USAID
FROM THE AMERICAN PEOPLE

# INSIGHTS FROM INNOVATIONS: LESSONS FROM DESIGNING AND IMPLEMENTING FAMILY PLANNING/REPRODUCTIVE HEALTH VOUCHER PROGRAMS IN KENYA AND UGANDA

Kadi Ya Uzaaji
huduma za uzaaji kwa bei nafuu na usalama

KADI ZA UZAAJI
Zinauzwa karibu nawe kwa bei nafuu na unaweza kuzitumia kwenye kliniki na hospitali zilizo idhinishwa kulipia huduma za uzaaji kwa njia salama.

Kadi Ya Jamii
huduma za upangaji uzazi kwa bei nafuu na usalama

November 2009

This publication was produced for review by the United States Agency for International Development. It was prepared by Aneesa Arur, Nelson Gitonga, Barbara O'Hanlon, Francis Kundu, Maggie Senkaali, and Richard Ssemujju for the Private Sector Partnerships-*One* Project.

PSP-*One*
PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

***Technical Report***

**Technical Report Series**: PSP-*One* Technical Report Series addresses important issues relating to the private sector's role in reproductive health and family planning. Papers in the series may discuss lessons learned and best practices, highlighting PSP-*One* technical areas.

**Recommended Citation:** Arur, Aneesa, Nelson Gitonga, Barbara O'Hanlon, Francis Kundu, Maggie Senkaali, and Richard Ssemujju. November 2009. *Insights from Innovations: Lessons from Designing and Implementing Family Planning/Reproductive Health Voucher Programs in Kenya and Uganda.* Bethesda, MD: Private Sector Partnerships-*One* project, Abt Associates Inc.

**Download:** Download copies of PSP-*One* publications at: www.psp-one.com

**Contract/Project No.:** GPO-I-00-04-00007-00

**Submitted to**: Patricia Mengech, CTO
Bureau of Global Health
Global Health/Population and Reproductive Health/Service Delivery Improvement
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abt Associates Inc.■ 4550 Montgomery Ave, Suite 800 North ■
Bethesda, Maryland 20814 ■ Tel: 301/913-0500.■ Fax: 301/652-3916
■ www.PSP-One.com ■ www.abtassoc.com

*In collaboration with:*
Banyan Global ■ Dillon Allman and Partners ■ Family Health International ■
Forum One Communications ■ IntraHealth International ■ O'Hanlon Consulting
■ Population Services International ■ Tulane University's School of Public Health and Tropical Medicine

# INSIGHTS FROM INNOVATIONS: LESSONS FROM DESIGNING AND IMPLEMENTING FAMILY PLANNING/REPRODUCTIVE HEALTH VOUCHER PROGRAMS IN KENYA AND UGANDA

**DISCLAIMER**
The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

# CONTENTS

**Acronyms** .......... v

**Acknowledgments** .......... vii

**Executive Summary** .......... 1

**1. Introduction** .......... 7

1.1 About Vouchers .......... 7
1.2 About this Technical Report .......... 8

**2. Socioeconomic and Policy Context: Kenya and Uganda** .......... 11

2.1 A Quick Review of FP and SM Indicators .......... 11
2.2 Policy Factors .......... 13

**3. Vouchers in Kenya and Uganda** .......... 15

3.1 A Bird's Eye View of the Two Voucher Programs .......... 15
3.2 Diving Deeper -Roles and Functions in the Kenya RH-OBA Pilot and Uganda RHVP .......... 16
3.2.1 Stewardship .......... 18
3.2.2 Voucher Program Management .......... 19
3.2.3 Health Service Delivery .......... 20
3.2.4 Generating Demand .......... 21

**4. Key Results: Voucher Service Use, Quality, and Costs** .......... 23

4.1 SM and FP Voucher Use in Kenya RH-OBA .......... 23
4.2 Quality Improvements in Kenya RH-OBA .......... 25
4.3 SM Voucher Uptake in Uganda RHVP .......... 26
4.4 Quality Improvements in Uganda RHVP .......... 27
4.5 Kenya RH-OBA and Uganda RHVP Expenditures .......... 27

**5. Learning Lessons from What Works (Or Doesn't Work)** .......... 29

5.1 Do RH/FP Voucher Programs Work? .......... 29
5.2 What Insights Lead to Better Implementation? .......... 32
5.2.1 Stewardship .......... 34
5.2.2 Voucher Program Management .......... 35
5.2.3 Health Service Delivery .......... 37
5.2.4 Marketing Vouchers .......... 38

**6. Conclusions** .......... 39

**Annex A. Tables and Figures: Kenya and Uganda** .......... 41

**Annex B. Kenya RH-OBA Tools .............................................. 51**

**Bibliography ….....……... …....…………………………………74**

## LIST OF TABLES

Table 1: Categorizing the Main Functions of a Voucher Program..........16
Table 2: Recommendations to Strengthen Implementation of Voucher Programs..........32
Table A.1: Socio-economic and Health Indicators in Kenya and Uganda..........42
Table A.2: Voucher Program Context and Policy Environment..........43
Table A.3: Voucher Program Overview..........45
Table A.4: Voucher Program Roles and Functions – A Bird's Eye View……………… ..........47
Table A.5: Key Voucher Program Results..........50

## LIST OF FIGURES

Figure 1: Disparities in Current Use of Modern FP in Kenya and Uganda by Wealth Quintile..........11
Figure 2: Comparison of Sources of FP in Kenya and Uganda..........12
Figure 3: Differences in Institutional Deliveries in Kenya and Uganda by Wealth Quintile..........12
Figure 4: SM Deliveries in Kenya by Wealth Quintile and Source (KDHS 2003)..........13
Figure 5: Organization of the Kenya RH-OBA Program..........17
Figure 6: Organization of the Uganda RHVP..........18
Figure 7: Breakdown by LAPM Type: FP Voucher Users Compared to All Women..........23
Figure 8: Voucher Service Provider (VSP) Claims by Type of VSP for Family Planning in RH-OBA Pilot..........24
Figure 9: Voucher Service Provider (VSP) Claims by Type of VSP for Safe Motherhood in RH-OBA Pilot..........25
Figure 10: Quality Improvements Made by RH-OBA Facilities..........26
Figure 11: Trends in RHVP: Vouchers Sold and Voucher Claims Submitted, March–July 2009..........27
Figure 12: Demand and Supply-side Constraints that Limit FP Voucher Uptake..........35

# ACRONYMS

| | |
|---|---|
| **ANC** | Antenatal Care |
| **BCC** | Behavior Change Communication |
| **BTL** | Bilateral Tubal Ligation |
| **CBD** | Community-Based Distributor |
| **CBO** | Community-Based Organization |
| **DHS** | Demographic and Health Surveys |
| **FPAK** | Family Planning Association of Kenya |
| **GoK** | Government of Kenya |
| **GPOBA** | Global Partnership on Output-Based Aid |
| **HSSPII** | Health Sector Strategic Plan II |
| **IUCD** | Intrauterine Contraceptive Device |
| **KfW** | Kreditanstalt für Wiederaufbau (German Development Bank) |
| **KIHBS** | Kenya Integrated Household Budget Survey |
| **LAPM** | Long-Acting and Permanent Methods |
| **FBO** | Faith-Based Organization |
| **FP** | Family Planning |
| **M&E** | Monitoring and Evaluation |
| **MOH** | Ministry of Health |
| **MOMS** | Ministry of Medical Sciences (Kenya) |
| **MOPHS** | Ministry of Public Health and Sanitation (Kenya) |
| **MSI** | Marie Stopes International |
| **MSIU** | Marie Stopes International Uganda |
| **NCD** | Non-communicable Disease |
| **NCAPD** | National Coordinating Agency for Population & Development |
| **NGO** | Nongovernmental Organization |
| **NHIF** | National Health Insurance Fund |
| **NSHIF** | National Social Health Insurance Fund |
| **PNC** | Postnatal Care |
| **PPP** | Public-Private Partnerships |
| **PSP-*One*** | Private Sector Partnerships-*One* |
| **PWC** | PricewaterhouseCoopers |
| **RH-OBA** | Reproductive Health Output-Based Aid |
| **RH** | Reproductive Health |
| **RHVP** | Reproductive Health Voucher Project |
| **SM** | Safe Motherhood |
| **STI** | Sexually Transmitted Infection |
| **VD** | Voucher Distributor |
| **VMA** | Voucher Management Agency |
| **VSP** | Voucher Service Provider |
| **WDI** | World Development Indicators |

# ACKNOWLEDGMENTS

The authors would like to thank Mursaleena Islam, Abt Associates Inc, Benjamin Bellows, Population Council, and Rena Eichler, Broad Branch Associates, for their thorough review of and comments on this report. The authors also appreciate the insights on designing and implementing voucher programs shared by the participants at the Family Planning Voucher Innovations Workshop in September 2009. Finally, they thank the United States Agency for International Development (USAID) for its support of this study; in particular, they acknowledge the support of Ishrat Hussein, USAID technical advisor, Patricia Mengech, USAID technical advisor, and Alex Todd, USAID senior technical advisor.

# EXECUTIVE SUMMARY

## Introduction

Health policy in developing countries has traditionally focused on public provision of free or highly subsidized services to lower the cost of seeking care and to ensure universal access to critical services such as family planning (FP) and reproductive health (RH). However, many people in developing countries, even the poor in Sub-Saharan Africa, choose to seek health care in the private sector and pay out-of-pocket to do so. Concerns about equity have sparked interest in approaches like vouchers that can lower the financial burden on individuals by targeting subsidies directly to clients of FP/ RH products and services. A health voucher is a token that can be exchanged for a pre-defined set of health services or products. Health vouchers enable public subsidies for services or products to follow the client, rather than being tied to providers. Clients buy vouchers for a specified set of services or products at a pre-defined price, or obtain vouchers free of charge.

Despite the growing interest among policymakers, donors, and FP/RH practitioners, there is limited information on the first generation of health services voucher programs in countries like India, Uganda and Kenya. The purpose of this technical report is, therefore to provide practical guidance for those involved or interested in designing, financing, or implementing FP/RH voucher programs in Sub-Saharan Africa. This report brings together insights on what has worked well and (just as importantly) on what has not worked well based on the Reproductive Health Voucher Project (RHVP) in Uganda and the Reproductive-Health Output-Based Aid (RH-OBA) voucher pilot program in Kenya. Although the primary focus of this paper is to identify guidelines to help design an effective FP/RH voucher program, many of the observations included can be applied to all voucher programs designed to increase use and access of critical health services.

## A Bird's Eye View of the Two Voucher Programs

The Kenya RH-OBA voucher pilot was established in 2005 and covers three rural districts and two Nairobi slums. Individuals who fall below a poverty threshold are eligible to buy a FP voucher for long-acting and permanent methods for the equivalent of about US$1.25 and a Safe Motherhood (SM) voucher for antenatal care (ANC), institutional delivery and postnatal care (PNC) services for about $2.50. The RH-OBA pilot is financed by the German Development Bank (known by its acronym KfW) and the Government of Kenya. Price Waterhouse Coopers (PWC), an international firm with auditing expertise, is the Voucher Management Agency (VMA). RH-OBA vouchers can be redeemed at 54 public, private for-profit and private non-profit providers.

In Uganda, by contrast, the RHVP was established in late 2008 in a partnership between the Government of Uganda, KfW, and the Global Partnership on Output Based Aid. RHVP has plans to scale up a "Healthy Life" voucher for treatment of sexually transmitted infections (STIs) to six districts and has introduced a "Healthy Baby" SM voucher for ANC, delivery and PNC in 12 districts with the intention of implementing it in 22 districts of Southern and Western Uganda. The SM vouchers are sold to women for the equivalent of $1.50. Marie Stopes International Uganda, a non-governmental organization (NGO) with social marketing, FP and health services expertise, is the VMA. RHVP vouchers can only be redeemed at private for-profit and non-profit providers.

## Promising Results in Voucher Service Use, Quality, and Costs

In less than five years, the two voucher programs have shown promise in achieving their stated objectives of increasing poor women's access to quality health services.

### SM and FP voucher use

***Kenya RH-OBA.*** In Kenya, uptake of RH-OBA SM vouchers has been high. Between June 2006 and October 2008, 78,651 SM vouchers were sold and 60,581 women used SM vouchers to deliver in a participating facility. In contrast, use of FP vouchers was considerably lower than expected. In the same period, only 25,620 FP vouchers were sold, and 11,296 (41 %) of these were used. Examination of provider claims data reveals that FP voucher users overwhelmingly prefer implants to other long-acting and permanent methods. Almost two-thirds (60%) of FP voucher users selected implants, compared to a third (35%) who chose female sterilization (bilateral tubal ligation, or BTL). Only 5 percent opted for intrauterine contraceptive devices (IUCDs).

Interestingly, voucher utilization patterns indicate that the poor in Kenya prefer to use private for-profit and non-profit providers. In the area of FP, non-profit providers were the preferred provider (59%) across all voucher site locations. Both public and for-profit providers delivered a similar volume of FP services (22% and 20% of FP claims, respectively). Private non-profit providers appear to be a particularly important source of surgical methods of contraception: private non-profit providers submitted 90 percent of all claims for BTLs. Non-profit providers were also the preferred provider for SM services and accounted for 45% of SM claims.

***Uganda RHVP.*** Uptake of the Uganda RHVP and Kenyan RH-OBA SM vouchers are not easily comparable since the RHVP is a year old. Between February 2009 and June 2009, 4,034 RHVP SM vouchers were sold and close to 2,451 (61%) used for ANC, institutional deliveries, or PNC services. Uptake in the first few months of RHVP may have been low as voucher systems take a long time to set up, particularly on the large scale of the RHVP. It is also important to note the gap (61%) between the number of vouchers sold and used is now closing.

### Quality improvements

***Kenya RH-OBA.*** There is clear evidence that public and private voucher service providers (VSPs) have invested in making quality improvements. Eighty-five percent of public, 89 percent of for-profit, and 67 percent of non-profit VSPs used voucher revenue to improve infrastructure, buy equipment or drugs and supplies, hire new or pay existing staff, or create patient amenities. While all types of VSPs used voucher revenue to hire staff and pay salaries, the proportion of public facilities doing so is relatively low, possibly because public sector facilities are only permitted to hire non-clinical support staff.

***Uganda RHVP.*** As the SM voucher component is in its early stages, the information available on quality improvements made by VSPs or the quality of their services is limited. RHVP staff observations, however, suggest that VSPs have already begun to invest in quality by hiring and replacing staff, making infrastructure improvements, buying drugs or other commodities, and investing in staff training.

### Kenya RH-OBA and Uganda RHVP expenditures

The Kenya RH-OBA program expenditures to date are approximately $8.96 million spread across three rural districts and two slums in Nairobi. The available data show that SM vouchers and FP vouchers accounted for 76 percent and 3 percent, respectively, of the total expenditures and overhead for the

remaining 21 percent. A rough analysis shows the program spent approximately about $135 per SM voucher used (including ANC, institutional deliveries, ambulance transport to a referral facility, treatment for complications, and PNC) and $31 per FP voucher used.

The three-year budget of the Ugandan voucher program (including that for STI vouchers) is approximately $6.3 million to be spread over 22 districts. The Uganda RHVP reports overhead costs of approximately 10 percent of the total budget. The RHVP spent approximately $268 per SM voucher used. As the program is at a relatively early stage and has been engaged in designing and setting up systems, overhead accounts for 96 percent of all RHVP expenditures so far.

## Learning Lessons from What Works (Or Doesn't Work)

Although the Kenya and Uganda voucher programs have been operating for a short period of time, the Uganda and Kenya program managers identified initial lessons on designing and implementing voucher programs that offer insights on how to strengthen the next generation of voucher programs in Africa.

***Do FP/RH voucher programs work? Yes but***…..Kenya's experience with SM vouchers and Uganda's with STI vouchers shows that vouchers can help increase uptake of SM and STI services. The evidence, however, is less clear in the case of Kenya's FP vouchers. A complex mix of factors is responsible for low uptake of FP vouchers. However, financial barriers are not the main obstacle to FP use, suggesting that an independent FP voucher program may not be the most appropriate strategy.

**To Use (or Not To Use) Vouchers for FP?**

Below is a decision tree to help guide the decision on whether vouchers are appropriate for FP in a given context:

**IF** financial barriers are a key bottleneck to FP use, then
Consider a stand-alone FP voucher program if there currently is not a voucher program or
Consider adding FP to an existing voucher program

**IF** financial barriers are NOT the primary barrier to FP use, then do not create a stand-alone FP voucher program
Identify the main barriers to FP use and consider other strategies to address these barriers
Examples include behavior change communication (BCC) to address cultural constraints about FP, training to build staff skills, contracting for procurement of FP commodities

**IF** financial barriers are NOT the primary barrier to FP use **AND** a voucher program for a related RH services already exists
Consider bundling FP services with related voucher services, for example with a Safe Motherhood Plus voucher
*In addition* identify the main barriers to FP use and consider other strategies to address these barriers

***Voucher programs are feasible to implement.*** The East African experience with FP/RH vouchers confirms that voucher programs are feasible to implement in low-income countries. There has been no indication that systematic fraud - one of the more challenging implementation issues associated with vouchers - has been a serious problem in either Kenyan or Ugandan program. There are insufficient cost data, however, to determine if voucher programs are a "good value" compared to other strategies to increase use of key health services. More data are needed to better estimate the cost-effectiveness of vouchers compared to other strategies to increase FP/RH use.

***Voucher programs harness private sector for public health objectives.*** As the Kenyan and Ugandan experience demonstrate, vouchers offer clients a choice of providers. The target clientele, predominantly poor, used their vouchers at private ̃ both for and not for profit ̃ voucher facilities in greater proportions than the general population. The Uganda and Kenya voucher programs also demonstrate that, when voucher clients bring in revenue, private sector providers are very interested and willing to deliver essential health services, even preventive services.

### Insights from Implementation

Kenya's and Uganda's experience offers practical insights for policymakers and practitioners interested in designing and/or implementing FP or other voucher programs. The following list summarizes the preliminary lessons from implementing the two voucher programs.

**1) Explicitly define and ensure that all required VMA functions are carried out.** There is a wide range of core VMA functions required. As both the Uganda and Kenya programs demonstrated, it is often difficult for one organization to perform the full range of functions required. If the VMA cannot perform all of them, then contract out specific functions.

**2) Fill in health systems support gaps.** As the Kenya RH OBA experience demonstrates, when the public sector does not provide key services such as ensuring adequate supply of FP products or implementing BCC activities to generate demand, then the VMA may also have to include these functions in the voucher program.

**3) Apply audience research to design and modify voucher programs.** Formative research at the design phase informs voucher benefits, distribution, and price policies, and helps design BCC and voucher marketing strategies.

**4) Monitor and evaluate the program to improve performance.** A robust monitoring system - through data generated by claims, distribution, and reimbursements supplemented with independent cross-checks – provides information needed to detect fraud, track program performance and adjust the program to further improve performance.

**5) Use payments to attract and retain high performing public, for-profit, and non-profit providers.** Getting provider reimbursement levels right and processing claims efficiently are essential to engage and retain public and private providers and ensure their responsiveness to clients.

**6) Create incentives for, and support VSPs, to improve quality.** Although VSPs use voucher payments to make quality improvements, they are unlikely to invest in other types of quality improvements (e.g., clinical training) that are less visible to clients. Therefore, it is important for the VMA to create opportunities and incentives for VSPs to continuously improve their technical and clinical quality.

**7) Sustained marketing and BCC are necessary to generate demand.** All voucher programs need immediate pre- and post-launch marketing and BCC support to generate awareness about the benefits of buying and using vouchers. In the case of the FP services, intensive and sustained BCC support is needed to generate demand for and address cultural barriers to using FP.

## CONCLUSIONS

Voucher programs in health are the latest trend in public health policy. Several developing countries, with international donor support, are considering or in the process of implementing a voucher program (examples include India, Tanzania, Uganda, Kenya and Bangladesh). The insights and practical guidance offered in this report are a first step to better understanding voucher programs strengths and weaknesses. However, more research is needed to inform the design and expansion of voucher programs throughout the developing world. Important areas for further study include:

***Impact evaluation***
Vouchers are a relatively untested approach in low-income countries. Although results from these early experiences are positive, there is a clear need for rigorous research that can conclusively establish that voucher programs can increase coverage of FP/RH and other health services among underserved target populations.

***Cost and cost-effectiveness evaluation***
Without more detailed data on costs, voucher service use, and health impact, it is not possible to precisely estimate the "bang-for-the-buck" of a voucher program compared to other strategies that can be used to increase use and quality of RH/ FP services.

***Using technology to simplify implementation and reduce overhead costs***
Technology, such as mobile phone technology, could potentially be used to simplify voucher distribution, submission and processing of claims, payment to providers, and even follow-up with voucher clients. This can help reduce the overhead costs of implementing voucher programs and facilitate scale-up.

# 1. INTRODUCTION

## 1.1 ABOUT VOUCHERS

Health policy in developing countries has traditionally focused on public provision of free or highly subsidized services, financed largely through supply-side subsidies, to lower the costs of seeking care and ensure universal access. However, it is now increasingly clear that many people in developing countries, even the poor in Africa, choose to seek health care in the private sector and pay out-of-pocket to do so.[1] Use of private services by the poor also raises questions about equity: whether routing public subsidies exclusively through public providers is the most effective way of reaching the poor, or the most equitable way of channeling public funds. These concerns have sparked interest in approaches like vouchers that can lower the financial burden on individuals seeking family planning and reproductive health (FP/RH) products and services by targeting subsidies directly at end-users of FP/RH products and services and allowing end-users to "vote with their feet" for providers of their choice.

A health voucher is a token that can be exchanged for a pre-defined set of health services or products. Health vouchers enable public subsidies for services or products to follow the client, rather than being tied to providers. Clients buy vouchers for a specified set of services or products at a pre-defined price, or obtain vouchers free of charge. Voucher holders can then exchange the vouchers for those services or products at participating providers. The price that voucher holders pay for voucher services or products at participating providers may vary considerably depending on the degree of subsidy associated with the vouchers. Vouchers can also be used to cover other costs of accessing health services (such as transport, lost wages, and other opportunity costs) if these are important barriers to increasing the use of health services. Vouchers can therefore reduce financial barriers to using FP/RH services or products by giving voucher holders a discount on the retail price of health services or by compensating other costs of using health services.

Voucher programs also can effectively regulate participating voucher service provider (VSP) quality by making entry to and continued participation in the voucher program conditional on meeting minimum quality standards. Moreover, when voucher programs allow clients to choose between participating providers, and providers are paid based on those voucher services that they actually provide to clients, competition often contributes to increased provider efficiency and directly improves provider quality and responsiveness to clients as the providers attempt to attract more voucher clients.

If designed and implemented well, voucher programs in health service delivery hold out promise in the following areas:

- **Improving access and equity** in the use of health services and products by reducing financial barriers to using services and products.
- **Targeting specific population groups**, such as the poor, rural, or other underserved groups. Voucher distributors act as gatekeepers to determine eligibility for receiving or buying a voucher,

[1] Islam, M. 2006. *Vouchers for Health: A Focus on Reproductive Health and Family Planning Services*. Bethesda, MD: Private Sector Partnerships (PSP)-*One,* Abt Associates Inc.

thereby reducing potential conflict of interest where service providers are responsible for determining eligibility for subsidized services.

- **Harnessing the private sector and enabling choice among providers** by allowing voucher holders to choose between pre-approved participating public or private providers.[2]

- **Ensuring efficiency, responsiveness to clients and quality improvements** by linking voucher payments to services delivered, prompting VSPs to compete for voucher clients.

- **Increasing the likelihood that the decision to use FP is voluntary** by asking clients to pay a small price for the voucher before going to a health facility where FP is available. Voluntary acceptance of FP is particularly important when provider payments are linked to services provided, as such links can potentially motivate providers to pressure women to accept a FP method.

Early signs of promising results from the first generation of health services voucher programs in countries like India, Uganda, and Kenya have sparked interest among the FP/RH community to see if voucher programs can address the barriers associated with FP acceptance. Interested policymakers and FP/RH practitioners, however, have limited information based in the experience of health voucher programs to guide the design and implementation FP/RH voucher programs

The purpose of this technical report, therefore, is to provide practical guidance to policymakers, donors, and voucher program implementers involved or interested in designing, financing, or implementing FP/RH voucher programs in Sub-Saharan Africa by bringing together insights on what has worked well and (just as importantly) on what has not worked well from the experience of FP/RH voucher programs in Africa. Although the primary focus of this paper is to identify guidelines to help design an effective FP/RH voucher program, many of the observations can be applied to all voucher programs designed to increase use of and access to critical health services.

The technical report focuses on two FP/RH voucher programs:

- The Reproductive-Health Output-Based Aid (RH-OBA) voucher pilot program in Kenya that offers Safe Motherhood (SM) and FP vouchers.[3] Special emphasis is on identifying lessons learned from the Kenyan RH-OBA FP voucher experience, as FP-specific vouchers have had lower uptake than broader RH vouchers.

- The Reproductive Health Voucher Project (RHVP) in Uganda, which currently offers SM vouchers and intends to launch Sexually Transmitted Infection (STI) vouchers in the near future.

## 1.2 ABOUT THIS TECHNICAL REPORT

The report is the output of an extensive process of review, consultation, and analysis. It brings together findings from a review from published and unpublished secondary literature, primary data collection, and extensive interviews conducted by Private Sector Partnerships (PSP)-*One* staff with the Kenyan RH-OBA and Ugandan RHVP teams as part of the preparation for a PSP-*One*-sponsored Family Planning

[2] The term 'private providers' refers to both private for-profit and private non-profit providers, with the latter including nongovernmental organization (NGO) and faith-based organization (FBO) providers.

[3] The RH-OBA pilot also comprises vouchers for gender-based violence recovery services. The scope of this technical report does not include the RH-OBA experience with these vouchers.

Voucher Innovations Workshop held in Nairobi, Kenya, September 8-11, 2009. Key workshop participants also reviewed and commented on a preliminary draft of this report.

Section 2 discusses the socioeconomic and policy environment in which the Kenya and Uganda voucher programs are implemented. Sections 3 and 4 present key similarities and differences in the design and implementation arrangements for the two voucher programs and highlights important results on their performance. The final section (5) focuses on identifying strengths and weaknesses, deriving insights on what works (and doesn't) and concludes with recommendations on "do's and don'ts" for FP voucher programs. Detailed information on the voucher program context, components, and performance are presented in detailed tables in Annex A. Annex B presents tools used in the RH-OBA pilot.

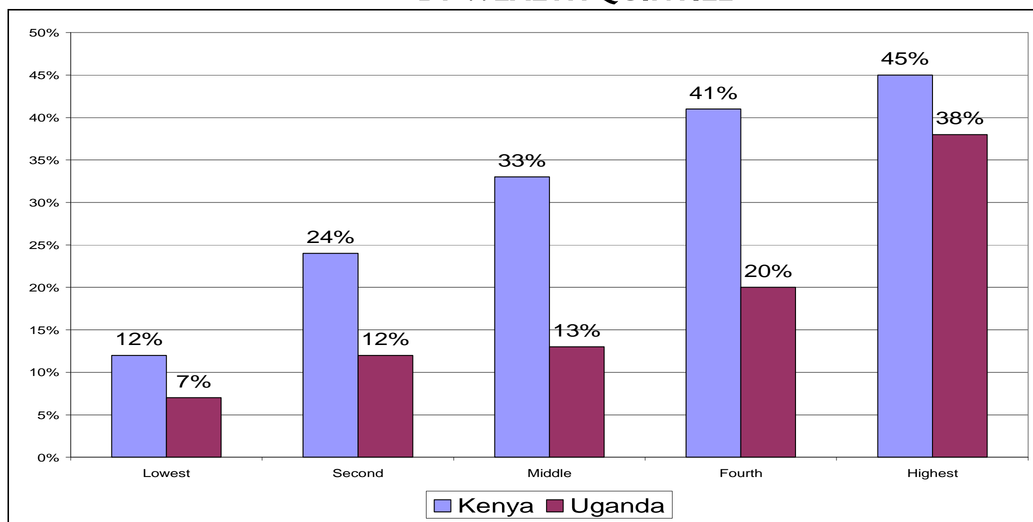
# 2. SOCIOECONOMIC AND POLICY CONTEXT: KENYA AND UGANDA

## 2.1 A QUICK REVIEW OF FP AND SM INDICATORS

Many aspects of the socioeconomic and health context make vouchers a potentially attractive policy option to increase use of FP/RH services in Kenya and Uganda (see Annex A, Table A.1 for details). Use of modern FP methods in Kenya is low: contraceptive prevalence rate (CPR) is 23 percent and total fertility rate (TFR) is high at 4.9. Statistics on FP use in Uganda is even starker: Modern contraceptive use is only 15 percent and TFR is 6.7. Unmet need for FP is fairly high among currently married women in both Kenya and Uganda at 25 percent (KDHS 2003) and 41 percent (UDHS 2006) respectively.

A substantial proportion of the Kenyan and Ugandan population live below the poverty line (46% and 38% respectively). High poverty headcounts and wealth disparities in modern FP use in both countries suggest that financial barriers could potentially contribute to low FP use. Contraceptive use by the wealthiest 20 percent of Kenyans is almost four times higher than that by the poorest 20 percent (Figure 1). In Uganda the wealthiest one-fifth of Ugandans are over five times more likely to use FP than the poorest fifth.

**FIGURE 1: DISPARITIES IN CURRENT USE OF MODERN FP IN KENYA AND UGANDA BY WEALTH QUINTILE**

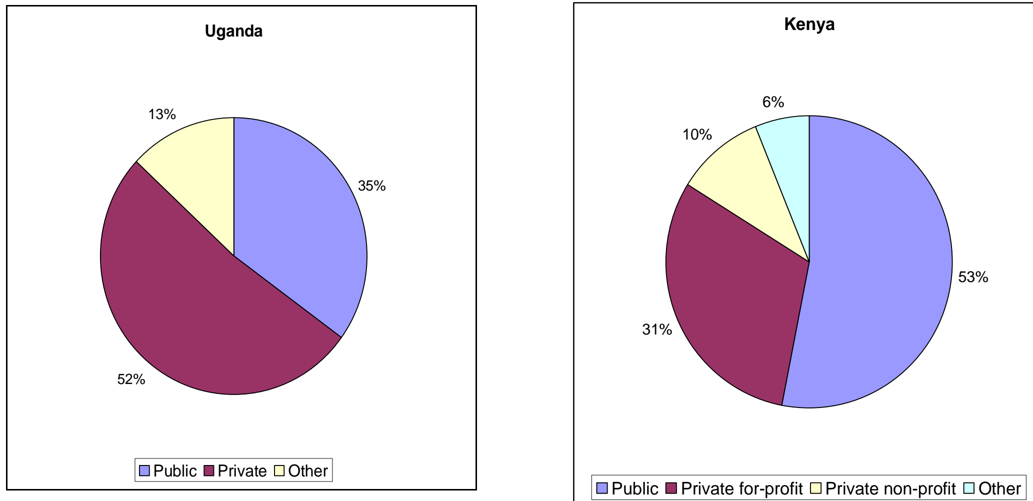



*Data source: Kenya Demographic and Health Survey (DHS) 2003/ Uganda DHS 2006*

Despite subsidized FP services in the public sector, the private sector remains an important source of FP methods in Kenya and Uganda (Figure 2). In Kenya, more than half (53%) receive their FP services and methods in the public sector, almost one third (31%) in the for-profit sector, followed by 10 percent in

the non- profit sector. In Uganda, as well, the majority (52%) seeks FP services in the private sector (for-profit and non profit combined[4]) while a little over one third (35%) seek FP in the public sector.

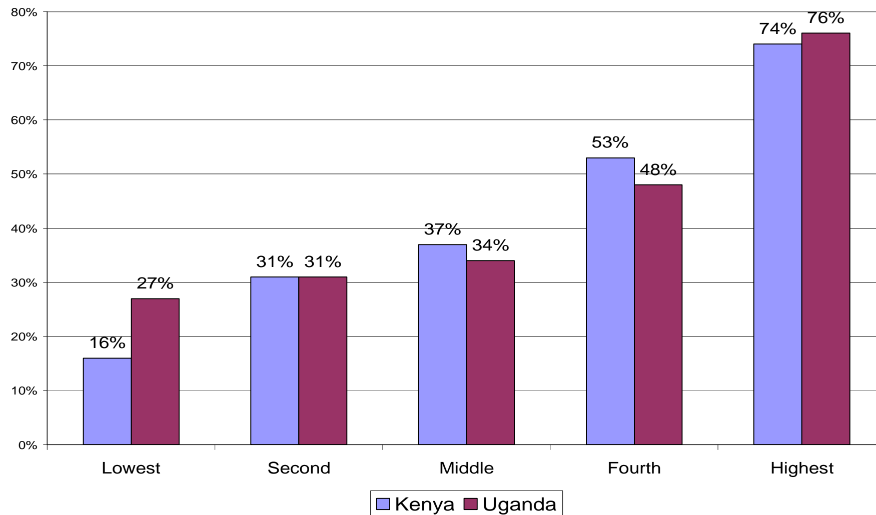
**FIGURE 2: COMPARISON OF SOURCES OF FP IN KENYA AND UGANDA**




*Data source: KDHS 2003 and Uganda DHS 2006*

There are similar concerns with increasing use of SM services, such as institutional deliveries, as high rates of maternal mortality persist (see Annex A, Table A.1 for details). Less than half of all deliveries or births take place in a health facility (40% of deliveries in Kenya and 42% in Uganda). Furthermore, the poorest women in both Kenya and Uganda are more likely to deliver at home than the richest one-fifth of women- nearly five times more likely in Kenya and thrice as likely in Uganda (Figure 3).

**FIGURE 3: DIFFERENCES IN INSTITUTIONAL DELIVERIES IN KENYA AND UGANDA BY WEALTH QUINTILE**

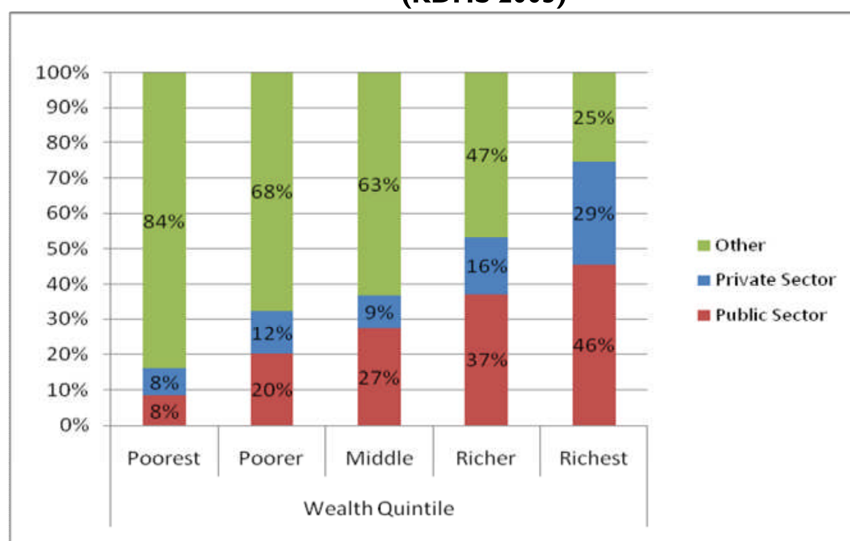



*Data source: Kenya DHS 2003/ Uganda DHS 2006*

[4] The Uganda DHS report 2006 does not present separate figures for FP source from private for-profit and private non-profit sectors. Hence only combined figures are presented.

Although the majority of women who deliver in an institutional setting do so at a public facility (65% in Kenya and 71% in Uganda), the private sector accounts for a sizeable share of institutional deliveries (35% in Kenya and 29% in Uganda). In fact, many of the women who seek SM care in the private sector are poor, while many who can afford to pay for private deliveries in the private sector receive free or subsidized care in the public sector. Figure 4 illustrates SM deliveries by income level and source in Kenya. In this example, the majority of births among poor women take place at home (84%); of the remaining births, equal numbers take place in public and private facilities (8% each of total births). A significant percentage of the wealthiest women (46) deliver at public facilities.

**FIGURE 4: SM DELIVERIES IN KENYA BY WEALTH QUINTILE AND SOURCE (KDHS 2003)**




## 2.2 POLICY FACTORS

Policy environments in Kenya and Uganda are conducive to private sector partnership innovations in FP/RH. The Ministries of Health (MOH) in Kenya and Uganda view FP and maternal and child health as priority intervention areas. The Kenya Health Policy Framework (2004-2010) clearly recognizes the need to facilitate the function of the private sector while exercising oversight over private sector operations. Both the Health Sector Strategic Plan II and the Vision 2030 social pillar recognize the role of the private health sector and the importance of partnerships. Moreover, both the Kenyan Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Sciences (MOMS) list public-private partnerships (PPPs) as a priority in their past and current strategic plans. Although several partnerships already exist, a formal PPP unit has not been set up in either the MOPHS or MOMS. Uganda, in contrast, has both a PPP policy and an active PPP unit in its MOH.

The Kenyan and Ugandan contexts present a good confluence of need and opportunity in the policy environment for innovating with FP/RH vouchers, and scaling up or mainstreaming these innovations if proven effective. Both Kenya and Uganda are currently implementing FP/RH voucher pilots with SM vouchers (Kenya and Uganda) and FP vouchers (Kenya only). Their experiences offer useful insights for policymakers and practitioners considering voucher programs. While the two pilots are similar in many respects, key differences in design features, implementation arrangements, and results have created opportunities for cross-fertilization as both programs expand in scale of operation and scope. Their experiences with implementing voucher programs also holds lessons for FP/RH voucher programs elsewhere in Africa.

# 3. Vouchers in Kenya and Uganda

To better understand how a voucher program can possibly help increase access to FP/RH services, one must first become familiar with what the Kenyan and Ugandan voucher programs offer and how they are organized to administer and deliver services. This section first provides a brief description of each voucher program, followed by a discussion of similarities and differences between the programs' management and structure. (See Tables A.3 and A.4 in the Annex for an overview of the Kenya and Uganda voucher programs.)

## 3.1 A BIRD'S EYE VIEW OF THE TWO VOUCHER PROGRAMS

The *Kreditanstalt für Wiederaufbau* (German Development Bank or KfW) and GoK-supported RH-OBA pilot was established in 2005 to improve use, responsiveness, and quality of FP and SM services and give clients a choice of providers. From a health perspective, the RH-OBA pilot aims to reduce maternal and perinatal mortality. To meet these objectives, the RH-OBA pilot offers two health vouchers: an FP voucher for long-acting and permanent methods (LAPM) of contraception and an SM voucher that covers ANC, delivery, and PNC services.[5] The vouchers are targeted to the poor. Clients who are below a defined poverty threshold in three rural districts and two Nairobi slums can buy an FP voucher for approximately US$1.25 (KSh100) and an SM voucher for $2.5 (KSh200). Since promoting provider choice is one of the key objectives of the Kenya RH-OBA pilot, vouchers are valid at 54 accredited public (37%), private for-profit (33%), and private non-profit providers (30%).

The Ugandan RHVP was established through a partnership between the Ugandan MOH, KfW, and the Global Partnership on Output-Based Aid (GPOBA), a World Bank-managed trust fund. Funding from GPOBA is designated to cover health service delivery costs for all the vouchers used in the first 12 (eventually 22) participating districts of Southern and Western Uganda, while funding from KfW is earmarked for project administrative and management expenses. RHVP plans to implement a 'Healthy Baby' voucher for SM services in the 22 districts. It will also launch a 'Healthy Life' voucher for STI treatment in six districts, based on the 2006-08 pilot in four districts of Mbarara region. The RHVP is a young program, having officially commenced in August 2008 with the SM vouchers. However, it is a second-generation voucher program that builds on the experience of the Ugandan STI voucher pilot in Mbarara and the Kenyan RH-OBA pilot. Its SM voucher is inspired by the RH-OBA SM voucher, offering the same benefits to voucher holders and targeting poor population groups. Women who meet the poverty criteria in RHVP-covered districts are eligible to buy the voucher for $1.50 (USh3,000). So far, implementation has begun in 12 of the planned 22 districts. Unlike the RH-OBA program, only private providers participate in the RHVP:[6] 27 (57%) are for-profit providers and 20 (43%) are non-profit providers. Both the RH-OBA pilot and RHVP are competitive, allowing voucher holders to choose between participating VSPs.

---

[5] As noted above, the scope of this technical report does not include the RH-OBA experience with gender-based violence recovery services vouchers.

[6] The main reason for this is that MOH policy does not permit cost sharing in public health facilities. The cost of the voucher is regarded as a co-payment and hence would violate MOH policy. There are ongoing efforts to address this policy and bring in public providers.

## 3.2 DIVING DEEPER - ROLES AND FUNCTIONS IN THE KENYA RH-OBA PILOT AND UGANDA RHVP

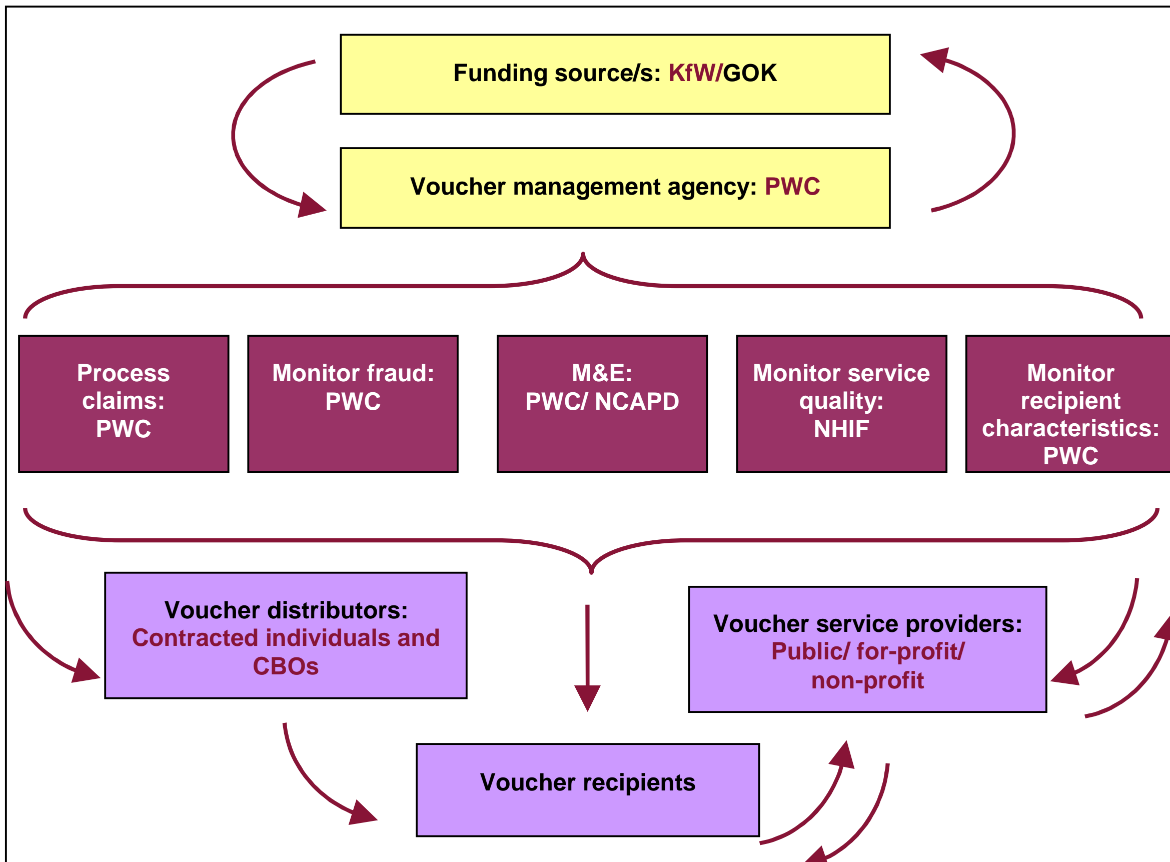
For a voucher program to succeed, it must effectively carry out a variety of functions. Each voucher program organizes these functions in different ways, especially in regard to voucher management. This section looks at how the Kenyan RH-OBA pilot and the Ugandan RHVP are organized and highlights similarities and differences between them. For easy reference, Table 1 enumerates the main functions that all voucher programs must carry out and groups them into four main categories: stewardship, voucher program management, ensuring health service delivery, and generating demand.

**TABLE 1: CATEGORIZING THE MAIN FUNCTIONS OF A VOUCHER PROGRAM**

| Category | Functions |
|---|---|
| **Stewardship** | • Defining voucher program policies (what services are covered/ who can buy vouchers/setting prices for vouchers/ establishing payment rates for participating providers)<br>• Overseeing the voucher program<br>• Financing and planning for long-term sustainability |
| **Voucher program management** | • Selecting a voucher management agency (VMA)<br>• Defining the VMA's role<br>• Processing voucher claims that providers submit for reimbursement<br>• Monitoring and controlling fraud<br>• Monitoring voucher recipient characteristics, i.e., to ensure that they meet eligibility criteria<br>• Monitoring and evaluating whether program objectives have been met |
| **Health service delivery** | • Identifying and engaging voucher service providers (VSPs)<br>• Accrediting VSPs<br>• Contracting VSPs<br>• Monitoring and supporting VSP quality of services<br>• Ensuring availability of drugs and FP supplies |
| **Demand Generation** | • Identifying, recruiting and retaining voucher distributors<br>• Distributing vouchers<br>• Targeting voucher recipients<br>• Community outreach and behavior change communication<br>• Marketing the vouchers |

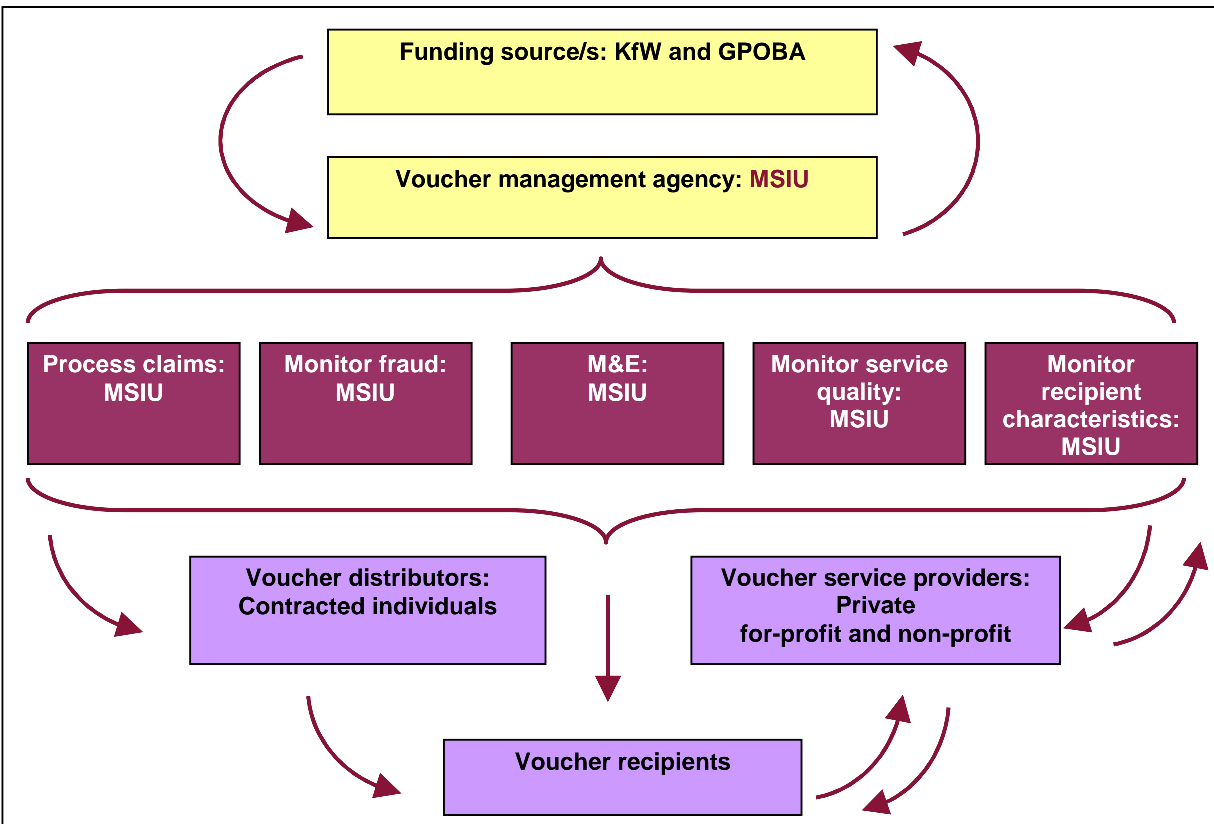
On the following pages, figures 5 and 6 show the organizational structure of the Kenya and Uganda programs, respectively, illustrating the management functions and different organizations that carry them out.

**FIGURE 5: ORGANIZATION OF THE KENYA RH-OBA PROGRAM**




*Note: PWC= PricewaterhouseCoopers, M&E=monitoring and evaluation, NCAPD=National Coordinating Agency for Population and Development, NHIF=National Hospital Insurance Fund, CBO=community-based organization*

**FIGURE 6: ORGANIZATION OF THE UGANDA RHVP**




*Note: MSIU=Marie Stopes International Uganda*

### 3.2.1 STEWARDSHIP

An important difference between the Kenyan and Ugandan voucher programs lies in who is responsible for program oversight as distinct from hands-on management. The Kenyan RH-OBA pilot separates oversight from program management. The National Coordinating Agency for Population and Development (NCAPD), the apex government body concerned with population policies, is responsible for oversight. A steering committee with members from the MOPHS and KfW supports the NCAPD in overseeing the program. PricewaterhouseCoopers (PWC), an international firm with auditing expertise, is the Voucher Management Agency (VMA). In the Ugandan RHVP, the VMA ̃ Marie Stopes International Uganda (MSIU) ̃ also has oversight responsibility, resulting in an overlap between stewardship and management.

Long-term planning for financing and sustainability are important concerns as the voucher schemes in Kenya and Uganda are donor financed. Neither voucher program has an existing sustainability plan. The Kenyan RH-OBA is planning a scale-up and is in the process of developing medium-term plans, while the Ugandan RHVP expects to begin sustainability planning in 2010 as the program becomes more established.

### 3.2.2 VOUCHER PROGRAM MANAGEMENT

Voucher management is the backbone of a functional voucher program. As noted above, the Kenya and Uganda program VMAs are different types of organizations, and these differences are reflected in the respective VMA's core competencies. In Kenya, the multinational PWC was selected as VMA through a competitive bidding process primarily for its financial management and auditing expertise, which comprises fraud monitoring and the ability to design and implement robust reimbursement systems. In Uganda, the selection process was informal: the non-profit MSIU, with its FP/RH service delivery and technical oversight, social marketing, and behavior change communication (BCC) expertise, grew into the VMA role via its participation in a KfW-supported condom social marketing activity in Mbarara.

An important management function is processing of voucher claims and VSP reimbursement. Voucher claims must be processed quickly and efficiently to retain VSPs whereas attractive reimbursement rates help to engage providers in voucher programs. Claims databases can also contribute to routine monitoring of fraud, depending on the types of information the databases bring together. The Ugandan RHVP claims processing system builds on lessons learned with the STI pilot voucher program in Mbarara. That program contracted Microcare Limited, a private firm in Kampala, in 2005 to develop a claims database that could be used to track claims, identify fraud, and monitor quality. However, the database developed did not work effectively and generated considerable frustration for MSIU.[7] Thus, in the RHVP, MSIU has taken on the responsibility of developing a fully functional claims database in-house to facilitate rapid claims processing, ensure effective reporting, and prevent payment delays. This claims database is expected to be functional by the end of September 2009.

Currently, the Kenyan RH-OBA pilot's claims processing and fraud monitoring system is the more comprehensive. It uses a database to track technical and financial information from claims and link claims data with reimbursements and voucher distribution data. By linking data from different sources, the database serves as a tool for monitoring fraud by providers or distributors. In addition to this electronic information, both PWC and MSIU field staff use field visits to providers and distributors and home visits to voucher recipients to detect and eliminate fraud. PWC also conducts random client exit interviews at health facilities; responses are then cross-checked against provider claims. In Uganda, MSIU has hired a care manager to perform this and other quality assurance and client support tasks.

The FP and SM vouchers in Kenya and the SM vouchers in Uganda are poverty targeted. In both programs, eligible recipients are identified using an easily implemented poverty screening tool developed by Marie Stopes International (MSI) modeled on community-based research; the tool is customized to each district to capture local markers of poverty. It is implemented by community-level voucher distributors (VDs). No data are available on the sensitivity and specificity of the tool, i.e., on how well the tool sorts the program-eligible poor from non-poor. However, Kenya RH-OBA program staff appear satisfied with the tool and report no major concerns with targeting. In Uganda, RHVP staff and VDs are also satisfied with the tool for the SM voucher and report no major concerns.

Monitoring VSP quality helps to ensure that voucher holders receive high-quality services. The RH-OBA pilot and RHVP organize provider quality monitoring different ways. Since the RH-OBA VMA (PWC) is an auditing firm with little technical quality monitoring experience, the program outsources quality monitoring to the National Hospital Insurance Fund (NHIF). Accounts of the NHIF's performance,[8]

---

[7] Bellows, B. and M. Hamilton. 2009. Vouchers for Health: Increasing Utilization of Facility-Based STI and Safe Motherhood Services in Uganda. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

[8] Report of mid-term review of the Reproductive Health Output-Based Approach Project in Kisumu, Kitui, Kiambu, Korogocho, and Viwandani 2005-2008, submitted to the NCAPD, February 28, 2008. Narrative accounts from PSP-*One* team interviews with Kenya RH-OBA team.

however, suggest that it did little continuous, post-accreditation quality monitoring. Nor did it provide post-accreditation training or other support to improve provider quality. In contrast, in Uganda, the RHVP VMA itself (MSIU) is responsible for monitoring service provider quality. MSIU achieves this through a combination of clinical audits, which include interviews with VSP staff, management, and clients, and facility assessments to gauge quality and adherence to project protocols. MSI staff use a variety of post-accreditation tools to monitor quality including a checklist for quality assurance processes, inspections, and observations of service delivery.

Health vouchers are a relatively innovative approach and many questions remain about their effectiveness. Hence monitoring and evaluating voucher program functioning is important to keep voucher programs on track and to contribute to the larger body of knowledge on what works. The computerized claims processing system as implemented in Kenya increases the ease with which voucher programs can be monitored with routine data.

However, no evaluation research is available to document the impact of the RH-OBA pilot on service coverage, quality, or on the cost-effectiveness of vouchers as a strategy to achieve policy objectives for FP/RH services. Also, the Uganda RHVP is at an early stage, so no evaluation results are available. Household surveys were conducted to evaluate the population impact of the Uganda STI pilot[9] and findings will be discussed in the results section.

### 3.2.3 HEALTH SERVICE DELIVERY

As mentioned previously, the Kenyan RH-OBA pilot contracts public, private for-profit, and private non-profit providers, while the Uganda RHVP uses only private (for- and non-profit) providers, as MOH policy in Uganda does not permit any cost sharing (e.g., selling vouchers) with clients in public facilities. The processes that the Kenya and Uganda programs used to identify, accredit, and contract VSPs are similar. Service providers in project districts were mapped by independent consultants who were contracted to identify eligible providers and generate information on their capacity to deliver voucher services. Providers who met pre-specified criteria were accredited and invited to join the voucher programs.[10] Providers who accepted were formally contracted by the VMA using contracts specifying reimbursement rates and quality, monitoring, and reporting protocols with which the providers must comply. In both programs, VSP fraud or failure to meet requirements is grounds for contract termination.[11]

VSP Facility in Uganda

*Photo Courtesy Nelson Gitonga*

Training and other forms of quality support make an important contribution to maintaining and improving technical quality. VSPs in both programs receive induction training on how to fill out claims forms and follow other financial protocols. However, the MSIU team in Uganda is also directly responsible for training VSPs to build their clinical skills when they join the program and via refresher

---

[9] In 2005, Ben Bellows, then a Ph.D. candidate at the University of California, Berkeley, evaluated the STI voucher pilot in partnership with the Mbarara University of Science and Technology.

[10] Early in the RH-OBA pilot, PWC relied on the Population Council to develop an accreditation and quality assurance manual.

[11] Both the Kenyan RH-OBA pilot and the Ugandan STI pilot (predecessor to the RHVP) report one instance of VSP contract termination on such grounds.

training. In Kenya, the NHIF was assigned the responsibility of training and re-training VSPs to build and maintain clinical skills but, for a number of reasons, it was not able to provide this support. This may have adversely affected the RH-OBA FP voucher program: limited staff skills on LAPM have been identified as a problem.[12] For-profit VSPs are especially affected by inadequate training support, as they tend to not to be included in government-sponsored FP/RH training, though they are formally entitled to participate. In other instances, VSPs are reluctant to spend money on training or to allow their staff time away from work to attend training.

Public, for-profit, and non-profit VSPs in the voucher programs rely on the government distribution systems for subsidized FP-related drugs and supplies (in Kenya) and SM-related drugs and supplies (in Kenya and Uganda). While both programs report problems with stock-outs of drugs and supplies, neither has set up mechanisms to provide drugs and supplies in the event of stock-outs in government distribution systems although VSPs can buy those drugs and FP supplies from private distributors or retail pharmacies. Kenyan public and private VSPs complain about stock-outs of supplies from the Kenya Medical Supplies Agency, and this has constrained their capacity to provide quality FP services.[13]

### 3.2.4 GENERATING DEMAND

Generating demand for vouchers is a basic voucher program function. All programs require three main types of support to generate demand: (1) marketing and promotional activities to generate awareness about the voucher program and to convince clients of the benefits of using vouchers, (2) marketing and BCC to generate demand for the services that are covered by vouchers, and (3) facilitating voucher service use by ensuring that target clientele can obtain vouchers with ease. As discussed below, generating demand is particularly important for FP vouchers. Since voucher distributors (VDs) are both retail outlets for physical vouchers and gatekeepers who determine eligibility for vouchers, we include identifying, recruiting, and retaining VDs and targeting voucher recipients in the "generating demand" category.

Kenya's RH-OBA and Ugandan RHVP vouchers are both targeted at the poor, and both programs have identified and recruited VDs who are rooted in local communities and accessible to poor clients. In Kenya, PWC initially recruited organizations to act as VDs. However, it found that using organizations dispersed accountability across the organization, making it difficult to hold any one individual responsible for performance; subsequently PWC shifted to contracting individuals to act as VDs. By contrast, in Uganda, VD selection is based solely on recommendations from the local communities and VSPs. VDs can include a wide variety of players including commercial outlets, community groups, and faith-based organizations.

The Kenyan and Ugandan voucher programs rely on their VDs to screen potential clients for poverty. This necessitates user-friendly poverty screening tools that are easy to use and that quickly sort the eligible poor from the non-eligible with an acceptable level of accuracy ̃ thus minimizing voucher leakage to the non-poor or under-coverage of the poor. As noted above, both programs customized MSI poverty screening tools to incorporate local markers of poverty or vulnerability.[14]

---

[12] Report of mid-term review of the Reproductive Health Output-Based Approach Project in Kisumu, Kitui, Kiambu, Korogocho, and Viwandani 2005-2008, submitted to the NCAPD, February 28, 2008. PSP-*One* team interviews with staff providers.

[13] PSP-*One* interviews with Kenya RH-OBA VSPs.

[14] See Annex B for examples of tools used in the Kenya RH-OBA pilot.

Balancing incentives for VDs is also important given their critical gatekeeping role. VDs need to be motivated to promote vouchers, but only to eligible clients. The Kenya program initially paid VDs a commission for every voucher sold. This proved to be a high motivator to sell vouchers indiscriminately, and voucher sales to the non-poor increased. In response, PWC changed the payment strategy and now pays VDs a salary retainer. VDs are contracted for short (three-month) terms, and their contracts are renewed only if PWC deems the number of voucher sales to eligible poor clients to be satisfactory. The Ugandan VDs earn a specified mark-up on the voucher price.

Raising awareness about voucher programs and communicating their benefits to target populations requires a combination of marketing and BCC that focuses on increasing the attractiveness of voucher services. Drawing on MSIU's social marketing expertise, a comprehensive marketing/BCC strategy was planned for the RHVP start-up phase and as an ongoing activity. This mirrors the integrated marketing/BCC strategy implemented as part of the Ugandan STI pilot, which included sustained activities to educate the target audience on STI symptom recognition and inform potential clients on how and where STI treatment vouchers could be used. It used radio advertisements primarily to generate awareness about the STI voucher program, and a radio call-in talk show to address misperceptions and questions about STIs. MSIU staff visited communities on market days to screen a documentary film about the voucher program and answer audience questions. They also set up market-day booths where they would provide information and sell STI vouchers. [15]

Voucher Client in Uganda

*Photo Courtesy Nelson Gitonga*

The Kenya voucher program did not conduct target audience research to design a marketing/BCC strategy for either FP or SM vouchers; nor did it implement a sustained marketing/BCC campaign. Instead, activities focused on the launch stage. Lowe Scanad, an advertising agency, implemented a one-month long launch campaign to increase awareness about and promote FP and SM vouchers at each project site. The launch campaign used multiple media including radio spots, road shows and other community events, and door-to-door communication. It also developed and distributed materials, such as color coordinated posters, brochures, banners, and t-shirts.

[15] Personal communication, Ben Bellows

# 4. KEY RESULTS: VOUCHER SERVICE USE, QUALITY, AND COSTS

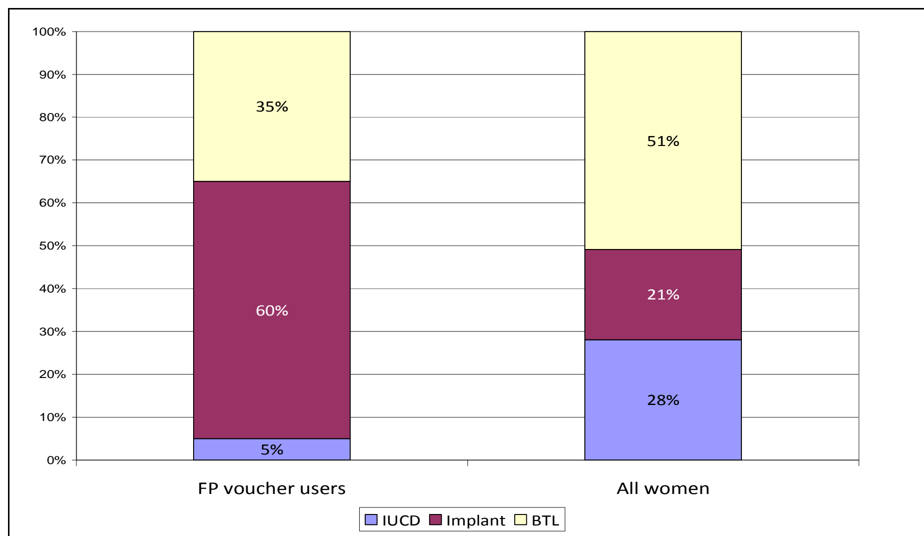
In less than five years, the two voucher programs have shown promise in achieving their stated objectives of increasing access to quality health services among poor women. This section presents some preliminary findings on uptake and use of the different voucher programs, quality improvements resulting from increased revenue from voucher clients, and competition between VSPs, and estimates of the costs of administering voucher programs. (See Table A.5 in Annex A for a summary of key results from the Kenya and Uganda voucher programs.)

## 4.1 SM AND FP VOUCHER USE IN KENYA RH-OBA

In Kenya, uptake of RH-OBA SM vouchers has been high. Between June 2006 and October 2008, 78,651 SM vouchers were sold and 60,581 women used SM vouchers to deliver in a participating facility. In contrast, use of FP vouchers was considerably lower than expected. In the same period, only 25,620 FP vouchers were sold, and 11,296 (41%) of these were used.

Examination of provider claims data reveals a different pattern of long-acting and permanent method (LAPM) use compared to all women using LAPMs in the 2003 DHS (Figure 7). FP voucher users overwhelming prefer implants to other LAPMs. Almost two thirds (60%) percent of FP voucher users selected implants, compared to a third (35%) who chose female sterilization (bilateral tubal ligation, or BTL). Only 5 percent opted for intrauterine contraceptive devices (IUCDs). In contrast, in the Kenya DHS , over half of the women using a LAPM selected BTL (51%), followed by 28% using IUCDs. with 21 percent using implants.

**FIGURE 7: BREAKDOWN BY LAPM TYPE: FP VOUCHER USERS COMPARED TO ALL WOMEN IN KENYA DHS 2003**




*Source: RH-OBA provider claims and Kenya DHS 2003*

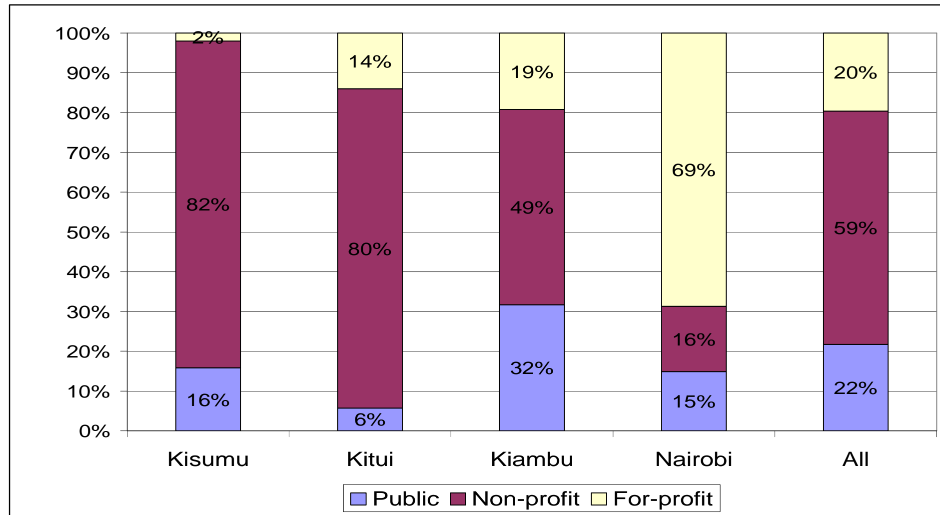
Interestingly, voucher utilization patterns indicate that the poor in Kenya prefer to use private for-profit and non-profit providers. Provider claims from Kenya RH-OBA provide an indication of the volume of voucher services delivered by different types of VSPs (Figures 8 and 9).

- In the area of FP, non-profit providers were the preferred provider (59%) across all voucher site locations. Both public and for-profit providers delivered a similar volume of FP services, at 22 percent and 20 percent of FP claims, respectively (Figure 8).

- Private non-profit providers appear to be a particularly important source of surgical methods of contraception: private non-profit providers submitted 90 percent of all claims for BTLs.

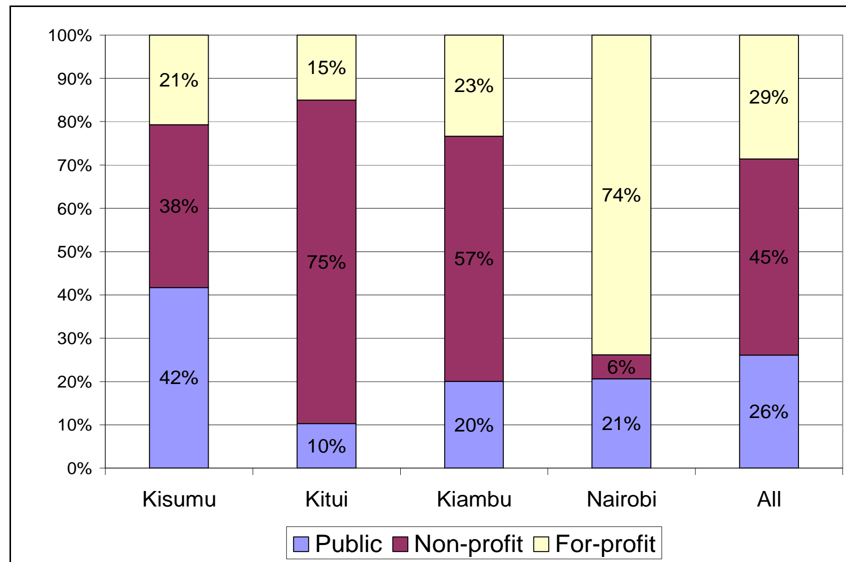
- Non-profit providers were also the preferred provider for SM services and accounted for 45 percent of SM claims (Figure 9).

**FIGURE 8: VOUCHER SERVICE PROVIDER (VSP) CLAIMS BY TYPE OF VSP FOR FAMILY PLANNING IN RH-OBA PILOT**




*Source: RH-OBA Phase I & II Claims Data*

**FIGURE 9: VOUCHER SERVICE PROVIDER (VSP) CLAIMS BY TYPE OF VSP FOR SAFE MOTHERHOOD IN RH-OBA PILOT**




*Source: RH-OBA Phase I & II Claims Data*

However, when disaggregating voucher claims by geographic site it is clear that the share of for-profit VSPs in both FP and SM services delivered is very large in Nairobi (69% and 74% of FP and SM claims, respectively) but relatively low in the remaining sites. This could be a reflection of the greater concentration of or higher perceived quality of for-profit providers in and around Nairobi relative to the remaining, relatively rural, areas.

This preference for private providers (both for- and non-profit) is consistent with findings from the Kenya 2004 Service Provision Assessment,[16] which found that consumers preferred private facilitates for a variety of reasons including shorter wait times and fewer stock-outs of FP methods and supplies. Consequently, clients perceived quality to be higher at private sector facilities.

## 4.2 QUALITY IMPROVEMENTS IN KENYA RH-OBA

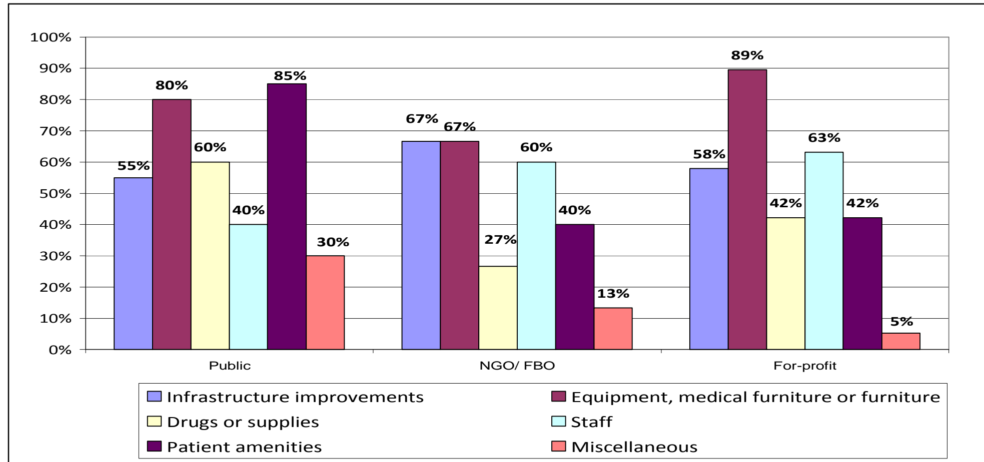
There is clear evidence that public and private VSPs have invested in making quality improvements (Figure 10). In fact, findings from the mid-term review of the RH-OBA program suggest that the voucher program has become an important source of SM clients, and possibly of SM revenue. Voucher clients dominate the client base of the voucher facilities − the percentage of voucher SM clients among all delivery clients is around or over 70 percent for all voucher facilities except Pumwani Maternity Hospital in Nairobi, the largest maternity hospital in Kenya.

Eighty-five percent of public, 89 percent of for-profit, and 67 percent of non-profit VSPs used voucher revenue to improve infrastructure, buy equipment or drugs and supplies, hire new or pay existing staff, or create patient amenities. While all types of VSPs used voucher revenue to hire staff and pay salaries,

[16] Hutchison, Paul; Mai Do, and Sohail Agha. November 2009. Client Satisfaction and the Quality of Family Planning Services: A Comparative Analysis of Public and Private Health Facilities in Ghana, Kenya, and Tanzania. Bethesda, MD: Private Sector Partnerships-*One* project, Abt Associates Inc.

the proportion of public facilities doing so was relatively low, possibly because public sector facilities are only permitted to hire non-clinical support staff.[17]

**FIGURE 10: QUALITY IMPROVEMENTS MADE BY RH-OBA FACILITIES**




*Source: RH-OBA Claims Data*

It is important to note that the vast majority of improvements made by the Kenyan RH-OBA VSPs are improvements that are visible to clients and could potentially help facilities attract more clients. This suggests that competition for voucher clients may result in the types of quality improvements that clients value. The other side of this is that facilities may be less likely to invest in improvements that will not bring in more clients˜ unless strong quality monitoring pushes them to do so. To illustrate, few VSPs (only two of 54) used voucher revenue to train staff, although staff skills in FP are a constraint to providing FP voucher services, because FP vouchers have not demonstrated their revenue potential to VSPs.

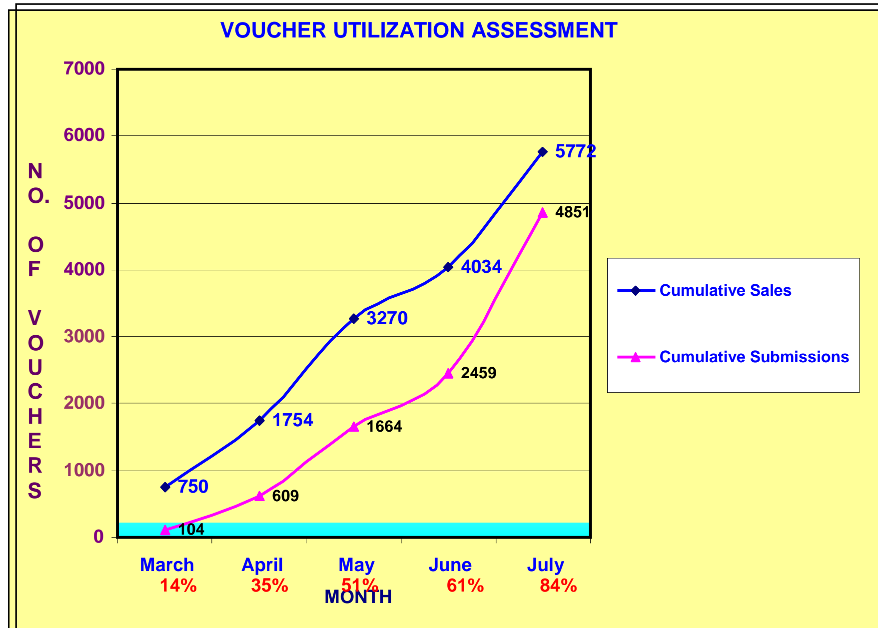
## 4.3 SM VOUCHER UPTAKE IN UGANDA RHVP

Uptake of the Uganda RHVP and Kenyan RH-OBA SM vouchers are not easily comparable since the RHVP is a year old, whereas the RH-OBA pilot has been implemented for close to 4 years. Between February 2009 and June 2009, 4,034 RHVP SM vouchers were sold and close to 2,451 (61%) used for ANC, institutional deliveries, or PNC services. This is fairly low, representing fewer SM vouchers used per month compared to RH-OBA vouchers. However, uptake in the first few months of RHVP may have been low because voucher systems take a long time to set up, particularly on the large scale of the RHVP program. It is also important to note the gap (61%) between the number of vouchers sold and the number used. According to MSIU, if all the VSPs who provided SM services had submitted correctly completed claims, the proportion of "used" vouchers would have been 70-85 percent of all vouchers sold. The RHVP's own analysis shows that the gap between sales and use is now closing (Figure 11).

---

[17] Twelve of 54 (22%) VSPs reported using voucher revenues to provide in-kind or financial staff incentives. Interestingly, seven of the 12 were public sector VSPs (35%of all public sector VSPs) and all of the remaining were non-profit VSPs; none were for-profit VSPs.

**FIGURE 11: TRENDS IN RHVP: VOUCHERS SOLD AND VOUCHER CLAIMS SUBMITTED, MARCH–JULY 2009**




*Source: RHVP sales and claims data*

Evaluation-research on the STI voucher pilot in Mbarara[18] finds evidence of population-level impact. Knowledge about STI symptoms increased 18 percent ($p<0.05$) in the pilot sites between the first and second years of the pilot. Use of STI treatment among those with STI symptoms in the preceding six months also increased by 15 percent between the first and second years, although this increase was not statistically significant ($p>0.05$).

## 4.4 QUALITY IMPROVEMENTS IN UGANDA RHVP

As the SM voucher component is in its early stages, the information available on quality improvements made by VSPs or the quality of their services is limited. RHVP staff observations, however, suggest that VSPs have already begun to invest in quality by hiring and replacing staff, making infrastructure improvements, buying drugs or other commodities, and investing in staff training.

VSP Facility in Uganda

*Photo Courtesy Nelson Gitonga*

## 4.5 KENYA RH-OBA AND UGANDA RHVP EXPENDITURES

The Kenya RH-OBA program expenditures to date are approximately $8.96 million (Euros 6.1 million) spread across three rural districts and two slums in Nairobi. The three-year budget of the Ugandan voucher program (including that for STI vouchers) is approximately US$ 6.3 million to be spread over

[18] Bellows, B. and M. Hamilton. 2009. Vouchers for Health: Increasing Utilization of Facility-Based STI and Safe Motherhood Services in Uganda. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

22 districts, or about $287,000 per district. So far, approximately $657,283 (about 10.4% of the budget) has been spent to set up and provide SM "Healthy Baby" voucher services in the 12 districts covered so far.

Overhead or administrative expenditures in the Kenya RH-OBA pilot are estimated to be 21 percent of total expenditures to date.[19] By comparison, the Uganda RHVP reports administrative costs of approximately 10 percent of the total budget. However, as a proportion of RHVP total expenditure to date, administrative costs account for 95 percent. This can be explained by the expenditures being mainly for the set-up phase of a relatively new program and the fact that the program has used only 10 percent of its budget so far. As the program matures, the percentage of total expenditure going to voucher services is expected to increase.

Again, regarding the RH-OBA pilot, SM vouchers and FP vouchers accounted for 76 percent and 3 percent, respectively, of the total expenditures and overhead for the remaining 21 percent. A rough analysis of these expenditures shows that the program spent approximately about $135 per SM voucher used (including ANC, institutional deliveries, ambulance transport to a referral facility, treatment for complications and PNC) and $31 per FP voucher used. In Uganda, the RHVP spent approximately $268 per SM voucher used. Overhead accounts for 96 percent all RHVP expenditures so far as the program is at an early stage and has been primarily focused on setting up systems.

The costs presented above include expenditures incurred on setting up, monitoring and delivering services as part of a voucher program. With the available data it is unclear what proportion of these expenditures is one-time program design and program set-up expenditures and what proportion are fixed and will not vary with service volumes. These estimates therefore present a rough idea of the unit costs per voucher service delivered on scaling-up. More detailed data are also needed on the total costs of delivering services and monitoring service delivery with comparable public, non-profit and for-profit private providers in order to make comparisons of whether voucher programs are more cost-effective than other approaches to increasing the use and quality of RH/ FP services.

[19] Figures on overhead costs were obtained from voucher program staff. They were not independently verified.

# 5. LEARNING LESSONS FROM WHAT WORKS (OR DOESN'T WORK)

Although the Kenya and Uganda voucher programs have been operating for a short period of time, they offer preliminary findings on whether vouchers are promoting use of key health services such as SM, STI and FP, and improving quality and client responsiveness. Moreover, the Uganda and Kenya program managers identified initial lessons on designing and implementing voucher programs that offer insights on how to strengthen the next generation of voucher programs in Africa.

## 5.1 DO RH/FP VOUCHER PROGRAMS WORK?

**Vouchers are a promising tool to increase service use when financial barriers are a key constraint to use**

Kenya's experience with SM vouchers and Uganda's with STI vouchers shows that vouchers can help increase uptake of SM and STI services. In Kenya, although it is not known how the voucher program affected coverage, it is clear that the volume of SM voucher services is large: over 60,500 women delivered at a health facility with an RH-OBA voucher. In Uganda, STI treatment seeking (for those with symptoms) increased by 15 percent within a year of implementation.[20] The potential increase in voucher uptake in these health services may even be greater than observed if vouchers subsidized transportation costs in remote areas and other out-of-pocket expenses that families incur in using health services where these expenses are a deterrent to use.

[20] The Ugandan RHVP SM voucher program is too new to generate comparable results on SM service use.

### Box 1: A Closer Look at FP Vouchers in Kenya

***Diagnosing Low FP Voucher Uptake in Kenya***

Use results for FP vouchers in Kenya tell a different story from that of other RH voucher services. Uptake was disappointing relative to the SM vouchers. For every one FP voucher redeemed, over eight times as many vouchers were redeemed for ANC. The Kenya FP voucher experience suggests that a combination of demand- and supply-side factors may be responsible for the low uptake:

- FP is subsidized or free at primary level public sector facilities. Voucher clients, however, have to pay $1.25 to buy an FP voucher. Although this voucher enables clients to use FP services at higher level public facilities and private facilities where user charges are levied, even a low price may be perceived as too much.
- Limited BCC by RH-OBA or MoH to address cultural barriers to using FP and concerns about side-effects or other health effects of using FP. Yet, 41 percent of currently married women who are FP non-users cited husband's opposition, religious prohibition and concerns about health or side-effects from FP as the reason they do not intend to use FP (KDHS 2003)
- FP vouchers do not cover methods preferred by clients such as injectables.
- Supply-side bottlenecks to providing FP services: FP skill gaps are a key constraint across provider types in Kenya. Private providers, in particular, have limited options to build staff skills as they tend to get passed over in government-sponsored training. Stock-outs of FP supplies are a persistent problem in the Kenyan context. These supply-side factors contribute to client perceptions of low quality and limited demand, which, in turn, erodes VSPs' incentives to make investments to improve quality of FP services to attract more clients.
- Limited promotional activities to generate awareness about the benefits of using vouchers for FP and to encourage the use of vouchers

***Lessons from the FP Voucher Experience in Kenya***

The general recommendations for voucher programs presented in Table 2 are relevant to FP vouchers as well. The following list, however, focuses on FP-specific lessons generated from the RH-OBA pilot.

- **Consider if a stand-alone voucher program is the "right" intervention to reach your FP objectives:** First, carefully examine whether financial barriers are the most significant barrier to FP use. In some contexts, non-financial barriers may be far more important.
- **Piggyback on high-demand vouchers**: In Kenya, FP vouchers could be bundled with other, high-demand vouchers and offered at a discount. The popularity of the SM voucher indicates that post-partum FP could present a logical cross-over to FP with a "Safe Motherhood Plus" voucher that subsidizes both SM and FP services.

***Strategies to Increase FP Use through Vouchers***

If you decide to include FP in an existing voucher program, then consider the following interventions specific to addressing the unique challenges of FP:

- **Know your target audience:** Invest in rigorous audience research on FP-related knowledge, service use patterns, perceived needs, barriers and willingness-to-pay when designing voucher benefits. When pricing FP vouchers, it is especially important to carefully consider the implications of heavily subsidized public sector/ non-profit services for voucher demand.
- **Design a benefit package that offers FP methods clients want:** To illustrate, Kenya DHS 2003 data finds that 47 percent of non-FP using currently married women identify injectables as the method they would prefer to use in the future.
- **Invest in marketing and BCC to generate demand for vouchers**: Target audiences may need to be convinced about the benefits of using FP and their FP-related myths and misconceptions dispelled before they can be convinced of the benefits of using FP vouchers. Appropriately designed marketing and BCC are therefore vital.
- **Identify and address larger health systems constraints to quality service delivery:** Few VSPs have been willing to invest in improving staff FP skills, perhaps because of perceived limited benefits given low volumes of FP voucher clients. Also, systemic issues like FP stock-outs are difficult for individual VSPs to address. It is important, therefore, to diagnose systemic problems and design solutions. A few examples include inviting private VSPs to participate in MOH trainings, allowing private VSPs access to subsidized FP products, and linking payments to quality improvements,

The evidence, however, is less clear in the case of Kenya's FP vouchers. Phase 1 of the RH-OBA program targeted FP voucher sales of 60,000, but only 25,620 vouchers were actually sold (about 42% of target) and 11,296 vouchers used (44% of FP vouchers sold). See Box 1 above for an analysis of the Kenya FP Voucher Program.

The Kenyan experience suggests that an independent, "stand-alone" FP voucher (i.e., vouchers that cover only FP services) may not be the most appropriate strategy to increase use when financial barriers are not a key bottleneck. Box 2 recommends when and how policymakers and FP managers should consider a voucher program.

**Box 2: To Use (or Not To Use) Vouchers for FP?**

Below is a decision tree to help guide the decision on whether vouchers are appropriate for FP in a given context:

**IF** financial barriers are a key bottleneck to FP use, then
Consider a stand-alone FP voucher program if there currently is not a voucher program or
Consider adding FP to an existing voucher program

**IF** financial barriers are NOT the primary barrier to FP use, then do not create a "stand-alone" FP voucher program
Identify the main barriers to FP use and consider other strategies to address these barriers
Examples include BCC to address cultural constraints about FP, training to build staff skills, contracting for procurement of FP commodities

**IF** financial barriers are NOT the primary barrier to FP use **AND** a voucher program for a related RH service already exists
Consider bundling FP services with related voucher services, for example with a Safe Motherhood Plus voucher
*In addition,* identify the main barriers to FP use and consider other strategies to address these barriers

**Vouchers contribute to improving quality and client responsiveness**

The majority of Kenya RH-OBA VSPs are making quality improvements with voucher revenue. Eighty-five percent of public, 89 percent of for-profit, and 67 percent of non-profit VSPs reported making some kind of quality improvements. Competition to attract more voucher clients is an important underlying motivator for making improvements, which implies that vouchers are increasing the responsiveness of service providers — including public providers — to what they perceive as their clients expectations. A likely contributor to public VSPs' interest in attracting voucher clients could lie in the additional revenue they receive from vouchers and the autonomy that facility managers are given (within some overarching constraints) in how to use this revenue. At least a third of all public VSPs reported spending some proportion of voucher revenue on improving staff amenities or providing in-kind or financial staff incentives.

**Voucher programs are feasible to implement**

The East African experience with FP/RH vouchers confirms that implementing voucher programs is feasible in low-income countries. There has been no indication that systematic fraud - one of the more challenging implementation issues associated with vouchers - has been a serious problem in either Kenyan or Ugandan program. There is insufficient cost data, however, to determine if voucher programs are "good value" compared to other strategies to increase use of key health services. More data are needed to better estimate the cost-effectiveness of vouchers compared to other strategies to increase FP/RH use. The available expenditure data do not allow us to separate out one-time voucher program set-up expenditures and the proportion of voucher program expenditures that are fixed (rather than varying with the volume of service delivery) to estimate project expenditures per voucher service delivered on scale-up.

**Vouchers harness the private sector for public health objectives**
As the Kenyan and Ugandan experience demonstrate, vouchers offer clients a choice of providers. The target clientele, predominantly poor, used their vouchers at private voucher facilities — both for and not for profit — in greater proportions than did the general population. The Kenya DHS 2003 found that 65 percent of deliveries take place in public facilities and 35 percent in private facilities. Examining source of delivery by income group, however, shows that 16 percent of the poorest Kenyans deliver in private facilities. By contrast, 67 percent of SM voucher users delivered in a private facility; only 33 percent delivered in a public facility. FP voucher users also prefer private providers: 78 percent of FP vouchers are redeemed at a private facility. In the general population, only 47 percent got their current FP method from a private source (Kenya DHS 2003).[21] The Uganda and Kenya voucher programs also demonstrate that, when voucher clients bring in revenue, private sector providers are very interested in and willing to deliver essential health services, even preventive services.

## 5.2 WHAT INSIGHTS LEAD TO BETTER IMPLEMENTATION?

Kenya's and Uganda's experience offers practical insights for policymakers and practitioners interested in designing or implementing FP or other voucher programs. Table 2 summarizes the key operational lessons learned. Box 3 offers recommendations on the benefits of integrating FP into an existing RH voucher program. The following discussion provides additional information on a select number of insights outline in Table 2.

**TABLE 2: RECOMMENDATIONS TO STRENGTHEN IMPLEMENTATION OF VOUCHER PROGRAMS**

| | Kenya RH-OBA Pilot | Uganda RHVP |
|---|---|---|
| **Stewardship: Defining VMA's role** | ++<br>VMA functions are split across multiple organizations with complementary strengths. Increases range of expertise but creates co-ordination concerns. | ++<br>Single organization performs all VMA functions. Fewer coordination problems but more limited range of expertise. |
| | **Recommendations**: Define critical skill sets for the VMA based on key functions needed for an effective voucher program and support available from the larger health system. Decide if one single organization can carry out all VMA functions or if VMA functions should be split across many organizations to ensure that all the necessary expertise is available to effectively carry out all voucher program functions. | |
| **Stewardship: Designing voucher benefits policies** | +<br>Relatively limited target audience research at baseline to inform design of FP voucher. | +<br>SM voucher component designed with lessons from predecessor STI pilot, Kenyan RH-OBA pilot, provider surveys, and analyses of DHS data. |
| | **Recommendation:** Knowing your target audience is important to design programs that are "valued" by clients. Invest in audience research to develop a voucher with benefits that address audience needs. | |
| **Voucher program management:** | +++<br>Quick and efficient claims processing system that brings together program data from multiple sources. | +<br>Improved claims processing system which addresses problems identified with claims processing system in STI pilot. |

[21] However, when making these comparisons, it is important to remember that Kenyan vouchers are targeted exclusively to the poor living in geographically restricted pilot areas. They are not representative of the larger population of Kenya.

<table>
<tr><th></th><th>Kenya RH-OBA Pilot</th><th>Uganda RHVP</th></tr>
<tr><td>Processing voucher claims and monitoring fraud</td><td colspan="2">Recommendation: Consider contracting out design and implementation of claims processing systems to an organization with strong or prior experience in this domain. Learn and borrow claims administration lessons from existing health insurance firms, both public and private.</td></tr>
<tr><td rowspan="2">Voucher program management: Evaluating program objectives</td><td>++<br>Evaluation relies exclusively on analyses of voucher claims. No population-based impact data are available.</td><td>++<br>Evaluation for STI pilot based primarily on survey data generated through separate research process.</td></tr>
<tr><td colspan="2">Recommendations: Marry the two approaches to generate empirical evidence on effectiveness of voucher strategies. Use claims data for monitoring and adjusting voucher program. Build in a strong evaluation design before beginning implementation.</td></tr>
<tr><td rowspan="2">Voucher program management: Monitoring service quality</td><td>+<br>Limited ongoing monitoring of VSP quality.</td><td>+++<br>Robust quality monitoring processes with quality improvement approach.</td></tr>
<tr><td colspan="2">Recommendation: Assess effectiveness of existing health system mechanisms to monitor quality of VSPs. If inadequate, quality monitoring should be part of the VMA's role assuming in-house capacity exists. If not, VMA should contract-out quality monitoring and ensure implementation of this function.</td></tr>
<tr><td rowspan="2">Health service delivery: Engaging voucher service providers</td><td colspan="2">+++<br>Revenue from provider payments is an important motive for participation. This is particularly true for private providers.</td></tr>
<tr><td colspan="2">Recommendation: Collect data at the design stage to ensure that the reimbursement price is right for providers. Public sector providers typically receive supply-side subsidies for voucher services. Reimbursement rates acceptable to public providers may not be adequate for private sector providers. Clear payments terms are essential, particularly for not- and for-profit providers.</td></tr>
<tr><td rowspan="2">Health service delivery: Retaining voucher service providers</td><td>++<br>Efficient claims processing ensures that providers are paid in a timely manner.</td><td>++<br>Hiccups with claims processing in STI pilot resulted in provider drop-out.</td></tr>
<tr><td colspan="2">Recommendation: Ensure efficient claims processing systems. Contract out design to an organization with expertise and closely monitor timeliness of reimbursements.</td></tr>
<tr><td rowspan="2">Health service delivery: Supporting service quality</td><td>-<br>No quality support to VSP.</td><td>+++<br>MSIU supports VSP to improve quality.</td></tr>
<tr><td colspan="2">Recommendation: Ensure that at least one of the VMA entities has capacity to assess and monitor VSP quality. Also need mechanisms to support quality improvements. Explore a sliding scale of reimbursement rates based on quality scoring or performance payments linked to quality improvements as a further incentive for providers to improve all aspects of quality.</td></tr>
<tr><td rowspan="2">Health service delivery: Ensuring availability of drugs & other supplies</td><td colspan="2">-<br>No mechanism in voucher program to procure drugs or FP supplies if there are stock-outs in the public delivery system.</td></tr>
<tr><td colspan="2">Recommendation: Assess drugs/FP commodities security when designing the voucher program. Where stock-outs are routine, consider an emergency mechanism to procure or finance procurement while long-term solutions are identified.</td></tr>
<tr><td rowspan="2">Generating demand: Raising awareness of voucher program</td><td colspan="2">+++<br>Multi-media campaign to raise awareness implemented at program launch.</td></tr>
<tr><td colspan="2">Recommendation: All vouchers, irrespective of type of service, must be supported by marketing and BCC that educates the target population about the benefits of vouchers and how to obtain voucher services.</td></tr>
<tr><td rowspan="2">Generating demand: Behavior change communication to generate demand</td><td>-<br>No BCC or promotional activities implemented after initial program launch activities.</td><td>+++<br>Comprehensive multi-media marketing and BCC strategies implemented during launch and sustained through the life of STI pilot. Similar plans for RHVP.</td></tr>
<tr><td colspan="2">Recommendation: Define voucher marketing and communication strategy based on the type of voucher services. More BCC is needed to generate demand for services that clients do not perceive as high priority (like FP) or stigmatizing services that do not benefit from word-of-mouth promotion (like STI services).</td></tr>
</table>

### 5.2.1 STEWARDSHIP

**Explicitly define the competencies required to ensure that all key VMA functions are carried out**

Core VMA functions include: selecting, accrediting and contracting providers; processing voucher claims; monitoring and controlling fraud; monitoring recipient characteristics, service quality, and program impact; and ensuring and monitoring voucher distribution and marketing vouchers. As both the Uganda and Kenya programs demonstrated, it is often difficult for one organization to perform the full range of functions required. Voucher programs should therefore:

1) Identify the functions needed in the voucher program, ensuring that key support from the larger health system is available. If the support is not available, then these functions should become part of the VMA's responsibilities.

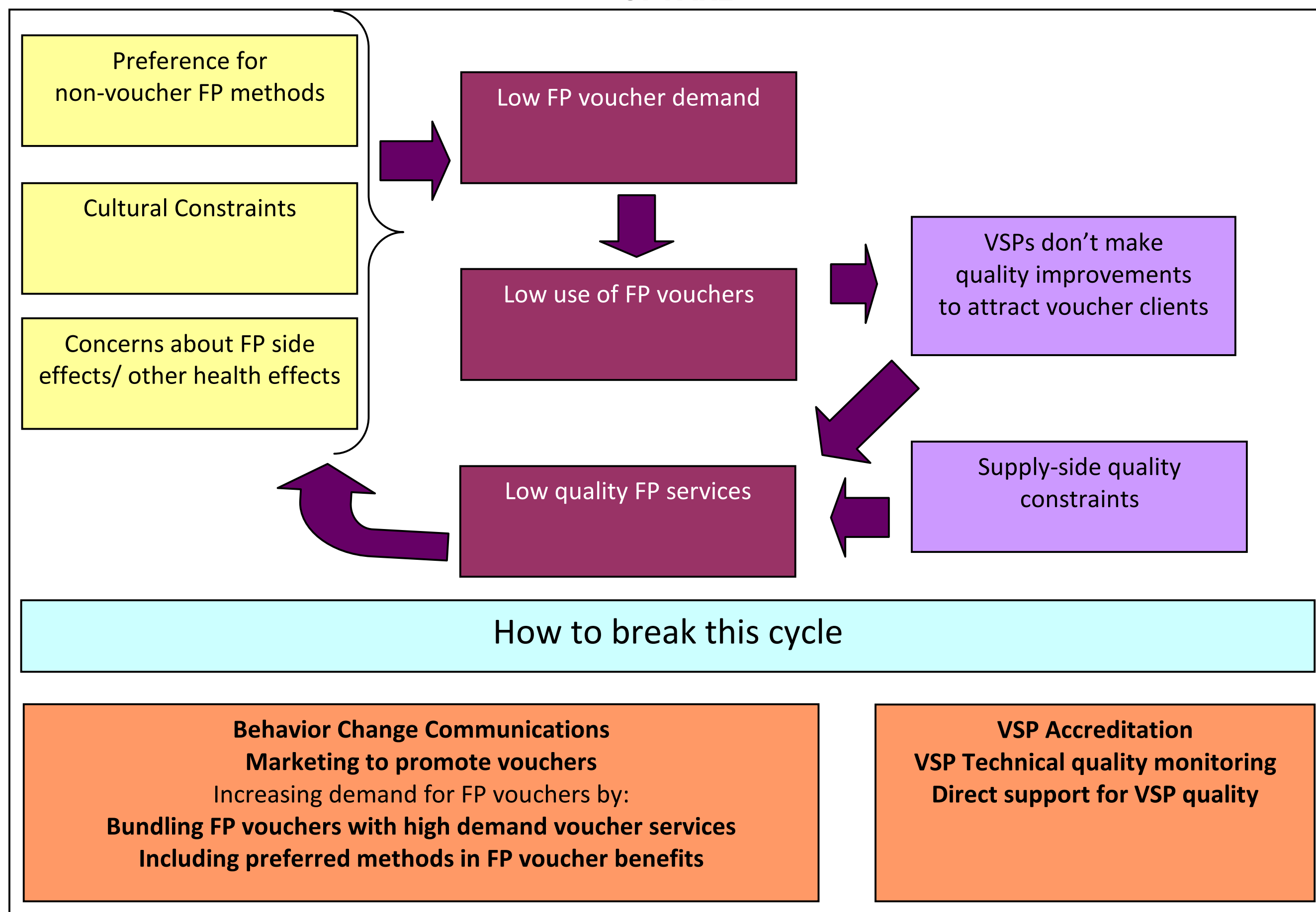
2) Assess whether it is possible or desirable for the VMA implement all these key functions. If not, then

3) Contract out specific technical functions, but ensure that the VMA remains responsible for making sure that the functions are carried out. The two voucher programs, however, underscore the challenges in coordinating all functions when they are split across multiple organizations.

**Fill in the health system gaps**

As the Kenya RH OBA experience demonstrates, when the public sector does not provide key services such as ensuring an adequate supply of FP products or implementing BCC activities to generate demand, then the VMA may also have to ensure that these functions are implemented. (See Figure 12 below for an illustration of how supply-side gaps, and demand-side non-financial concerns, can create a vicious cycle of low FP quality and low voucher uptake, unless these constraints are addressed).

**FIGURE 12: DEMAND AND SUPPLY-SIDE CONSTRAINTS THAT LIMIT FP VOUCHER UPTAKE**




### 5.2.2 VOUCHER PROGRAM MANAGEMENT

**Apply audience research to design and modify a voucher program**

Formative research during the design phase clarifies target audience knowledge, attitudes, service use patterns, and willingness to pay for specific voucher services. Insights from the research inform voucher benefits, distribution and price policies and helps design BCC and voucher marketing strategies.[22]

**Data generated by a voucher program**

- Profiles of voucher buyers and voucher users
- Profiles and proportions of voucher buyers who chose not to use a voucher that they bought by geographic location
- Which distributor each client bought his or her voucher from
- Where each client who bought a voucher chose to redeem it
- Where each client chose to go for voucher services
- Volume of voucher services delivered by each VSP
- Volume of voucher sales
- Reimbursements by type of service to each VSP
- Lags between claims submitted and reimbursements made to each VSP

**Monitor and evaluate the program to improve performance and generate empirical evidence on voucher program impact**

A robust monitoring system provides information to detect fraud, track program performance, and adjust the program to further improve performance. A key

[22] For more details on the 'how to' please see World Bank. 2005. Guide to Competitive Vouchers in Health. Downloaded from: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/AGuidetoCompetitiveVouchersinHealth.pdf>

strength of voucher programs is that routine implementation creates a "census" on FP voucher buyers and users. (See the text box for a list of the data generated through distribution, claims and reimbursements.) These, and other, data can be used to track program performance and identify problem areas that need to be addressed For example, long lags between claims submission and VSP reimbursements indicate the need to identify and implement solutions if VSP drop-outs are to be prevented. Also, routinely generated data helps detect and manage fraud. VSP claims for reimbursement can be matched against distributors' data to identify potential fraud with a few cross-checks by third parties to keep voucher distributors and VSPs "honest."

**Box 3: Why integrate FP into an existing RH voucher program?**

Vouchers can help to achieve the following FP objectives:

**Targeting FP subsidies directly to the poor (or other defined target groups)**
Voucher subsidies follow clients rather than being tied to providers. Using vouchers can ensure more effective targeting of subsidies to defined beneficiary populations such as the poor. Voucher distributors sell or give vouchers to eligible clients. This also eliminates conflict of interest that arises when providers are responsible for determining eligibility by separating targeting from the provision of services.

**Promoting voluntary choice of FP**
When clients pay for FP vouchers (even if this price is nominal) or invest the time and effort required to obtain an FP voucher, it is safe to conclude that they themselves have chosen to use FP without pressure from service providers.

**Expanding clients' choice of providers and access to a range of FP methods supported with without straining available FP resources**
VSPs are only paid if clients choose to use their services and hand over vouchers in exchange for a specific voucher service. This means that voucher programs can include a wider range of providers to increase access. Since providers are only paid for services actually rendered, the third party can support a wider range of FP services as part of the voucher program, but pays only for services that clients prefer to use. This eliminates the need to hold resources in reserve for FP services that may not be used.

**Increasing providers' responsiveness to FP clients expectations and increase client perceived quality**
Voucher programs can motivate VSPs to respond to clients' expectations of quality, and can increase investment in quality improvements that clients value when VSPs compete for voucher clients.

**Minimizing waste of FP resources**
Vouchers enable a third party purchaser of health services to verify at minimal additional cost (a) whether services were actually delivered, and (b) whether they were delivered to the intended beneficiaries independently of providers' own records or information systems, and without relying on expensive independent monitoring surveys to verify providers claims of service delivery. The former is desirable not only because provider records and information systems are liable to be incomplete and inaccurate in low income settings, but also because providers have an incentive to inflate service delivery records when these records are linked to the payments they receive. Security features on the voucher itself allow provider claims for reimbursement to be matched against distributors' data on clients who bought vouchers to identify potential fraud. A few independent cross-checks can help to keep voucher distributors and providers 'honest'.

**Accurately aligning resource allocation to providers with demand for FP services**
When providers are paid based on FP services they actually deliver, resources are automatically allocated in direct relation to use, rather than on forecasts of demand.

**Generating data for decision-making on FP**
The process of implementing a voucher program itself generates a treasure trove of information that can be used to track voucher program effectiveness and inform future decisions about how to make FP voucher programs more effective. Data generated through the distribution, claims and reimbursements process includes:

- Profile of each client who buys a voucher, including their place of residence
- Where each client bought his or her voucher
- Whether each client who bought a voucher chose to redeem it for FP, and for which FP method
- Where each client who redeemed his or her voucher chose to redeem it for FP
- Which providers are preferred by voucher clients
- Voucher sales by geographic location

These data present a census of information on <u>all</u> FP voucher buyers/ users.

### 5.2.3 HEALTH SERVICE DELIVERY

**Use payments to attract and retain high performing public, for-profit, and non-profit providers**

Getting provider reimbursement levels right and processing claims efficiently are essential to engage and retain public and private providers and ensure their responsiveness to clients. The Kenya voucher experience indicates that voucher revenue is a major factor motivating all types of providers to participate. Both public and private VSPs perceive voucher revenue as an opportunity to serve poor clients while also generating revenue for their facilities or for staff benefits (for instance, free tea is provided to staff in one urban dispensary with voucher revenue). Voucher revenue can create strong incentives for VSPs to compete to attract voucher clients and expand voucher service delivery. Competition for revenue from voucher clients can also spur VSPs to make improvements likely to attract more clients as demonstrated by the RH-OBA experience. Conversely, erratic or delayed provider reimbursements can demotivate VSPs and lead to drop-outs, as the Uganda STI pilot experience indicates.

*Reimburse providers so that delivering voucher services is attractive.* The Kenya experience suggests that this is important for providers, irrespective of profit motive. For public VSPs, it is important to ensure that the facility can retain revenue and have some control over its use; otherwise, motivation to participate in the voucher program and expand voucher-targeted services may be diluted. For private VSPs, it is important that reimbursement is adequate to cover costs and motivate expansion of voucher services, and that services are paid in a timely and consistent manner. The Kenyan experience also suggests that private VSPs, particularly for-profit ones, may require higher reimbursements than public VSPs, which receive direct government subsidies to deliver voucher services and hence can be retained in the program with lower reimbursement rates.

*Adjust provider reimbursement rates if necessary.* Provider reimbursement levels could bias providers in favor of some services more than others if some services allow greater profit for the same effort and inputs than others. It is therefore important to ensure that reimbursement rates do not bias providers, monitor voucher service delivery to identify any clear imbalances in service provision, and adjust reimbursement rates if needed.

**Create incentives for quality improvement and support VSPs to improve quality**

As the Kenya and Uganda programs demonstrate, VSPs compete to attract voucher clients, often using voucher revenue to make quality improvements they believe clients will value. However, VSPs — particularly private sector VSPs- are unlikely to invest in other types of quality improvements, such as training, that are less visible to clients. Therefore it is important for the VMA to ensure overall program quality by creating opportunities and incentives for VSPs to continuously improve their technical and clinical skills. Possible strategies include: rigorous monitoring of technical quality with credible consequences for failure to meet quality standards; offering subsidized FP products; and allowing private VSPs to attend publicly- or donor-supported training, including private VSPs in MOH supportive supervision systems. The VMA can also link quality to VSP payments as a "carrot" for technical quality improvements such as a sliding scale of reimbursement rates based on specified quality indicators, or quality bonus payments to VSPs who demonstrate improvements.

### 5.2.4 MARKETING VOUCHERS

**Sustained marketing and BCC are necessary to generate demand**

All voucher programs need immediate pre- and post-launch marketing and BCC support to generate awareness about the benefits of buying and using vouchers. As the Kenya SM voucher experience indicates, word-of-mouth promotion was adequate for SM voucher uptake, despite the absence of sustained marketing and BCC activities. In the case of the FP services, intensive BCC support is needed to inform target groups of the benefits of FP use, particularly in light of limited FP-focused BCC by the public sector.

# 6. CONCLUSIONS

The first generation of health voucher programs in low income settings offers promise in achieving policy and health objectives:

- **Increase use of SM services through vouchers.** In both the Uganda RHVP and Kenya RH-OBA voucher programs, uptake and use of vouchers for SM services have been high. The results with FP vouchers, however, have been mixed. The FP voucher experience highlights that vouchers are a promising tool when financial barriers are a critical constraint.

- **Quality improvements and client responsiveness prompted by voucher payments.** In the case of Kenya, there is clear evidence that public and private VSPs have used voucher revenue to improve infrastructure, buy equipment or drugs and supplies, hire new or pay existing staff, or create patient amenities. Although Uganda's SM program is in its early stages, observations confirm similar investments being made.

- **Voucher programs harness private sector for public health objectives.** As the Kenyan and Ugandan experience demonstrate, vouchers offer clients a choice of providers. The target clientele, predominantly poor use their vouchers at private for-profit and non-profit -providers. Also, private sector providers are very interested and are willing to deliver essential health services, even preventive services, when voucher clients bring in revenue.

Although they are relatively new programs, the Kenya RH-OBA and Uganda RHVP experience provide practical guidance to policymakers, donors, and voucher program implementers interested in designing, financing, or implementing vouchers in Sub-Saharan Africa. One of the most important insights is when and how to use vouchers for FP/RH services. Addressing financial barriers with vouchers will not increase use substantially when non-financial barriers are the primary determinants of low service use, as is the case of FP/RH. Nevertheless, policymakers and FP managers should consider bundling FP with an existing high-demand voucher, such as SM or STIs. Adding FP to an already popular voucher program can still yield the desired public health objectives by:

- Targeting subsidies more effectively to the poor

- Ensuring that use of FP is voluntary

- Expanding client choice of providers and methods with available FP resources

- Increasing provider responsiveness to FP client expectations and increasing client perceived quality

- Increasing transparency and minimizing waste of FP resources

- Aligning resource allocation for FP more closely with demand for FP services

When combining FP into an existing voucher program, policymakers and managers should ensure adequate budget to fund the BCC and other activities needed to raise awareness and create demand for the additional FP service.

Voucher programs in health are the latest trend in public health policy. Several developing countries, with international donor support, are considering or in the process of implementing a voucher program (examples include India, Tanzania, Uganda, Kenya, and Bangladesh). The insights and practical guidance offered in this report are a first step to better understanding the strengths and weaknesses of voucher programs. However, more research is needed to inform the design and expansion of these programs throughout the developing world. Important areas for further study include:

**Impact evaluation**

Vouchers are a relatively untested approach in low-income countries. Although results from early experiences are positive, there is a clear need for rigorous research that can conclusively establish that voucher programs can increase coverage of FP/RH services among underserved target populations in a cost-effective way. Program monitoring data cannot substitute for population-based research to identify the impact of voucher programs. It is essential that rigorous evaluation designs be built into future pilots at the design stage.

**Cost and cost-effectiveness evaluation**

More detailed data are needed on the total costs of implementing voucher programs— including the costs of managing and monitoring vouchers — and on their impact on service use, quality and health. Without more detailed information on the costs, service use, quality, and health impact of voucher programs, it is not possible to precisely estimate the "bang-for-the-buck" of a voucher program relative to other supply-side strategies for increasing the use and quality of RH/FP services.

**Using technology to simplify implementation and reduce overhead costs**

Technology, such as mobile phone technology, could potentially be used to simplify voucher distribution, claims submission and processing, provider payment, and even follow-up with voucher clients. This can help reduce the overhead costs of implementing voucher programs and facilitate scale-up.

# ANNEX A. TABLES AND FIGURES: KENYA AND UGANDA

### TABLE A.1: SOCIO-ECONOMIC AND HEALTH INDICATORS IN KENYA AND UGANDA

| **Socioeconomic indicators** | **Kenya*** | **Uganda**** |
|---|---|---|
| Total population | 37.5 million (WDI 2007) | 31 million (WDI 2007) |
| Per capita income | US$640 (WDI 2007) | $370 (WDI 2007) |
| % of population living in poverty | 46% (KIHBS 2006) | 38% (WDI 2003) |
| **Family planning indicators** | **Kenya** | **Uganda** |
| Total fertility rate | 4.9 | 6.7 |
| Contraceptive prevalence rate (Modern method use among all women) | 23% | 15% |
| Modern FP current use (all women) by wealth quintile | Lowest – 10%, second – 18%, middle – 23%, fourth – 28%, highest – 30% | Lowest – 6%, second – 10%, middle – 12%, fourth – 17%, highest – 28% |
| Modern FP method mix (All women) | Pills: 5%<br>IUCD***: 2%<br>Injectables: 11%<br>Implants: 1%<br>Male condom: 2%<br>Female sterilization: 3% | Pills: 2%<br>IUCD: 0.1%<br>Injectables: 8%<br>Implants: 0.3%<br>Male condom: 3%<br>Female sterilization: 2%<br>Male sterilization: 0.1% |
| Source for current modern FP method | Public: 53%<br>Private for-profit: 31%<br>Private non-profit (including FPAK and CBD): 10%<br>Other: 6% | Public: 35%<br>Private: 52%<br>Other: 13% |
| **Safe Motherhood** | **Kenya** | **Uganda** |
| Maternal mortality ratio | 414 per 100,000 | 435 per 100,000 |
| Women with 2+ ANC visits | 84% | 89% |
| ANC coverage at most recent birth by wealth quintile | Lowest – 80%, second – 90%, middle – 93%, fourth – 94%, highest – 95% | Lowest – 94%, second – 95%, middle – 96%, fourth – 95%, highest – 98% |
| ANC coverage at most recent birth by source: public/ private for-profit/ private non-profit | Public: 70%<br>Private for-profit: 12%<br>Private non-profit: 15%<br>Other: 3% | Public: 78%<br>Private: 16%<br>Other: 6% |
| Institutional deliveries/ births | 40% | 42% |
| Institutional deliveries/ births by public vs private for-profit/ private non-profit | Public: 64%<br>Private: 36% | Public: 71%<br>Private: 29% |
| Institutional deliveries by wealth quintile | Lowest – 16%, second – 31%, middle – 37%, fourth – 53%, highest – 74% | Lowest – 27%, second – 31%, middle – 34%, fourth – 48%, highest – 76% |

Note: WDI-World Development Indicators, KIHBS= Kenya Integrated Household Budget Survey, FPAK= Family Planning Association of Kenya, CBD=community-based distributor, IUD-intrauterine device
* Unless otherwise stated, information is from the Kenya DHS 2003
** Unless otherwise stated, information is from the Uganda DHS 2006
***IUCD= intrauterine contraceptive device

## TABLE A.2: VOUCHER PROGRAM CONTEXT AND POLICY ENVIRONMENT

| **Health policy context** | **Kenya** | **Uganda** |
|---|---|---|
| Top health priorities | Ministry of Public Health and Sanitation (MOPHS) strategic priorities:<br>1. Improve equitable access to public health services (maternal and neonatal health, child health, malaria)<br>2. Improve the quality and effectiveness of public health and sanitation services<br>3. Foster effective governance and partnerships in improving public health service delivery<br>4. Improve efficiency of public health system<br>5. Improve financing of the public health and sanitation service<br><br>Kenya Health Policy Framework (2004-2010) priorities:<br>1. Ensure equitable allocation of government resources<br>2. Increase cost-effectiveness and efficiency of resource allocation<br>3. Manage population growth<br>4. Enhance the regulatory role of government in health care provision<br>5. Create an enabling environment for increased private sector and community involvement in service provision and financing<br>6. Increase and diversify per capita financial flows to the health sector | The Health Sector Support Program II (HSSPII) priorities:<br><br>1. Health promotion, disease prevention, and community health initiatives<br>2. Improved maternal and child health<br>3. Control of communicable diseases<br>4. Control of non-communicable diseases and conditions |
| Is FP a stated MOH priority? | Yes. This prioritization is articulated in the following policy documents:<br>1. Reproductive Health Policy<br>2. Commodities Security Strategy<br>3. Long-Acting and Permanent Method Strategy<br>MOPHS promotes the following FP methods: pills, condoms, injectables, implants, bilateral tubal ligation, vasectomy, and IUCDs | Yes. All FP methods are considered to be a priority including permanent methods (See HSSPII 07-10) |
| **Private health sector policy context** | **Kenya** | **Uganda** |
| Are public-private partnerships (PPPs) a MOH priority? | MOPHS: Partnerships are a priority, including PPPs<br><br>Ministry of Medical Services (MOMS): Private sector involvement in health is a priority | MOH has a PPP policy addressed to for-profit and non-profit providers<br><br>PPP unit exists in MOH |

| | | |
|---|---|---|
| | No specific policy guidelines or frameworks have been formulated for implementation of PPPs<br><br>There is also no PPP policy or PPP unit currently in MOPHS or MOMS | |
| Existing mechanisms to work with the private health sector in FP/RH | Multiple mechanisms are currently used, including:<br>1. Training: Training on medical updates are open to private providers<br>2. Commodities/ supplies: Government medical commodities and supplies are also distributed to private providers<br>3. Regulation: Quality norms apply to both public and private providers<br>4. Financing: The National Hospital Insurance Fund (NHIF) currently includes both public and private providers | PPP unit<br>Uganda Private Midwives Association<br>Midwives and Nurses Council<br>Uganda Medical and Dental Practitioners Council<br>Allied Health Professionals Council (MOH) |

### TABLE A.3: VOUCHER PROGRAM OVERVIEW

| **General Information** | **Kenya** | | **Uganda** |
|---|---|---|---|
| Name of voucher program | Reproductive Health Output-Based Aid (RH-OBA) Pilot | | Reproductive Health Voucher Program (RHVP) |
| Year established | October 2005 | | Safe Motherhood – Healthy Baby Vouchers – August 2008<br>Healthy Life STI Vouchers to be launched in September 2009 |
| Voucher program goals and program objectives | 1. Improve access to and use of FP and SM services<br>2. Improve responsiveness and quality of FP and SM services<br>3. Strengthen freedom of voucher holders to choose from among participating providers<br>4. Reduce maternal and perinatal morbidity and mortality<br>5. Provide lessons to the proposed National Social Health Insurance Fund (NSHIF) | | 1. Reduce the number of mothers and children dying or being disabled due to absence or under-utilization of skilled medical attendance during pregnancy and child delivery<br>2. Reduce the burden of STIs |
| **Benefits package** | **Kenya** | | **Uganda** |
| Benefits | Safe Motherhood | Family Planning | Safe Motherhood |
| Description of benefits | 1. 4 ANC visits<br>2. Institutional delivery care<br>3. Transfer to referral facility<br>4. Treatment for/ management of any complications<br>5. PNC for up to 6 weeks after delivery | 1. Insertion of IUCD or implant<br>2. Bilateral tubal ligation (BTL)<br>3. Vasectomy<br>4. Treatment for complications from above methods (if inserted with FP voucher) | 1. 4 ANC visits<br>2. Institutional delivery care<br>3. Transport in cases of emergency<br>4. Transfer to referral facility and treatment for/ management of any complications<br>5. PNC for up to 6 weeks |
| Eligible voucher recipients | Poor men (FP) and poor women (SM and FP) living in pilot areas. Poverty is assessed using a poverty assessment tool | | Poor women living in voucher program districts. Poverty is assessed using a poverty assessment tool |
| Geographic coverage | 3 rural districts: Kisumu, Kitui, and Kiambu<br>2 urban slums: Korogocho and Viwandani in Nairobi | | 22 districts in Southern and Western Uganda |
| Population of area covered | 670,000 estimated rural poor in Kisumu, Kitui, and Kiambu<br>105,800 estimated urban poor in Korogocho and Viwandani<br>Total population of the pilot sites is about 3,000,000 | | 8 million (estimated) |
| Voucher selling price | Ksh200<br>($2.50) | Ksh100<br>($1.25) | Ush3000<br>($1.50) |
| **Health services** | **Kenya** | | **Uganda** |
| Voucher service providers (VSP) | Public: 20 (37% of total)<br>Private for-profit: 18 (33% of total)<br>NGO/ FBO: 16 (30% of total) | | For-profit: 22 (43%)<br>Non-profit: 29 (57%) |
| Reimbursement rates for VSP | ANC: $13 (Ksh1,000)<br>Normal delivery: $66 (Ksh5,000)<br>Caesarian delivery: $276 (Ksh21,000)<br>Surgical contraception (BTL or vasectomy): $39 (Ksh3,000)<br>Implants: $26 (Ksh2,000)<br>IUCD: $13 (Ksh1,000) | | Normal delivery inclusive ANC and PNC: $58<br>Complicated delivery: $140 |

| **Voucher program budget and costs** | **Kenya** | **Uganda** |
|---|---|---|
| Budget | $9.55 million for 3 years (Phase I) * | Estimated annual budget: $5,959,825 (Not including Healthy Lives STI Voucher) |
| Sources of financing to fund voucher program | KfW – 97% and Government of Kenya – 3% | Global Partnership On Output-Based Aid: 62%<br>KfW: 38% |
| Total program expenditure to date | $8.96 million (Kshs610,577,207 or Euros6.1 million) for Phase I<br>Safe Motherhood – 76%<br>Family Planning – 3%** | $657,283 |
| Administrative or overhead expenditures | 21% of total expenditures | 10% of total budget<br>95% of total expenditures |
| **Implementation status** | **Kenya** | **Uganda** |
| Current status of implementation | Phase I of pilot completed. Currently in Phase 2 where the project is being redesigned and strengthened based on the experiences and lessons of Phase I. Project is still restricted to the 5 sites. | Scaling up SM vouchers to 22 districts.<br>STI voucher implementation expected to commence in September 2009. |

* Budget for 3 years of Phase I: Euros6.5 million (1 Euro is converted as approximately $1.47)
** Gender violence accounts for 0.2% and administrative expenses for 9%.

### TABLE A.4: VOUCHER PROGRAM ROLES AND FUNCTIONS – A BIRD'S EYE VIEW

| Category | Function | Description | |
|---|---|---|---|
| | | **Kenya RH-OBA** | **Uganda RHVP** |
| **Stewardship** | Define policies:<br>(i) recipient policies, (ii) voucher benefit policies, (iii) provider reimbursement policies, and (iv) price policies | KfW, NCAPD, MOH and Consultant Design team were responsible.<br>Policies defined based on (i) survey of public, private for-profit, and private non-profit providers, (ii) consultations with stakeholders, (iii) experience with VMA, and (iv) experience from other countries. | KfW, GPOBA, MOH, MSIU, and MSI were responsible.<br>Policies defined based on lessons learned from Kenyan RH-OBA pilot and on STI voucher pilot. |
| | Program oversight | Oversight provided by NCAPD with support from the OBA steering committee which includes NCAPD, MOH KfW, PricewaterhouseCoopers (PWC), and the Backstopping Agency. In addition there is an Advisory Board with members from public, private for-profit, and private non-profit organizations that provides recommendations on OBA project implementation. | MSIU and MSI London are responsible. MSIU and MSI report directly to KfW and GPOBA.<br>Oversight mechanisms include quarterly reports, internal monthly reports, and review meetings. |
| | Finance and plan for long-term financing sustainability of voucher program | The long-term plan for the sustainability is to have the Government of Kenya take up the responsibility for financing and implementation of the program with the support of development partners. The RH-OBA program has already been earmarked for scale-up under the Vision 2030 development blueprint. | KfW funds are earmarked for administrative/overhead expenses while GPOBA funds are earmarked for service provision.<br>No long-term sustainability plans have been formulated as yet. Planning is expected to begin after midterm review in 2010. |
| **Voucher program management** | Select Voucher Management Agency (VMA) | PWC was selected as the VMA based on a competitive bidding process in 2005. | MSIU was assigned VMA role (sole source procurement). KfW and Government of Uganda selected MSIU. |
| | Define VMA's role | NCAPD, KfW, and the MOH defined VMA's role. | KfW and MOH defined VMA's role. |
| | Process voucher claims | PWC is responsible for processing voucher claims. VSPs submit claims once a month to PWC. | MSIU is responsible for processing voucher claims. MSIU checks paper claims for completeness and compliance with treatment guidelines and enters them into an Excel spreadsheet. Reimbursements are transferred electronically to providers' bank accounts. |

| Category | Function | Description | |
|---|---|---|---|
| | | **Kenya RH-OBA** | **Uganda RHVP** |
| | Monitor and control fraud | PWC monitors and controls fraud. Two streams of data are used:<br>1) Computerized claims processing system can be used to reconcile providers'/distributors' claims against each other.<br>2) Checks by PWC field staff:<br>(a) Client exit interviews<br>(b) Home visits to clients | MSI monitors and controls fraud by:<br>1) Checking claims for consistency<br>2) Checking and accrediting providers<br>3 Security features on voucher<br>4) Monitoring CBD activity |
| | Monitor characteristics of recipients | PWC monitors characteristics of recipients. PWC compiles reports from distributors and undertakes exit interviews | MSI monitors recipient characteristics through the following mechanisms:<br>1) BCC team undertakes community visits<br>2) Spot checks to CBDs and VSPs<br>3) Stakeholders involvement is assured (local council leaders and local authorities) |
| | Monitor service quality | Population Council developed a manual for quality assurance, but was not involved in quality monitoring.<br>NHIF contracted to monitor service quality through:<br>1) Monthly rapid facility assessments and client exit interviews<br>2) Regular visits to VSPs | MSI – VMA monitors service quality through a number of mechanisms including:<br>1) Quality assurance support provision by project coordinator<br>2) Training and Continuing Medical Education<br>3) Technical letters to VSPs for guidance |
| | Monitor and evaluate program objectives | NCAPD, KfW and Ministry of Health are responsible for monitoring and evaluation through the following mechanisms:<br>1) Regular VMA reports<br>2) Field visits<br>3) Internal and external evaluations | MSI KfW and GPOBA are responsible for monitoring and evaluation:<br>Mechanisms include field visits, quarterly and activity reports and audit checks |
| **Health Service Delivery** | Identify and engage VSPs | PWC and NHIF jointly carry out these functions. A survey was conducted to identify available providers. | MSIU is responsible for identifying and engaging VSPs. MSIU contracted an independent consultant (PS Consulting) for baseline mapping of providers before accreditation. |
| | Accredit VSPs | NHIF was contracted by PWC to accredit VSPs based on pre-defined quality parameters. | MSIU and PS consulting jointly accredited VSPs. |

| Category | Function | Description | |
|---|---|---|---|
| | | Kenya RH-OBA | Uganda RHVP |
| | Contract VSPs | PWC contracted VSPs. | MSIU contracted VSPs. Once accredited, draft contracts are shared with providers. Providers are allowed 4 weeks before final negotiations on terms and prices are concluded and the contract signed.<br>Future plans to brand contracted VSPs |
| | Support quality of VSPs (e.g., training, external quality supervision, other?) | NHIF was contracted by PWC to support quality of VSPs. | MSI is responsible for supporting VSP quality. Quality support mechanisms include:<br>1. Quality assurance and direct assessments<br>2. Training and CME<br>3. Support and Supervision visits |
| | Ensure availability of drugs and FP supplies | Not an assigned role. VSPs are responsible for obtaining their own drugs and FP supplies. | No mechanisms to ensure drug availability within RHVP. |
| **Generating Demand** | Identify, recruit, and retain voucher distributors<br>Distribute voucher | PWC is responsible.<br>PWC identifies, recruits, and contracts prominent individuals residing in OBA communities to distribute vouchers. | MSI is responsible.<br>Main selection criterion is recommendation by community and VSP. Vouchers are distributed by the behavior change/sales team, volunteer CBDs, drug shops and pharmacies, NGO, CBOs, and FBOs. |
| | Target voucher recipients | VDs are responsible.<br>Distributors apply poverty grading tool. | VDs are responsible. CBDs apply poverty grading tool, which is customized by district. |
| | Community outreach and other behavior change strategies | Not implemented except at launch (see below). | MSI is responsible.<br>Comprehensive BCC strategy planned. Radio campaigns and radio shows with call-in format to promote awareness and address questions about vouchers. Information, Education and Communication (IEC) materials produced and distributed. District health teams support BCC. |
| | Marketing of voucher program | PWC contracted an advertising agency (Lowe Scanad) to conduct a month-long multimedia launch campaign at each project site. | MSI is responsible. A variety of channels are used to market SM program. This includes road shows in local communities, radio, OBA web site, and print media. |

**TABLE A.5: KEY VOUCHER PROGRAM RESULTS**

| Results | | Kenya RH-OBA | Uganda RHV |
|---|---|---|---|
| **Service utilization results** | Number of vouchers used | Public: 20,069 (SM) and 2,329 (FP)<br>Private: 17,195 (SM) and 2,232 (FP)<br>FBO/NGO: 23,317 (SM) and 6,736 (FP) | 4,034 Health Baby Vouchers (SM) sold as of June 2009. Of these, claims have been submitted for 2,459.<br><br>63% of claims were submitted by for-profit providers and 37% by non-profit providers.<br><br>88% of vouchers have been redeemed for ANC, 9% for normal deliveries, 1% for caesarians, and 2% for PNC. |
| **Quality results** | Quality improvements | Most VSPs are making quality improvements to attract clients. In all, 85% of public, 67% of NGO/FBOs, and 89% of for-profit providers used voucher revenue to improve infrastructure, buy equipment, drugs or supplies, hire new or pay existing staff, or create patient amenities. Many non-profit and for-profit VSPs hired new or paid existing staff with voucher revenue. Regulations do not permit public facilities to hire new clinical staff, so public facilities tend to hire or pay support staff with voucher revenues.<br><br>Although staff skills are a key obstacle to delivering FP voucher services, few (2 of 54 VSPs) used voucher revenues to build staff skills. | As the RHV program is relatively new, few data are available on quality improvements.<br><br>Program staff accounts suggest that VSPs are making quality improvements. The improvements made include:<br>- Hiring staff<br>- Improving facility infrastructure<br>-Buying drugs<br>-Doing record keeping |
| **Efficiency results** | Administrative costs as part of voucher program budget | 21% of total expenditure | 10% of budget<br>96% of total expenditures |

# ANNEX B. KENYA RH-OBA TOOLS

| REPRODUCTIVE HEALTH-OUTPUT BASED APPROACH<br><br>VOUCHER SERVICE CLAIM FORM<br><br>Voucher Management Agent<br><br>College House 3rd Floor Kionange Street, along University Way<br><br>P.O. Box 43963 (00100, Nairobi. Tel: +254 (020)246687 / 6752794 Fax: +254 (020) 217773<br><br>E-mail: info@vma-oba.co.ke | | | |
|---|---|---|---|
| Voucher Type | | | |
| Name of Distributer | | Voucher serial number | |
| (A) General Patient Information | | | |
| Surname | | Other Names | |
| Age | | Sex LMP. EDD. | |
| If patient is a minor Guardians Name | | Marital Status | |
| Parity | | | |
| | | | |
| National I.D. No | | Location | |
| Postal Address | | Village | |
| (B) To be completed by voucher service provider | | | |
| Attendants Name | | Profession | |
| Description of service provided | | Indicate need for follow up or referral and facility referred to | |

| | |
|---|---|
| | |

(C) Cost of service provided

| | | Amount (Kshs) | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | Total | |

Service Providers' Declaration

I hereby confirm that all information stated in this form is true and complete and that I have provided all services as described above.

Signed………………………………………………………………………Date……………………………..Providers official stamp

Claim forms will be submitted to VMA within 30 days from the date of service

Service Providers' Declaration

I hereby confirm that all information stated in this form is true and complete and that I have provided all services as described above.

Thumb Print

Signed……………………………………………………………
…Date……………………………..

**RH-OBA PROJECT KIAMBU DISTRICT**
**VOUCHER DISTRIBUTION LIST**
**TYPE OF VOUCHER ………………………………………….**
**NAME OF THE VOUCHER DISTRIBUTOR…………………………………………………………..**
**LOCATION OF SALE……………………………………………………………………………….**
**PERIOD ENDING ……………………………………………….**

| Date Sold | Card No. | Client's Name | Client's ID No. | Age | Guardian's Name | Guardian's ID No. | housing structure | access to health | water source | fuel for cooking | land ownership | sanitation | Occupation | M-Income | Meals /day | p scored | Division of residence | V price |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

**Signature …………………………………..**

**Voucher Distributor**

***FORM C 3 OF 6***

NATIONAL HOSPITAL INSURANCE FUND. ACCREDITATION & QUALITY ASSURANCE CONSULTANT. REPRODUCTIVE HEALTH ON OUTPUT BASED AID PROJECT. QUALITY ASURANCE MONTHLY MONITORING EVALUATION TOOL .

FACILITY'S (VOUCHER SERVICE PROVIDER-VSP) NAME: ……………………………………………………………………………………………………….

VSP ADDRESS……………………………………………………………………………………………

DATE OF EVALUATION……………………………………………………………………………….

VSP'S REPRESENTATIVE NAME……………………………………………………………………………

VSP'S REPRESENTATIVE DESIGNATION……………………………………………………………….

VSP'S REPRESENTATIVE SIGNATURE………………………………………………………………..

VSP'S OFFICIAL STAMP.

………………………………………………………………………………………………………

SCORING SYSTEM:

5……. Yes.

0……. No.

SCOPE 1:

CLIENT EXIT INTERVIEW.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| **1.** | Voucher easily available. | | |
| **2.** | Facility easily accessible. | | |
| **3.** | Services at the facility. | | |
| **4.** | Total bill coverage. | | |
| **5.** | Appropriateness of the voucher. | | |
| | **TOTAL SCORE** | | |

SCOPE 2:

CLIENT FLOW ANALYSIS.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| 1. | Evidence of client orientation. | | |
| 2. | Target no. Of clients met. | | |
| 3. | Referral system in place & used. | | |
| 4. | Evidence of follow up measures. | | |
| | **TOTAL SCORE** | | |

SCOPE 3:

REVIEW OF PATIENTS RECORDS.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| 1. | State of OBA-RH Patients records. | | |
| 2. | Availability of case summary copy. | | |
| 3. | Qualified records personnel. | | |
| 4. | Standards of records observed. | | |
| 5. | Secure record keeping. | | |
| | **TOTAL SCORE** | | |

SCOPE 4:

VSP'S OBSERVATIONS.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| 1. | Staff assigned to the project. | | |
| 2. | Any profit made this month. | | |
| 3. | Improvement on service provision. | | |
| 4. | Project arrangement processes. | | |
| | **TOTAL SCORE** | | |

SCOPE 5:

ACCREDITATION STATUS.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| **1.** | State of Infrastructure. | | |
| **2.** | Standard equipments available. | | |
| **3.** | Adequate qualified personnel. | | |
| **4.** | Expected services timely given. | | |
| **5.** | Physical Environment status. | | |
| **6.** | Adherence to Standards. | | |
| **7.** | Guidelines upheld & followed. | | |
| **8.** | Evidence of individualized care. | | |
| **9.** | Patients' rights upheld & taught. | | |
| **10.** | Safety precautions observed. | | |
| | **TOTAL SCORE** | | |

SCOPE 6:

CLAIMS REIMBURSEMENT.

| NO. | DIMENSION. | POINTS. | REMARKS. |
|---|---|---|---|
| **1.** | Timely submission of claims Within the agreed time frame. | | |
| **2.** | Availability of claim documents. | | |
| **3.** | Timely reimbursement by VMA Within the agreed time period. | | |
| | **TOTAL SCORE** | | |

SCOPE 7:

QUALITY IMPROVEMENT TEAM.

| **NO.** | **DIMENSION.** | **POINTS.** | **REMARKS.** |
|---|---|---|---|
| **1.** | Presence of an active Q.I.Team. | | |
| **2.** | Availability of Q.I. Plans. | | |
| **3.** | Timely implementation of Q.I plans. | | |
| **4.** | Support of Q.I.T by Management. | | |
| **5.** | Evidence of continuous Q.I. | | |
| | **TOTAL SCORE** | | |

GRAND TOTAL SCORE _______________ OUT OF A POSSIBLE SCORE OF 180.

EVALUATION DONE BY QUALITY ASURANCE OFFICER (S):

1. ____________________________________ ____________________ ___________

(NAMES) (SIGNATURE) (DATE)

2. ____________________________________ ____________________ ___________

(NAMES) (SIGNATURE) (DATE)

*Please send this form with an accompanying report of your findings.

Retain a copy of the same.

NHIF-SQA DEPT, RH-OBA 2006.

Support to Kenya's Output Based Programme

Adaption of the Participatory Poverty Grading Tool

Marie Stopes Kenya Participatory Poverty Grading Tool – Summary Form

First Name:______________________________ Surname:______________________________

Age:______________ Sex:____________ Marital Status:__________ No of children:______

| Indicator | Score<br><br>(Circle appropriate score) |
| --- | --- |
| Housing<br><br>Level 1: temporary housing made of mud or cardboard<br><br>Level 2: semi- permanent housing made of cemented mud, wood, or iron sheet<br><br>Level 3: permanent house made of brick or stone | <br><br>1<br><br>2<br><br>3 |
| Access to health services<br><br>Level 1: home based care, herbal medicine, traditional birth attendants<br><br>Level 2: public hospital<br><br>Level 3: private hospital or clinic | <br><br>1<br><br>2<br><br>3 |
| Water source<br><br>Level 1: free, untreated water from river or spring<br><br>Level 2: bought water from community tap or well<br><br>Level 3: private water tap or well | <br><br>1<br><br>2<br><br>3 |
| Fuel for cooking<br><br>Level 1: firewood or saw dust<br><br>Level 2: charcoal or kerosene<br><br>Level 3: electricity | <br><br>1<br><br>2<br><br>3 |
| Security/Garbage*<br><br>Level 1: no doors or windows/scattering | <br><br>1 |

| | |
|---|---|
| Level 2: wooden doors and windows/paper garbage bags<br><br>Level 3: steel door or watchman/paid garbage collection | 2<br><br>3 |
| Sanitation<br><br>Level 1: bush/flying toilet (rural/urban)<br><br>Level 2: community pit latrine<br><br>Level 3: private pit latrine | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 199/499 KSh (rural/urban)<br><br>Level 3: 200/500 KSh (rural/urban) or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: one meal or less<br><br>Level 2: more than one meal, less than 3 meals<br><br>Level 3: three meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:______________ Date:_____________ Time taken to complete:_____________

Marie Stopes Kenya Participatory Poverty Grading Tool – KATOPE NAIROBI

First Name:________________________________ Surname:________________________________

Age:_______________ Sex:____________ Marital Status:__________ No of children:______

| Indicator | Score<br><br>(Circle appropriate score) |
|---|---|
| Housing<br><br>Level 1: house made of mud, carton or wood, no foundation<br><br>Level 2: iron sheet (mabati) house with cemented foundation<br><br>Level 3: brick house with cemented foundation | <br><br>1<br><br>2<br><br>3 |
| Access to health services<br><br>Level 1: home care by relatives, herbalists, TBAs<br><br>Level 2: public hospital, small private clinics<br><br>Level 3: private hospital | <br><br>1<br><br>2<br><br>3 |
| Water source<br><br>Level 1: borrowed from community tape or neighbor-not sufficient<br><br>Level 2: bought water from community tap<br><br>Level 3: water tap | <br><br>1<br><br>2<br><br>3 |
| Rent<br><br>Level 1: 300 KSh<br><br>Level 2: 300 to 699 KSh<br><br>Level 3: 700 KSh more | <br><br>1<br><br>2<br><br>3 |
| Garbage disposal<br><br>Level 1: scattering | <br><br>1 |

| | |
|---|---|
| Level 2: paper garbage bags<br><br>Level 3: paid garbage collection | 2<br><br>3 |
| Sanitation<br><br>Level 1: flying toilet<br><br>Level 2: community pit latrine<br><br>Level 3: private pit latrine | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 499 KSh<br><br>Level 3: 500 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:______________ Time taken to complete:______________

Marie Stopes Kenya Participatory Poverty Grading Tool – KOROGOCHO NAIROBI

First Name:_________________________________ Surname:_________________________________

Age:________________ Sex:____________ Marital Status:__________ No of children:_______

| Indicator | Score<br><br>(Circle appropriate score) |
|---|---|
| Housing<br><br>Level 1: house made of mud or carton or a mixture thereof<br><br>Level 2: iron sheet (mabati) or wooden house<br><br>Level 3: block or brick house | <br><br>1<br><br>2<br><br>3 |
| Access to health services<br><br>Level 1: home care by relatives or volunteers, herbalists, TBAs<br><br>Level 2: public hospital<br><br>Level 3: private hospital or private clinic | <br><br>1<br><br>2<br><br>3 |
| Water source<br><br>Level 1: water from river, rain or burst pipes (untreated)<br><br>Level 2: bought water from community tap<br><br>Level 3: private water tap | <br><br>1<br><br>2<br><br>3 |
| Rent<br><br>Level 1: 300 KSh or less<br><br>Level 2: 300 KSh to 699<br><br>Level 3: 700 KSh more | <br><br>1<br><br>2<br><br>3 |
| Garbage disposal<br><br>Level 1: scattering | <br><br>1 |

| | |
|---|---|
| Level 2: paper garbage bags<br><br>Level 3: paid garbage collection | 2<br><br>3 |
| Sanitation<br><br>Level 1: flying toilet<br><br>Level 2: community pit latrine<br><br>Level 3: private pit latrine | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 499 KSh<br><br>Level 3: 500 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:_______________ Time taken to complete:_______________

Marie Stopes Kenya Participatory Poverty Grading Tool – KOROGOCHO NAIROBI

First Name:________________________________ Surname:________________________________

Age:_______________ Sex:____________ Marital Status:__________ No of children:_______

| Indicator | Score<br><br>(Circle appropriate score) |
| --- | --- |
| Housing<br><br>Level 1: house made of mud or carton or a mixture thereof<br><br>Level 2: iron sheet (mabati) or wooden house<br><br>Level 3: block or brick house | <br><br>1<br><br>2<br><br>3 |
| Access to health services<br><br>Level 1: home care by relatives or volunteers, herbalists, TBAs<br><br>Level 2: public hospital<br><br>Level 3: private hospital or private clinic | <br><br>1<br><br>2<br><br>3 |
| Water source<br><br>Level 1: water from river, rain or burst pipes (untreated)<br><br>Level 2: bought water from community tap<br><br>Level 3: private water tap | <br><br>1<br><br>2<br><br>3 |
| Rent<br><br>Level 1: 300 KSh or less<br><br>Level 2: 300 KSh to 699<br><br>Level 3: 700 KSh more | <br><br>1<br><br>2<br><br>3 |
| Garbage disposal<br><br>Level 1: scattering | <br><br>1 |

| | |
|---|---|
| Level 2: paper garbage bags<br><br>Level 3: paid garbage collection | 2<br><br>3 |
| Sanitation<br><br>Level 1: flying toilet<br><br>Level 2: community pit latrine<br><br>Level 3: private pit latrine | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 499 KSh<br><br>Level 3: 500 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:______________ Time taken to complete:______________

Marie Stopes Kenya Participatory Poverty Grading Tool – KISUMU

First Name:________________________________ Surname:________________________________

Age:_______________ Sex:____________ Marital Status:__________ No of children:_______

| Indicator | Score<br><br>(Circle appropriate score) |
|---|---|
| Housing<br><br>Level 1: mud or old iron sheet house<br><br>Level 2: cemented mud house or iron sheet house, cemented floors<br><br>Level 3: brick or stone house, cemented floors | <br><br>1<br><br>2<br><br>3 |
| Access to health services<br><br>Level 1:herbalists, TBAs<br><br>Level 2: public hospitals<br><br>Level 3: private or NGO clinics | <br><br>1<br><br>2<br><br>3 |
| Water source<br><br>Level 1: bore hole or river water for cleaning/washing and drinking<br><br>Level 2: bore hole or river water for cleaning/washing, tap water for drinking<br><br>Level 3: tap water for everything | <br><br>1<br><br>2<br><br>3 |
| Monthly Rent<br><br>Level 1: 300 KSh or less<br><br>Level 2: 300 to 699 KSh<br><br>Level 3: 700 KSh and over or ownership | <br><br>1<br><br>2<br><br>3 |
| Fuel for cooking<br><br>Level 1: Mura (saw dust) or firewood | <br><br>1 |

| | |
|---|---|
| Level 2: Kerosene or charcoal<br><br>Level 3: electricity | 2<br><br>3 |
| Sanitation<br><br>Level 1: flying toilet<br><br>Level 2: shared pit latrine<br><br>Level 3: private pit latrine (not shared) | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 199 KSh<br><br>Level 3: 200 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:_____________ Time taken to complete:_____________

Marie Stopes Kenya Participatory Poverty Grading Tool – KIAMBU

First Name:________________________________ Surname:________________________________

Age:_______________ Sex:____________ Marital Status:__________ No of children:_______

| Indicator | Score<br><br>(Circle appropriate score) |
|---|---|
| Housing | |
| Level 1: mud house, mud floor | 1 |
| Level 2: wood house, mud floors | 2 |
| Level 3: stone house, cemented floors | 3 |
| Access to health services | |
| Level 1:herbalists, TBAs | 1 |
| Level 2: public hospitals | 2 |
| Level 3: private hospital | 3 |
| Water source | |
| Level 1: spring water (untreated) | 1 |
| Level 2: borrowed from well owners | 2 |
| Level 3: private well | 3 |
| Fuel for cooking | |
| Level 1: illegal firewood | 1 |
| Level 2: bought firewood | 2 |
| Level 3: charcoal or gas | 3 |
| Landownership; | |
| Level 1: less than 1/8 of an acre | 1 |

| | |
|---|---|
| Level 2: 1/8 acre to less then 1 acre<br><br>Level 3: 1 acre or more | 2<br><br>3 |
| Sanitation<br><br>Level 1: bush<br><br>Level 2: shared pit latrine<br><br>Level 3: private pit latrine | <br><br>1<br><br>2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 199 KSh<br><br>Level 3: 200 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:______________ Time taken to complete:______________

Marie Stopes Kenya Participatory Poverty Grading Tool – KITUI

First Name:________________________________ Surname:________________________________

Age:_______________ Sex:____________ Marital Status:__________ No of children:_______

| Indicator | Score<br><br>(Circle appropriate score) |
|---|---|
| Housing | |
| Level 1: mud house, tin roof | 1 |
| Level 2: mud house or iron sheet (mbati) roof | 2 |
| Level 3: brick house, plastered walls, cemented foundation | 3 |
| Access to health services | |
| Level 1:herbalists, TBAs | 1 |
| Level 2: public hospitals | 2 |
| Level 3: private hospital or clinics | 3 |
| Water source | |
| Level 1: Kalundu river (untreated) | 1 |
| Level 2: bought from community tap | 2 |
| Level 3: private water tap | 3 |
| Fuel for cooking | |
| Level 1: illegal firewood-insufficient | 1 |
| Level 2: mixture of bought firewood and charcoal | 2 |
| Level 3: charcoal kerosene | 3 |
| Sanitation | |
| Level 1: bush | 1 |

| | |
|---|---|
| Level 2: shared pit latrine<br><br>Level 3: private pit latrine | 2<br><br>3 |
| Daily income of interviewee<br><br>Level 1: less than 100 KSh<br><br>Level 2: 100 to 199 KSh<br><br>Level 3: 200 KSh or more | <br><br>1<br><br>2<br><br>3 |
| Average number of meals per day<br><br>Level 1: 1 meal or less<br><br>Level 2: more than 1 meal, less than 3 meals<br><br>Level 3: 3 meals or more | <br><br>1<br><br>2<br><br>3 |
| | Total score |

Interviewers Initials:_______________ Date:______________ Time taken to complete:______________

# BIBLIOGRAPHY

Bellows, B. and M. Hamilton. 2009. Vouchers for Health: Increasing Utilization of Facility-Based STI and Safe Motherhood Services in Uganda. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Hutchison, Paul; Mai Do, and Sohail Agha. November 2009. Client Satisfaction and the Quality of Family Planning Services: A Comparative Analysis of Public and Private Health Facilities in Ghana, Kenya, and Tanzania. Bethesda, MD: Private Sector Partnerships-*One* project, Abt Associates Inc.

Islam, M. 2006. *Vouchers for Health: A Focus on Reproductive Health and Family Planning Services*. Bethesda, MD: Private Sector Partnerships (PSP)-*One,* Abt Associates Inc.