



**HEALTH  
POLICY  
PROJECT**

# Targeting FP/RH Services to the Poor through Output-Based Aid

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Improving Financial Access to Health Services for the Poor  
Calabar, Nigeria, November 2011



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# Kenya is still far from reaching MDG5

- Maternal and neonatal health indicators
  - Maternal mortality ratio: 488/100,000
  - Neonatal mortality ratio: 31/1000
  - Newborn deaths: 24% of deaths of children under age 5
- High unmet need for family planning (26%)
  - 13% for spacing
  - 13% for limiting
- The poor have worse indicators

# RH Output-Based Aid (OBA)— A solution to reverse the trend

- Concentrate RH financial resources on the poor women who need them the most and would otherwise not have access to them
  - **Safe motherhood:** antenatal care, delivery—caesarean, normal + complications
  - **Family planning:** Surgical contraception, implants, IUCD + complications
  - **GBV:** Defilement, rape, domestic violence

# Use Poverty Grading Criteria to Target Services

## Indicators

- Housing
- Cooking fuel
- Daily income
- Meals per day
- Garbage disposal
- Asset ownership
- Access to health services
- Water sources



Photo by Open Cage

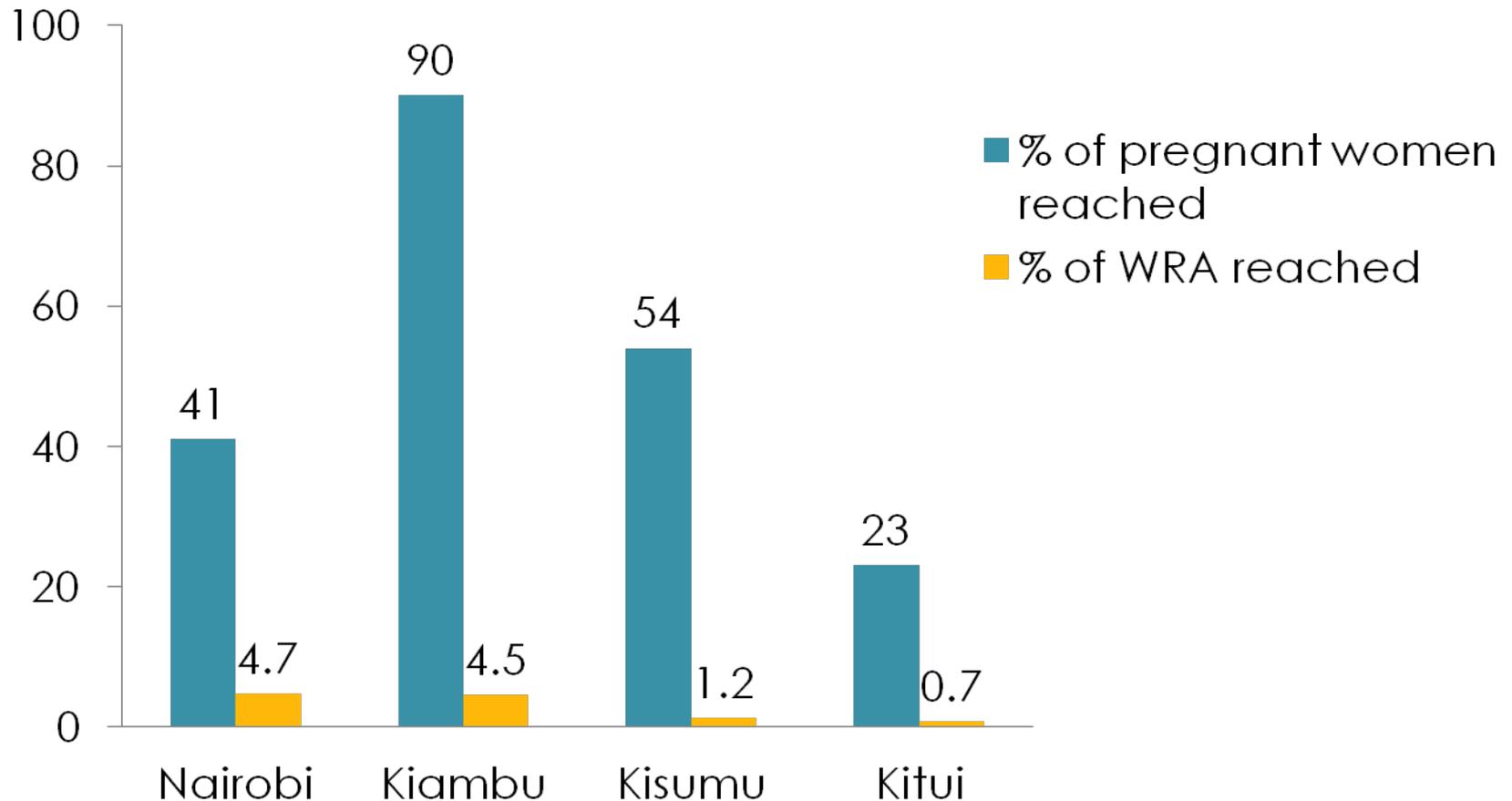
# How the Scheme Works

- Targets poor women (lower 2 quintiles) in 5 districts
- Subsidizes vouchers to clients (\$1–\$2)
- Defines benefits package (\$10–\$350)
- Gives clients opportunity to choose service providers
- Has the following design
  - Financing: German (90%) and Kenya (10%)
  - Steering committee and advisory board
  - Voucher management agency (VMA)–design, marketing, accreditation, monitoring and evaluation
  - Reimbursements based on output and quality

# Phase I Project Outcomes and Outputs

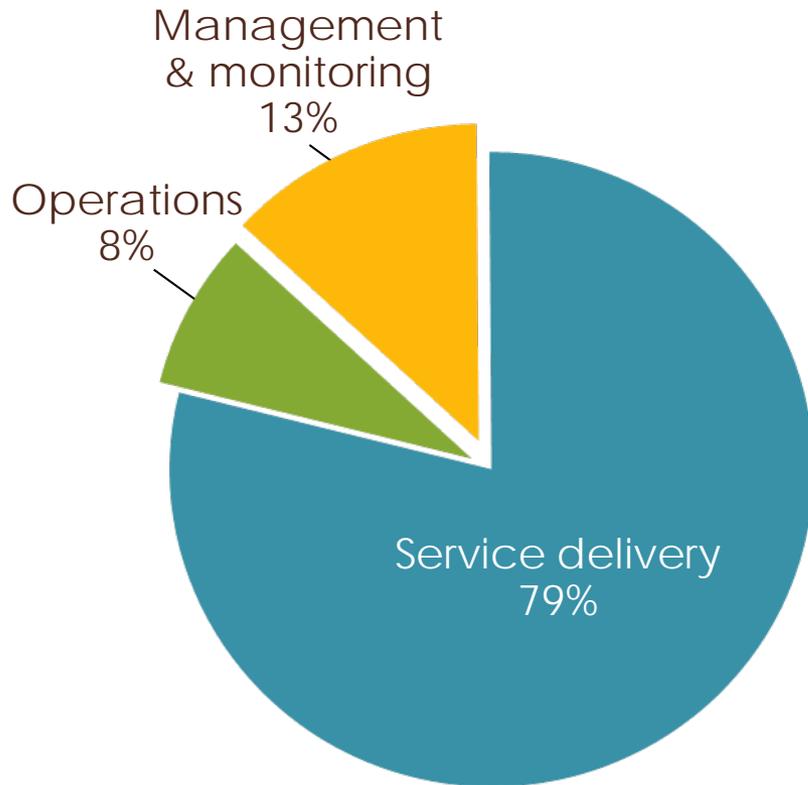
- High acceptance of safe motherhood vouchers—112%
  - High promotion, vouchers purchased as an insurance against high cost of complications
- Disappointing acceptance of FP vouchers (12%)
  - Lack of short-term methods, poor promotion, stockouts of FP methods, unrealistic targets
- Low uptake of GBV services (0%)
  - Social and cultural factors, less community involvement and awareness, unrealistic targets

# Percentage of the Poor Reached

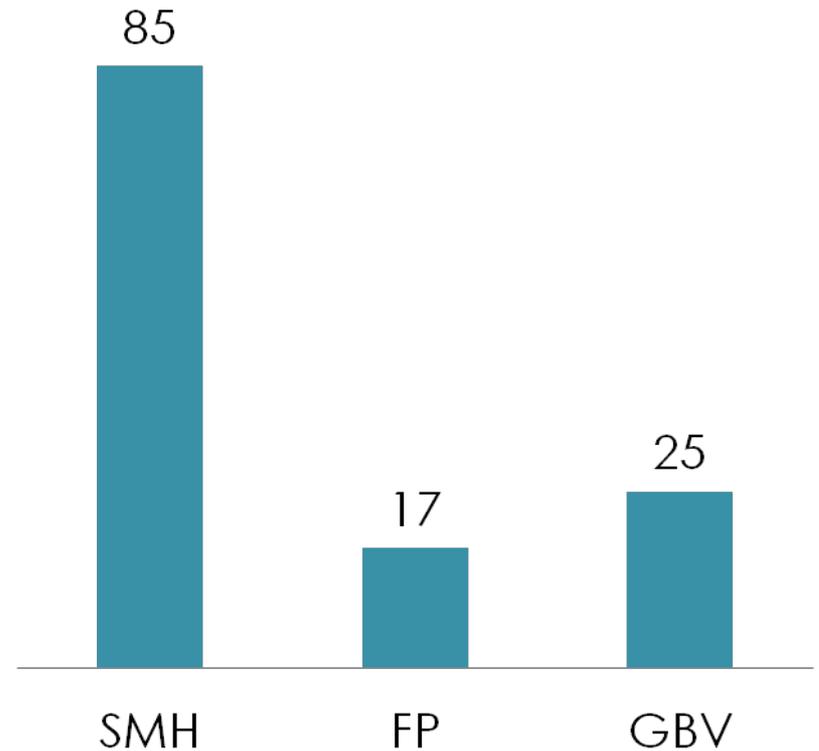


# Overall Cost Analysis

## Expenditures



## Unit Costs in Euros (€)



# Key Points

## OBA

- Provides financing based on outputs
- Has high potential to reduce neonatal and maternal mortality
- Encourages service providers to invest in services, which the community feels are a priority
- Encourages provision of high-quality services
  - Providers who offer low-quality services lose clients
- Promotes successful public private partnership

# Challenges

- Fraud
  - Collusion between providers and clients
- Client identification
  - Sale of vouchers to the better-off
- Tool effectiveness—domestication
- Low uptake of long-term FP methods and GBV services
- Weak institutional structures—ministry, VMA
- Pricing or compensation—not based on sound costing

# Lessons learned

- Cost prevents the poor from accessing RH services
- Vouchers give the poor improved choices
- Competition improves quality of services
- Fraud and abuse need close and continuous supervision
- Efficiency in claims processing maintains the trust and confidence of service providers
- Voucher scheme works better in urban areas

# Relevance for Nigeria

- Shift toward demand-side financing
- Revamping of the national social health insurance—targeting, reimbursements, claim processing, accreditation
- Performance incentives as a health system strengthening strategy
  - Provide wider outreach
  - Conduct costing to improve reimbursements
  - Involve all service providers
  - Target specifically to rural areas
  - Create phase-out plan to submit to the government
  - Reduce high household out-of-pocket expenses (69%–50%)

# Summary



OBA has great potential to improve access to and uptake of RH services by economically disadvantaged groups of the population, helping to achieve MDG5



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# Thank You!

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