SHOPS UGANDA HEALTHY BABY VOUCHER PROGRAM: FROM THE EYES OF THE PROVIDER

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SHOPS UGANDA HEALTHY BABY VOUCHER PROGRAM: FROM THE EYES OF THE PROVIDER

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INTRODUCTION

Uganda's fertility rate is among the highest in the world at 6.2 children per woman. Maternal mortality is also high at 438 deaths per 100,000 live births; death during child birth accounts for 18 percent of all deaths among women ages 15 to 49. Only 58 percent of births are attended by a skilled provider. Due to limited human resources and infrastructure, the public sector is overstretched to offer free comprehensive health services to a population that is largely rural. Rather than spending a long time travelling to a public facility, and without funds to seek care at a private facility, pregnant women often opt to deliver at home. Voucher programs offer a solution to both the financial and geographical barriers preventing pregnant women from accessing care as many private providers are located closer to poor pregnant women in rural areas.[1]

While most documentation of voucher programs has focused on the experience of the recipients, this document summarizes the experiences of healthcare providers that participated in a maternal health voucher program, discussing successes and unique lessons learned from the provider perspective to guide implementation of future voucher programs.

THE HEALTHY BABY VOUCHER PROGRAM

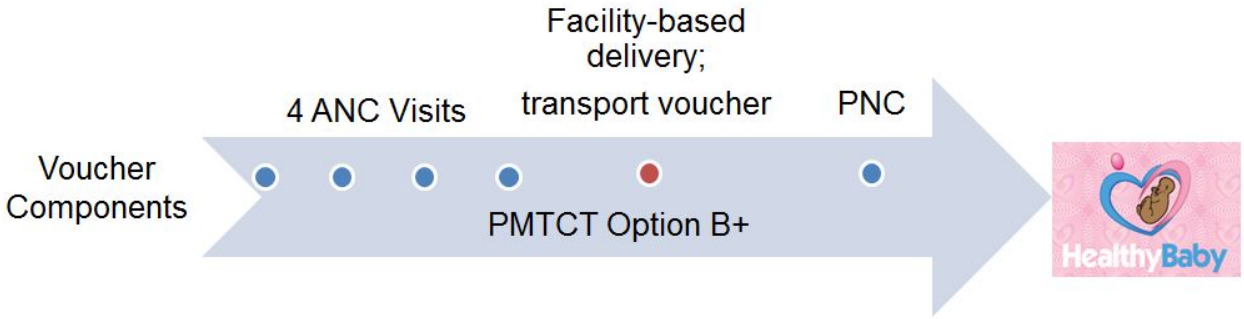
The Strengthening Health Outcomes through the Private Sector project (SHOPS), funded by the United States Agency for International Development, implemented a maternal health voucher program in Uganda as part of the Saving Mothers Giving Life Initiative (2012-2014). The goal of the program was to increase access to affordable comprehensive obstetric care for poor women through the private sector while improving and maintaining the quality of obstetric care within the private sector. The voucher program operated in four western districts of Kabarole, Kamwenge, Kibaale, and Kyenjojo. SHOPS partner Marie Stopes International (MSI), through its local affiliate Marie Stopes Uganda (MSU), acted as the voucher management agency.

Under the Healthy Baby Voucher Program (HBVP), women could purchase a voucher at 3,000 Ugandan Shillings (approximately 1.20 US Dollar) from a Village Health Team (VHT) volunteer in their community, which gave them access to a package of services at no additional cost for antenatal clinic visits (ANC), delivery (normal, assisted or caesarian), and post-natal clinic visits (PNC)—services that can be found frequently at private health facilities. In addition to these services, the voucher gave access to prevention of mother-to-child transmission services (PMTCT) using Option B+.[2] The voucher covered free treatment for other complications in pregnancy, such as malaria and urinary tract infections. HBVP also provided free transportation services to a health facility for delivery and covered transport costs to and services at referral facilities for complicated deliveries.

[1] Uganda Bureau of Statistics (UBOS) and ICF International Inc. 2012. Uganda Demographic and Health Survey 2011. Kampala, Uganda: UBOS and Calverton, Maryland: ICF International Inc.

[2] Under Option B+, an HIV+ pregnant woman is started on antiretroviral treatment regardless of CD4 count and will receive treatment for life.

HEALTHY BABY VOUCHER PROGRAM COMPONENTS



HBVP partnered with 47 private health facilities in western Uganda: 18 faith-based, 5 nonprofit, and 24 for-profit clinics and hospitals. The majority of the facilities (26) were small, with about 4–6 staff, while 16 were medium-sized clinics with 6–8 staff. The program included five hospitals that functioned primarily as referral facilities, while small- and medium-sized facilities, operated primarily by clinical officers or nurses, provided day-to-day maternity care to the voucher clients.

Over the course of two years, HBVP distributed 36,887 vouchers in western Uganda, which has allowed 27,176 women to deliver safely at a health facility (a 74 percent redemption rate).

PROVIDER EXPERIENCE

Participation in a voucher program requires a number of investments by the health provider, both in time and materials. SHOPS interviewed staff at eight participating health facilities to gain their insights on the experience of implementing HBVP and the challenges and benefits of being part of the program. These facilities were purposively selected based on facility type (private for profit, faith-based or public with private wing), size (a mix of large and small/medium), and previous experience/tenure with the voucher program.

UPGRADING THE FACILITY TO JOIN THE PROGRAM

Prior to joining HBVP, the facilities had to pass MSU's assessment for quality of services. In accordance with national protocol, the assessment determined whether the facility had the appropriate staff, equipment, and infrastructure to provide high-quality maternal health services. Private health facilities often did not meet these standards, and providers had to make investments in their facilities in order to join the voucher program. For example, one provider interviewed said that he purchased a refrigerator for the laboratory and an autoclave for sterilizing instruments to meet national standards. Several providers mentioned that they had to modify their facility layout so that the waiting room area, consultation room, and delivery room were separated to respect client privacy.


Autoclave purchased to meet voucher standards.

Upfront investment was difficult for many of the small-scale private providers who have limited cash flow, and the voucher program did not provide any funding for upgrades. This meant that not all private providers who would have liked to be part of the program could be included because their facility standards were too low and upgrading costs too high. Some providers suggested that the program should consider giving advance payments to facilities to help them implement necessary upgrades ahead of the start of services

Despite the financial challenges, many providers took the risk because they felt that participation in the voucher program had the potential for a significant revenue increase that would be cover upfront costs. Ultimately, all interviewed providers agreed that making these upgrades had improved the quality of services that they provide to all their clients and that a positive long-term investment benefited their facilities beyond the life of the voucher program. At the same time, several worried about the need for additional investments in equipment because participation in the voucher program led to greater demand for services.

ESTABLISHING SYSTEMS TO BRING IN THE CLIENTS

HBVP leveraged the existing community outreach system in Uganda, called the Village Health Teams (VHTs), to sell the vouchers. VHTs play an integral part in the Uganda Ministry of Health's strategy to improve access to health care for its rural population. They are volunteers selected by their community to promote health and improved access health care information

and services. VHTs are trained in various health topics, frequently conduct community sensitization meetings, and act as distribution agents for basic health commodities such as condoms, mosquito bed nets, and water purification products.

Each participating provider selected two VHT members serving the community near the facility to act as community-based voucher distributors (CBVDs), given the geographic spread of the communities. The CBVDs marketed the voucher program in their communities, identified pregnant women who might be interested in purchasing the voucher, sold the voucher, and followed up with the clients to make sure that they were using the voucher services.

Voice of the Provider

"I'm glad I was able to choose my own voucher distributors. I chose those whom I knew had good integrity, was reliable and trustworthy, and above all, knowledgeable about the community and their health care needs."

CBVDs were the primary mechanism for providers to publicize their services and attract clients to their facility. HBVP provided guidance to the providers on how to select strong CBVDs and gave suggestions on how to motivate them. Many providers encouraged the CBVDs to continue following up with voucher clients by sharing a portion of the claims revenue with them. Some facilities chose a simple revenue-sharing plan where the CBVD received a set amount for each voucher that they sold. Others, putting emphasis on actual services provided, gave payments to the CBVDs for each client that came in for a service. A handful of facilities opted not to use any incentives. One provider who chose to share the revenue for each sale made by his CBVDs stated how difficult it was to encourage follow-up. According to this provider, while the CBVD is in the community functioning as a VHT, they tend to focus more on the sales and less so on the follow-up.

For voucher programs like HBVP where there is a set of services within one voucher, there is a risk that clients may not take advantage of all the services. Follow-up with clients is therefore essential to a successful program. And from the perspective of the provider, getting women to come in and use all the voucher services also means increased revenue. Several providers voiced the concern that there had not been systematic follow-up of clients.

INTRODUCING NEW SERVICES TO THE FACILITY

In 2012 Uganda passed a policy that required all providers who administer maternity services to also provide PMTCT Option B+. Roll-out of this policy has been a challenge. Many private providers offered maternity services to the population, but the public sector did not have the resources to train and accredit them to provide PMTCT and ART services. Receiving ARVs was another challenge. Even when providers are trained in clinical service provision they often lack the record keeping standards and reporting practices that are required to receive commodities for free from the public sector.

All providers participating in HBVP were trained in PMTCT and ART through a one-week workshop. In collaboration with the District Health Office and the Association of Obstetricians and Gynecologists of Uganda, the HBVP also conducted a combined on-site supportive supervision and accreditation exercise. After all facilities passed successfully, the HBVP worked with the districts to include these private providers in the drugs and commodities distribution network of the public sector. To allay concerns by the district over the lack of consistent and accurate monthly reports produced by the private providers, the HBVP provided additional training on record keeping and required facilities to submit copies of completed monthly reports to the District Health Office. PMTCT is a new line of service that most private facilities did not have the training, accreditation, or ARVs to

Voice of the Provider

"I am grateful for the training that I have received through this voucher program. I got this training for free, and I have it for life!"

administer prior to joining the voucher program. All HBVP providers interviewed stated that they enthusiastically took on this new service, since this would allow them to become a one-stop shop for the community, broadening their appeal and client base, when previously they had to make referrals for these services.

RECORD KEEPING AND VOUCHER PROCESSING

Vouchers sometimes increase the amount of paperwork that a facility must manage. As part of HBVP, providers were required to complete voucher-specific claims forms and keep health records that were often more detailed than what the facility was used to keeping. For example, to be able to receive reimbursement for the delivery of a baby, providers had to ensure that a completed partograph, which graphically records the progression of labor, accompanied the claims form. Additionally the details for every test conducted during an ANC visit needed to be submitted along with the claim forms.

Front-line workers understood the need for the additional paperwork—to meet the voucher program standards and service provision best practices—but found it to be a significant burden, adding to their workload and taking away time spent with patients. These workers wanted allowances to compensate for the additional time and effort required to implement the program. According to one facility manager, “with allowances they will be happy to work.” At the same time, facility managers agreed that the standards set by the voucher program had improved overall record keeping at their health facility and that front-line staff were now more serious about meeting their assigned roles and responsibilities.

Better record keeping also helped to improve the relationship between the public and private sectors. Private providers that were part of HBVP were required to fill out monthly health service reports to the District Health Office in order to receive their reimbursements. This mandatory reporting by the providers resulted in a jump in the number of facilities with completed data reporting (more than 95 percent reported on time to the District Health Office). When interviewed, several public sector administrators mentioned that they had been recognized by their peers and the Ministry of Health for this achievement. Seeing how the private sector can contribute to public health goals, these public sector administrators noted that their perception of private health facilities had shifted, from adversary to partner.

Prior to initiating voucher services, all participating providers were sensitized to the implementation process for the voucher program. Overall, providers interviewed had a good understanding of how the program functioned and the various program components. However, several providers interviewed stated that there was lingering confusion among their staff about how the program worked and that, in particular, there was misunderstanding/miscommunication on how to process voucher claims. As a result there have been instances where staff were not collecting vouchers from clients after providing services, leading to losses in revenue. In addition, several providers also voiced frustration over delays in settling claims which impacted working capital and complicated salary payments.

STREAMLINING REFERRALS FOR TREATMENT OF COMPLICATIONS

By covering all costs associated with deliveries, HBVP enabled facilities to develop a more effective referral system for complications enabling referrals to the closest higher-level facility regardless of whether it was public or private. Higher level public facilities are clustered around densely populated areas and can often be an hour’s drive away from a lower-level private facility. Higher level private facilities are traditionally avoided for referral out of concern for the woman’s ability to pay. This choice could put a woman’s health at risk as treatment for a complication may be delayed due to geographical and financial barriers. Many of the providers

managing lower level facilities stated that they felt more confident and proud of their ability to provide services because they knew that if complications occurred they would be able to choose the best treatment option for the mother and refer her to the nearest higher-level facility without worrying about her ability to pay. Providers making referrals would still be reimbursed for providing basic emergency obstetric care.

MAINTAINING HIGH CLINICAL STANDARDS

HBVP implemented a mentoring and monitoring system in order to maintain high standards of clinical care including infection prevention mechanisms, emergency preparedness and stock management. In collaboration with the Association of Obstetricians and Gynecologists of Uganda, the program conducted quarterly mentoring and support supervision visits at each participating facility (one day per facility) to ascertain compliancy and adherence to required clinical standards. According to one service provider, “I was doing very badly on clinical standards and the first time the team evaluated me, I scored 60 percent, but after successful mentoring and support supervision, I now score 92 percent.” Providers felt that this quality assurance process helped make their facilities more appealing to the community and improved marketability at the district level. According to one provider, based on improved clinical standards, “the district has given me the cooling facility for vaccines and I have been connected to the district vaccine distribution network.” With many facilities improving their clinical quality to meet program standards, overall quality of care and service provision has greatly improved and the exposure risks to providers have gone down.

LASTING EFFECTS OF THE VOUCHER PROGRAM

There were many positive implications of the voucher program for the participating providers, in addition to providing life-saving maternal health services to poor women in western Uganda. Most notably, providers interviewed felt that the various changes made in order to meet voucher program standards (such as structural investments in their facility and improving record keeping) had improved their reputation in the community. One provider stated that because of the voucher program, his facility is now known as the place “where mothers and children should go to get care.”

Improved reputation brought greater popularity and awareness of the clinic within the community. Several providers commented that their client base had increased for non-voucher services as well. One clinic operator stated that the community did not know about the existence of the clinic before the voucher program. However, with the community outreach by the CBVDs, people in the villages now knew that the facility existed and offered many of the services that they seek.

Many providers interviewed had reinvested, or had plans to reinvest, the revenue from the voucher program into their facility so that they could continue to grow. For example, the Nightingale Domiciliary, which is operated by Sister Hellen Nkojoge, was able to use funds from claims reimbursements to add a new wing so that it can serve more mothers. This in turn further increases revenue and generates capital to reinvest in and improve the facility.

HBVP also enhanced ties between private facilities and District Health Offices, improving data reporting from the district to the facilities and strengthening the supply flow of commodities including antiretroviral drugs and vaccines (for those enrolled in the district immunization program).

HBVP ended in November 2014. The end of the program was a concern for several providers who felt that “a sustainable program is where the voucher is always in place.” While they have

seen many positive effects from participation in the program there is also concern about what will happen in terms of demand for services and income generation after the end of the program.

Sister Hellen and her staff stand outside the new wing.