

Vouchers: making motherhood safer for Kenya's poorest women

Germany's contribution to the achievement of MDG5 in Kenya

Motherhood: a game of chance

Of all public health indicators, maternal mortality shows the biggest disparity between rich and poor worldwide. Globally, around 358,000 women die each year as a result of pregnancy or childbirth complications, 99% of them in developing countries. The majority of maternal deaths occur in sub-Saharan Africa, which is home to less than 14% of the world's people. In Kenya, the maternal mortality ratio (MMR) is estimated at 488 per 100,000 live births, and the lifetime risk of maternal death is one in 38.

Up to 40% of pregnant women anywhere in the world may develop complications before, during or just after childbirth, and for around 15% of pregnant women the complications may be life-threatening: the survival of mother and child depends on access to quality maternity services that can manage such cases. In much of the developing world, however, the provision of quality maternal health care is grossly inadequate.

Addressing this problem was recognised as a key challenge by the summit of world leaders held in 2000. Millennium Development Goal (MDG) 5 set countries a target of achieving universal access to reproductive health by 2015, and reducing the level of MMR by three-quarters between 1990 and 2015. However, in six African countries, including Kenya, MMR has actually increased during this period, driven partly by high levels of HIV infection.

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German Development Cooperation (GDC)¹, on behalf of the Federal Ministry for Economic Cooperation and Development (BMZ), has a long history of support for reproductive health in Kenya and, in order to achieve progress towards MDG5, the two governments decided on a voucher scheme to improve access to reproductive health care for the country's most disadvantaged women. Launched in 2006 with funding from the KfW Entwicklungsbank (KfW) the scheme is today jointly funded by the Kenyan government. It builds on, and continues to benefit directly from, the work done by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH to strengthen the capacity of Kenya's reproductive health services to meet the people's needs.



>> Thanks to the voucher programme, this young mother had four antenatal appointments and gave birth attended by professional care givers.

¹ GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organizations Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Entwicklungsbank (KfW).



>> Lumumba clinic has invested some of its OBA income in new blankets, bed linen and curtains for the maternity ward.

The voucher programme

Voucher programmes are part of what is known as ‘output-based aid’ (OBA), a ‘demand-side’ approach to healthcare financing that is attracting growing interest today. The principle behind such programmes is that women below a certain poverty threshold are sold vouchers, at highly subsidised rates, which entitle them to certain specified services at accredited health facilities. On submission of the voucher and an invoice for their services, healthcare providers are reimbursed by the funding agency, and can decide for themselves how to use the income to support services.

Unlike with the more traditional ‘supply side’ model of health care financing, where health services are centrally planned and funds are invested in building and maintaining hospitals and clinics, demand side funds are invested in the client. Kenya’s voucher programme empowers women in that they can choose which facility to attend from a number of accredited institutions, and change providers if they are unhappy with the service. The OBA approach also introduces competition between facilities, giving them an incentive to improve quality in order to attract clients.

Kenya’s voucher scheme covers maternity care, family planning, and care for survivors of gender based violence. It currently operates in six geographically and socioeconomically varied sites across Kenya – home to approximately 400,000 poor women of reproductive age – and further expansion is planned.

Programme management

The day-to-day running of Kenya’s programme is carried out by a voucher management agency (VMA) which is answerable to a programme management unit (PMU) within the Ministry of Health (MoH). The VMA is guided by a steering committee comprised of representatives of government ministries, KfW, and the publicly-owned National Health Insurance Fund. Technical assistance is provided by EPOS Health Management, a consultancy based in Germany, which also helps support the PMU.

The VMA’s functions include programme design, marketing and distribution of the vouchers, contracting of health facilities to provide services, continuous monitoring of quality, and reimbursement of claims.

Voucher distribution

Each project site has a field manager employed by the VMA to supervise and support a team of about 20 voucher distributors each, and to liaise with accredited health facilities to ensure the smooth running of the scheme at the frontline. It is the job of the voucher distributors, who are also employed directly by the VMA, to sensitise communities and recruit clients. In order to test women’s eligibility, the distributors use a questionnaire originally designed as a poverty identification tool by Marie Stopes International, which is adapted to local circumstances.

Combating fraud is a constant challenge. Measures to avoid it include designing the programme such that voucher distributors have no contact with service providers, who have no involvement in selling vouchers. In addition, field managers regularly check the distributors’ voucher registration records, and carry out spot checks among clients to confirm their eligibility.

Service providers

In order to be accredited, a facility must be able to meet a specified standard of care, and is assessed on its infrastructure, staffing levels, equipment and supplies, and mechanisms for referral if necessary. In working with the health sector in Kenya, GIZ, most recently through GIZ, has a long encouraged partnership with the private sector. This has created an enabling environment for the voucher programme to work with both public and private health providers in order to achieve maximum coverage of the population. By the end of phase II in October 2011, the programme had a total of 87 service providers – 47 from the public sector, 19 private health facilities, 15 run by faith-based organisations (FBOs) and 6 by non-governmental organisations (NGOs).

The effectiveness of the programme also relies on the District Health Management Teams (DHMTs) of the MoH, who are responsible for supporting all health facilities within their areas and for capacity-building of the healthcare workforce. Reproductive health is a key part of the DHMTs’ mandate, so there is mutual benefit in having close links with the voucher programme. GIZ works directly with DHMTs to build their capacity through management training and mentoring schemes, and provision of equipment and supplies for family planning in some districts.

The technical committee of the programme carries out an annual review of all accredited service providers to ensure standards are maintained. The field managers visit the providers regularly to see that the committee's recommendations have been acted on and to double-check the paperwork regarding voucher claims. Field managers also talk to clients accessing services about their personal experiences, and every year the VMA conducts systematic 'client satisfaction' surveys.

Reimbursement

Service providers are reimbursed by the VMA on submission of a voucher accompanied by a detailed invoice. Field managers periodically check the service providers' records on site to see that everything is in order, and documentation is checked carefully once it reaches the VMA. Invoices are also reviewed by independent medical experts to ensure that treatment – for childbirth complications, for example – is justified.

Initially, the reimbursement rates for services were negotiated with each health facilities, up to a certain ceiling. However, this was inefficient, so flat rates for each service category were set by the steering committee. Although there is some dissatisfaction with the set rates, the voucher scheme remains attractive to service providers because it expands their client base and provides a predictable income stream that gives them the confidence to invest in their services.

Achievements

Because of limited coverage, it is difficult to assess the impact the voucher scheme might have had on maternal mortality. However there is good evidence that the programme has been effective at increasing access to reproductive health services for poor women, and that among service providers, capacity and quality have improved significantly.

Safe motherhood vouchers

In its first eighteen months, sales of vouchers for safe motherhood were double what had been projected in the original plans. Data

from selected health facilities also showed an increase in professionally assisted births (among both voucher and non-voucher clients) of 57% overall, though with considerable variation between sites. By the end of phase I (October 2008), 76% of the safe motherhood vouchers sold had been used for assisted childbirth. Of the remaining 24%, some were used for antenatal care only and some were not used at all.

A review conducted towards the end of phase II estimated on the basis of trends thus far that the programme would have provided services for 124,000 pregnant women by the end of the phase (October 2011), and projected that the number of assisted births would have doubled from an average of 2,000 per month at the end of phase I to 4,000 a month by the same date.

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Family planning vouchers

At present, family planning vouchers cover only long-term methods – hormonal implants, IUCDs, sterilisation and vasectomy. A review of phase I found that towards the end of the third year, only 48% of the 25,746 vouchers sold in the first two years had been used. Possible reasons for clients' reluctance to access family planning included inadequate counselling by service providers, stock-outs of supplies, and long queues at some family planning outlets. Misconceptions, such as the idea that IUCDs will encourage promiscuity, also appeared to undermine willingness of clients to go for services.

However, there has been a dramatic increase in the use of the vouchers in phase II. Whereas in the last year of phase I, around 350 voucher clients a month went for family planning, the average for the six months from October 2010 was more than 1000 clients a month, and the review team projected that by the end of phase II, the uptake of services would be around 226% of the targeted figure.



>> L. to r.: Voucher distributor Violet Auma explains to a new client in Kisumu how the safe motherhood voucher works.

>> The vouchers incorporate a hologram and watermark that make them virtually impossible to forge.

Gender based violence vouchers

The Kenya Demographic and Health Survey (KDHS) 2009 found that nearly one in four women had experienced physical violence in the 12 months before the survey, and that for 12% of women questioned, first intercourse had been forced against their will.

In 2006 the government passed The Sexual Offences Act. However, stigma, shame and fear surrounding gender-based violence (GBV) make women extremely reluctant to report it, and have limited the impact of this component of the voucher scheme. By year three of phase II, GBV vouchers had achieved only 29% of the targeted uptake, and the projection was that 1000 survivors or gender violence would have received services by the end of the phase.

The cost

In the initial budget, approximately 31% of funds were allocated for management services, to include the costs of international consultancy and design and development of the programme. By the end of phase II, however, the VMA's costs were projected to be around 15% of expenditure as the number of clients accessing services increased. Significantly, the administration costs incurred by the VMA include key activities – such as identification of the poor, accreditation of service providers, and quality monitoring – that should be covered by national programmes, but are done so inadequately or not at all.

The data show that in phase II, the safe motherhood services accounted for 89.5% of service delivery expenditure, compared with 9.8% for family planning, and 0.7% for GBV. These percentages translated into average programme expenditure per client of 74 Euros for safe motherhood, 19 Euros for family planning and 21 Euros for GBV, which included a proportion of management and other general programme costs.

Part of a wider vision

The voucher scheme should not be seen as a stand-alone programme, but as part of a wider vision for Kenya's health services based on a national social health insurance (NSHI) scheme that GIZ has been helping the government to design. The voucher programme incorporates many key features of a health insurance scheme, such as systems for accreditation and quality assurance of facilities, and for registering clients, processing claims and combating fraud. For this reason it is being closely watched as a stepping stone towards a nationwide health insurance scheme, which is being seriously considered following a comprehensive review of financing options for the health services undertaken by the MoH in 2009 with support from the former GTZ (now GIZ) and The World Bank. Observers are interested to see how the voucher scheme is managed and key decisions made; how well service providers cope with the administrative requirements of making claims; what is involved in working with all sectors (public, private, FBO and NGO); how reimbursement rates are worked out; and, importantly what users feel about the system.

Peer review

The full version of this report has been reviewed by two independent experts in this field. They agreed that the approach generally meets the eight criteria of "good practice" that are standard requirements for publications in the German Health Practice Collection – that it be effective, transferable, participatory and empowering, gender sensitive, based on solid monitoring and evaluation, innovative, cost effective and sustainable. However, they were cautious about the evidence for long-term sustainability.

The reviewers noted, inter alia, that:

- "demand-side financing is inherently **participatory and empowering**;"
- "the voucher scheme is **gender sensitive** by design;" and
- "the programme described seems to make a major contribution to our understanding and evidence regarding what remains an under-utilised and **innovative** approach."

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