreditation. Initially, many facilities were contracted with the aim of supporting competition and patient choice, and with the understanding that their service quality would improve over time. The intent was to cultivate capacity and experience among providers and within the NHIF, which would yield benefits beyond the scope of the voucher program.

Accredited facilities had to meet the staffing and infrastructure requirements of the voucher program. The facilities were expected to have properly trained staff who met national professional standards. All physicians, nurses, midwives, pharmacists, and public health professionals had to be registered with their appropriate professional health councils, e.g., Kenya Medical and Dental Practitioners Board and The Nursing Council. The registration of health care providers and facilities is compulsory (Griffith 2004). In addition, the non-governmental health facilities needed to acquire a Service Delivery Point (SDP) number from the MOH so that they could receive government-provided drugs, vaccines, and other medical supplies to which they were entitled as VSPs.

The midterm review (MTR) of the voucher program (Mati et al. 2008) found one facility operating without an SDP number, which meant that it could not receive vaccines and contraceptives directly from the MOH. Consequently, infants born at this facility had to be referred elsewhere for the BCG vaccine for tuberculosis. (The World Health Organization recommends BCG for all newborns in TB-endemic areas [Rekha and Swaminathan 2007]).

STANDARD OF CARE

Although routine NHIF reviews of facility compliance with the standards of care were to be used as a basis for renewing VSP annual contracts, this was never implemented. As noted above, the Population Council developed a manual detailing, by procedure, the standards of care and providing sample quality monitoring tools (Warren et al. 2006) that were to have been used in Phase I of the voucher program. The authors of this case study reviewed the following tools:


- Accreditation Manual
- Criteria for Voucher Service Provider Selection
- Quality Assurance Monthly Monitoring Evaluation Tool
- Quarterly Quality Review Tool
- Quarterly Support Supervisory Tool
- Monthly Client Exit Evaluation Form

Although the facility standard-of-care reviews did not take place, the quality of health care provision in public facilities could be strengthened through periodic training on best practices – the MOH gives all public providers (in and out of the voucher program) periodic training that can help them earn continuing medical education (CME) credits.

For private providers in the voucher program, however, there was neither CME opportunity nor regular facility review. The MTR found one private voucher facility with implants in stock but no staff trained to insert them, although insertion is a minor surgical procedure. A solution that seems apparent – to mandate more training – is not without problems: routine medical training has clear cost implications for private VSPs. Allowing staff to attend training means that the facility will have to operate without that person/s or get a short-term replacement, at additional cost. To encourage these facilities to support staff training, they must be convinced that the better-trained staff will enhance long-term productivity (and service quality), outweighing the short-term cost of training.

The SM Voucher helps combat economic barriers preventing Kenyan women from receiving safe delivery services and postnatal care.





PwC screened claim forms for completeness and medical logic. (See the claim form in the Annex A) The claims could have provided a perspective on the facilities' standard of care. It was not clear to the authors, however, that the claims were measured against any explicit quality targets or that there was even sufficient information reported on the claims forms to measure aspects of health care quality.

Although the MTR did not identify the percentage of non-compliant facilities, it did identify a range of problems encountered by VSPs trying to comply with the standard of care. Often the inadequate practice was the result of shortcuts taken to maximize reimbursement revenue. The MTR recommended the use of management safeguards to avoid facility overcrowding, underuse of supplies such as gloves, and discharge before patient is ready (Mati et al. 2008).


PRICING AND REIMBURSEMENT

VSPs of all types – public, private, NGO, and FBO – received up to the maximum reimbursement rates shown in Table 2. Rates were negotiated with each facility before the facility was contracted. Generally, government facilities were reimbursed at a lower rate than private ones, because the government covers major expenses (staff time and supplies) in public facilities separately. Unlike in the Uganda voucher program, the Kenya voucher program could make voucher reimbursements directly to the VSP, rather than to the district health office (Bellows and Hamilton 2009).

TABLE 2: MAXIMUM REIMBURSEMENT RATES BY SERVICE FOR SM, FP, AND GVR VOUCHERS

Voucher service	KSh	US\$†
SM: Normal delivery	5,000	\$70
SM: C-section or other complicated delivery	21,000	\$292
FP: BTL and vasectomy	3,000	\$42
FP: Implant	2,000	\$28
FP: IUCD	1,000	\$14
GVR	Full cost	Full cost

Rates for SM services include KSh 1,000 for 4 antenatal visits, about US\$3.50 per visit.



The typical turnaround time for reimbursement was 30 days. Nearly all private and FBO providers expressed satisfaction with the speed of claims processing and reimbursement. Not surprisingly, public and FBO facilities were very enthusiastic about the program as it represented additional revenue above what they received from government and donors, whereas private providers were more interested in improving the reimbursement amounts.

Both the service costs and fees charged by providers varied for non-voucher patients, according to a selection of provider concerns published in the MTR (Mati et al. 2008). This variation was greatest for C-sections, for which providers charged KSh 12,000–30,000 for non-voucher patients; the voucher program reimbursement for this service was KSh 21,000. A few private providers reported that their costs for complicated deliveries exceeded the reimbursement amount. Other providers, especially public clinics, were not sure of their costs, and subsequently the VMA assisted them with financial record keeping.

Some providers reported that a large number of the claims they submitted, in some cases more than a quarter, were rejected because of incorrect or incomplete information on the claim form (Mati et al. 2008). Overall, the voucher program seems to be having a positive capacity-building effect in terms of familiarizing providers with the process of reimbursement and tracking their expenditures.

REACHING USERS

Advertising agency Lowe Scanad was contracted to market the vouchers. Marketing methods included multimedia presentations at public meetings, religious congregations, and market days. Radio advertisements were used, but no specific data are available on coverage or the number of radio spots. Branded images, slogans, and printed materials were developed. Figure 2 shows promotional posters for the SM and FP services.

FIGURE 2: POSTERS FOR SAFE MOTHERHOOD AND FAMILY PLANNING SERVICES



PwC designed and printed the vouchers, which were given to voucher distributors. Distributors identified poor women in need of reproductive health services and potentially eligible for vouchers. To determine eligibility, they used a poverty grading tool (see Annex B) developed by MSK that measured poverty according to locally meaningful concepts like number of meals per day and home building materials. If the women were found eligible, they were allowed to buy a voucher from the distributor at the prices of KSh 200 for the SM voucher and KSh 100 for the FP voucher.

Prior to the 2006 launch of the voucher program, community groups were proposed as good voucher distributors. Youth and women's groups were encouraged to sell vouchers to pregnant women and individuals seeking long-term FP options. As the program progressed into 2007, the model appeared to work well in Kisumu and Kitui districts but improper or fraudulent voucher sales were reportedly common in the Nairobi slums and Kiambu district. (Specific numbers are not available.) Voucher distributors in the latter areas competed to sell vouchers because they earned a commission on every sale. Once NCAPD identified the

leakage, distributor reimbursement was changed to a fixed monthly salary on an annual salary to be renewed if no significant numbers of unusual sales were observed. Spot-checks were conducted at a sample of patients' homes to confirm that the patients qualified as low income. Such checks discouraged widespread improper sales but required an ability to follow up and locate patients, which is not cost effective on a sufficiently large scale to prevent all such cases.

Patients trade vouchers for services at contracted provider facilities, and providers submit claim forms to the VMA for reimbursement. As noted above, the reimbursement process usually takes about 30 days from the date of submission.

There are two additional points about voucher distribution to be noted:

The GVR voucher is free of charge and, as with the other services, the provider is reimbursed on previously negotiated rates. This was to maximize the incentive for potential clients to seek, and VSPs to provide care. GVR service clients often feel shame and confront a great deal of social stigma, even in health care facilities, in a health system that is largely unresponsive to gender violence. Fewer than 400 claims have been submitted for this service.

Purchase of the FP voucher is an important indication that the patient is exercising choice to seek long-term birth control. However, there is some concern in policymaker and global reproductive health circles that government-funded FP incentives compel patients into choices they may regret. Charging for the voucher is considered an important signal that the patient is making the decision freely and is sure about using the service.

Local voucher distributors assess voucher eligibility based on a poverty grading tool.





PROGRAM IMPACT

When evaluating the impact of a voucher program, five categories of outcomes commonly are considered: patient and provider knowledge, service quality, facility utilization, service expenditures, and disease burden (prevalence or incidence). These outcomes are generally measured at either the facility level or, less commonly, in the general population, and comparisons made between groups that received the intervention and similar groups that did not receive the intervention.

The data from the Kenya voucher program do not allow for making a population impact assessment. However, a retrospective facility-level evaluation is possible as PwC has routinely collected facility data from VSPs and poverty screening interviews done by voucher distributors. The NCAPD has also recorded voucher and non-voucher maternal deliveries at contracted clinics and can compare voucher and non-voucher utilization trends over time.

In addition to impact evaluation, program managers could use this generous amount of facility data to improve monitoring of program service quality and cost effectiveness. For example, combining non-voucher utilization with known facility costs for non-voucher deliveries provides a cost-to-output ratio that could then be directly compared with voucher delivery costs.

Population impact assessment generally requires data collected outside of routine voucher program operations. In 2006, the NCAPD contracted

Microde Consultants to conduct a baseline survey and design a framework for monitoring and evaluation. Microde carried out a records review at selected contracted facilities and made recommendations for improved information management (Mwongo and Odiko 2007). The need for a population impact evaluation was clear in the planning stages and recommended a year into the program by the MTR team, but to date no evaluation has been conducted.

UTILIZATION: IMPACT ON PATIENTS

The 2004 SM voucher feasibility report proposed an initial target of 100,000 deliveries in the first two years of the program. However, as planning progressed, the final pre-launch target, based on the size of the estimated KfW grant, and estimated service delivery and overhead costs, was reduced to 51,000 deliveries. Once the program began, actual utilization of the voucher far surpassed this lower target and supplemental funds were needed to pay for the additional deliveries.

The voucher program reaches some portion of pregnant women who previously did not deliver at facilities because of economic barriers. However, women continue to face barriers to delivering in health facilities – for example, an abrupt onset of labor and or lack of transport that prevented them from reaching a facility. The voucher program alone may not be enough to overcome the delivering at home.

In contrast to the popularity of the SM voucher, utilization of the FP voucher services was low; that is, while the FP voucher accounted for roughly two-thirds of all FP services provided at contracted facilities, the use of FP methods in general remained lower than anticipated. Increasing utilization remains a central goal of the Kenya voucher program.

**TABLE 3: UTILIZATION BY SERVICE,
JUNE 2006–OCTOBER 2008**

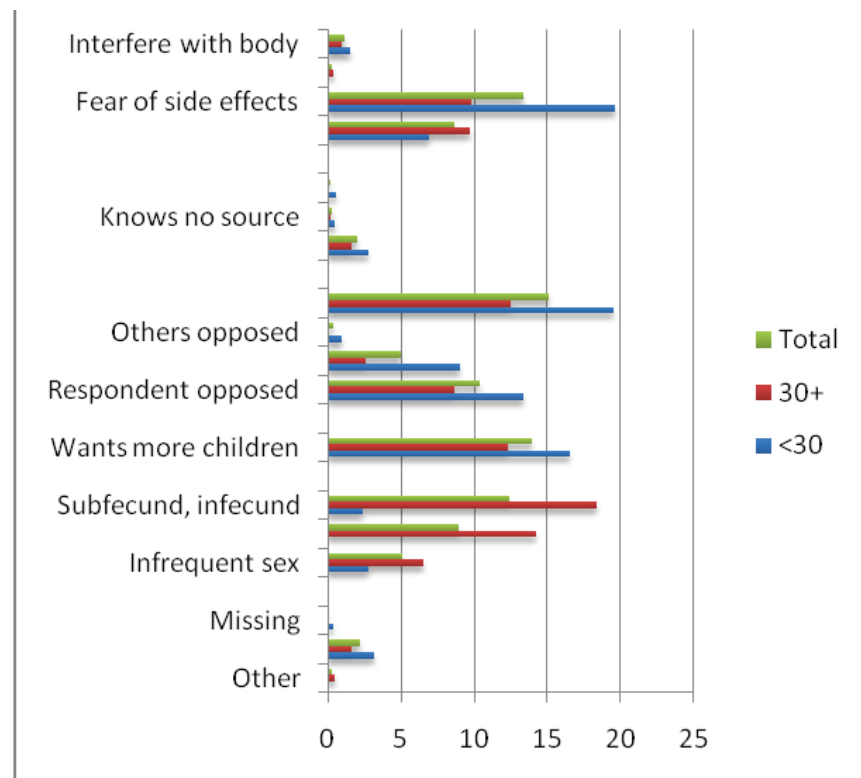
Voucher service	Non-voucher	Voucher	Target	Sales
SM deliveries, all	67,259	60,581	51,000	78,635
FP, all	5,973	11,296	62,000	25,620
BTL	774	3,954	–	–
Vasectomy	4	5	–	–
IUCD	1,805	594	–	–
Implants	3,390	6,743	–	–
GVR	–	337	1,000	–

Voucher and non-voucher actual patient volume, target patient volume, and voucher sales, by service. The voucher program accounted for roughly half of all deliveries and two-thirds of FP services among contracted facilities. However, FP utilization was much lower than anticipated, and fewer than half of all FP vouchers sold had been used by October 2008.


One important reason for the low uptake of FP vouchers may be an exaggerated fear of side effects of modern contraception methods. Data from the 2003 KDHS, presented in Figure 3, support this conclusion. This implies a need for a stronger educational component to the FP voucher marketing efforts. Other reasons for not using contraception, such as personal opposition or religious prohibition, might also be influenced through marketing.

FIGURE 3: MAJOR REASONS NOT TO USE A MODERN CONTRACEPTIVE METHOD

The most important reasons for respondents under 30 not using modern contraception are safety concerns, religious prohibition, personal opposition, and the desire for more children. For respondents older than 30 years, there is less need as well. Sourcing and access are not major issues for any age group.



Source: 2003 KDHS



In the presence of a voucher or other demand-side subsidy, the first patients to purchase the voucher are those whose utilization has been limited solely by cost or access, and all voucher programs can capture these patients. For other patients, underutilization of a service may be driven by non-economic factors such as cultural norms or fears of harmful side effects. The data in Figure 3 indicate that non-economic factors may be responsible for the limited uptake of FP vouchers in the target population. Marketing should be designed to address these non-economic barriers by linking the voucher brand to a perception of safety.

CAPITALIZATION: IMPACT ON PROVIDERS

Many providers, like Huruma Nursing Home in Nairobi and Neema Hospital in Kitui, have used the additional revenue from voucher patients to expand their facilities, purchase beds, buy equipment and generators, and hire additional staff. Some facilities have expanded the range of services they offer by installing a simple surgical theater to handle procedures that previously had to be referred (Mati et al. 2008). In addition to supporting the costs of care and choice among patients, the voucher program has allowed providers to capitalize much more rapidly than they could have done with the previous level of demand. Thus the voucher program subsidy, beyond benefitting patients directly, also represents an investment in the health care system at large. Furthermore, it is a targeted investment, in that providers themselves are making decisions about how to spend the additional revenue where it will be most useful.

It would be interesting to understand how the additional revenue generated by the voucher subsidy has influenced take-home pay for providers. The VMA might consider a monthly or quarterly survey of providers to monitor the economic impact of the program on both take-home pay and the specific capital investments they choose to make.

PROGRAM COSTS

Table 4 presents the program costs for the SM and FP vouchers for the period July 2006–October 2008. The total program expenditure, including overhead costs and reimbursement to providers, is given in Kenya shillings and in euros as reported to KfW at the end of Phase I in October 2008. The portion of costs spent on management, training, and marketing is 21 percent of the project budget.

TABLE 4: TOTAL EXPENDITURES ON PHASE I OF THE OBA VOUCHER PROGRAM, JUNE 2006–OCTOBER 2008

All amounts are as reported to KfW in 2008.

Expenditure	Euro	KSh	
Direct service costs			
Reimbursing GVR VSPs	8,908	914,184	
Reimbursing FP VSPs	201,810	19,817,182	
Reimbursing SM VSPs	4,621,540	463,195,705	
<i>Subtotal</i>	<i>4,832,258</i>	<i>483,927,071</i>	<i>79%</i>
Management costs			
Distributor training	8,109	804,410	
Bank charges / miscellaneous	10,277	1,034,950	
GVR VSPs training	10,723	1,063,650	
PwC pricing report in 2006	14,165	1,405,131	
Process monitoring (NCAPD)	18,554	1,840,541	
Commission to distributors	49,246	4,970,929	
VSP accreditation and training	63,785	6,223,222	
Quality assurance (NHIF)	138,775	14,004,090	
Marketing and communications	192,871	19,132,386	
PwC management fee	764,000	76,170,827	
<i>Subtotal</i>	<i>1,270,505</i>	<i>126,650,136</i>	<i>21%</i>
Total expenditure	6,102,763	610,577,207	100%



SUMMARY

The Kenya voucher program was implemented to address the burden of reproductive and perinatal morbidities in the context of a rapidly growing population with a stagnant use of modern FP methods. At the same time, the program was designed to directly subsidize utilization of reproductive health services among the poor, and to accustom the NCAPD management team and health care providers to a reimbursement model of payment.

Uptake of the SM voucher surpassed targets and accounted for nearly half of all deliveries at contracted facilities. However, FP voucher uptake remains low; with a rising TFR, this voucher should be a high priority going forward. The 2003 KDHS found that 44 percent of married women want no more children, and that the most common reasons for not using a modern FP method have to do with fear of harmful side effects and personal or religious opposition. Well-designed marketing can improve the perception of FP safety and emphasize the advantages of a smaller family. Focus groups may be beneficial in further exploring barriers to uptake among Kenyan women. Given that FP was included in the original voucher program (indicating that increased FP uptake was a government priority) and recognizing the remarkable low costs to administer the FP voucher (1 percent administrative costs), changes could be made to improve uptake. Low uptake to date suggests that marketing efforts have not been fully effective. Alternative marketing



strategies may encourage uptake. Operations research into FP patients' decision-making process could also help identify uptake barriers beyond marketing constraints.

There is a need for providers to maintain standards of care and for the program to monitor compliance. The extent and quality of program monitoring is unclear from current documentation, and it is likely that better monitoring efforts could benefit the program. Service data are collected by PwC and shared with NCAPD and KfW; however, additional data on service quality and facility finances could improve the monitoring effort.

It is important that there be a rigorous attempt to estimate the population impact of the voucher program. To do this, program funds would need to be set aside or external resources accessed to make comparisons between populations served and not served by vouchers. Assessing population impact may not be possible unless the program expands to a new service or a new geographic area, with a baseline household survey to collect data on pre-program health outcomes in areas with and without access to the voucher. With data from a follow-up survey after 12–18 months, comparisons could be made on average health status of populations “exposed” to the voucher service and population “unexposed.”

The evaluation should also consider the program's cost-effectiveness. Data would need to be drawn from clinics that do not accept vouchers, but which are otherwise similar to clinics that do accept vouchers. Costs and patient outcomes could be observed and comparisons made on the relative cost-effectiveness of the voucher service. Monthly or quarterly surveys of providers could be used to measure the effect of the program on capital investments made by providers, and compare reimbursement amounts with provider costs and fees for non-voucher patients.

The voucher program is beginning a second phase in which the current services will be expanded within the same geographic areas. In this expanded program, there are opportunities to consider how a large number of services, perhaps even a primary health care package, would operate effectively under a claims reimbursement model. Up to now, the management agency has assumed that a fee-for-service model is the appropriate strategy; however, evidence from across the globe indicates that paying fees for each service is likely to induce utilization beyond what is cost effective once services amenable to “supplier induced demand” are added to the package (Labelle et al. 1994).

Supplier-induced demand may partly explain the increase in C-sections as higher reimbursement rates for the procedure may be inducing more C-sections than necessary or desirable. In the current reimbursement schedule, normal deliveries are reimbursed at \$72 and complicated deliveries are reimbursed at \$292. There is evidence that C-sections increased significantly after facilities were contracted, which may have been due to the much higher reimbursements allowed. Interestingly, a comparison of the proportion of C-sections among voucher and non-voucher clients in the first two years of the program shows that the proportion is higher among the non-voucher clients. One alternative pricing model is a case-based approach in which an average price would be paid for all deliveries. Such an approach could remove provider incentives that encourage unnecessary obstetric surgeries. Under the expanded program with its additional services and more complicated management, it may emerge that a case-based reimbursement strategy, with fewer price points and greater incentive for cost containment, is more efficient.

In the expansion, new facilities will likely be added, including lower-level government health posts that do not charge for normal deliveries, unlike higher-level health facilities and hospitals. The motivation to include such health posts is to further habituate the government health system to a reimbursement process as a payment model for public health care. However, the free services represent an uptake challenge to voucher services that charge a co-payment of KSh 200. The management agency may therefore need to reconsider voucher pricing to patients. While properly



For every woman who dies in childbirth, up to 20 women suffer morbidities, often with severe medical and social consequences.



incentivized voucher distributors are the primary “gate-keepers” for voucher use, the price of the voucher itself is an important secondary mechanism for targeting and fraud prevention. Continuing to charge for the voucher may undermine utilization for free services, or drive patients used to receiving normal delivery care free of charge back into the hands of untrained birth attendants. On the other hand, distributing the voucher free of charge may fail to check fraud. Both potential failures should be considered when setting the price of the voucher.



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For more information about Health Systems 20/20 please contact:
Health Systems 20/20 | www.healthsystems2020.org
Abt Associates Inc. | www.abtassociates.com
4550 Montgomery Lane
| Suite 800 North | Bethesda, MD 20814 | USA
E-mail: info@healthsystems2020.org
| www.healthsystems2020.org