Reproductive Health Voucher Programs in Kenya and Uganda

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Challenges in achieving Millenium Development Goals 4&5

Kenya and Uganda are at serious risk for not achieving the 2015 Millennium Development Goals regarding child and maternal health (MDG 4 to reduce childhood mortality & MDG 5 to improve maternal health). In order to improve the MDG indicators, access for reproductive health services needs to be expanded for the poor and underserved.

The existing health financing structures in Kenya and Uganda are currently inadequate to address this challenge. It is necessary to identify the most appropriate and efficient financing strategy to translate monies from governments and donors into the provision of health services and improvements in health status. Supply-side strategies, where monies are typically granted to government agencies to support the provision of health inputs, have been criticized for several reasons: having poor allocative efficiency, ignoring demand-side barriers to health care consumption, and providing little incentive for providers to perform at their best and attract clients.

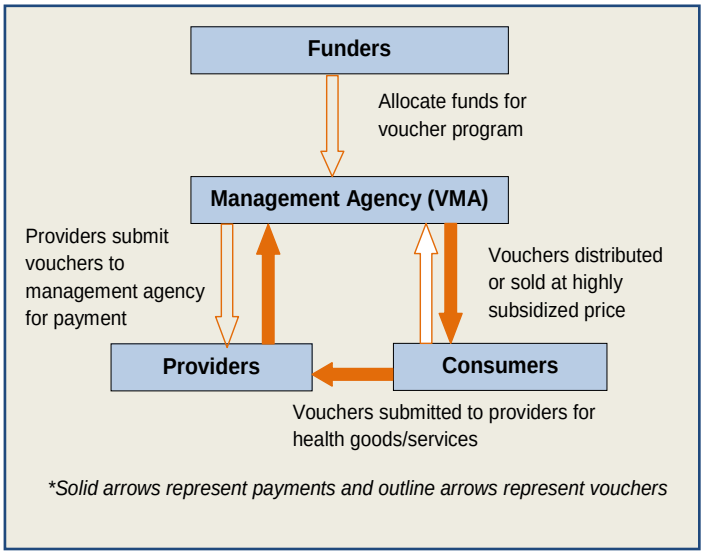
Ultimately, long-term health financing strategies are needed for Kenya and Uganda that are equitable, sustainable, and appropriately designed for the population. Experiences from high-income countries; however, demonstrate that this is a gradual process. An intermediate approach is needed to introduce elements of long-term health financing systems, including a focus on outputs instead of inputs, guaranteed provider payments, competition, quality monitoring, private sector participation, and fraud detection. As such, an intermediate approach can introduce governments, health providers, and patients to health insurance concepts and serve as a catalyst for developing long term health financing options, while addressing MDG 4 and 5 goals in the short term.

Demand-side financing and vouchers

Demand-side financing systems shift purchasing power from governments and donors to consumers, while addressing other demand-side barriers, with the goal of stimulating demand for health services.

Vouchers are one form of demand-side financing where providers are reimbursed based on the number of services they deliver. Typically, voucher programs involve four primary actors: (1) the funders, which may be governments and/or donors; (2) the voucher management agency (VMA) that administers the program; (3) the providers of health care goods and/or services; and (4) the clients or voucher recipients in need of health care.

Both Kenya and Uganda launched reproductive health voucher programs in 2006. The Kenya program provides vouchers on safe motherhood (antenatal care, facility-based deliveries, and postnatal care) and long-term modern family planning methods. Uganda's voucher program began with diagnosis and treatment of sexually transmitted infections (STIs) and later added a safe motherhood voucher.



In Kenya and Uganda, the VMA conducts several essential activities in administering voucher programs, including accrediting and contracting providers, quality monitoring, distributing vouchers to clients, marketing and raising awareness of the voucher system through media campaigns, and processing provider claims and conducting fraud control.

Providers may be contracted from both the public and private sector, depending on national policy. Both public and private facilities are contracted in Kenya, while only private facilities are eligible to become voucher clinics in Uganda.

For voucher distribution, community-based distributors sell safe maternity vouchers to poor pregnant women who are identified using a poverty grading tool. STI treatment vouchers in Uganda are sold at local drug shops and pharmacies to anyone with STI complaints. A physical paper voucher has tear-off stubs for each visit to the provider.

Since the Kenya and Uganda programs were launched in 2006, the programs have provided over 110,000 facility-based deliveries (96,000 in Kenya and 14,000 in Uganda), approximately 27,000 long-term modern family planning methods, and 30,000 STI diagnosis and treatment visits.

Two primary cost components of voucher programs are service costs and set-up/ administrative costs, including expenses for system design, provider accreditation, developing information systems, marketing, and creating an evaluation system. Ongoing administrative costs include program management, monitoring, and provider training. In Kenya, the total expenses per service are $119 per safe motherhood package and $24 for long-term family planning. Uganda STI expenses are estimated at $53 per STI client.

Administrative costs are estimated at 20-27% of total costs in Kenya and 32% in Uganda. As to be expected, administrative costs in early stage of voucher programs are high for

establishing needed systems. As programs develop, these costs should be reduced.

Impact of Vouchers

Evaluation research on voucher programs across the globe has found that they have been successful in targeting specific populations, increasing health-related knowledge, increasing utilization of specified health services, and increasing the quality of services provided.

Research on the Kenya and Uganda programs has found:

Utilization

- In Kenya, utilization of assisted deliveries and family planning increased at contracted clinics after the voucher program was implemented.
- Uganda's contracted STI clinics found a 200% increase in STI clients after the voucher program was introduced.

Targeting

- In voucher contracted clinics, Kenya's voucher clients were poorer than non-voucher clients, indicating that targeting to the poor was successful.
- Post-voucher implementation, fewer women in Uganda report "lack of money" for the reason of not seeking STI treatment.

Quality

- Voucher-contracted facilities in Kenya and Uganda used voucher revenues to make quality improvements, such as infrastructure enhancements, additional staff and renewed equipment and supply stocks.

Knowledge

- After implementation of the STI voucher program in Uganda, individuals in the population were more able to list STI symptoms, indicating that health knowledge improved.

Health

- After one year of the Ugandan STI program, there was a reduction in the prevalence of syphilis, with a greater reduction among those living near voucher-contracted facilities.

KfW-funded Vouchers in Kenya and Uganda

	Kenya	Uganda
Voucher services offered	Safe motherhood (SM) for safe delivery, prenatal and postnatal care Family planning (FP) for long-term family planning methods	HealthyLife (HL) testing and treatment for STIs HealthyBaby (HB) for safe delivery, prenatal and postnatal care
Location	Four rural districts and two urban informal settlements	Four initial districts expanded to 22 districts in western Uganda
Service provision	2006 - 2011: 96,000 deliveries, 27,000 long-term family planning	2006 - 2010: 14,000 deliveries 30,000 STI visits

Advantages of Vouchers

There are several advantages to using a voucher system. First, by including private sector providers, the private health care market is strengthened and client choice and competition is increased. With a standardized payment, competitors can compete on quality and quality of care can improve under vouchers. Quality is also expected to increase in voucher programs due to established standards and training.

The ability to target specific populations and increase allocative efficiency is another important advantage of voucher programs.

By selling vouchers at subsidized prices, voucher programs can generate some revenue and familiarize clients with the concept of pre-payment for health services.

Continuing Challenges

High set-up and administrative costs need to be addressed if vouchers are going to be successful in the long-term. Given the hopes that voucher programs will improve the efficiency of health care delivery, the costs of setup and further administrative costs will require further scrutiny. A balance will need to be found between high quality program management as well as affordability in the national context. However, as knowledge and experience grows in this area, these costs should lessen substantially in the future.

Another important challenge is reaching the poorest and most remote individuals. The farther a person is from health services, the less likely they are to receive treatment. Additional focus and innovations are needed to address distance-related barriers to health care services.

If voucher programs are to transition into a sustainable and long-term financing strategy, voucher structures and mechanisms will need to be incorporated into national strategies. Both Kenya and Uganda have shown some degree of government ownership, and in Kenya, the approach has already found entry into national strategies. However, further ownership by national-level stakeholders is required if these programs are to meet their long-term aims. Additionally, more donor funding will be needed before voucher schemes and subsequent long-term health financing options can be fully financed within each country.

Looking forward

Encouraged by the successes in Kenya and Uganda, new KfW-funded reproductive health voucher programs are being implemented in Cambodia, Tanzania, Yemen and Cameroon.

More information on KfW-funded voucher programs is available in a detailed policy brief.
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Photo by Dr. Dirk Müller