The Reproductive Health Vouchers Program in Kenya
Summary of findings from program evaluation

Reproductive Health Vouchers Evaluation Team
Population Council
September 20th 2011

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Evaluating reproductive health voucher programs globally

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BTL	Bilateral Tubal Ligation
C/S	Caesarean Section
DHMT	District Health Management Team
DRH	Division of Reproductive Health
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ID	Identity Card
IUCD	Intra-Uterine Contraceptive Device
KES	Kenya Shilling
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
LAPM	Long-Acting or Permanent Method
NCAPD	National Coordinating Agency for Population and Development
NHIF	National Hospital Insurance Fund
OBA	Output-Based Aid
PwC	PricewaterhouseCoopers
QA	Quality Assurance
TCQA	Technical Committee on Quality Assurance
VMA	Voucher Management Agency

1.0 PROGRAM BACKGROUND

The Government of Kenya has implemented the reproductive health vouchers program since 2006 with funding from the German Development Bank (KfW). The ultimate objective of the program is to significantly reduce maternal and neonatal mortality by improving access to appropriate reproductive health services for the poor through incentives for increased demand and improved service provision. The vouchers are made available through distributors appointed by PricewaterhouseCoopers (PwC)—the voucher management agency (VMA)—to poor women in Kisumu, Kitui, and Kiambu districts, and in Korogocho and Viwandani informal settlements in Nairobi. From mid 2011, the program began distributing vouchers in Kilifi and Kaloleni districts as well.

The program subsidizes comprehensive safe motherhood services (antenatal, delivery and post-natal care) at a cost of KES 200 and long-acting or permanent family planning methods (implants, intrauterine contraceptive device [IUCD], and voluntary female surgical contraception) at a cost of KES 100. There are additional vouchers that are made available to women seeking gender-based violence recovery services at no fee. The distributors use a poverty grading tool consisting of eight items on household assets and amenities that are unique to each district to identify poor women from the community who qualify for the vouchers. The vouchers are then redeemed for services at contracted health facilities in the program sites. The facilities then submit claims to the VMA for reimbursement for the cost of services rendered to voucher clients.

2.0 PROGRAM EVALUATION

The Population Council is conducting an external evaluation of the program with funding from the Bill and Melinda Gates Foundation. The objectives of the evaluation are:

1. To assess the effect of the program on improving access to, quality of, and reducing inequities in the use of reproductive health services; and

2. To evaluate the impact of the program on improving reproductive health behaviors and outcomes at the population level.

This report summarizes some of the initial findings from the first round of data collection as part of the broader set of evaluation activities. This report is based on the following sets of data from three intervention and three comparison districts (excluding Kilifi and Kaloleni districts) and the two informal settlements in Nairobi:

- **Health facility assessment** including 1,877 observations of client-provider interactions, exit interviews with 1,823 clients, 201 provider interviews, 1,171 record reviews, 55 facility inventories, 55 service statistics, and costing data from 26 facilities;

- **Population-based household survey** of 2,527 women and 658 men from three voucher (Kisumu, Kiambu and Kitui) and three non-voucher (Uasin Gishu, Nyandarua and Makueni) areas for comparison;

- **Qualitative assessment** involving 42 focus group discussions (FGDs), with women and men, chiefs, local leaders and voucher distributors; and 96 in-depth interviews (IDIs) with facility in-charges, providers, local administration, and VSP/field managers in Kisumu, Kiambu, Kitui districts and Nairobi – Korogocho and Viwandani urban slums;

- **Social and verbal autopsy[1] interviews** were conducted to establish the biological cause of death and the social, behavioral, and health systems contributors to maternal and neonatal deaths. We followed all deaths of women between the ages of 15-59 years and all neonatal deaths to determine the cause of death within a 5km radius of study facilities. Cause of death was determined using the WHO ICDC 10. A total of 633 verbal autopsies were conducted, of these 95 maternal deaths and 181 neonatal deaths were determined;
  The purpose of the verbal and social autopsy in the context of OBA program was to provide complimentary population-level data that can be utilized in informing some of the missed opportunities in addressing maternal and neonatal mortality that can be perhaps addressed by the voucher program.

- **Voucher sales and claims data** from the VMA from 2006 to end of 2010;

- **Document review** of design reports, contractual documents, program review reports, and steering committee minutes.

[1] "Verbal autopsy" is the nonjudgmental investigation of the causes and the associated factors of all deaths that occur outside health facilities. It entails conducting interviews with close relatives or friends who cared for the deceased before the death. "Social autopsy" refers to an interview process aimed at identifying social, behavioral, and health systems contributors to maternal and child deaths.

3.0 KEY EVALUATION AREAS

The evaluation focuses on eight key areas that fall within two broad categories: 1) program organization and management, and 2) program outcomes. The key areas include:

1) Program management

- **Program management:** governance, program policy, planning, financing, and available human resources at program (VMA) and facility levels.

- **Implementation:** process, marketing, distribution, claims and reimbursement including monitoring and fraud control at program and facility levels.

2) Program outcomes

a) **Quality:** accreditation, quality assurance, capital investment, and improvement in quality of services provided.
b) **Cost utility and effectiveness:** service costs and out-of-pocket expenses for voucher clients.
c) **Knowledge:** services covered by the voucher program, danger signs in pregnancy and for newborn.
d) **Health service utilization:** use of long-term family planning methods, antenatal care, health facility delivery, skilled delivery care, and post-natal care services at facility and population levels.
e) **Equity:** socio-economic inequities in health service utilization at facility and population levels.
f) **Health status and outcomes:** complications, pre-term deliveries, miscarriages, perinatal mortality/stillbirths, neonatal and maternal mortality.

4.0 KEY FINDINGS

4.1 Program Management

- ***Effective leadership and implementation:*** Having a policy champion at the lead executing agency for Phases I and II of the program (the National Coordinating Agency for Population and Development, NCAPD) ensured effective leadership and implementation of the program. This was achieved through popularizing the program within government and donor circles that in turn ensured appropriate political and financial support for it.

- ***Enhanced accountability in program management:*** This was made possible by putting in place different committees such as the Advisory Board, the Steering Committee, and the Technical Committee on Quality Assurance (TCQA). The committees used a number of strategies to ensure effective program management and implementation such as pegging subsequent implementation activities on outputs of previous phases. Enhanced accountability was also ensured by the strong internal management system put in place by the VMA, PricewaterhouseCoopers, that included internal monitoring and evaluation as well as claims processing and approval.

- ***Strengthening private – public health partnerships:*** Strategic partnership between the private and public sector when well managed can help improve public health goods as was demonstrated by the involvement of PwC, a private entity.

- ***Limited involvement of the Ministry of Health***: Although the Division of Reproductive Health was a member of the Advisory Board and Steering Committee there was little involvement during Phase 1. This may have resulted in missed opportunities in the needed reproductive health expertise. However they played a key role as the coordination of the Technical Committee on Quality Assurance in monitoring existing facilities and accrediting new ones.

- ***Fragmented monitoring of accredited facilities by National Hospital Insurance Fund (NHIF):*** This parastatal institution was given the mandate to carry out accreditation of health facilities and Quality Assurance (QA) on a six monthly basis. Although a QA manual was developed for the program, NHIF rarely used it. Fortunately the Steering Committee supported the TCQA to carry out the QA activities in Phase 2.

4.2 Implementation

4.2.1 Process

- ***Learning and adaptation to local settings due to phased implementation:*** The implementation process was conducted in two initial phases, with a mid-term review of the program. This provided an opportunity for learning and adapting the program to local settings. It further allowed for making any necessary changes to program operations.

- ***Unpredictability of context and bureaucratic processes may cause delays in implementation process:*** The implementation of the program has, however, been characterized by delays. The launching of the initial phase was delayed for four months due to the availability of funds. This caused subsequent delays in finalizing contracts for marketing, accreditation of facilities, and quality assurance. There were also further delays due to a gap in funding in 2008 pending final contracts for Phase II of the program. Through this experience, there may be need to factor in sufficient time to account for unpredictability of events.

4.2.2 Marketing and Distribution

- ***Use of the provincial administration vital for creating awareness and for distribution:*** Using local administrative structures including community and opinion leaders played a vital role in creating awareness about the program. The local administrative structures further served as fixed distribution points for the vouchers.

- ***Use of poverty grading tool ensured appropriate targeting of the poor:*** The use of the poverty grading tool to identify beneficiaries coupled with visits to potential beneficiaries' homes to confirm the information provided resulted in adequate targeting in some sites. As one elder noted during FGD in Nairobi: "*I think they have reached the poor. If the intention is to reach the poorest of the poor, vetting must be done…As I told you, no complaints about discrimination or other underhand practices have reached our offices so far as I am concerned*."

- ***Use of multiple marketing campaigns had varied levels of success:*** Initial plans to use multiple marketing campaign strategies such as local radio advertisement, road shows and information materials had varied levels of success. For instance, radio broadcasts worked well in Kisumu but not in Kiambu where it attracted many people from Nairobi who were not the target population and had to be discontinued.

- ***However, weak marketing strategy especially in remote rural settings led to inadequate information on the program:*** The VMA contracted an agency, Lowe Scanad, to undertake

the marketing activities with a view to creating demand. The marketing agency's role was limited by budgetary and time constraints as well as the complex strategies required in Phase 1 only. Their role was reduced to a one-off activity with limited interactions across sites. For effective implementation, there is need for the program to have a continuous social marketing strategy that involves community members such as using local leaders to identify distributors.

- ***Limited knowledge of vouchers and poor distribution in remote areas:*** Partly because of poor sensitization and accessibility in remote areas, there was limited knowledge and distribution of the vouchers in these settings. Especially around the facilities that were only accredited in 2010. For example, one FGD participant in Kitui noted that: *"We have distribution points but there are areas that have not been well penetrated, so clients don't know well of the services."*

- ***Instances of leakage:*** Despite the use of the poverty grading tool in targeting of beneficiaries, there was evidence of leakage of the vouchers to non-poor women. For instance, 20% of non-poor women (according to the grading tool) living near facilities that have implemented the program since 2006 reported having ever used the vouchers.

- ***Instances of some eligible clients missing out***: Distributors and community members reported during FGDs that the poverty grading tool had some shortcomings in its scoring system as it sometimes left out genuine needy cases. For example, one FGD participant in Kiambu noted that: *"…for me, my husband lost his job and I do not work. Now we have no money and we live in this small room. We thought living in this small room as squatters made us voucher client but they refused."* This suggests the need for periodically assessing the eligibility criteria and revising the poverty grading tool to reflect the changing poverty levels given that poverty indicators are not static. There is also need to explore how community members can be involved in vetting the poor.

- ***Lack of formal identification prevents some eligible women from purchasing vouchers:*** Some pregnant adolescent girls aged below 18 years were unable to purchase vouchers because they had no formal identification documents. In Kenya, the identification (ID) cards are only issued at age 18. Moreover, the government has issued only limited numbers of ID cards in the last three years. There is therefore need to explore alternative forms of identification for those seeking vouchers but lack formal identification.

- ***Dishonesty on the part of clients and some retailers provided additional challenge for effective distribution of vouchers:*** Participants in the FGDs reported how some women would provide false information and even rent a poor woman's house in order to be eligible

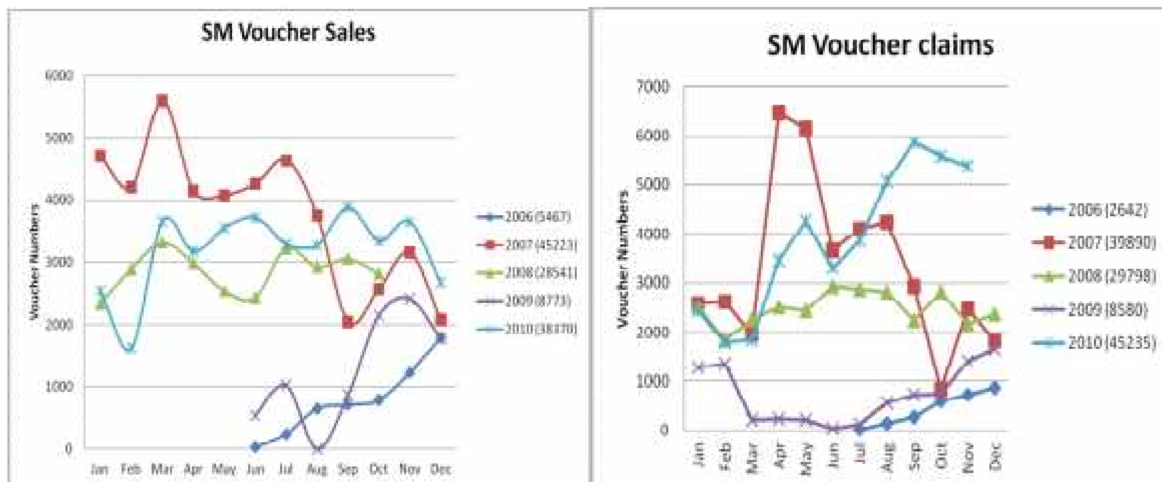
for the vouchers. In addition, some community health workers who were distributors sold the vouchers to non-poor women at higher prices. As one FGD participant in Kisumu noted: *"Community health workers don't charge the vouchers for 200/-, they will charge for 1,000/- to 1,500/- ."*

4.2.3 Claims and Reimbursement

- ***Claims and reimbursement process to monitor and control fraud:*** A computer-based claims and reimbursement system was set up that could process claims within 30 days, account for funds, and link accounting and claims processing systems. This required strict adherence to procedure whereby providers filed the necessary documentation after offering services to voucher clients while the VMA verified and approved payment or rejected the claim.

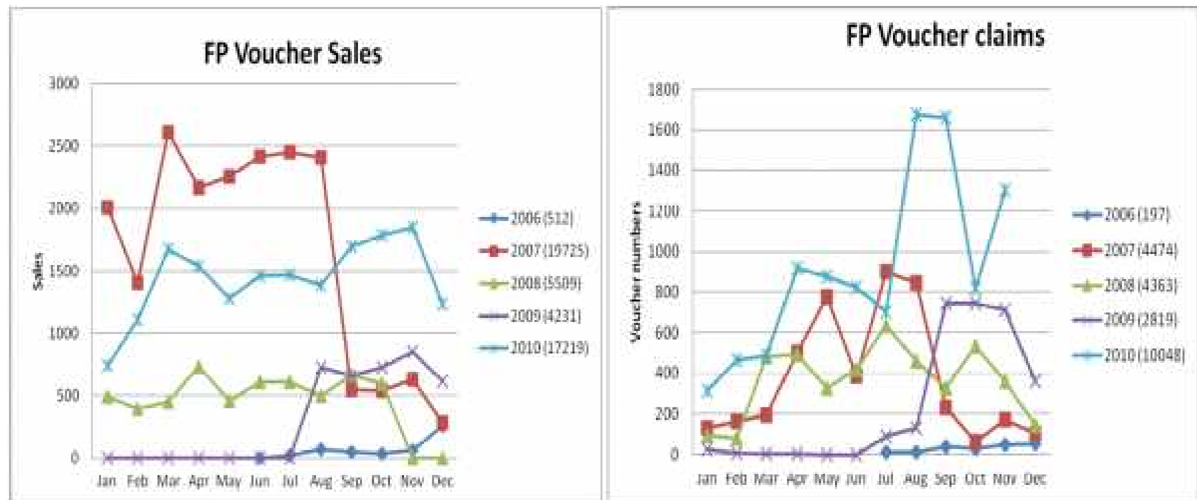
- ***Dramatic increase in voucher sales with more safe motherhood vouchers being sold:*** By the end of December 2010, a total of 173,570 vouchers had been sold with safe motherhood vouchers comprising 73%.

Figure 1: Comparison between safe motherhood voucher sales and claims by year



- ***High number of voucher claims with more safe motherhood vouchers being claimed:*** A total of 149,599 vouchers (86% of the sales) had been redeemed by the end of December 2010 with 84% being for safe motherhood services, 15% for family planning and 1% for gender-based violence recovery services.

Figure 2: Comparison between family planning voucher sales and claims by year



- ***Decline in voucher sales after initial increase due to funding gap:*** In spite of the initial dramatic increase in voucher sales, the number of vouchers sold stopped between October 2008 and May 2009 due to a nine-month gap in funding.

- ***Voucher claims between July 2006 and December 2010 were for the following:***
  - Safe motherhood voucher claims: normal delivery (57%), antenatal care (20%), caesarean section (9%) and obstetric/newborn complications (8%). 6% of claims were rejected.
  - Family planning vouchers claims: implants (70%),
  - Gender based violence recovery services: 66% of the claims were for managing clients who had experienced sexual assault (rape, defilement or sodomy).

- ***Perceptions among providers that the claims and reimbursement process is slow:*** There was a perception among providers that the claims and reimbursement process was slow and cumbersome. One provider in Kiambu noted that: *"I think the process of reimbursement takes too long. There's a time you claim and the time you are receiving this money it takes quite a while."* Some of the delays were occasioned by challenges to the claims processing system within the VMA

- ***Lack of proper communication between the VMA and the providers further undermined the claims and reimbursement process:*** In-depth interviews with providers showed that they did not receive information detailing what is reimbursed and what is not and the reasons for rejected claims. One provider in Kiambu noted that: *"Feedback is not good at all because you write to them, you communicate through the mobiles, you call them for meetings but you just discuss. There is no solution to it."* For effective implementation, there is need for continuous

flow of information not only between the VMA and the service providers but among all partners involved in the program.

- ***Lack of adherence to guidelines by providers partly contributed to delays in claims processing and reimbursement:*** Some providers violated the guidelines by attending to clients for conditions not included in the benefit package resulting in rejections of claims. Other claims were rejected because the claim forms were signed by hospital staff on behalf of the clients, the providers tampered with the voucher details, incomplete or inconsistent documentation, and late submission.

- ***Staff transfers posed additional challenges to the claims and reimbursement process:*** Once providers who were trained on the voucher process moved elsewhere, there was limited or no additional training or updates for new staff. This resulted in poorly completed claims forms which were then rejected by the VMA. This in turn delayed the reimbursement process as the VMA sent back the claims forms for amendments. Coupled with problems of lack of adherence to program guidelines, this suggests the need for continuously training service providers on the voucher process.

- ***Lack of standard operating procedures that could provide guidance on the claims process:*** There was lack of standard operating procedures to guide the claims process. Putting in place such procedures could have minimized the chances of rejections attributable to poor documentation.

- ***Trends in rejected claims mirror trends in voucher sales and claims:*** Although no claims were rejected from accredited facilities in the first six months of submission (July – December 2006), the number of rejected claims reached 2,829 in the following year (January – December 2007) before declining to 2,116 in 2008 and 841 in 2009. In 2010, the number of rejected claims increased to 2500. A total of 8,299 vouchers submitted for payment between July 2006 and December 2010 were rejected representing 6% of all the claims submitted for different services. As already noted, rejections were largely due to insufficient documentation and flouting of program regulations.

4.3. Program outcomes

4.3.1 Quality

4.3.1.1 Accreditation and Quality Assurance

- ***Facilities accredited to set standards of national staffing and infrastructure:*** The accreditation was done against accreditation criteria developed by VMA, Population Council and Division of Reproductive Health (DRH) and set standards of national staffing and infrastructure. It was carried out by the National Hospital Insurance Fund (NHIF) in consultation with the Technical Committee on Accreditation and Quality Assurance.

- ***Evidence of exceptions in the accreditation process:*** Some facilities were, however, accredited due to their remote location even though they did not meet set standards in order to enhance competition and client choice with the understanding that service quality would improve over time. Such facilities were given a grace period to improve quality and achieve requisite score for accreditation.

- ***Lack of clarity regarding the role of NHIF in accreditation undermined quality assurance:*** It was evident that there was lack of clarity regarding the role of NHIF in the accreditation process. Quality assurance inspection was also not implemented fully: Although quality assurance inspection was ***to b***e conducted every six months, this was not fully implemented. In addition, the accreditation process was not well synchronized with a feedback mechanism to the providers, especially regarding the areas that needed improvement.

- ***No difference in the expected quality of care for antenatal, post-natal and family planning services between accredited and non-accredited facilities:*** Based on the Kenya Quality Model framework of structure, process and outcome of care, trained researchers observed client provider interactions. There was no significant difference in the observed quality of care (norms and standards) scores between accredited and non-accredited facilities. Out of the expected score of 83, accredited and non-accredited facilities had mean scores of 43 and 41 respectively, which is different from the perceived quality of care by clients. The program therefore needs to constantly monitor quality of care to ensure that accredited facilities offer the minimum service package.

- ***Absence of provider skills update as an integral component of the program also undermined quality:*** Interviews with providers showed that few of them received skills update on a range of reproductive health topics. This suggests that although according to the program design it was assumed that facilities would use the funds to build the capacity of their staff

through additional training, this has not happened. This has implications for quality of care. Results from observations of client-provider interactions, for instance, showed that only about 33% of providers built rapport with clients while less than 20% provided adequate information to clients.

4.3.1.2 Service Improvement

- ***Improved capital investment at the facility level:*** Some service providers felt that the program has contributed significantly to the improvement of the quality of health care services and expansion of the facility. For instance, one service provider in Kitui reported that *"Because of that reimbursement, we are doing very well, we are able to pay our salaries well. We were able to build that…that building there…We have constructed a maternity… and have done a lot of renovations with the OBA, so to us it's a benefit."*

- ***Voucher clients were generally satisfied with the services they received especially in public health facilities:*** The proportion of voucher clients who were interviewed upon exit and reported satisfaction with the services they received was higher than that of non-voucher clients. In particular, 92% of voucher clients reported being satisfied with the services they received compared to 85% of non-voucher clients. This is supported by evidence from FGDs. As one voucher client in Kitui put it: *"[You are treated] nicely because you are attended to fast. You don't have to go to the cash office, they just feed your details into the computer and you go for treatment."*

- ***Instances of voucher clients being accorded preferential treatment in some sites:*** Findings from FGDs indicate that voucher clients were being given preferential treatment in some sites. As one voucher client in Kitui put it during FGD: *"We queue but we don't see any problem…But in case of a problem, you'll be attended to before the others."*

- ***Concerns about reimbursable amount, delays in reimbursement, and client volumes undermined service quality in private facilities:*** Some private providers were concerned that the ceiling set for reimbursement for various services was too little. Others raised concerns about delays in reimbursement while others were so overwhelmed by the demand of voucher clients that they could not serve their regular clients as they did before. This led to some of the private providers pulling out, limiting access for voucher clients or giving preference to those who can pay higher prices. One voucher client in Kiambu noted during FGD that: *"The reception when you go to deliver is bad. Once they see the voucher, you are not lucky…There is a problem there because you cannot be received the same way as a person who has money."*

- ***Instances of disrespectful and abusive care accorded some voucher holders in some sites:*** Although voucher clients were generally satisfied with the services, some reported poor service although indications were that this depended on the provider. As one voucher client in Kiambu noted during FGD: *"Let me just say that the problems are many…When you go to the clinic you'll encounter them. When you went for services using the voucher, you would be told at the gate "Was I there when you got pregnant!" So when you go there you don't even talk, you just pray that you get served so you can leave."*

- ***Public health facilities faced challenges utilizing money from the program to improve service quality:*** Public health facilities did not initially have direct control of funds generated from the program given the government policy of managing such funds through the District Health Management Teams (DHMTs). The bureaucracy of accessing the funds therefore limited its use for exclusively improving service quality. One provider in Kitui reported during in-depth interview that: *"I am telling you now this money we are not able to use it as the OBA money. It is consolidated as the hospital money so trying to push it back to the facility like now the maternity it is a struggle."*

- ***Referral of clients requiring emergency obstetric care further impacted on the services received:*** Some of these referrals were to non-accredited facilities where clients have to pay for services. In some cases where referrals were made to accredited facilities, voucher clients were unable to meet the transport costs. In addition some lower lever facilities would refer clients that could have actually been managed in that facility. One voucher client in Kitui reported during FGD that: *"You are told to go to [name of facility] for referral and you don't have bus fare. You are now forced to go back home to look for money or look for another cheaper facility."*

4.4 Cost Utility and Effectiveness

4.4.1 Service Costs

- ***Negotiated reimbursement in order to contain service costs:*** Although the VMA set ceilings for reimbursement of various services based on a baseline study conducted at the design stage, the actual reimbursement rates were negotiated with each service provider based on the respective cost situation at the facility. Additional expenses due to medical complications were covered by the VMA provided they were adequately documented.

- ***The reimbursement rates set in 2006 did not change over the reporting period (2006-2010)*** ANC – Kshs 1000, normal delivery Kshs 4000, Cesarean Section Kshs 20,000, implant Kshs 2000, IUCD insertion Kshs1000. Complications reimbursed as per individual claims (see table).

Service type	Average reimbursement (KSh)		
	Public facilities	Private facilities	All facilities
Safe motherhood			
Normal delivery	4,667	5,454	5,208
Caesarean section	19,795	23,726	22,314
Antenatal care	1,036	1,196	1,151
Complications	4,680	4,659	4,664
Family planning			
IUCD	1,137	1,094	1,115
Implants	2,013	2,011	2,011
BTL	2,962	3,023	3,021
Vasectomy	2,500	3,750	3,125
Gender-based violence	3,056	4,446	3,897

- ***Average reimbursement rates remained constant over time but slightly higher in private facilities:*** As expected, average reimbursement rates remained constant across different facilities over the period July 2006 to December 2010. However, private health facilities registered slightly higher rates for most of the services compared to public ones.

- ***Some private providers still felt that the reimbursable amount was not enough:*** Although the actual reimbursement rates were negotiated, some private providers felt that the ceiling set was too low. One private provider in Kiambu reported that: *"I also feel the amount of money they are giving us is not enough…When it comes to normal delivery, our normal delivery ranges from five to around eight or ten thousands but the OBA they are giving us four thousands…Come to C/S, our C/S ranges from about twenty one to around thirty. They are only giving us twenty thousand."*

4.4.2 Out-of-pocket Expenses

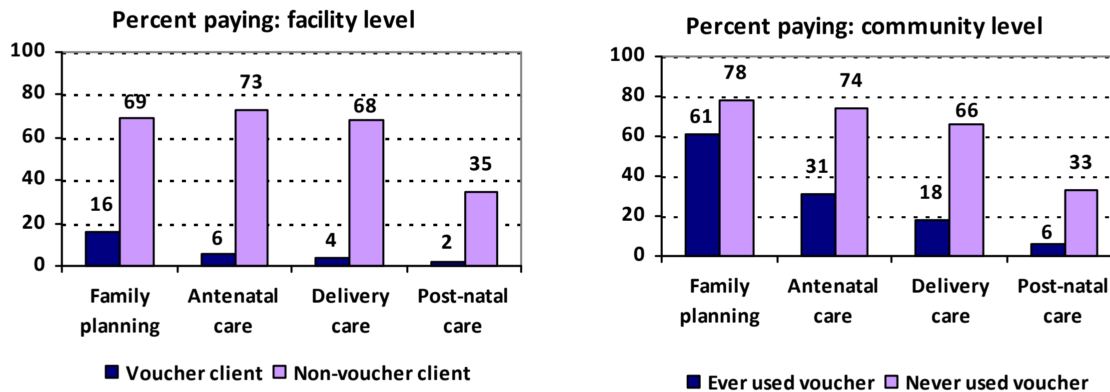
- ***Voucher clients made payments for services that are not covered or the providers felt were not part of the benefit package:*** Exit interviews with family planning voucher clients who paid for services show that they mostly paid for injectables. Qualitative interviews further show that some providers made voucher clients seeking safe motherhood services pay additional amounts for services they (providers) regarded as not being part of the benefit package such as laboratory tests and medicine. As one voucher client in Kitui put it: *"One person tells you to go the lab and the other asks you to pay for the service even with the voucher and buy medicine."*

- ***Reduced out-of-pocket expenses for voucher clients:*** Although voucher clients are not supposed to pay for services (such as lab tests), exit interviews with clients at facilities showed that the proportion of voucher clients that paid for services was much lower than

that of non-voucher clients. According to one voucher client in Kitui: *"It has been good because if you go to the hospital with a voucher, you won't pay."*

- ***Reduced out-of-pocket expenses for women who had ever used a voucher from the community:*** At the community level, the proportion of women interviewed who had ever used a voucher and paid for services was much lower than that of women who had never used vouchers.

Fig 3: Out of pocket expenses among women exiting health facility and women in the community



4.5 Knowledge

- ***Majority of women living near voucher facilities had heard about the reproductive health vouchers:*** 82% of the women living near facilities that have implemented the program since 2006 had heard about the vouchers compared to only 3% of the women from non-voucher sites. Among those living near facilities that were accredited in 2010, 88% had heard about the vouchers.
- ***Safe motherhood voucher was the most well known while family planning and gender-based violence recovery vouchers were less known***: 82% of the women from sites that have been in the program since 2006 reported knowing about the safe motherhood voucher. In contrast, 25% of the women had heard about the family planning voucher while only 2% had heard about the gender-based violence recovery voucher.

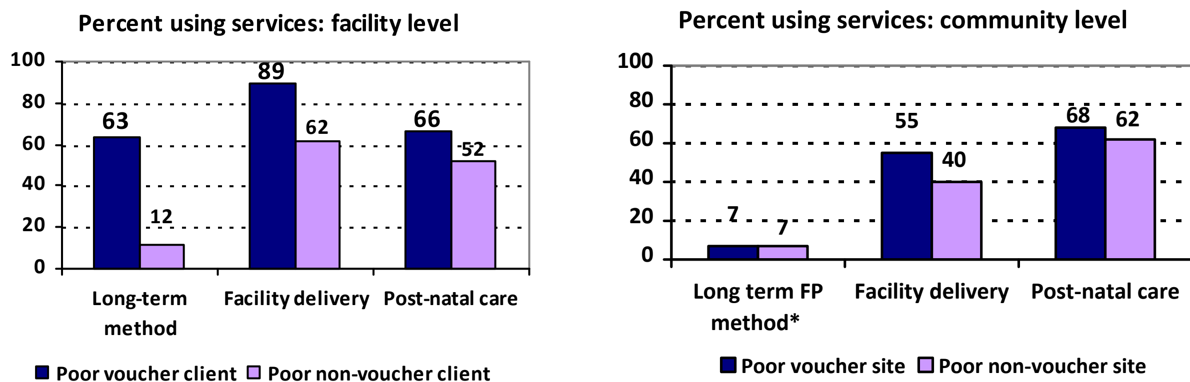
- ***Women who had heard about the vouchers were also more likely to be aware of dangers during pregnancy and childbirth:*** 71% of the women who had heard about the vouchers were aware of specific dangers a woman might expect during pregnancy, childbirth or immediately after childbirth. In contrast, 65% of the women who had not heard about the vouchers reported such knowledge.

4.6 Health Service Utilization

- ***Greater use of reproductive health services by poor voucher clients:*** Substantially higher proportions of poor voucher clients compared to poor non-voucher clients obtained long-term family planning methods, delivered at a health facility, and received skilled delivery care and post-natal care services. One voucher client in Kitui noted during FGD that: *"There are changes because most of us never used to go to clinic. We would get pregnant and stay at home. When you're told to go to hospital you would say, I don't have money, I don't have money. But now you won't find anyone staying at home."*

- ***Greater use of services by poor women from communities near voucher facilities:*** Poor women living near facilities that have implemented the program since 2006 (voucher sites) were more likely to use safe motherhood services (health facility delivery, skilled delivery care and post-natal care) compared to poor women from facilities that do not implement the program (non-voucher sites).

Fig 4: Accessing services for women exiting health facilities and women in the community



* Within previous 12 months

- ***Low uptake of family planning vouchers attributable to countrywide low acceptance of long acting and permanent methods (LAPM) and service delivery constraints as well as societal barriers:*** Findings from provider interviews show that there are limited skills in provision of LAPMs and findings from the FGDs show that the low uptake of the family planning voucher was due to negative male perceptions and societal misconceptions about family planning as well as poor treatment of low-income clients by providers. For example, one FGD participant in Nairobi noted that: "*There was a case I went to sort out of a man beating the wife for family planning, her body had become cold so that's how the 'wazees' [men] are barriers.*"

- ***Distance to the accredited facilities and lack of support for transport posed challenges to some voucher clients:*** Voucher clients who participated in the FGDs reported that poor road infrastructure and high transport costs to accredited facilities hindered them from seeking services at contracted facilities. For example, according to one voucher client in Kiambu: *"Even if you have a voucher, the taxi charges about 3,000 shillings to hospital, you would rather pay 1,200 they charge delivery here rather than take a taxi [to accredited facility]."* The program therefore needs to explore the possibility of covering transport costs for voucher clients as is the case with similar programs in Bangladesh and Cambodia.

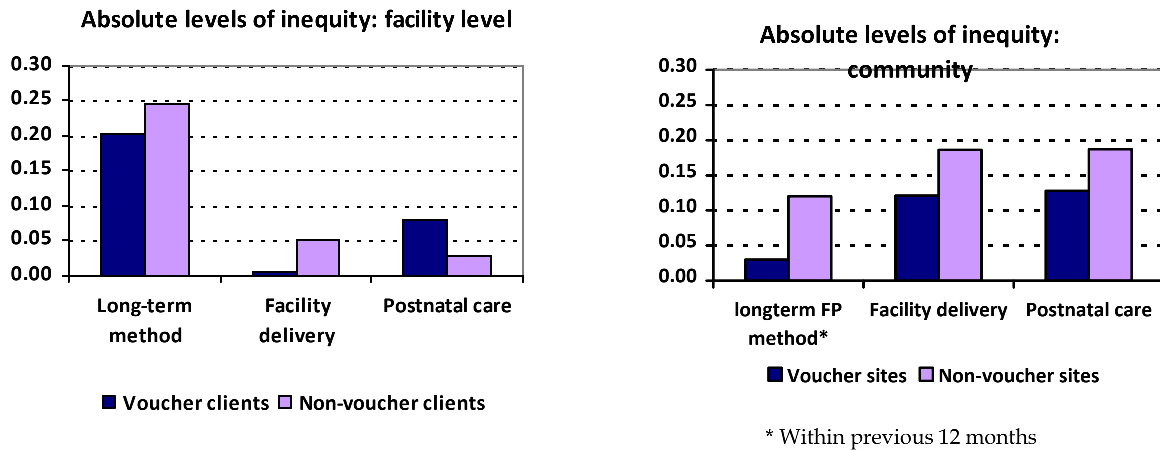
- ***Some voucher clients feared being tested for HIV:*** Some women who had bought the vouchers feared they would be tested for HIV and therefore delivered at home or with traditional birth attendants. One voucher client in Kitui noted that: *"There is this other one that when women are pregnant, they are afraid to go to the hospital because of HIV testing so some have that fear so they are afraid to go to the hospital as they will be asked to take the test. At times you find there are those women who used to assist there before, back in the community, they are now afraid of AIDS, and when a woman gets to deliver they are afraid to assist, the woman is neglected and she dies due to their fear."* Although this problem is not unique to vouchers, the program can contribute towards addressing it by enhancing the capacity of the distributors and providers to offer clients more information on the importance of HIV testing and counseling during antenatal care or delivery visit.

4.7 Equity

- ***Reduced socio-economic inequities in service utilization among voucher clients:*** The gap between poor and non-poor women regarding the use of long-term family planning methods, health facility delivery, and skilled delivery care was narrower among voucher compared to non-voucher clients based on concentration index that measures the degree of socio-economic inequities in health.

- ***Reduced socio-economic inequities in service utilization among women living near voucher facilities:*** There were lower absolute levels of inequities in the use of health facility delivery, skilled delivery care and post-natal care services among women living near facilities that have implemented the program since 2006 compared to those living near facilities that do not implement the program.

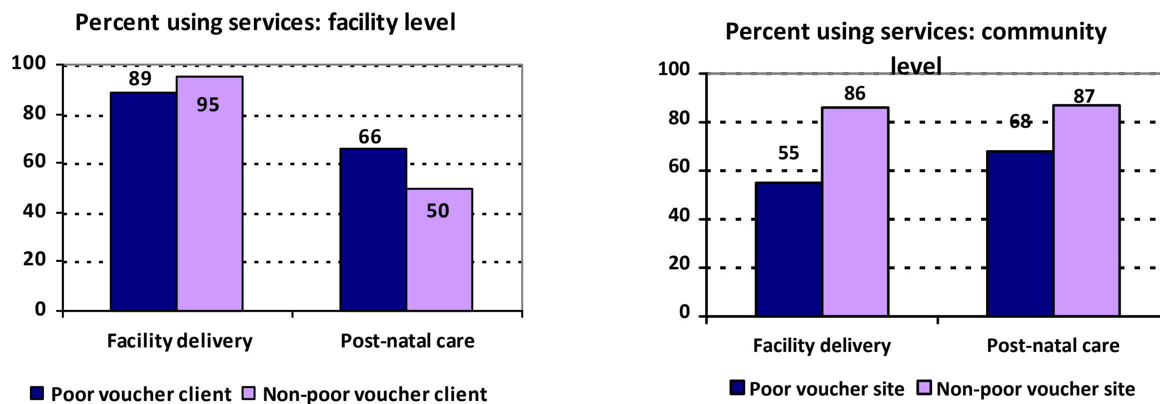
Fig 5: Inequity between women exiting health facility and women interviewed in community



* Within previous 12 months

- ***Non-poor women still more likely to use services compared to poor women:*** Despite increased utilization of services by poor women and reduced inequities between the poor and non-poor, the proportion of non-poor women delivering at a health facility or receiving skilled delivery care is still higher both at the facility and community levels. However, at the facility level, the use of post-natal care services was higher among the poor compared to non-poor voucher clients. In contrast, at the community level, the use of post-natal care services remained higher among non-poor women living near voucher facilities.

Fig 6: voucher and non voucher clients exiting health facility and in the community



4.8 Health Status and Outcomes

- ***Perceived decline in maternal deaths in the community as a result of the safe motherhood voucher:*** Community members felt that maternal deaths had declined since the voucher enabled them to deliver at a health facility under skilled care. One voucher client in Kitui noted during FGD that: *"We used to bleed a lot [when they gave birth at home] because you haven't seen a doctor and a doctor would know what medicines to give to stop the bleeding. Most of us used to bleed a lot because this person [who assisted during delivery at home] didn't have advice to give you, she's not learned, she is not a doctor, and she's just a person like you…Deaths used to be higher then than now and that's also a change."*

- ***Delay in seeking or receiving care was one of the major contributors to maternal mortality among voucher clients:*** Findings from verbal and social autopsy audits indicate that in Kitui, for instance, three of the eight maternal deaths recorded occurred to women who had the safe motherhood voucher. The three women had sought care from traditional birth attendants.

5.0 IMPLICATIONS FOR SCALE-UP

5.1 Perspectives of Community Members

Community members including voucher clients, non-voucher clients and opinion leaders felt that there was need to:

- improve the monitoring of distributors to ensure they visit all places for better coverage in remote areas;
- improve community sensitization through media campaigns and enhanced engagement with local leaders; and
- cover transport costs for pregnant women, support facilities to acquire ambulances or have taxis ready, or accredit more facilities that are readily accessible to clients.

5.2 Perspectives of Distributors, Retailers and Field Managers

The voucher distributors, retailers and field managers felt that the program could be strengthened by:

- improving community sensitization through media campaigns and increased involvement of local leaders;
- making arrangements with certain taxi drivers in areas with no ambulances, initiating mobile clinics or putting in place shelter homes for expectant mothers;

- increasing number of distributors, continuously training them, providing them with transport to enable them reach remote areas, and ensuring that there are no stock-outs; and
- Frequently and continuously training service providers on the claims and reimbursement process.

5.3 Perspectives of Service Providers

The service providers, on the other hand, suggested that the program could be strengthened through:

- putting in place feedback mechanisms between the VMA and the providers especially regarding what is reimbursed and what is not and the reasons for non-reimbursement;
- setting up regional audit offices for the VMA and frequently and continuously training providers on claims and reimbursement in order to speed up the process;
- covering transport costs for voucher clients, having an ambulance for the program in each region, making pre-arrangements with taxi drivers, or initiating mobile clinics;
- increasing the number of distributors especially in remote areas, continuously training them, and ensuring that the vouchers are available at all times;
- providing promotional materials such as posters and T-shirts and providing information to other government ministries so that they can also assist in marketing the vouchers;
- lowering and controlling the prices of the vouchers as well as improving the identification and vetting criteria for voucher clients; and
- ensuring that facilities are well-equipped to provide services to voucher clients in order to avoid instances of referral.

6.0 KEY LESSONS AND RECOMMENDATIONS

6.1 Key Lessons

Program area	Successes	Challenges
Program management	▪ Use of strategic approaches (various committees) to ensure accountability in program management ▪ Use of poverty grading tool and visits to ensure appropriate targeting of clients and minimize fraud	▪ Improving communication flow among different partners ▪ Improving awareness about the vouchers and the distribution system especially in remote areas ▪ Monitoring and controlling fraud in voucher sales and claims ▪ Improving the claims and reimbursement process
Program outcomes	▪ Improved services in some facilities due to capital investment ▪ Increased utilization of reproductive health services by poor women ▪ Improved knowledge of dangers during pregnancy and child birth among voucher clients ▪ Reduced out-of-pocket expenses for voucher clients ▪ Improved satisfaction with services received by most voucher clients ▪ Reduced inequities in health service utilization between poor and non-poor women	▪ Increasing awareness about and uptake of family planning and gender-based violence recovery vouchers ▪ Improving quality of care through constant monitoring and training of providers ▪ Ensuring that accredited facilities are accessible to voucher clients especially in remote settings ▪ Managing referrals for pregnant women requiring emergency obstetric care ▪ Bridging the persistent gap in health service utilization between poor and non-poor women

6.2 Recommendations

The challenges that the program faces suggest the need for:

- a system of continuous flow of information among partners;
- improved sensitization of vouchers including enhanced community engagement;
- improved distribution system including vetting and verification;
- building the capacity of service providers in claims and reimbursement process and technical skills;
- ensuring a continuous monitoring of quality of care; and
- appropriate measures to address distance and transport issues.