

OBA Lessons Learned Series is a forum for discussing and disseminating project insights at the conclusion of projects in supporting the delivery of basic services to the poor. GPOBA is a partnership established in 2003 by the UK (DFID) and the World Bank. Its other donors are the International Finance Corporation (IFC), the Netherlands (DGIS), Australia (AusAID), and Sweden (Sida). For more information visit www.gpoba.org or email us at gpoba@worldbank.org.

LESSONS LEARNED



Uganda Reproductive Health Voucher Scheme

In September 2008, the Global Partnership on Output-Based Aid (GPOBA) launched an output-based aid (OBA) voucher scheme to bring maternal and other reproductive health services to rural communities in Western Uganda. The project set out to deliver 50,456 safe deliveries and 35,000 sexually transmitted disease (STD) treatments. WHO guidelines and their national adaptations for safe deliveries and the management of STDs were used to define the list of approved medications and services that would be reimbursable under the scheme.

About 20 districts in Western Uganda participated in this pilot to help target communities gain access to reproductive health services through the OBA voucher scheme.

DEVELOPMENT CHALLENGE

A 2006 study found that about 435 women die per 100,000 live births in Uganda because of lack of access to health service facilities and professional health care.

Some key facts:

- Just 36 percent of pregnant women give birth at health facilities.
- About 42 percent of all deliveries are attended by skilled professionals.
- Most women still rely on Traditional Birth Attendants with little or no formal training.
- Some expectant mothers have to walk over nine miles to the nearest health facility.
- Uganda's decentralized health system has left rural areas poorly resourced.

OBA APPROACH

OBA links the payment of aid to the delivery of specific "outputs"—in this case a "safe delivery" (SD) package of four prenatal visits, a delivery attended by a trained medical professional, and one post-natal visit or screen and treatment for STDs. Service users paid 3,000 shillings, about US\$1.20, per voucher for services costing from 60,000 shillings (US\$24) to 200,000 shillings (US\$78). Service delivery was contracted out to local clinics that were accredited by Marie Stopes International-Uganda (MSI-U) to

offer services to patients in exchange for pre-paid vouchers.

Service providers then submitted claims for reimbursement to MSI-U, once approved services had been delivered to patients. This arrangement was first tested in Uganda by the German Development Bank (KfW) for patients with STDs.

As is typical in OBA schemes, explicit targeting by income or geography ensured that subsidy payments helped those who needed it most—the poor—and independent verification ensured that funds were paid to service providers only after the pre-agreed services or outputs had been delivered.

RESULTS ACHIEVED

By December 2011, when the project closed, more than **136,000 people** had been independently verified as having received a range of reproductive health services, including:

- **49,348 SD packages** (98 percent of target) and
- **31,658 STD treatments** (90 percent of target), through the OBA project.

This note captures some of the key lessons learned from the implementation of the OBA voucher scheme.



Project Partners

GPOBA

Approved a grant of US\$4.3 million to subsidize the cost of services related to safe childbirth and the treatment of STDs.

KfW

Acted as the fiduciary agent for the GPOBA scheme and on behalf of the Ministry of Health (MoH), managing the Independent Verification Agent and the Voucher Management Agency (VMA).

MOH

Acted on behalf of the Government of Uganda (GoU) to engage with project partners and to ensure that the project was consistent with national health sector priorities.

MSI-U

Sub-contracted by MoH to act as the VMA, with responsibility for identifying and accrediting service providers and processing claims for reimbursement.

questioned by the target beneficiaries, fueled by word-of-mouth misinformation. The disruption highlighted a need to plan for and maintain project continuity in the event of unexpected disruptions.

5 An innovative marketing approach mitigated the impact of unexpected disruptions on project outcomes: The election-related disruption led to a three-month extension of the voucher redemption period toward the end of the project. An additional 15,000 vouchers had to be sold to meet the project's original goals. Faced with a challenge to truncate the time-to-market for vouchers, MSI-U used a four-part approach: 1) target areas with the highest population, 2) prioritize providers, 3) segment areas by Comprehensive Emergency Obstetric Care—the rationale being the perceived need to refer emergency cases on a timely basis, and 4) engage the most active distributors in the goal to move the 15,000 vouchers. The result of this targeting effort was a total of 14,200 vouchers sold in a period of three weeks.

6 Financial integrity along with user and service provider satisfaction were key to achieving project outcomes: The scheme helped providers make major improvements in knowledge, clinical practice and quality of care, as well as achieve increased revenues. A 2010 user satisfaction survey conducted by the Population Council found that 94 percent of voucher users (when asked) said they were satisfied with the quality of health care services, compared with 76 percent of patients who did not use vouchers. The project's success resulted in the GoU committing additional funds of US\$3 million to support the development of new voucher projects.

The project was led by Peter Okwero, a Senior Health Specialist in the World Bank's Africa region and Leslie Villegas, an Infrastructure Specialist with GPOBA.

Lessons Learned

- 1 The project built on proven experiences by using lessons from a successful precedent:** In 2006, KfW launched an OBA pilot in Uganda which financed the diagnosis and treatment of STDs. GPOBA's pilot built on the success of KfW's experience which had already proved that a voucher approach improved marketability, simplified targeting of sales to the poor, minimized the administrative burden for service providers, and controlled overall project costs.
- 2 A community-based PPP model helped with awareness-building, service provider selection and voucher sales:** Voucher Community-Based Distributors (VCBDs), essentially healthcare educators travelling from village-to-village explaining the benefits of using a clinic for delivery or to access STD treatments, proved to be an essential tool for the project's success. Using their local knowledge and the oral tradition of the villages they visited, VCBDs raised awareness of the scheme and generated strong community participation. An extensive mapping exercise was carried out 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 required for effective participation in the scheme and targeted service providers whose catchments included poor groups, especially those in rural areas and high-risk groups. Vouchers were made easily accessible through a distribution network of vendors and local retail outlets located in close proximity to target populations. In addition, a communications campaign used existing community groups to also raise awareness about the scheme and promote the use of skilled medical attendance for child birth.
- 3 Mobile phone technology made project communications and data management more efficient:** The project successfully tested and proved that critical project transactions can be sped up and errors reduced by using text messaging (SMS). The trial found that using SMS to manage claims from service providers enhanced productivity and efficiency, including saving some providers up to 3.5 hours of travel time to submit paper claims to a central location; reducing manual input of claims data; and improving data collection by providing automated archiving of claims information.
- 4 Unexpected disruptions threatened the project's continuity, marketing and beneficiary engagement:** Campaigns for Uganda's national elections began in October 2010 and immediately depleted personnel resources—specifically the VCBDs and the community leaders who supported them. As a result, voucher sales plummeted and the awareness of project services and benefits began to be