More Choices for Women: Vouchers for Reproductive Health Services in Kenya and Uganda

BY LINDSAY MORGAN[1]

A Family

In a village near Bushenyi, in southwest Uganda, nestled among tea estates and hills blanketed in banana trees, a young woman lives with her husband and children. She is thirty years old and has just had her eighth child. The first seven were born on the floor of their windowless mud hut, with chickens pecking at crumbs a few feet away. There was nothing for the pain. No clean bed and sheets. No one waiting with a scalpel to cut the umbilical cord. No team of nurses and doctors monitoring her blood pressure or the baby's heart rate.

She lived through these births. But for every 100,000 live births in Uganda, about 450 women do not.[2]

One day, she heard on the radio about a voucher she could buy for 3,000 shillings (US $1.60) that would enable her to deliver her baby at the health clinic up the hill, attend antenatal and postnatal visits, and receive screening for malaria, HIV and other sexually transmitted infections (STIs), plus transportation to a hospital in case of complications.

Who knows why she bought the voucher. Because now, after seven children, she was worried about complications, the health of her baby, her own survival? Maybe. Because she had always been worried but could finally do something about it? Could be. Because the laminated pink and purple voucher is attractive, a sign of privilege? Because she and her husband didn't want the mess of blood and other fluids that come with childbirth on the floor of their home again? Because she wanted to feel pampered, taken care of for a few days?

Whatever the reason, she bought a voucher from the wrinkled old man in the village who distributes them. He was easily recognizable from his vest, emblazoned with the voucher brand, *Healthy Baby*, and the price in

Curt Carnemark, 1987, World Bank

bright, cheerful colors. She went for the antenatal visits, and had her baby.

I meet her one sunny morning on the hillside where she lives. Her oldest girls are hiding in the folds of her pretty green and blue skirt while her husband stands off to the side, arms behind his back, watching his boys chew on cassava, barefoot in the dirt.

She pulls back the dingy blanket wrapped around the bundle in her arms and beckons me to come and see: A tiny baby boy. Eyes shut tight with sleep. Little hands and fingernails.

New life.

Reproductive Health Voucher Schemes in Uganda and Kenya

Voucher programs like the one this family benefitted

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[2] According to the 2006 Uganda Demographic and Health Survey (UDHS), 400-500 Ugandan women die in childbirth per 100,000 live births. Another 7,000 mothers per 100,000 births suffer significant, potentially life threatening, complications. The 2006 UDHS report also observed one of the world's highest estimated total fertility rates, with an average of 6.7 children born in a woman's lifetime. Only 43 percent of maternal deliveries took place in a health facility.

from, a demand-side approach to results-based financing, are gaining currency in policy circles in developed and developing countries. The idea is simple: a purchaser contracts accredited health facilities and vouchers are distributed to patients entitling them to services at any contracted facility of their choice. The voucher is either heavily subsidized or free for the patient, and the provider is reimbursed for the cost of provision, plus a reasonable profit, after delivery has been verified.

Uganda launched a voucher program for safe motherhood services and management of STIs across southwestern Uganda in 2008 after success with an earlier STI voucher pilot. A similar voucher program was launched in neighboring Kenya in 2006 in three rural districts and two Nairobi slums.[3] In addition to safe motherhood vouchers,[4] the Kenyan program sells vouchers for family planning, which can be used for long -term methods, and gender-based violence counselling services, which are free.[5]

In both programs, facilities must meet certain standards to be accredited, such as having a basic level of laboratory capacity, running water, and electricity during at least part of the day, among other things. (As with any RBF approach to stimulate demand for health services, the supply of health services should be considered prior to implementation, as scant supply can translate into less effective programs.) Both private and public sector facilities were contracted in Kenya, while in Uganda, the scheme only operates in the private sector.[6]

Distributors sell vouchers and disseminate information about the program. In order to target the poorest, they assess clients with a Poverty Grading Tool on criteria ranging from housing, water sources and sanitation, to daily income, and number of meals per day. (In Uganda, the STI vouchers were sold at drug shops to anyone who complained of STI symptoms.)

Facilities submit invoices to a voucher management agency and are paid generally within thirty days. For private facilities in Kenya and Uganda, reimbursement is made directly to facilities' bank accounts. In Kenya, public facilities have been reimbursed through the district health office although under new health sector reforms, they have begun to open bank accounts and manage their own finances. There are no requirements for how service providers use the profit, but many use funds to upgrade or expand facilities, buy equipment and hire new staff.

PriceWaterhouseCoopers (PWC) serves as the voucher management agency in Kenya, responsible for identifying potential facilities, contracting those that are accredited, managing voucher distributors, processing claims and disbursing reimbursements. Under the first phase of the pilot, the National Hospital Insurance Fund accredited facilities and the National Coordinating Agency for Population and Development (NACPD) was responsible for program oversight, with support from a steering committee comprised of representatives from the Ministry of Health (MOH) and German Development Bank (KfW). In Uganda, the program is managed by Marie Stopes Uganda (MSU), a UK-based reproductive health service provider and social marketing organization, which is responsible for both management and oversight.

In Kenya, the program is financed by the German Development Bank (KfW) with US$8.4 million for phase I (2005-2008), and $13 million for phase II (2008-2011). The scheme is currently undergoing a redesign in which new providers will be contracted and service packages developed. In Uganda, KfW and the World Bank co-financed the scheme with US$6.3 million between 2008-2011. USAID is financing a new family planning voucher that MSU will launch in early 2011 for the southwestern region.

Results: Mostly Good—But It's Complicated

In Kenya, uptake for the safe motherhood voucher was high—77 percent of distributed vouchers were redeemed, and there was an increase in facility deliveries even among non-voucher clients when the vouchers were temporarily unavailable between Phase I and II. In the Ugandan STI pilot, over 19,000 individuals were seen for diagnosis and treatment of STIs between 2006 and 2008, and an external evaluation found significant decreases in the prevalence of syphilis and gonorrhoea. In the subsequent expansion, between February 2009 and July 2010, 56,422 *HealthyBaby*

[3] Bangladesh, Cambodia, and Tanzania are also each in various stages of designing and implementing voucher programs. All five countries' programs are being rigorously evaluated by the US-based NGO, the Population Council.

[4] These entitle women to four antenatal visits, access to a qualified health worker during delivery, and six weeks of postnatal care, and cost 200 Kenyan shillings (Ksh) (US$2.50).

[5] 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 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).

[6] This is due to an MOH policy prohibiting cost-sharing in public health facilities.

vouchers were sold and more than 33,000 redeemed, while 37,046 *HealthyLife* vouchers were sold. [7]

The effects on health facilities have been pronounced. The Kathe Medical Care Center, for example, an accredited facility in southern Uganda, has experienced a high and rapid increase in the number of deliveries: from 15 in all of 2008, to 58 per month between January and July 2010. The owner of the facility, Asaf Kamugisha, says he has expanded the facility and hired new staff thanks to the extra income from vouchers: Kathe's budget before vouchers was 5 million shillings a month. Now it is about 25 million shillings a month.

Family planning and gender-based violence vouchers had a slower start in Kenya. More than 10,000 family planning vouchers were sold but only 41 percent were redeemed between 2006-2008 and fewer than 400 gender-based violence vouchers—which are distributed free at health facilities and police offices—were redeemed in the first three years of the program.

The issues behind decisions to seek reproductive health services are deeply personal and complex. [8] "There are a lot of cultural issues at play," says Francis Kundu, Program Officer at the NCAPD in Nairobi. "Financial incentives are not enough."

In Uganda, where USAID-financed family planning vouchers will be distributed in early 2011, providers are keen to participate but aware of the challenges they will face as they encourage women to consider use of these services. At the Angela Domiciliary Clinic in Kashari sub-county, Angela Ndahweje, a midwife and owner of the facility, says many women are afraid of side effects; they hear "rumors" about getting sick or losing their appetite as a result of long-term family planning methods. Counseling on the side effects of various treatments may help, she says, but an even bigger obstacle is that even among women interested in family planning, the decision to begin is not theirs alone to make. "They always say, okay, but let me ask my husband."

"If you educate the women on these things," says Dr. James Tanu Duworko, Family Planning and Reproductive Health Advisor to USAID in Kampala, "but the men are not involved, you are wasting your time."

Providers' opinion also counts: there were early reports in Kenya of providers counseling women to wait before deciding to use an intrauterine contraceptive device.[9] A combination of intensive community marketing and provider training has helped to improve family planning voucher redemption over the past two years.

And despite DHS data suggesting that gender-base violence is widespread, and counseling out of reach for the poor, many women believe these issues should be handled at the community level, informally, because the consequences of handling it formally can be serious.

Moreover, though uptake for safe motherhood vouchers has been high, facilities continue to experience a host of issues in trying to encourage women to deliver safely. At Bitooma Health Center in Uganda, Martin Mbuguru, the manager, says that though overall they have had more deliveries since the voucher program began, the national trend of women coming in for antenatal visits but not for the delivery, is also true among voucher clients. He thinks part of the problem is that he is competing with a traditional birth attendant in a nearby village who earns a living delivering babies in women's homes, and has stubbornly tried to maintain her patients. "If vouchers disappear, she will be happy," he jokes.

And some women, he says, refuse to be referred to higher-level facilities, even when they have life-threatening complications. He has seen women, after he has begged them to go to the hospital, return home where they have died.

Why would they do this?

"They want to be comfortable," he says. "Some are afraid of being cut open and operated on in a foreign place with strangers."

Administering Voucher Programs: Neither Easy Nor Cheap

The idea of voucher and accreditation schemes is relatively straightforward, but there are important details in their design and management that, if

[7] 36,249 *HealthyLife* voucher claims have been reimbursed; however this figure includes second and third follow-up visits by clients and their partners. So far, MSI has received 23,760 first time client and partner visits, driven by a whopping 70% referral rate (13,954 first client visits and nearly 9,806 first partner visits) in the 37,046 vouchers sold.

[8] Short-term family planning methods (such as condoms) are generally free in public facilities. Anecdotal evidence suggests that women in, for example, Kitui, purchased the maternal care vouchers as insurance against delivery complications rather than with obvious intentions to use for normal deliveries. At facility level, there has been an increase in deliveries even among non-voucher clients although the 2008-09 national demographic and health survey found little change in the proportion of facility-based births.

[9] As with patients, some providers have concerns about side effects of IUDs and personal beliefs about contraception generally which may have contributed to their initial reluctance to promote their usage.

overlooked, can undermine the programs. The process of establishing programs involves identifying beneficiaries, which may require either a poverty grading tool or other means testing; identifying voucher distributors who must be trained and supervised; marketing the program; identifying and accrediting providers; contracting providers; establishing a claims processing system; and monitoring and evaluating the program. It is a lengthy and information dense process.

Managing claims is cited by both PWC and MSIU as one of the most challenging elements of the programs. In Uganda, MSIU originally contracted a private firm to manage claims, but the partnership came to an end near the end of the first pilot, at which point MSIU began reviewing claims itself, archiving the data in commonly available spreadsheet software. One year later, MSIU contracted another firm to develop a new database for managing claims, but they continue to process claims internally and are working down a backlog of more than 1,000 claims accrued since the initial uptick in client visits.

Fraud is a central concern in voucher programs. MSU hired medical professionals to review claims as they were entered into a database. Unusual treatments, high numbers of surgical deliveries, chronic errors on claims forms, and delays in claims submission are all triggers for follow-up. But there are few random site visits to compare MSU records with facility data or interview clients, which may explain why MSIU has found so little evidence of fraud.

And there are other instances of cheating. For example, in Kenya, voucher distributors were initially paid based on the number of vouchers sold, but this led to distributors selling vouchers to women who did not qualify. They are now paid a monthly salary. (In Uganda they are paid a commission on each voucher they sell, as there is less concern about "leakage" in largely rural communities where virtually everyone is poor.)[10]

Better and more supervision could help, but this is difficult when facilities are remote, cut off by lack of internet access and patchy mobile phone coverage. "The biggest challenge in what we do," says MSU country director Jon Cooper, "is working with remote teams, motivating them, preventing fraud, supervision."

The costs of establishing and managing these voucher pilots vary. In Kenya, the portion of costs spent on management, training, and marketing was 21 percent of the phase I budget (although in each subsequent year of the project the overhead to disbursement ratio fell). In the Uganda STI pilot, claims processing alone accounted for 21 percent of the budget.

Another cost is time. It took three years in Uganda, but according to Cooper: "We have a decent product, it's well-managed…we have a committed, passionate technically able team and a system that works, a network of accredited providers who understand the program and peer educators who know the scheme and like it."

The problem is that KfW's support is drawing to a close and World Bank support sunsets in June 2011.[11] Although USAID has awarded MSU a five-year grant to subsidize new family planning vouchers, all safe motherhood and STI vouchers have been sold. A concerted effort will be needed to get a new round of funding in place.

"It takes time to build trust in these communities," says Cooper, "and now they have it, and the program is ending, and clients are upset."

(Un)Conventional Wisdom About Vouchers

Vouchers are attractive, the conventional wisdom goes, because they empower patients, letting them choose where to seek health services, including at private facilities.[12] Letting patients choose is thought to spur competition among providers, creating incentives for facilities to lower prices and improve quality.[13]

"By empowering low income clients to choose or reject a service provider in this fashion, a powerful incentive is created for providers to improve the quality of their services in order to attract the most clients."[14]

[10] Several technical reports detail these challenges, and one compares the two country experiences, but broadly, they are the same old thing.

[11] The KfW decision has to do with competing priorities at the parent BMZ ministry in Berlin, which is emphasizing other sectors (energy, finance) as priorities. The World Bank originally approached the voucher scheme as a way to expand an interesting KfW project. To continue the project now, the Bank will need to be convinced that it is worth more support. Discussions are ongoing.

[12] Health policy in developing countries has traditionally focused on public provision of services, and neglected the private sector. Although the majority of women who deliver in an institutional setting in Kenya do so at public facilities (65 percent), many who deliver in the private sector are poor.

[13] Vouchers for Health: Using Voucher Schemes for Output-Based Aid. April 2002 Peter Sandiford, Anna Gorter, and Micol Salvetto, Note Number 243, World Bank.

[14] Voucher schemes for sexual and reproductive health services: a Marie Stopes International (MSI) perspective, http://www.mariestopes.org/documents/publications/Voucher-Factsheet.pdf.

But do vouchers really expand patient choice? In the Nairobi slum of Korogocho, where there are multiple accredited facilities near each other, a patient could easily walk to any of them. But the nearest facility to the Kathe facility in Uganda is nine kilometers away. Bitooma Health Center is even more remote. In areas where there is one facility or none (as in the case of areas in Kenya where Marie Stopes operates mobile units), vouchers are less a tool of empowerment and consumer choice and more a targeted subsidy for specific services at particular locations.

If patients are not really choosing between facilities, it is unlikely that facilities are really competing with each other for patients. A review of the Bangladesh maternal voucher scheme, for example, found "little evidence that the mechanism encourages competition due to the limited provision of health care services."

The same is true in rural areas of Kenya and Uganda. Even in Korogocho, facility managers downplay the competition motive for facility improvements. They and managers of rural facilities both say they improve their facilities first, because they are strongly encouraged to do so, and second, as a way to ensure they will be left with something when donor funds for the program run out. Infrastructure and other improvements are an investment to mitigate against the assumed future loss of revenue.

Voucher schemes are also touted as a bridge to health insurance. In Kenya, attempts were made to introduce an insurance fund for the poor in 2003/04 but the plan was defeated by a Parliament worried it was not financially feasible, and that targeting the poor would be difficult. And in Uganda, legislation for comprehensive health insurance is being amended and will likely be tabled next year after the election.

However, for countries considering if and how to finance and operationalize insurance for the poor, vouchers are thought to be a good model. Says Cooper: "getting people used to buying a voucher prepares them for contributing to insurance."

But does it? For patients, there is anecdotal evidence from Kenya that suggests that women in Kitui district purchased safe motherhood vouchers as insurance against delivery complications. However, it is not clear that vouchers for services people *do* need today will translate into them paying for insurance for services they may or may not need in the future.

Beyond the Hype: Vouchers Still Hold Big Promise

Vouchers may not live up to the hype (what aid program does?), but the results are nonetheless impressive: in both Kenya and Uganda, patients are coming to facilities, where they can be tested and treated for STIs and where the safe delivery of their babies can be nearly guaranteed. And facilities are investing in infrastructure, supplies, and staff, which makes them more comfortable and responsive to patients. Moreover, the accreditation, claims reimbursement, and fraud control mechanisms used in voucher pilots can be a helpful model for governments, even if the practice of paying for vouchers does not directly prepare individuals to pay for health insurance.

"The public sector is often focused on investing in tertiary care in public facilities; the value of engaging the private sector is often overlooked," says Ben Bellows, who is managing an evaluation of voucher programs in five countries for the Population Council. "The MOH may distrust the private sector or see it as competition against the public system. Vouchers say: look guys, here's how you can work with them."

As Kenya and Uganda show, voucher programs take time and continued investment to design and administer, but the evidence suggests they can increase access to essential services, enable facilities to be more responsive to patients, and best of all, improve health outcomes for the poor.

For more on vouchers see:

Bellows, B and Hamilton, M. Vouchers for Health: Increasing Utilization of Facility-Based STI and Safe Motherhood Services in Uganda. Health Systems 20/20. June 2010. Available at: **http://www.healthsystems2020.org/content/resource/detail/2576/**

Bellows, N, Bellows, B, and Warren, C. The Use of Vouchers for Reproductive Health Services in Developing Countries: Systematic Review. Tropical Medicine and International Health. Available at: **http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2010.02667.x/full**

[15] "Vouchers as demand side financing instruments for health care: A review of the Bangladesh maternal voucher scheme," Jean-Olivier Schmidt, Tim Ensor, Atia Hossain and Salam Khan
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-4YB27G6-1&_user=10&_coverDate=07%2F31%2F2010&_rdoc=1&_fmt=high&_orig=search&_sort=d&_docanchor=&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=bc2810d8b4629267b37089545a32eca5