

A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?

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Accepted 15 December 2009

It is now more than 2 years since the Ministry of Health and Family Welfare of the Government of Bangladesh implemented the Maternal Health Voucher Scheme, a specialized form of demand-side financing programme. To analyse the early lessons from the scheme, information was obtained through semi-structured interviews with stakeholders at the sub-district level. The analysis identified a number of factors affecting the efficiency and performance of the scheme in the program area: delay in the release of voucher funds, selection criteria used for enrolling pregnant women in the programme, incentives created by the reimbursement system, etc. One of the objectives of the scheme was to encourage market competition among health care providers, but it failed to increase market competitiveness in the area. The resources made available through the scheme did not attract any new providers into the market and public facilities remained the only eligible provider both before and after scheme implementation. However, incentives provided through the voucher system did motivate public providers to offer a higher level of services. The beneficiaries expressed their overall satisfaction with the scheme as well. Since the local facility was not technically ready to provide all types of maternal health care services, providing vouchers may not improve access to care for many pregnant women. To improve the performance of the demand-side strategy, it has become important to adopt some supply-side interventions. In poor developing countries, a demand-side strategy may not be very effective without significant expansion of the service delivery capacity of health facilities at the sub-district level.

Keywords Demand-side financing, maternal health voucher, access, maternal health services

KEY MESSAGES

- The pilot demand-side financing program appears promising for poor households in rural Bangladesh, with the maternal health vouchers creating significant purchasing power.
- Careful planning is needed before implementation to ensure that adequate administrative and financial resources are mobilized for timely processing and disbursement of vouchers and incentive payments, and that selection criteria for enrolment are contextually appropriate and understood.
- Where local health service capacity is limited, a demand-side strategy may not be very effective without significant expansion of the service delivery capacity of health facilities.

Introduction

Bangladesh has achieved impressive progress in immunization coverage, reduction in fertility and child mortality over the last few decades (MOHFW 2001). Despite the improvements in child health and family planning outcomes, the maternal mortality ratio has remained relatively static at an unacceptably high level of around 320 per 100 000 live births (NIPORT 2003). Deliveries attended by skilled personnel are also largely unchanged, remaining below 18% of all births (NIPORT 2007). Low utilization of maternal health services is one of the factors contributing to high maternal and neonatal mortality and morbidity in the country. Evidence suggests that poor individuals often do not use free public health services (UNDP 2004). Supply-side problems and demand-side barriers are considered responsible for the low utilization of maternal health services in Bangladesh. Supply-side issues include non-availability of maternal and neonatal health services, drugs and commodities, discrimination against poor women and imposition of unofficial user fees. The cultural and social belief system, social stigma associated with pregnancy and birth, distance of the facility from home, lack of information on sources of care, lack of awareness on the value of maternal health services, and high access costs (e.g. direct and indirect costs) are considered important demand-side barriers (Ensor 2004).

Public facilities providing maternal and neonatal health care services in Bangladesh get governmental subsidies to improve access to these highly effective medical interventions. In other words, these services are being organized and provided in Bangladesh under a supply-side financing mechanism where the providers receive funds to ensure access to care for all either free of charge or at a highly subsidized rate. Although the supply-side financing has been in place for many years now, women from low-income households still face significant barriers to access. A survey of women in four poorly performing districts of Bangladesh indicates that 27% of women did not use the supposedly free public health facilities for delivery due to lack of money (Mitra and Associates 2008).

Failure of the supply-side financing strategy to reach the poor has prompted the Government of Bangladesh to initiate a pilot program called the 'Demand-side Financing Maternal Health Voucher Scheme' (MHVS). The main purpose of the pilot program is to reduce demand-side barriers faced by poor women so that they will be able to access quality maternal health services. Since the demand-side voucher system transfers funds to the health facilities through consumers, it is hoped that the health facilities will become more responsive to the needs of the clients. The ultimate goal of the project is to decrease maternal morbidity and mortality, particularly among poor socio-economic groups, to achieve the target for Millennium Development Goal 5.

Concept of demand-side financing

Demand-side financing (DSF) is a mechanism to increase the purchasing power of voucher-recipients to obtain specified health services or goods through the market system (Pearson 2001). This is considered an effective mechanism of targeting

essential health services to specific population groups such as pregnant women, children or the poorest. In a DSF mechanism, intended beneficiaries receive resources directly from the implementing agency. These additional resources empower the beneficiaries to obtain access to quality health care services based on their needs. The DSF scheme should also be helpful in protecting households from the catastrophic household expenditure associated with relatively high-cost interventions like emergency obstetric care. The DSF instruments include vouchers or coupons, health funds or insurance schemes. All the DSF instruments are intended to subsidize the target health services so that the out-of-pocket cost of medical care at the point of delivery becomes significantly lower than the market price or fee charged.

A demand-side financing scheme for maternal and neonatal health is expected to reduce financial barriers to access and, therefore, should improve utilization of the service-types by the poorer sections of the population. Since the DSF allows the client to choose the providers, this should also encourage the provision of quality health care services through increased competition in the market. By design, revenue earned by a health facility from the DSF clients is directly proportional to the number of clients seen. Therefore, this scheme should enhance the quality and quantity of targeted services supplied in order to attract a higher number of DSF clients to the facilities (Sandiford *et al.* 2005).

Demand-side Financing Maternal Health Voucher Scheme in Bangladesh

The Ministry of Health and Family Welfare (MOHFW), with technical and financial support from the World Health Organization, is now implementing the Demand-side Financing Maternal Health Voucher Scheme in 33 sub-districts of the country (MOHFW 2007). Initially the pilot scheme was adopted in 21 sub-districts and has recently been expanded to an additional 12 sub-districts. Conscious attempts were made to select disadvantaged geographic areas for inclusion in the DSF scheme. Developmental indicators such as literacy rate, population density, poverty levels and the presence of community-based skilled birth attendants were used in selecting the sub-districts.

Beneficiaries

The scheme used two different types of targeting mechanisms. In the nine sub-districts under universal targeting, all the pregnant women are entitled to receive the vouchers. In the remaining 24 sub-districts, targeting is based on means-testing, i.e. on economic status of the beneficiaries. Poor and vulnerable pregnant women were defined as the target group in these 24 sub-districts. Following criteria were used to identify the target women: resident of the sub-district, current pregnancy is the first or the second pregnancy, functionally landless, i.e. owing less than 6534 square feet of land, household earning less than US\$38.50 per month, and lack of ownership of other productive assets.

Benefits

The service components covered by the vouchers are three antenatal care (ANC) check-ups, safe delivery at a facility or at home by skilled birth attendants, one postnatal care (PNC) checkup within 6 weeks of delivery, and management of complications including caesarean section from designated providers. Transportation costs provided through the system are about US\$7.70, which includes US\$4.60 for three ANC visits, US\$1.55 for institutional delivery and US\$1.55 for one PNC visit. Pregnant women receive this money in cash after the completion of the visits. In addition to these services, women who deliver at facility receive about US\$31 in cash for buying nutritious food and a gift box of value US\$7.70. The gift box contains baby soap, a big towel, two sets of baby clothing and one large bottle of nutritious drink powder. The components of the benefit package of the scheme are shown in Table 1. Each pregnant woman referred from the sub-district to the district level also receives an additional US\$7.70. This payment is for covering part of the travel costs associated with seeking care from the referral centre. The current design of the scheme does not allow payment of travel costs for seeking care from a referral facility located outside the sub-district in which the client lives.

Health service providers

The covered services must be received from an authorized or 'designated' provider working in the public, non-governmental (NGO) or private sector. The designated service providers are reimbursed through locally assigned banks upon submission of evidence of service provision to the DSF scheme clients. Non-governmental and private providers receive full reimbursement for the services provided. Government health care

Table 1 List of services covered by the vouchers and the reimbursement rate

| Voucher service components | Reimbursement rate (US\$)* |
|--|----------------------------|
| Registration | 0.15 |
| Lab tests for 3 ANC visits: 2 blood and 2 urine tests | 2.15 |
| Consultation fees for 3 ANC visits and 1 PNC visit | 3.07 |
| Conduct of safe delivery Safe delivery | 4.61 |
| Medicine | 1.54 |
| Forceps/Manual removal of placenta/DE&C/vacuum extraction | 15.38 |
| Eclampsia management | 15.38 |
| Caesarean section with medicine | 92.30 |
| Transportation to referral facility | 7.70 |
| Referral fee from sub-district to district level | 7.70 |
| Gift to pregnant women and baby after delivery at facility | 7.70 |
| Incentive to mother after delivery at facility | 30.76 |

*1 US\$ = 65.00 Taka.

Source: Demand-Side Financing Pilot Maternal Health Voucher Scheme Proposal (MOHFW 2007).

providers are reimbursed 50% of the voucher value as incentive payment and the remaining 50% of the value is deposited in a newly created seed fund account. At the start of the scheme in the area, a designated officer opens the seed fund account with an initial deposit of US\$1000 provided by the project. The seed fund may be used for improvement of service provision, repair and maintenance of the health facility, and for any other activities related to maternal and child health/survival.

Management of the MHVS at the sub-district level

A Sub-district DSF Committee is responsible for monitoring and supervision of the activities of MHVS. This committee allocates vouchers to Union DSF Committees for distribution among the beneficiaries. The Sub-district DSF Committee reports to the National DSF Committee.

Distribution of voucher and cash incentive at the sub-district level

Under the scheme, community health workers such as Female Health Assistants or Family Welfare Assistants identify pregnant women in their catchment areas within the 1st trimester. They register the pregnant women using a form developed by the project. The registration form contains information needed to determine the eligibility for participation in the scheme.

From the list of all registered pregnant women, the Union DSF Committee selects eligible pregnant women using the pre-set selection criteria. The committee is responsible for distributing the vouchers to eligible women. The vouchers and transport subsidies are handed out during the monthly meetings of the scheme. A Female Health Assistant or a Family Welfare Assistant helps the Union DSF Committee in the distribution of vouchers and transport subsidies. They also provide information to women on eligible health care providers, transportation allowance rules and referral care in case of emergency. Each sub-district has a DSF organizer employed by the project who manages the voucher distribution and reports the use of vouchers.

The MHVS has been in operation in selected sub-districts of the country for more than 2 years. In order to strengthen the programme or to make minor adjustments to the scheme, it is important to document the early lessons learnt and challenges faced during the start-up process. This paper provides information on the implementation experience viewed from the perspectives of the beneficiaries and the implementing personnel.

Methodology

Selection of the sub-district for the case-study

Sarishabari is one of the first 21 sub-districts where the DSF scheme was started as a pilot project. This sub-district is located in the district of Jamalpur in Bangladesh. The sub-district is considered one of the poorest areas of the country with a population of about 342 000. Administratively, the sub-district is divided into eight unions (administrative units). Catastrophic floods occur every year due to overflowing of the river Jamuna on the western side. Landlessness and the proportion of marginalized displaced groups in the population are relatively

high in the district due to river erosion. Early marriage and pregnancies, large family size and poor state of pre-natal and maternal health care services place mothers at very high risk of complications (Mitra and Associates 2008). Sarishabari sub-district has five Union Health and Family Welfare Centres, which provide curative and preventive services including family planning. The sub-district health complex is a 50-bed hospital and this is the only referral facility in the area. The second tier of referral facilities in the area comprises the Jamalpur District Hospital and the Jamalpur Mother and Child Welfare Centre, both of which are located in Jamalpur town, 25 km from Sarishabari town. The DSF scheme was implemented in this area in April 2007.

Stakeholder interviews

In order to obtain information on the scheme and its implementation at the sub-district level, semi-structured interviews were conducted with the stakeholders. Stakeholders interviewed were selected based on the roles they played in the programme as well as their degree of involvement with the implementation of the MHVS. Nine of the interviews were conducted with individuals who played very active roles in the implementation of the voucher scheme. Four beneficiaries of the scheme were also selected for interview. A total of 13 interviews were conducted and the interviews lasted for about 30–45 minutes each. Table 2 reports the characteristics of the respondents interviewed. The interview guide included two segments: the first to understand the stakeholders' view of the DSF scheme and the second focused on the implementation-

related problems and concerns. The order of topics discussed during the interviews varied depending upon the characteristics of the respondents and the roles they played in the scheme. All interviews were conducted after assuring the interviewees full confidentiality.

Results

A number of convergent themes related to the implementation strategies of the scheme were identified from the interviews. The results are presented below by major themes raised.

Theme 1: Voucher distribution and eligibility criteria

During the first year of implementation, the number of vouchers distributed in the area was much higher than the expected number (7161 vouchers were distributed). About 60% of all vouchers distributed in the year were given out during the first 6 months of the scheme (April–September 2007). The implementation of the programme at the local level mistakenly assumed that all pregnant women are eligible to receive the vouchers irrespective of their socio-economic status. This is an indication of lack of planning of the start-up activities and breakdown of communication between the upper and lower levels of administrative units. This lack of communication between the local and district DSF committees created another significant problem: temporary suspension of voucher distribution for a few months due to shortage of voucher books. The scheme supplied the voucher books to the local committee based on the expected number of eligible pregnancies in the area, but inclusion of all pregnancies in the programme created unexpected shortages. After this initial mis-step, vouchers were given only to eligible pregnant women.

To avoid this type of problem in the future, the scheme decided to transfer the decision-making authority on enrolment from the local level to the sub-district level. Centralizing the process of identifying the target individuals is not ideal, but this was considered a quick-fix. Local level administrators of the programme thought that it was difficult to follow the strict selection criteria adopted by the DSF for enrolling pregnant women. The poorest among the pregnant women had more than two children but the scheme defined a target pregnancy as either the first or the second pregnancy. Many local administrative staff considered the selection criteria unfair and difficult to enforce at the field level.

Theme 2: Reimbursement for vouchers

Another problem faced by the scheme during its implementation phase was the delay in the release of funds which delayed the reimbursements. Due to late allocation of funds, voucher-supported service activities were hampered as both the beneficiaries and the health care providers did not receive the money they were supposed to get through the vouchers. One of the respondents expressed the problem as follows:

The flow of voucher funds were not timely and irregular fund disbursements delayed payments to beneficiaries and providers. They had to wait for a long period of time to receive their payments. Beneficiaries did not get their cash benefits when they sought care

Table 2 Characteristics of 13 stakeholders interviewed

| Characteristic | No. |
|---|-----|
| Gender | |
| Male | 6 |
| Female | 7 |
| Operational focus | |
| Management and supervision | 2 |
| Union Committee member | 2 |
| Service providers | 3 |
| Voucher distributor | 2 |
| Beneficiaries | 4 |
| Management and supervision | |
| Higher management & supervision | 1 |
| Field management & supervision | 1 |
| Service providers | |
| Medical Officers | 1 |
| Nurse | 1 |
| Family Welfare Visitor (FWV) | 1 |
| Voucher distributor | |
| Family Welfare Assistant (CSBAs)* | 1 |
| Health Assistant | 1 |
| Beneficiaries | |
| Pregnant women and who delivered recently | 4 |

*CSBA = community-based skilled birth attendants.

from approved facilities. This created significant mistrust between the implementing units and the beneficiaries. (Stakeholder # 1)

A number of beneficiaries also expressed their frustrations with the scheme. Two women who recently delivered mentioned that they did not receive cash incentives at the time of the interview. One of the beneficiaries stated:

It is more than three months since my daughter was born. I went to collect money with my voucher book last week. I did not receive any money and was told to come back later. (Stakeholder # 13)

Theme 3: Demand for services

All the local level administrators interviewed knew the details of the DSF scheme quite well and they held very positive views on the potential benefits of the scheme. Most observed that the implementation of the programme did increase the demand for antenatal, delivery and postnatal care by poor women in the community. The health complex saw increased demand for services, especially by the poorer sections of the community. Institutional deliveries also increased due to the presence of the scheme in the area. One respondent mentioned:

I think the DSF is there to protect the poor women. The scheme has reduced the financial burden on poor women and lowered the risk of complications associated with pregnancy and delivery. Compared to the previous years, a much higher number of poor pregnant women are now seeking and receiving maternal health services. Many are also coming to the health complex now for delivery. (Stakeholder # 2)

In our interviews, personnel involved with the implementation of the scheme thought that use of medical care services jumped significantly in the last 3 to 4 months of the first year compared with previous months. A new order issued by the Government of Bangladesh towards the end of the first year allowed public sector health care providers to get reimbursements through the voucher scheme. In the original plan, public sector providers were not allowed to receive reimbursements for the vouchers; after the policy change, government facilities became interested in generating extra funding through the vouchers.

Theme 4: Impact on family planning

Some stakeholders expressed concerns about the potential impact of the programme on family planning. They thought that the cash incentive would encourage poor women to become pregnant. One of the persons interviewed stated:

Under the scheme, poor women are receiving incentive payments in cash after delivery. This incentive is clearly important for poor households but this will reduce motivation for contraception in low-income families. (Stakeholder # 11)

Theme 5: Opinions on programme rules and suggestions for change

A number of interviewees thought that providing nutritious food and other necessary items for the mother and the newborn

would have been a better approach than the cash benefits. Some also thought that the cash benefit may not actually help the women directly. They are likely to spend this cash for other household activities.

Most of the individuals responsible for implementing the programme complained that the new scheme represented significant additional work for them on the top of their regular job. The scheme did not increase the supply of health care providers or management personnel, and therefore, the existing staff and health care providers had to assume a higher workload. Although the service providers received extra incentive payments, it appears that neither the providers nor the administrative personnel were happy with the incentive structure. The providers interviewed complained that the reimbursements were much lower than the fair level of payment for the services rendered. Among the administrative personnel, the source of dissatisfaction was lack of any extra payment for organizing, managing and supervising MHVS activities at the community level. Some the interviewees argued that although the administrative personnel are not directly involved in service provision, they play a very important role in ensuring proper implementation and functioning of the scheme. A stakeholder responsible for managing and supervising the voucher scheme said:

I have to work beyond office hours to manage and organize the activities of the new scheme. This is an additional assignment for me. Under this scheme, service providers receive extra financial benefits for providing services but, unfortunately, I don't receive any benefit for my work. (Stakeholder # 3)

According to a service provider:

My workload has gone up significantly since the introduction of the voucher scheme. I am receiving some money from the scheme but that is not enough compared to the increased workload and time involvement. I could have earned more income from my private practice. (Stakeholder #7)

Unlike the health care providers and management staff, beneficiaries of the scheme expressed satisfaction with the services received through the DSF vouchers. They were happy that they were getting maternal health services free of cost and receiving additional cash benefits for seeking care. The beneficiaries interviewed suggested that the scheme should include child health services as well so that they can obtain good quality health care services for their children. The beneficiaries also suggested that the voucher scheme per pregnancy should continue for three years to ensure continued good health of the mother and the baby.

Theme 6: Readiness of health service providers three to meet the increased demand

It was also noted in the interviews that since there was no accredited private health facility or NGO clinic in the sub-district, patients had no effective choice in the area. Therefore, improving the quality of services or responsiveness of the system to clients' needs through increased market

competition did not happen. Women in this area depend on public providers for their maternal health services.

Sarishabari sub-district has no private maternal and child care clinic. NGOs are not providing any health care here. Women in this area have no choice other than going to the public health care providers. Presence of any accredited private providers will increase women's choice and should improve the performance of public health providers. (Stakeholder # 4)

The sub-district health complex could not perform caesarean sections for several months within the project period due to non-availability of an anaesthesia consultant. The voucher scheme supported 43 caesarean sections, only 10 of which were conducted at the health complex during the first year of the scheme. The remaining 33 caesarean sections funded by the DSF vouchers were conducted at the referral facilities in Jamalpur town. One of the respondents stressed:

We need to have a full-time obstetrician/gynaecologist and a full-time anaesthesiologist here in the area. Positions of some service providers (Medical Officer and FWV) are vacant. The service providers currently providing services are seeing an increased workload due to the introduction of the scheme. We don't have enough capacity to meet the demand. (Stakeholder # 6)

The travel time and costs associated with emergency delivery cases may become prohibitively high if women need to travel to

the district town for the service. One of the beneficiaries mentioned:

I had to go outside Sarishabari sub-district for services. My family paid for travel, food and accommodation costs for me and for others accompanying me to the district facility. We had to take out loans to pay for all the costs incurred. (Stakeholder # 12)

The voucher scheme does provide additional money if the case requires referral to the district level but the actual out-of-pocket cost of travel and accommodation, according to the beneficiaries, exceeds the reimbursement allowed by the scheme.

Discussion

Figure 1 summarizes different aspects of the MHVS and its implementation, e.g. steps followed by the scheme, role of stakeholders and problems identified during the implementation stage. The most significant problem faced by the scheme in the study area was the delay in releasing funds for incentive payments. Non-payment of incentives created mistrust between the administrators of the scheme and the beneficiaries. Most beneficiaries assumed that the administrators actually received the money but kept it illegally for themselves. Another problem of the programme was discontinuation of voucher distribution for few months. The implementation of the scheme could have been much more efficient if the voucher distribution was not discontinued in late 2007. Therefore, future expansion of the

| Steps taken | Role of stakeholders | Problems faced or identified |
|--|--|--|
| Fund and vouchers were made available at the sub-district for distribution | Funds and vouchers are managed and supervised by sub-district and union DSF committee | Fund and vouchers were not available on a timely basis |
| ↓ | | |
| Target pregnant women identification process | Union committee members identify the target group and issue vouchers to target women | Errors in targeting |
| ↓ | | |
| Distribution of vouchers to pregnant women | Family Welfare Assistants and Health Assistants help in the distribution of vouchers | Not enough vouchers supplied to the local DSF committee for distribution |
| ↓ | | |
| Pregnant women receive vouchers | Pregnant women seek antenatal, delivery and postnatal care from designated service providers | Women did not receive cash incentive on time Limited option of health care providers. Public providers were only designated providers |
| ↓ | | |
| Pregnant women receive services from service providers | Family Welfare Visitors /Nurse /Medical Officer/Consultant provide maternal and neonatal health services | Emergency obstetric care (EmOC) often not available in the local area |

Figure 1 Steps, role of stakeholders and identified problems in providing maternal health services supported by the voucher scheme.

scheme should carefully plan the needs of the programme to ensure that adequate administrative and financial resources are mobilized for timely processing and disbursement of vouchers and incentive payments.

The selection criteria adopted by the program for enrolment of pregnant women should be carefully re-evaluated. The current system does not allow enrolment of women with more than two previous pregnancies. Most program administrators interviewed thought that the selection criteria were unfair for the poorest because the poorest women in the community are more likely to have two children or more. In addition to the fairness concern raised by the stakeholders, non-eligibility of the poorest pregnant women implies that the project may not be able to reduce maternal deaths and morbidities significantly. It appears that the enrolment criteria developed by the program will be difficult to implement and verify. Although this qualitative evaluation could not estimate the targeting efficiency, some of the administrative personnel mentioned that they allowed many poor women to enrol even though they had two or more children.

The design of the DSF voucher scheme limited the coverage of maternal care and financial benefits to the first two pregnancies to limit the potential impact of the voucher scheme on fertility. Although the scheme may encourage increased fertility rate, not allowing poor women to participate after their second child may not be socially desirable. Moreover, alternative approaches of providing benefits can be designed to minimize the effect of the programme on fertility. One of the suggestions proposed by women was to increase the duration of benefits to 3 years rather than limiting it to about 1 year. Longer duration of benefits will encourage use of family planning, thereby reducing overall fertility.

In the study sub-district, there was no private clinic or NGO facility that could provide quality maternal health and emergency obstetric care services. Poor pregnant women are entirely dependent on public health facilities for health services. In the absence of market competition, DSF is unlikely to improve the quality of maternal health care supplied in the market. The design of the programme should consider different forms of incentive payments to improve service quality and quantity in areas with limited or no market competition. In a context of low market competition, total voucher distribution may be expanded to create a larger market for maternal health services. A larger market may attract some private providers into the area. The programme may also combine supply-side policies with demand expansion generated by vouchers. The supply-side subsidies may be targeted towards private providers who are willing to relocate to underserved areas of the country.

In the study area, increased utilization of maternal health services was observed only after the scheme allowed public providers to receive incentive payments for the provision of services to enrolled women. Allowing additional incentive payments to public health care providers has both merits and disadvantages. On the positive side, the incentive payments help to expand the supply of essential health services without any increase in the number of providers. The incentive system will also improve service quality, efficiency and accountability of service providers at public facilities. Well-performing public

providers will be able to generate and keep significant additional resources for their use through the seed funds.

A possible negative consequence could be that the incentive payments adversely affect the routine work of public health facilities for which no additional money will be forthcoming. Moreover, incentive payments without any effective competition may not be quality enhancing in the longer run. Relatively high incentive payments for caesarean sections may also increase caesarean rates. In this review, it was not possible to explore whether the caesareans carried out under the voucher scheme were necessary or not. Unnecessary caesareans will affect maternal health negatively, and impose additional social costs on poorer households. The incentive payments may also have generated new problems and conflicts that were not present in the health care delivery system prior to the implementation of the scheme. A number of stakeholders responsible for the management and supervision of the scheme expressed their unhappiness with the system of paying extra money to health care providers while not paying any incentive payments to administrative staff, who are instrumental in setting up the system and enrolling the beneficiaries.

The findings of this study also raised an important concern about the readiness of the health care delivery system in meeting the needs of pregnant women in the community. It appears that the health system is not ready to meet the increased demand for comprehensive emergency obstetric care services generated by the MHVS. Sub-district health complexes, as a referral facility, were unable to provide comprehensive emergency obstetric care due to non-availability of specialized providers. The ability of the health complex to provide comprehensive emergency obstetric care services 24 hours a day should be strengthened.

In summary, the pilot project on DSF appears promising for poor households in rural Bangladesh. Even though many of the beneficiaries are illiterate, vouchers did create significant purchasing power. The initial lessons learned through this quick, qualitative study should be useful in avoiding future problems if the policy planners address these concerns before scaling-up the scheme to a wider geographic region of the country.

Acknowledgements

The authors are solely responsible for the content of this paper. The views expressed do not necessarily reflect the views of the organizations in which the authors are employed. The authors would like to express their gratitude to: Sarishabari health and family planning management team members for their help at all stages of this study; and Dr Rama Das and Mr Abu Taleb Tuhid, Jamalpur UN Joint Maternal and Neonatal Health Project Team members for their help in organizing the field visits and data collection.

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