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March 2014

MNCH Donor Review: Germany
Analysis of MNCH aid Policies in Kenya

Summary

Of all the public health indicators, maternal mortality shows the biggest disparity between the rich and poor worldwide. In 2008, 358,000 women throughout the world died as a result of pregnancy or childbirth complications. Of these maternal deaths, 99% occurred in developing countries, while 60% alone were in sub-Saharan Africa. Kenya is one Sub-Saharan country facing a high maternal mortality rate, with a maternal death risk of 1 in 38 (Armstrong 2012). To address this problem, the German Development Cooperation (GDC) and the Kreditanstalt für Wiederaufbau (KfW), a German government-owned development bank built on prior efforts of the German Society for International Cooperation (GIZ) with an aim to increase the access of Kenya's poorest women to reproductive health care through the provision of prepaid vouchers that entitle them to a range of basic services.

Introduction

"Out of pocket" expenses are the single biggest source of funding for Kenya's health care system, accounting for about 36% of the health budget. Not only is care at public health facilities relatively costly, the care offered at these facilities is often of a low quality also offer poor quality of services. Health centers frequently ask women to bring their own rubber gloves, cotton wool, pads and other supplies for giving birth. Patients often have to turn to local pharmacies for drugs, because public facilities are out of stock. Health facilities also face serious shortage in skilled personnel.

Previously, health spending had been dominated by prevention and management of HIV-AIDS, which overshadowed other health issues. This, coupled with the fact that

childbearing is seen as a normal process, has resulted in reproductive services being neglected by the health industry. However, in 2007 Kenya's Ministry of Health formally adopted the country's first National Reproductive Health Policy. Thus, reproductive health, previously a low priority in government spending on health. has recently received great attention.

Kenya's Ministry of Health sought increase the access of Kenya's poorest women to reproductive health care services by collaborating with the German government. The voucher scheme was launched with a budget of 6.58 million Euros from KfW for the first three year phase. It entered phase II in November 2008 with another 10.5 million Euros from KfW, and 9 million KSh (EUR 80,520) from the Kenyan Ministry of Health, which has allocated a further 54 million KSh (EUR 483,110) from its budget for phase III, starting November 2011 (Armstrong 2012).

Approaches and Results

Voucher Program

- The voucher program is part of "output-based aid" approach (OBA), a "demand-side" approach to health financing. Women below a certain poverty threshold are sold vouchers at heavily subsidized rates that entitle them to go health facilities for specific services. In the traditional "supply-side" approach, funds are invested in building and maintaining hospitals, which often fail to serve all patients that require medical attention. By stimulating the demand side of health financing, the voucher programme invests in the client rather than the facility.
- This scheme puts more power in the hands of the woman by allowing her the choice of health facility and the option to change providers should she be unsatisfied with the services. Moreover, this approach introduces competition between facilities, which gives them an incentive to improve quality in order to attract clients.

Organization

- The program is run by the Ministry of Health through the National Coordinating Agency for Population and Development (NCAPD).
- Operation of the program was carried out by two committees. The first committee was the advisory board in oversight role with members drawn from NGOs, the MoH, the GIZ, and other private organizations and associations. The second committee was the OBA Steering Committee comprising representatives from NCAPD, MoH Department of Reproductive Health (DRH), KfW and the technical team.
- The implementation process was managed by the voucher management agency (VMA) - a consortium of PricewaterhouseCoopers (PwC) and Population Council. The VMA makes arrangements to market and distribute sale of vouchers through local distributors and commissioned agents who received 25% commission per voucher. Each project site has a field manager employed by the VMA whose job is to supervise and support a team of about 20 voucher distributors.
    - When recruiting clients, distributors use a questionnaire originally designed as a poverty identification tool by Marie Stopes International, which takes into account the type of housing, rent or land ownership, number of children in the family, what kind of fuel the family uses, where they get their water from, access to sanitation, how often they eat, and family income as the key indicators of a woman's socio-economic status.
- Voucher service providers (VSP) are health facilities accredited by the VMA to have met a minimum standard of care, including infrastructure, staffing, equipment and supplies.
- Reimbursement for services is processed when health facilities submit to the VMA a detailed invoice along with the voucher handed over by the client.

Example: If she falls in the target community, woman A pays $10 for a voucher for a service that is worth $90. She goes to facility B for service. Facility B provides the VMA with completed service form, discharge summary, copy of patient A's identification card, and original voucher to receive $90 in reimbursement.

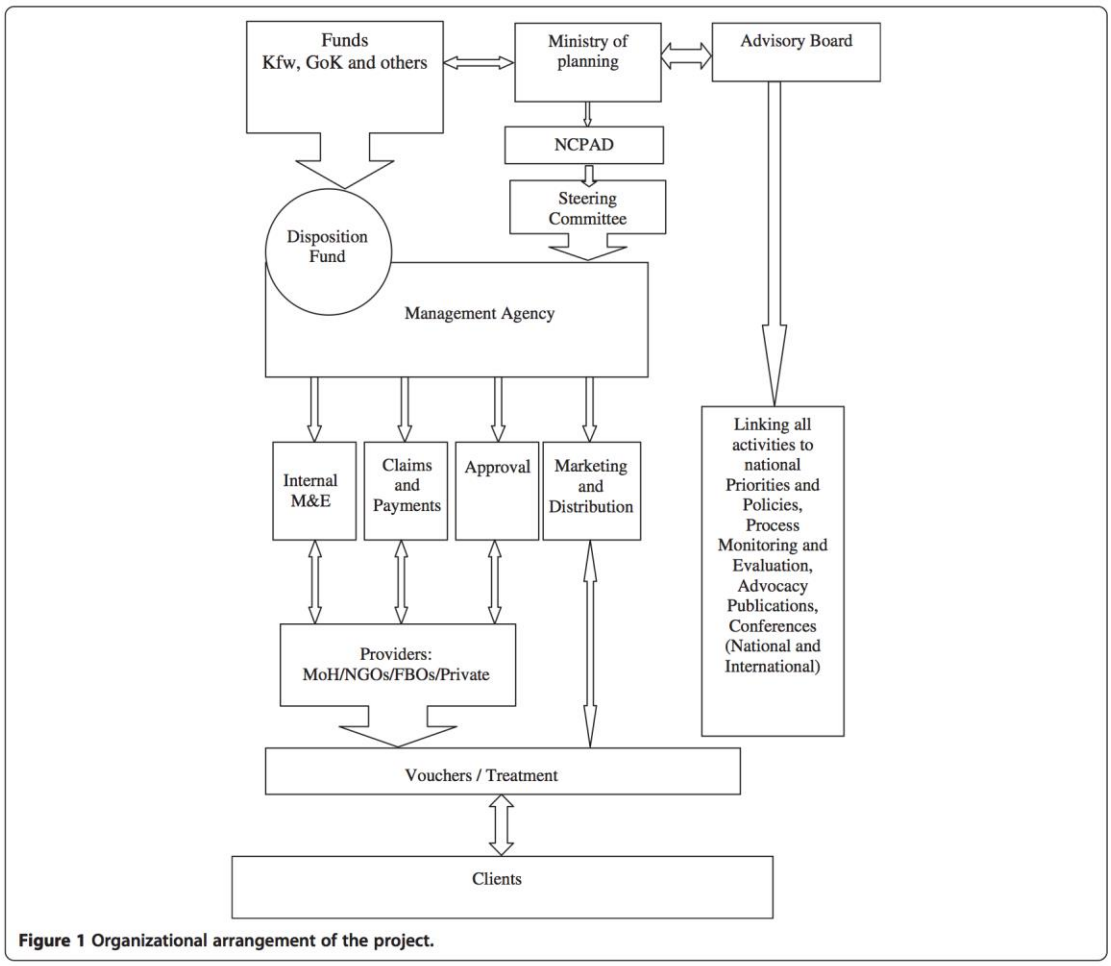

Figure 1 Organizational arrangement of the project.

Options

Kenya's voucher programme currently operates in six sites countrywide and covers a population of approximately 400,000 women. It provides three services: maternity care, family planning and care for survivors of gender-based violence.

1. *Kadi ya uzaaji* ("safe motherhood voucher") costs 200 KSh (approximately EUR 1.80). This entitles the client to antenatal care (a maximum of 4 clinic appointments); institutional delivery of her baby with treatment for complications and Caesarean section if required; and postpartum care up to 6 weeks.
2. *Kadi ya jamii* is for family planning and costs 100 KSh. It covers a single long-

term family planning method: a) insertion of an inter-uterine contraceptive device or a contraceptive implant; b) bilateral tubal ligation (sterilisation) for a woman; or c) a vasectomy for her partner.

3. *Kadi ya salama* is for care of survivors of gender based violence. This voucher is free of charge, and covers examination and all necessary tests, as well as psychosocial treatment for people who have suffered sexual violence.

Results

- It is difficult to assess the impact the program might have had on maternal and neonatal mortality due to the limited number of projects, but there is strong evidence that the voucher scheme has been effective at reaching poor women and has increased their access to reproductive health services
- Safe motherhood:
    - In its first eighteen months, sales of vouchers for safe motherhood for all sites together were double what had been projected in the original plans. In Nairobi, voucher sales were more than three times the targeted figure.
    - There is a 57% overall increase in professionally assisted births (among both voucher and non-voucher clients. In March 2011, 47% of the vouchers sold thus far had been used for antenatal care and 59% for professionally attended childbirth (Armstrong 2012).
    - Nevertheless, access varies among urban and rural districts, hinting at other complex factors influencing access.
- Family planning:
    - By May 2009, only 48% of the 25,746 vouchers sold up to November 2008 had been used. Possible reasons include inadequate counseling of clients by service providers, stock-outs of supplies, and long queues at some family planning outlets, as well as stigma about contraceptive use (Armstrong 2012).
    - From October 2010 to March 2011, however, the use of vouchers increased, reaching more than 1000 clients a month.

Analysis and limitations

- Voucher distribution was reliant on commissioned agents who received 25% commission per voucher. This approach was not well executed leading to malpractices such as disregarding adherence to the poverty grading tool, selling to women outside the target community or avoiding sparsely populated rural areas.
    - In response, full-time trained distributors were hired on a monthly stipend (Abuya 2012).
- The program allowed for a reimbursement procedure that could process claims within 30 days through a computer system. However, the process was slow and cumbersome and did not account to actual payments made. This was a sum of delays within the voucher management system, violation from facilities treating clients for conditions not included in the claim package, and submission of incomplete or falsified documentation. Moreover, bureaucratic barriers in the public health system meant that most public health facilities could not benefit from the proceeds of voucher clients.
    - Upon consultation with the Ministry of Health, it was agreed that money generated from the OBA would be used by the public service providers to improve care such as purchase of supplies, laboratory consumables, improve sanitary conditions, and hiring of staff on a temporary basis (Abuya 2012).
- The VMA managed to regularly monitor the claims and delinked voucher distribution from voucher service providers to avoid situations where claims were filed for ghost clients. In cases where distributors sold vouchers at higher prices, the VMA responded by putting up posters on the prices of vouchers on market days.

Discussion

A number of lessons can be taken from the implementation of the voucher programme in three areas: strategic management, implementation process and design elements.

- Lessons in strategic management are identified as follows:

    - Firstly, the use of an advisory board and a steering committee can help to institutionalize accountability, generate checks and balances, and allow adaptation of program elements to local settings to improve implementation (Abuya 2012).
    - Secondly, the program will be strengthened by further development of systems that are insulated from the routine turnover of key leaders. As evident in the program, the NCAPD team leader was part of the steering committee in the first phase, while the second phase was headed by the Director of Public Health and Sanitation. Already this institutionalization is underway with the development of a program management unit within the Ministry of Health (Abuya 2012).
    - Thirdly, strategic partnership between the private and public sector when well managed can help improve public health goods as was demonstrated by the involvement of PricewaterhouseCoopers and the VMA (Armstrong 2012).
- Lessons in implementation process:
    - Detailed planning beforehand and use of feedback mechanisms can allow for adjustment during the program.
    - Good planning can allow adequate time to account for unexpected challenges and mechanisms to counter such situations through effective management strategies (Abuya 2012).
- Lessons in design elements:
    - Effective communication with voucher service providers is crucial. For an effective system, an operational management information system ought to be considered to improve the voucher tracking system from point of service through claims review and reimbursement, as well as allow for flexible addition of new information technology modules. This would help improve payment speed and reduce fraud and error (Abuya 2012).
    - Policymakers should give the facility-level managers greater discretion on use of these reimbursement funds to improve quality of care for reproductive health services or share across the facility.

Abuya et al. *A Policy Analysis of the implementation of a Reproductive Health Vouchers Program in Kenya*. BMC Public Health 2012 12:540. http://www.biomedcentral.com/1471-2458/12/540

Armstrong, Sue. 2012. *Voucher: Making Motherhood Safer for Kenya's Poorest Women.* In the German Health Practice Collection. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. Accessed November 18, 2013. http://www.bmz.de/en/healthportal/good-practices/GHPC/Vouchers-MDG5/index.jsp