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SmartLessons
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Providing Safe Delivery Services With Vouchers:

The Reproductive Healthcare Voucher Project (RHVP) in Western and Southern Uganda

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Healthcare-and specifically maternal healthcare-is undoubtedly vital to the alleviation of poverty. The development community paid significant attention to healthcare by devoting three of its eight Millennium Development Goals (MDGs) to healthcare with two of the three MDG healthcare goals dedicated to child mortality and maternal health Clearly, the MDGs, especially the eradication of extreme poverty and hunger, cannot be achieved if population and reproductive health issues are not addressed. Uganda – where the average woman undergoes seven pregnancies – has the second highest fertility rate in the world. Maternal and perinatal health conditions account for 20.4% of the total disease burden in the country. The World Bank Group and the Global Partnership on Output-Based Aid (GPOBA) managed and helped fund this large scale project in western and southern Uganda. The Reproductive Healthcare Vouchers Project (RHVP) provided subsidized vouchers to women for a package of birthing services at clinics, services supplied by skilled medical practitioners. It also provided subsidized vouchers to couples for HIV/AIDS and other sexually transmitted diseases. This SmartLesson, in describing the project's outcomes also highlights some key lessons learned as vouchers were introduced for the first time in a health care context in the World Bank's Africa region.

Background

The Voucher Scheme

Vouchers have been used in healthcare, notably in the pilot project initiated by the German Development Bank Kreditanstalt für Wiederaufbau (KfW) upon which the RHVP is based. Still, the scale and complexity of the RHVP was a voucher management challenge that required new policies and practices. These policies and practices include layers of verification that innovatively support the financial soundness of the project.

There are two important ideas in this voucher system. The first is that the "customer," a woman in need of perinatal and maternal services or a couple in need of treatment and/or information about sexually transmitted diseases, initiates the transaction. The second idea is that the flow of funds through the voucher system is different from a conventional donor situation. Essentially funds follow the patients and are paid against agreed outputs.

Tight Control over Disbursements and Transparency

Here's how this complimentary feature worked. GPOBA and its development partner KfW, contracted Marie Stopes International Uganda (MSIU) as the Voucher Management Agency (VMA) to supervise overall operational management of the project.

- MSIU is an aid organization with significant international experience in constructing, maintaining, and managing healthcare infrastructure in numerous countries around the world.

- The output verification was conducted by an Independent Verification Agent (IVA) managed by KfW.

- MSIU also inspects and accredits healthcare facilities, assuring that the facilities meet generally recognized standards.

Products, Services and Pricing

The voucher scheme offered two different products. The first was a Safe Delivery (SD) Voucher (sold under the HealthyBaby brand name) that provided: Four visits with a skilled medical practitioner before a baby's birth (antenatal visits); normal deliveries with a medical professional in attendance, as well as any emergency treatment/transportation required; monitoring by medical staff after the birth for up to three days; and one postnatal visit including family planning counseling.

Getting the Message Out

The voucher scheme made use of Voucher Community Based Distributors (VCBDs). The VCBDs are the main channel for voucher sales in the communities. VCBDs are individuals who travel from village to village basically selling vouchers on a person to person basis. The effectiveness of the VCBDs was underscored by a brief period during the life of the RHVP when the VCBDs were recruited away from the RHVP to participate in a national election campaign. During that period voucher sales plummeted and much of the health education work they did had to be repeated.

Far Reaching Results

When the RHVP began, planners estimated that 136,000 people would benefit from the greater availability of reproductive healthcare services. According to the November 2011 final report of the Independent Verification and Evaluation Agent, a total of 137,964 vouchers were sold. This includes 106,306 SD vouchers and an additional 31,658 clients redeeming STD vouchers.

Some of the most notable achievements of the project are that 59,000 safe delivery clients (117 percent of target) and 31,658 STD treatment episodes (90 percent of target) were managed under the project.

Birth of an healthy baby in Uganda

The Status of Ugandan Women

While the focus of the RHVP is on healthcare, the project also has had a positive effect on the status of Ugandan women. In a speech to a gathering of representatives of donor organizations on January 10, 2010, U. S. Secretary of State Hillary Clinton said, "women's health is essential to the prosperity and health of all people." Secretary Clinton has also said that women's rights are human rights, an idea that was encoded in the third Millennium Development Goal.

It states that the 193 countries approving the MDGs will all work to "promote gender equality and empower women." Reducing a country's maternal mortality rate —a stated objective of the RHVP—is crucial to empowering Ugandan women to take charge of their own destiny.

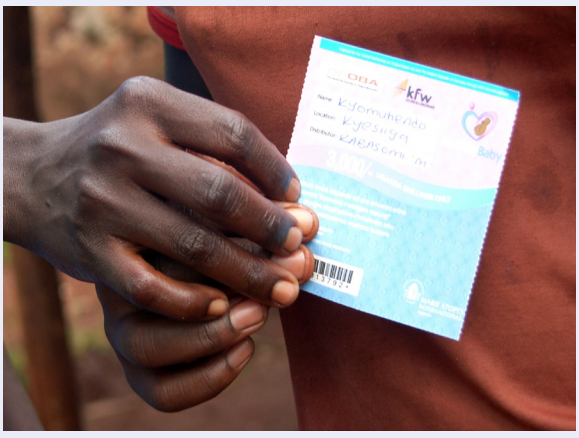
Lessons Learned

Lesson 1: Embracing local traditions helps to build awareness and voucher sales.

A well established link between rural Uganda's oral tradition and credibility was found to be the key to healthcare voucher sales. The RHVP used a community-based public-private partnership to help with awareness building, service provider selection, and voucher sales. The use of Voucher Community Based Distributors (VCBDs) proved to be an essential tool for the project. VCBDs are basically healthcare educators who travel from village to village—like itinerant salespeople—explaining the health benefits of having a baby in a clinic, or using a clinic for treatment of an STD. The VCBDs take advantage of the oral tradition of the villages they visit.

Lesson 2: A formal provider-selection process enhances service quality.

An extensive mapping exercise was carried out by the VMA to identify, train, and contract providers—including private hospitals, clinics, nursing homes and midwives' facilities—within the project's target districts. The selection of service providers took into account both the managerial and clinical capacity—basically experience and VMA certification—required for effective participation in the scheme and



A voucher being distributed

Sister Kerezin with OBA beneficiaries

targeted service providers whose areas of operation included poor groups, especially those in rural areas and high-risk groups.

Lesson 3: Text messaging brings a high degree of efficiency to project management.

The speed, convenience, and economy of text messaging are well matched to the huge amounts of data that the RHVP generates. More efficient claims processing is the main benefit, improving the flow of funds between service providers and the VMA. The quicker claims processing enhances cash flow to service providers resulting in improved delivery of services to patients since service providers are able to afford better trained clinicians and better equipped clinics. Other features of text messaging introduce additional cost efficiencies. In rural areas, travel time to a central location to submit form-based data is measured in hours. Text messages reduce that time dramatically and make better use of scarce personnel resources. Text messaging also facilitates error handling and allows management to make better-informed decisions. Errors that are handled more expeditiously reduce service bottlenecks, and the rapidity of text messaging means that decision makers have timely access to information giving them a real time perspective on operations.

Lesson 4: Close attention to quality of service yields client satisfaction.

One of the features of the RHVP design was a system for assuring that services would meet common medical standards for quality. MSIU manages quality control efforts for the RHVP. MSIU inspects and certifies healthcare providers and their personnel. This part of the program is partly responsible for the RHVP's high rate of client satisfaction. In the Population Council project evaluation document cited above, the Council reported: "High levels of satisfaction with services among voucher clients: 98% of HealthLife and 92% of HealthyBaby voucher clients reported satisfaction with the services they received."

Lesson 5: A locally created and maintained referral system can be highly effective.

The inability to quickly transfer women in need of birthing services to suitable health facilities is a major cause of delay and leads to poor outcomes at birth. Providers initially faced challenges in providing effective referrals.

Together with the service providers, the VMA addressed this by establishing a network of Comprehensive Emergency Obstetrics Care providers and Basic Emergency Obstetrics Care providers in Masaka and Mbarara sub-regions as explained above. VMA staff was tasked with regular visits to service providers to share knowledge and evaluate service provider operations. In Mbarara, the voucher service providers formed an association, Private Provider Forum, seeking to jointly tackle their common problems in management of referrals, ongoing medical education, and other issues. In Ishaka Hospital, a community group organized motorcyclists ("boda bodas") to transport mothers to hospital for delivery. The experiences offer several lessons, which the VMA is urged to compile to inform future OBA design (a work in process.) It was noted some of the emergency referrals stem from failure of referred mothers to transport themselves, necessitating considering the handling of referrals to facilities not vetted by the VMA in future OBA schemes.

Conclusion

Through the RHVP, a large number of poor rural Ugandan women and couples were able to obtain reproductive healthcare services that they were unlikely to have been able to access otherwise. In turn, this helped make progress toward meeting Uganda's 2015 Millennium Development Goal commitments. And the RHVP established a model for voucher systems dedicated to healthcare.