**PSI Somaliland- Safe Motherhood voucher program-*****Badbaadada Hooyada***

**Country:** Somaliland

**Health Area**: Safe motherhood (antenatal care and health facility delivery)

**Name of Incentive Scheme**: *Badbaadada Hooyada-* Safe Motherhood

**Target group**: Pregnant women of reproductive age

**Type of Incentive**: Demand-side financial incentive

**Situation Analysis**: The voucher program started in June 2010 in one region of Somaliland. The vouchers are distributed by Interpersonal Communication (IPC) agents to pregnant women who attend IPC sessions.

* **What behavior is the incentive meant to promote?** Increase utilization of antenatal care (ANC) and health facility delivery services among pregnant women who have attended IPC sessions
* **What problem, or barrier, is the incentive designed to address?**  The cost of four or more ANC visits and facility delivery is too expensive for low income women of reproductive aged (WRA)
* **Which of the 4Ps in the marketing plan are you addressing?** Price

**Vision of Success:**

Low income pregnant women can have access to affordable health facility services to receive appropriate advice and care for a healthy pregnancy, child birth and postnatal recovery.

**Description & Details of the Incentive Scheme**:

Antenatal visits:

* Pregnant women who attend the IPC sessions receive a voucher for a value of 1000 SLSH ($0.15) for an ANC visit at the selected health facilities. A woman will receive a total of 4 vouchers if she attends all 3 IPC sessions for a maximum of 4000 SLSH, which cover 50% of the total price at health facility.

Laboratory fees for ANC exam:

* Pregnant women who attend the IPC sessions receive one voucher for a value of 6000 SLSH ($0.9) to help cover the full cost for either urinalysis or hemoglobin test- the 2 basic laboratory tests recommended for ANC exams.

Delivery fees:

* Pregnant women who attend the IPC sessions receive a voucher for a value of 40,000 SLSH ($6) for delivery services, which cover 40% of the total price at health facility.

A pregnant woman that attends IPC sessions can receive all the above mentioned vouchers, depending on her stage of pregnancy.

Women must present a voucher to the selected health facility to receive this discount. The health facility will then collect the used voucher after providing the service and provide these vouchers to PSI for a reimbursement on a monthly basis. No reimbursement is made without a voucher.

* **What type of incentive is it?**  Financial incentive.
* **Do you use mhealth as part of the intervention?** No
* **What are your indicators?** 
  + # of women who have used ANC, laboratory and delivery vouchers

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| * **Administration:** |
| 1. **How often do you reimburse the individual receiving the incentive? How do you reimburse them?**   Clients are not reimbursed – rather, they pay a reduced fee when they receive the service (a percentage of the full cost of the service is covered by the voucher, depending on the type of services received). The selected health facilities are then reimbursed monthly by presenting the used vouchers to PSI. |
| 1. **How do you implement tracking and reimbursing incentive programs?**   After providing the service to the women, the health facility provider ensures that the women has both the IPC booklet signed by the IPC agent (as a method of checking that she has attended the IPC sessions) and the voucher (which contains the details on the specific service to be rendered).  PSI IPC agents collect and verify vouchers from the health facility at the end of each month and fill out the voucher reimbursement form.  The voucher reimbursement form and the used vouchers are then forwarded to the finance department to facilitate voucher reimbursements to the health facility. The providers are reimbursed using wire transfer check. |

1. **How do you track your incentive program?**

PSI IPC agents are responsible forverification of vouchers and forwarding the voucher reimbursement form to the PSI/Somaliland office. They do this by cross-checking voucher details collected from the health facility with the IPC voucher booklet. Additionally, community health promoters assigned to the IPC agents conduct random follow up visits and cross check if the women have used the service. This mechanism is not systematic.

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| **Unintended Consequences:** |
| 1. **Have you seen any unintended consequences from your incentive program?** No. 2. **Is your incentive program sustainable beyond the life of the project?** No, but it is expected that interpersonal communication interventions contribute to create sustainable life-saving behaviors, even without the use of the voucher. |
| **Platform Relevance:** |
| 1. **Do you have a system in place to receive feedback on the incentive program?** Nothing formal and systematic has been set-up to receive feedback on the incentive program. There are, however, some informal opportunities for clients to provide feedback during the follow up interviews conducted by IPC agents and/or follow up visits done by community health promoters at community level. |
| **Comprehensive Incentive Programs:** |
| 1. **Does your program look at both demand and supply side incentives? If so, how?** The voucher program addresses only the demand side and incentives women to access health facility services because they are affordable. 2. **If providing demand side incentives only, will facilities or shops be able to meet increased demand with quality services?** Health facilities are not supported directly by PSI and therefore this is not monitored and quality of services cannot be ensured. |
| 1. **If not, have you explored a supply side incentive aimed at improved adherence to quality standards? Does intervention target provider behavior change? Should it?** As the selected health facilities are not supported directly by PSI, this was not explored. |

* **Designing & Setting up the Incentive:**

The Safe Motherhood voucher program was designed as a mechanism to address the problem of *price* of ANC and delivery services at the selected health facilities where services were not provided for free. The Ministry of Health (MOH) and Regional Health Office (RHO) of Awdal region were closely involved during the design of the program.

* **Successes:**

From June 2010 to January 2013, 4,395 ANC, 772 delivery, and 656 laboratory vouchers have been used by WRA.

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| **Voucher Type** | **# Distributed to WRAs** | **# Submitted to facilities** | **% Vouchers submitted** |
| **ANC** | * + 4,459 | * + 4,395 | * + **98%** |
| **Delivery** | * + **783** | * + **772** | * + **98%** |
| **Laboratory** | * + **656** | * + **656** | * + **100%** |

* **Challenges:**

*Have vouchers been distributed only to low-income women?* It is difficult to know if the vouchers have been distributed only to low-income WRA. Because the safe motherhood program is implemented in low-income neighborhoods, it is assumed that most of the women attending the IPC sessions are low income. However, there is no mechanism in place to collect any documentation on the income status of the women who receive vouchers, nor do the community health promoters have means for identifying the income status of the women.

*Impact evaluation:* Health facility data (% of facility delivery, % of 2 or more ANC visits) was not recorded prior to the onset of the program to monitor the impact of the voucher program in increasing the percentage of health facility delivery and ANC coverage. The challenge in collecting this information was related to the lack of reliable data at health facility level at the beginning of the program.

*Distribution of vouchers-*At the beginning of the program, vouchers were distributed during the IPC sessions to all pregnant mothers; however, it was very common that women could not find the vouchers received during the IPC sessions when they needed the services. PSI then decided to change the distribution policy by giving the vouchers directly to the women when the service was rendered. This was possible as IPC sessions are conducted near the selected health facilities and therefore women or the health provider would call directly the IPC agent or community health promoter in order to receive the voucher.

1. **Recommendations & Lessons learned:**

*Verification of voucher clients.* It is important to establish systematic mechanisms to ensure that women are truly receiving the health services and therefore minimize fraud. This could have been done by conducting random phone calls to clients to confirm that the client did use the voucher and received the service. Moreover, systematic data collection during follow up visits and interviews both by community health promoters and IPC agents could have been in place.

*Performance indicators:* When the impact of the program in increasing utilization of services is difficult to measure, we recommend setting performance indicators at the beginning of the program that can be measured throughout the intervention (i.e. cost effectiveness, productivity of IPC agents for example).

*Understand key barriers to access to health services***:** It is important to understand if financial barriers are the key bottleneck to health facility delivery and ANC visits prior the launch of the program. In January 2013, a small survey done among women who have used the voucher highlighted that all participants said that the voucher subsidy was not the motivation for attending health facility, that price had not been a barrier, and that they hadn't known about the vouchers prior to the IPC session. This preliminary data suggests that the IPC session and information itself might be a greater driver than the voucher system. Formative research at the design phase of the program could have generated insight on how to better design the voucher program.

*Identify the target:* The vouchers were distributed to all women regardless of social economic status as it was assumed that all women attending IPC session are low income. It is important to find suitable ways and tools to identify women of low income status. This must be carefully designed and implemented in order to avoid any unintended impact within the community.

*Implementation:* The voucher program was feasible to implement. Although it was a paper-based voucher system, the collection, submission and claim of vouchers from health facilities was smooth. Nonetheless, it would be worthy to consider technology to simplify the process.

**Next Steps:**

The voucher program will be stopped as services are now provided for free at the selected health facilities through the support of an international NGO.

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