USAID | INDIA
FROM THE AMERICAN PEOPLE

SAMBHAV: Vouchers Make High-Quality Reproductive Health Services Possible for India's Poor

The Power of Innovations and Partnership

MARCH 2012

This publication was prepared for review by the United States Agency for International Development. It was prepared by Futures Group International.

Photo credits: Jignesh Patel, Gaurang Anand and Satvir Malhotra

Suggested citation: IFPS Technical Assistance Project (ITAP). 2012. *Sambhav: Vouchers Make High-Quality Reproductive Health Services Possible for India's Poor*. Gurgaon, Haryana: Futures Group, ITAP.

The IFPS Technical Assistance Project is funded by the United States Agency for International Development (USAID) under Contract No. GPO-I-01-04-00001500, beginning April 1, 2005. The project is implemented by Futures Group in India, in partnership with Bearing Point, Sibley International, Johns Hopkins University, and QED.

For further information, contact: Futures Group International, DLF Building No. 10 B, 5th Floor, DLF Cyber City, Phase II, Gurgaon- 122 002
www.futuresgroup.com

SAMBHAV: Vouchers Make High-quality Reproductive Health Services Possible for India's Poor

END OF PROJECT SYMPOSIUM

The Power of Innovations and Partnership

MARCH 2012

USAID | INDIA
FROM THE AMERICAN PEOPLE

FOREWORD

The Government of India (GoI) is committed to the achievement of the Millennium Development Goals, with a specific focus on reducing the total fertility rate, infant mortality rate, and maternal mortality rate. Improving access to family planning (FP) and reproductive health (RH) programs is necessary both for achieving these goals and the development of the nation.

Reaching the poor and the most vulnerable populations requires improving access to FP/RH services, addressing sociocultural norms regarding FP/RH services, and removing financial constraints to accessing services. Although government subsidies are intended to promote health amongst the vulnerable populations, these populations often are not able to take advantage of these subsidies.

Involving the private sector to improve access to and quality of services has proved to be effective, because even the poor often rely on the private sector in India. Thus, more affordable private services could hold the key to improved access to service.

Voucher schemes, generally operated as public-private partnerships (PPPs), or collaborative efforts between the public and private sectors, have had positive effects on health service utilization in many developing countries. Four voucher programs, called Sambhav, were implemented from 2006-2012 as part of the Innovations in Family Planning Services (IFPS) Project, a bilateral project of the GoI and the United States Agency for International Development (USAID), to expand access to FP/RH services to below poverty line (BPL) beneficiaries in selected districts of Uttar Pradesh, Uttarakhand, and Jharkhand.

The results have been encouraging, as the Sambhav voucher pilot programs facilitated delivery in private health facilities of nearly 12,500 infants, supported approximately 44,000 antenatal care visits and 10,300 postnatal care visits. Women and men also used approximately 9,500 vouchers to avail a range of FP methods. This positive response augurs well for pro-poor health policies and programs in developing countries.

I would like to take this opportunity to congratulate the IFPS Technical Assistance Project team and state government, private, and NGO partners for supporting successful implementation of the voucher pilot programs.

USAID hopes that models such as the Sambhav voucher schemes will serve as prototypes in the future to engage the private sector, ensure equity and accountability to those accessing services, and build on the existing systems for cost-effective and optimum service delivery and utilization.

Kerry Pelzman
Director
Health Office

U.S. Agency for International Development
American Embassy
Chanakyapuri
New Delhi – 110021

Tel: 91-11-24198000
Fax: 91-11-24198612
www.usaid.gov/in

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

ACKNOWLEDGMENTS

This report documents voucher schemes to increase access of the poor to family planning (FP) and reproductive health (RH) programs in three Indian states: Uttar Pradesh, Uttarakhand, and Jharkhand.
The public-private partnerships were undertaken with support from the Innovations in Family Planning Services (IFPS) Technical Assistance Project (ITAP). ITAP, implemented by Futures Group India in partnership with Bearing Point, Sibley International, Johns Hopkins University, and QED, provides technical assistance to the IFPS Project. The United States Agency for International Development (USAID) funded IFPS Project is a joint US-India initiative that has worked to promote improved FP/RH for India's poor communities and works in close collaboration with Ministry of Health and Family Welfare, Government of India as well as with state societies in Uttarakhand, Uttar Pradesh and Jharkhand.

Most importantly, this report highlights the achievements of numerous state and district partners who played an integral role in the design and implementation of the voucher systems. Key partners include the State Innovations in Family Planning Services Agency and district counterparts in Uttar Pradesh; Uttarakhand Health and Family Welfare Society; accredited private nursing homes and hospitals; chief medical officers (CMOs), auxiliary nurse midwives (ANMs), and other public health staff in target districts; medical institutes, including the Sarojini Naidu Medical College; healthcare provider associations; and non governmental organizations (NGOs) and community-level workers, including accredited social health activists (ASHAs), *sahiyyas*, and community health volunteers (CHVs). The project acknowledges the contributions of NIHFW and Prof. Ramesh Bhat, Former Professor, IIM Ahmedabad and Executive Chairman, WOne Management Systems for conducting the Cost Effectiveness Analysis for the Haridwar Pilot Voucher Scheme.

The project wishes to acknowledge the technical leadership and guidance provided by the USAID India Mission, especially Dr. Loveleen Johri, Shweta Verma and Vijay Paulraj.

Anita Bhuyan, Futures Group, compiled this report on behalf of ITAP, drawing on a range of published reports, unpublished project reports and databases, peer reviewed and grey literature, and interviews with project staff and partners. Several individuals contributed to the drafting and review of this report, including Dr. Suneeta Sharma, Dr. Gadde Narayana, Shuvi Sharma, Tanya Liberhan, Dr. A A Jayachandran, Heer Chokshi, Dr. Utpal Das, Dr. Nimisha Goel, Dr. Ajay Misra, Dr. Santosh Singh, Ashutosh Kandwal, Ashish K Mishra, Debabrata Bhuniya, Arshad Hussain, Pankaj Kumar, and Rajesh Singh. This report also draws on previous project documentation efforts by Dr. Carol Shepherd (Agra, Kanpur Nagar, and Haridwar); Tanya Liberhan (Gumla); and Dayl Donaldson, Himani Sethi, and Suneeta Sharma (Agra), which proved to be invaluable.

ABBREVIATIONS

ANC	Antenatal Care
ANHA	Agra Nursing Homes Association
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BPL	Below Poverty Line
CHV	Community Health Volunteer
CMO	Chief Medical Officer
DARC	District ASHA Resource Center
DGUS	Dharam Gramin Utthan Sansthan
DIFPSA	District Innovations in Family Planning Services Agency
DLHS	District-Level Household Survey
DPMU	District Project Management Unit
DQAG	District Quality Assurance Group
EPI	Expanded Program of Immunization
FOGSI	Federation of Obstetric and Gynecologists Societies of India
GoI	Government of India
FP	Family Planning
HIV	Human Immunodeficiency Virus
HLFFPT	Hindustan Latex Family Planning Promotion Trust
IEC	Information, Education, and Communication
IFA	Iron-Folic Acid
IFPS	Innovations in Family Planning Services
IPC	Interpersonal Communication
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
JSY	Janani Suraksha Yojana
MDG	Millennium Development Goal
MIS	Management Information System(s)
MoIC	Medical Officer in-Charge
NABH	National Accreditation Board for Hospitals and Health Care Providers

NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NRHM	National Rural Health Mission
NSV	No-Scalpel Vasectomy
PAG	Project Advisory Group
PIP	Program Implementation Plan
PMU	Project Management Unit
PNC	Postnatal Care
PPP	Public-Private Partnership
RCH	Reproductive and Child Health
RH	Reproductive Health
RTI	Reproductive Tract Infection
RSBY	Rashtriya Swasthya Bima Yojana
SDM	Standard Days Method
SIFPSA	State Innovations in Family Planning Services Agency
SLI	Standard of Living Index
SNMC	Sarojini Naidu Medical College
SRS	Sample Registration System
STI	Sexually Transmitted Infection
TT	Tetanus Toxoid
UKHFWS	Uttarakhand Health and Family Welfare Society
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VMU	Voucher Management Unit

EXECUTIVE SUMMARY

Improving the poor's access to high-quality family planning (FP) and reproductive health (RH) services is essential to the well-being of India's families and communities and the nation's development. With a rapidly growing population and the highest number of maternal deaths in the world, India will not meet its national goals, including the Millennium Development Goals (MDGs), unless the health of the poor improves. In response, India is among a rising number of developing countries implementing voucher schemes to increase access to reproductive, maternal, and child health services. Vouchers are a demand-side financing mechanism that gives purchasing power to the beneficiaries. While supply-side financing subsidizes *inputs* into the public health system, demand-side financing links subsidies to the beneficiaries and the desired *outputs*.

Background. Voucher schemes are often operated as public-private partnerships (PPPs)—collaborative efforts between the public and private sectors with clear, mutually agreed on roles, shared objectives, and specified performance indicators. Under these partnerships, the government monitors quality and reimburses providers for services delivered, while private providers deliver services at a negotiated reduced price. Other common aspects of voucher programs are standards for service quality and training of providers to deliver services according to standards. Involving multiple providers offers choices for the poor and introduces healthy competition among providers to improve quality to retain voucher clients. Recent systematic reviews find that voucher schemes have had positive effects on health service utilization, quality, and targeting resources to intended beneficiaries (Bellows et al., 2011; Meyers et al., 2011).

From 2006–2012, the pilot *Sambhav* voucher schemes have been implemented in northern India to reach below poverty line (BPL) families with FP/RH services. The program's name ("it is possible" in Hindi) signifies that it is possible for BPL families to access high-quality services in the private sector. The voucher schemes are one component of the Innovations in Family Planning Services (IFPS) Project, a collaborative effort of the Government of India and United States Agency for International Development (USAID)/India that has spanned two decades. IFPS supports national-level activities but emphasizes interventions in three priority states: Uttar Pradesh, Uttarakhand, and Jharkhand. The project is implemented by autonomous state health societies—the State Innovations in Family Planning Services Agency (SIFPSA) in Uttar Pradesh, Uttarakhand Health and Family Welfare Society (UKHFWS), and Jharkhand Health Society—in close collaboration with the state governments. In support of this bilateral initiative, the IFPS Technical Assistance Project (ITAP), implemented by Futures Group India and partners, facilitates multisectoral dialogue, strategic information analysis and use, in-country capacity building, and other technical assistance. A major thrust for ITAP is to develop, design, demonstrate, document, and disseminate innovative models and financing strategies, such as PPPs, to reach the poor and vulnerable communities with FP/RH services.

Analysis of the Problem. Design of effective, pro-poor policy and finance strategies must be informed by comprehensive understanding of the nature and level of social and health inequalities, barriers to service access and use, and the finance and service delivery options for addressing the specific inequalities and barriers in the given context. To inform program design, ITAP carried out thorough baseline surveys and assessments of existing services in the pilot areas to understand health status, service use, and barriers. These analyses revealed that poor women in rural and urban areas are less likely to avail maternal health services and have higher unmet need for FP than women from the higher income groups. Limited access to health services leads to higher fertility rates and maternal, neonatal, and child mortality and morbidity among the poor. Further, poor women incur substantial out-

of-pocket expenses for FP/RH services, including for medicines and transportation.

Voucher Scheme Design and Implementation. The four pilot districts included Agra (seven blocks), Kanpur Nagar (368 urban slums), Haridwar (two blocks), and Gumla (two blocks). The *Sambhav* vouchers targeted subsidies to BPL populations, while offering the poor a choice of private providers and enabling access to high-quality services. The vouchers covered a range of services, including antenatal care (ANC), institutional delivery, postnatal care (PNC), neonatal care, and FP. ITAP fostered active consultation with and feedback from all relevant stakeholders throughout the design, implementation, and monitoring of the pilot voucher schemes. The voucher management units (VMUs), headed by the district chief medical officers, coordinated the voucher programs. The VMUs distributed vouchers to nongovernmental organizations (NGOs) responsible for training and supporting community-level health workers known as accredited social health activists (ASHAs) in Agra and Haridwar, community health volunteers (CHVs) in Kanpur Nagar, and *sahiyyas* in Gumla. The community-level health workers, in turn, identified BPL and slum households, offered information on available services, distributed the vouchers to clients, and accompanied clients to seek services, as appropriate (e.g., institutional delivery). The community-level health workers were drawn from the communities they served. These women were instrumental in motivating clients to avail services, especially services such as PNC and FP that may not be perceived as essential by families in rural, urban slum, and tribal areas. Clients exchanged vouchers for services provided by private nursing homes and hospitals, which submitted the vouchers to the VMUs for reimbursement. Only accredited private facilities can participate in the program. Provider training, regular medical audits of accredited facilities, and client satisfaction surveys and follow-up helped promote quality improvement. The VMUs also monitored quality. The state health societies, SIFPSA and UKHFWS, facilitated the flow of funds to the VMU and fostered linkages between the government and private providers. A multi-partner Project Advisory Group (PAG) was also established for each pilot voucher program to provide a forum for discussing implementation challenges and devising solutions.

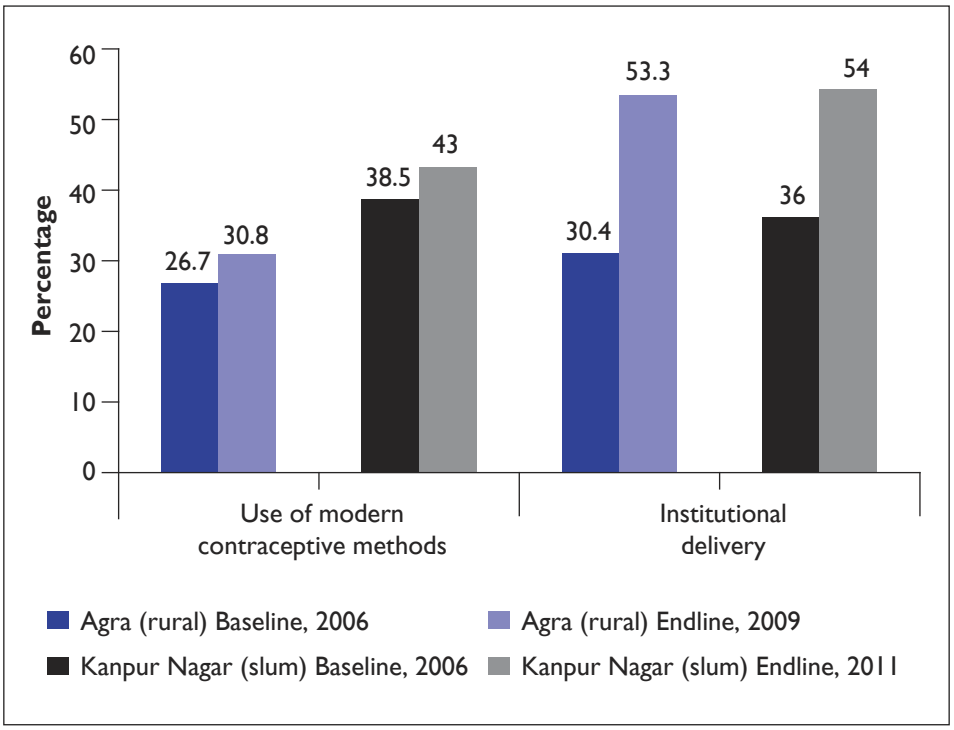
Elements of Program Success. Several strategies contributed to the success of the pilot PPP voucher models, including the following:

- Employing an evidence-based process to inform design, implementation, and monitoring that included baseline surveys, medical audits, client satisfaction surveys, and close tracking of voucher distribution and use.
- Strengthening and building on existing district structures, healthcare providers, community-level workers, and policy and planning processes, with a vision of future scale-up and sustainability.
- Taking various steps to build trust among all stakeholders.
- Ensuring genuine commitment from all partners for reaching the poor.
- Developing clear contractual guidelines for partners and predetermined pricing for the package of benefits.
- Accrediting and monitoring private providers for quality assurance and improvement.
- Enabling choice of providers for beneficiaries.
- Designing multiple communication strategies to promote demand for services.
- Ensuring close engagement between community health workers and clients, which was essential for increasing use of the vouchers and changing behaviors toward underutilized services.

Results. Together, the four *Sambhav* voucher pilot programs covered 11 rural blocks in three districts and 368 urban slums in one city, with implementation time periods ranging from 1–2 years. In total, the vouchers facilitated births of nearly 12,500 babies in private health facilities. The voucher schemes also promoted maternal health by supporting approximately 44,000 ANC visits and 10,300 PNC visits. In addition, women and men used approximately 9,500 vouchers to avail a range of FP methods. Figure 1 presents changes in service uptake among currently married women in Agra (rural) and Kanpur Nagar (slums), based on the baseline and endline surveys. The increase in service utilization for few healthcare services is found to be statistically significant ($p < 0.01$).

Stakeholders involved in implementing the program have shared their appreciation for the voucher schemes. Policymakers increasingly recognize the value of partnering with the private sector and have incorporated PPP initiatives into state health policies, budgets, and program implementation

FIGURE1: SERVICE UPTAKE AMONG MARRIED WOMEN IN AGRA (RURAL) AND KANPUR NAGAR (SLUMS), UTTAR PRADESH



plans. For the government, the voucher schemes help to meet public health goals and reduce strain on public sector human resources and facilities. Private nursing homes and hospitals are willing to offer services at reduced rates in return for increased client volumes—which provides a more stable flow of resources. This is especially desirable for small private nursing homes that may experience fluctuations in clients. Managers of private nursing homes also report that the association with a program to enhance health equity was a salient reason for joining the voucher scheme. In addition to remuneration for promoting services, ASHAs and other community-level health workers report a feeling of empowerment. The added training and supportive NGO supervision enables the ASHAs to develop skills and perform better at their jobs. The ASHAs also feel a sense of pride due to their ability to help fellow community members address health issues and gain access to high-quality services. Client satisfaction surveys and case studies reveal that clients, by and large, are satisfied with the quality of services received and feel that they are treated with respect. Most importantly, clients did not have to go into debt to have institutional deliveries, get treated for complications, and access FP services.

Going to Scale. The success of the pilot voucher schemes garnered interest from the state governments in Uttarakhand and Uttar Pradesh, each of which took steps to scale up the programs. Uttar Pradesh has expanded the voucher system through SIFPSA from 368 urban slums in one city to 1,562 slums in five cities, namely, Kanpur, Agra, Varanasi, Allahabad, and Lucknow. With a voucher distribution and quality assurance system in place, it is possible to incorporate additional vouchers as long as there is sufficient service capacity. Thus, in light of the low health-seeking behavior of populations in urban slums, the scaled-up program has included a general health check-up voucher in addition to the FP/RH services.

Building on the pilot voucher scheme in two blocks of Haridwar District, the Government of Uttarakhand decided to expand the approach to five districts—Almora, Dehradun, Haridwar, Nainital, and Udham Singh Nagar. There is a limited number of private providers in Uttarakhand's Himalayan areas. Therefore, the state also decided to make all BPL card holders, regardless of their district of residence, eligible for services provided by the accredited private nursing homes in the five districts. Clients in the hilly areas can receive vouchers from ASHAs in their districts or at the service sites by showing their BPL cards. Thus, the BPL population covered by vouchers has increased from an estimated 150,000 people in the pilot district to 2.58 million people across the state.

Implications for Pro-poor Health Policies and Programs. Health equity is a central focus for international development initiatives, from the 2015 MDGs to the new five-year, bilateral Health Partnership Program signed by the Governments of India and the United States. Engaging the private sector, ensuring that health systems are accountable to the citizens they are meant to serve, and building on existing in-country systems to foster ownership and sustainability are all essential strategies for meeting the health needs of the poor. Voucher programs incorporate these key

strategies and more. They also represent a cost-effective approach to complement existing strategies for reaching the poor through the public health system.

Going forward, steps should be taken to strengthen voucher programs. Key recommendations include empowering the poor with information and capacity so they are better able to decide for themselves which health services and schemes are right for them. It is also possible to expand services covered by vouchers and avoid missed opportunities to address other health issues of poor women and men who do seek services. Policymakers and planners should support sustainable financing mechanisms for voucher programs, especially as donor support phases out. The vouchers can direct scarce public resources to those most in need, while also mobilizing the private sector to provide public goods. Finally, the early implementation experiences of the scale-up of the *Sambhav* voucher schemes have demonstrated both challenges and successes. Additional research should document lessons learned and monitor the impact of scale-up on health outcomes, such as total fertility and maternal and child mortality.

Chapter 1

INTRODUCTION

Poor health outcomes and poverty are intertwined.[1] Improving the poor's access to high-quality FP and reproductive health (RH) services is essential to the well-being of India's families and communities and to the nation's development. With a rapidly growing population and the highest number of maternal deaths in the world, India will not meet its national socioeconomic goals, including the Millennium Development Goals (MDGs), unless the health of the poor improves. Innovative, effective health policies and financing strategies are needed. Despite investments in the large public health system, India's rural and urban poor have limited access to services and experience higher fertility and maternal, infant, and child mortality rates. In many developing countries, the poor benefit the least from government subsidies (Castro-Leal et al., 2000; Marmot, 2007). This is due to myriad barriers, including financial constraints, inadequate transportation, and sociocultural norms regarding FP/RH services. Government subsidies are intended to promote health among the most vulnerable populations, yet it is often the better-off who are in a position to take advantage of subsidized programs. This scenario raises serious concerns about equity, effective use of resources, and the long-term sustainability of the health system.

One way to improve access to services is by engaging the private health sector. While service utilization is low among the poor, those who do use health services often rely on the private sector (Winfrey et al., 2006). Making this option more affordable could improve access for a greater proportion of the poor population. India is among a growing number of developing countries implementing voucher schemes to increase access to reproductive, maternal, and child health services. Vouchers are a form of "demand-side financing"—a subsidy that places purchasing power in the hands of the beneficiaries, in this case, the poor. "Supply-side financing" subsidizes *inputs* into the public health system (e.g., staff salaries, facilities), while demand-side financing mechanisms link subsidies to the beneficiaries and the desired *outputs* (Bhatia et al., 2006). The outputs can be specific health commodities and services, such as FP, or a package of services, such as antenatal care (ANC), institutional delivery, and postnatal care (PNC). Under this approach, providers are reimbursed for services delivered; thus demand-side financing is also referred to as "output-based aid" (World Bank, 2005).

PROJECT GOAL

To provide affordable, accessible, and high-quality FP/RH services through accreditation of private facilities and to empower BPL families to choose and access a provider through a voucher distribution system

Voucher schemes are often operated as a public-private partnership (PPP) between the government and private healthcare providers. Under a PPP, each partner has clear, mutually agreed on roles. For example, the government monitors quality of the voucher-supported services at private facilities and provides reimbursement for services delivered, while the private providers agree to deliver a package of services at a negotiated, reduced price and in accordance with quality standards. Involving multiple healthcare providers enables choice for the poor and introduces an element of healthy competition, encouraging providers to improve their quality to attract and retain voucher clients.

[1] See http://www.who.int/social_determinants/en/.

From 2006–2012, four voucher schemes based on a PPP model to reach below poverty line (BPL) families with FP/RH services have been implemented in three north Indian states under the name *Sambhav*. This name highlights that it is possible for BPL families to access high-quality services. The voucher schemes are part of the Innovations in Family Planning Services (IFPS) Project, a joint effort of the Government of India (GoI) and the United States Agency for International Development (USAID)/India that has spanned two decades. IFPS is implemented through the state health societies, including the State Innovations in Family Planning Services Agency (SIFPSA) in Uttar Pradesh and the Uttarakhand Health and Family Welfare Society (UKHFWS), in close collaboration with the respective state governments. In support of this bilateral initiative, the IFPS Technical Assistance Project (ITAP), implemented by Futures Group India and partners, facilitates multisectoral dialogue, strategic information analysis and use, in-country capacity building, and other implementation assistance.

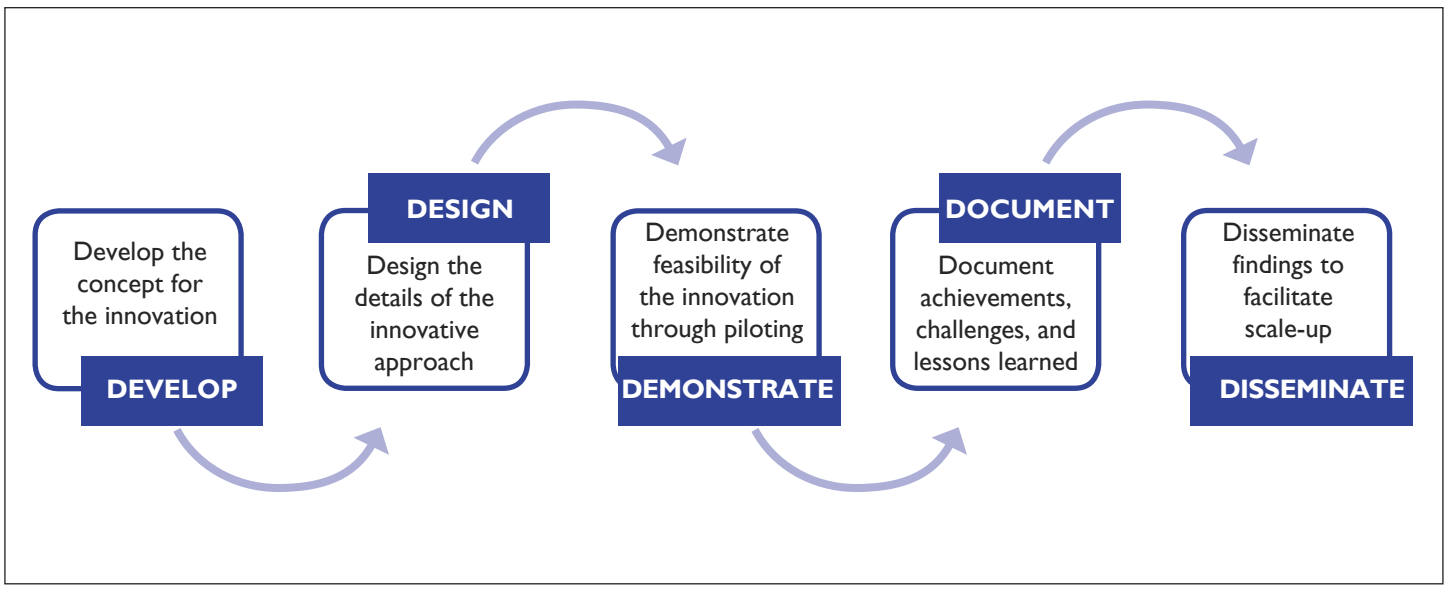
A major thrust for ITAP is to develop, design, demonstrate, document, and disseminate innovative models and financing strategies, including PPPs that reach the poor and vulnerable communities with FP/RH services (Figure 2). As a result, ITAP has collaborated with state and local stakeholders to design and pilot PPP voucher schemes in Agra and Kanpur Nagar, Uttar Pradesh; Haridwar, Uttarakhand; and Gumla, Jharkhand.

While facing challenges, each pilot voucher program demonstrated feasibility in promoting collaboration between the public and private sectors and success in improving access to, equity in, and quality of services for the poor. In the cases of Uttar Pradesh and Uttarakhand, the states have scaled up the program to other districts—reflecting increased country ownership and sustainability for innovative financing and service delivery strategies. (Note: The Jharkhand voucher scheme pilot began in late 2009 and was operational until December 2011. Plans for scale-up are under consideration at the time of this publication).

1.1 PURPOSE AND ORGANIZATION OF THE REPORT

This report aims to contribute to the growing literature on voucher schemes, demand-side financing mechanisms, and PPPs for reproductive, maternal, and child health among the rural and urban poor. It is hoped that experiences and lessons learned from the voucher schemes described herein will help inform the design of similar schemes in India and developing countries around the world. Section 2 of this report analyzes the health scenario for the poor in the selected pilot areas. Section 3 presents the rationale for why vouchers were seen as a potential solution to challenges in these areas and reviews international and Indian experiences with voucher schemes. Next, Section 4 focuses attention on the design, implementation, and monitoring of the four voucher schemes, highlighting the key approaches and decisions taken throughout the process. The achievements of the pilot projects and efforts to take the programs to

FIGURE 2: ITAP'S 5-D APPROACH



scale are discussed in Sections 5 and 6, respectively. Section 7 discusses challenges, lessons learned, and recommendations for further action.

It should be noted that this report is a compilation and summary of numerous published and unpublished materials[2] from the four voucher scheme pilots, including detailed baseline surveys, pilot proposals, workshop reports, project guidelines and training materials, documentation reports, presentations, medical audits, client satisfaction surveys, endline studies, and outputs from the projects' management information systems (MIS). In-depth analysis and presentation of all the implementation experiences are, thus, beyond the scope of this report.

A CLOSER LOOK

A HISTORY OF COMMITMENT AND COLLABORATION FOR REACHING THE POOR

India's Health Policy Context

In 1952, India was one of the first countries in the world to adopt a formal population program. The program sought to reduce India's birth rate "… to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy."[3] Successive five-year plans provided the framework and funding for development of a nationwide healthcare infrastructure and human resources for health, while policies such as the *National Health Policy 1983* emphasized "health for all" and achieving replacement levels of fertility. Over the past decade, the GoI has articulated strategies for achieving national demographic and health objectives in the *National Population Policy 2000*, *National Health Policy 2002*, *National Rural Health Mission* 2005 (NRHM), and the *Eleventh Five-year Plan*. To help achieve reproductive and child health (RCH) objectives, particularly improving access for the poor, India designed the multi-year RCH-II program, now part of the NRHM. The GoI has committed to achievement of the MDGs, specifically to reduce the total fertility rate, infant mortality rate, and maternal mortality rate. The Ministry of Health and Family Welfare is also increasingly recognizing the importance of meeting the health needs of both the rural and urban poor.

Given India's size and diversity, it is a challenge to translate policies into action in states, districts, and blocks. Despite India's substantial progress in poverty reduction, there remain disparities in human and economic development indicators.[4] Under NRHM, each state is responsible for developing a program implementation plan (PIP); a sector-wide approach is used for planning and financing RCH-II initiatives; and transfer of funds/budget allocation to states is linked to utilization of funds. The PIPs are also guided by the states' health goals and policies, including the *Population Policy for Uttar Pradesh* (2000), *Health and Population Policy of Uttarakhand* (2002), and the *Reproductive Health and Population Policy of Jharkhand* (2004) and *Family Planning Strategy of Jharkhand* (2010).[5]

USAID|India's Support for the Innovations in Family Planning Services Project

The IFPS Project began in 1992 as a joint effort of the GoI and USAID|India. It is intended to "serve as a catalyst for the GoI in reorienting and revitalizing the country's FP services."[6] Initiated in Uttar Pradesh, the project has been implemented in three phases (I: 1992–2004; II: 2004–2009; III: 2009–2012). The IFPS Project also includes national-level activities and has expanded state activities to Uttarakhand and Jharkhand. Together, the three northern states are home to more

[2] Among the reports this paper draws from are previous documentation efforts by Futures Group (formerly Constella Futures), including the following: Donaldson et al. (2008), ITAP (2009), Shepherd (2010), and Liberhan (2011).

[3] National Family Welfare Program, Government of India, 1952.

[4] In 1991, India's population was estimated at 846 million, with 36.0 percent living below the national poverty line. By 2011, India's population was estimated at 1.2 billion with 27.5 percent living below the national poverty line (Registrar General, India, "Census of India, Provisional Totals, 2011," and Planning Commission, *Economic Survey, 2008–09*).

[5] USAID/India has supported FP/RH policy development through the POLICY Project, USAID | Health Policy Initiative, Task Order 1, Health Policy Project, and the IFPS and ITAP projects.

[6] See http://www.sifpsa.org/about_us/profile.htm.

than 210 million people. They also experience low health status (compared with other Indian states) and large inequities in health among sub-populations within the states.

IFPS strengthens capacity of Indian institutions to implement FP/RH programs; builds the capacity of clinical and community-level providers; reduces barriers to the access of high-quality FP/RH services; and increases awareness, demand, and use of FP/RH services.[7] IFPS has been facilitated by the formation and strengthening of autonomous state health societies. In Uttar Pradesh, SIFPSA manages the IFPS Project and has local counterparts, District Innovations Family Planning Services Agencies (DIFPSAs), that carry out implementation on the ground. In the other states, the implementing agencies are the UKHFWS and Jharkhand Health Society.

ITAP: Support for Public-Private Partnerships in India

Since 2005, ITAP has served as the technical assistance provider for IFPS, building capacity of the state health societies and providing support for the design and implementation of key interventions. Promoting activities to develop, demonstrate, document, and leverage expansion of PPPs for the provision of high-quality FP/RH services is a key component of the IFPS Project. Public-private partnerships are collaborative efforts between the public and private sectors with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of health services in a stipulated time period.

Due, in part, to technical assistance from IFPS and ITAP, India's national government and states have increasingly adopted positive policy environments to engage the private sector to improve health services.

- ITAP's 2005 PPP concept note served as the key reference document to inform the national RCH program's PPP strategy.
- Over the course of the project, ITAP has assisted IFPS to develop, test, and document various PPP models, including voucher schemes, mobile health vans, subsidized sales of contraceptives, social franchising, contracting out, capacity building of private providers, and special campaigns with private sector health providers. These initiatives have helped to expand access to RCH services, improve service quality, and promote sustainability of RCH services.
- IFPS priority states, such as Uttar Pradesh and Uttarakhand, take a comprehensive sector-based approach to health needs and seek to involve the private sector in achieving the health goals.

Nationally, the draft *Twelfth Five-year Plan* recognizes the role of the private sector in health. The plan states that PPPs, if properly regulated, are a form of financing healthcare services to better reach beneficiaries and that their potential in India has yet to be fully explored.

[7] See http://www.usaid.gov/in/our_work/health/rh_doc1.htm.

Chapter 2

ANALYSIS OF THE PROBLEM

Design of effective, pro-poor policy and finance strategies must be informed by clear understanding of the nature and level of inequalities, barriers to service access and use, different finance and service delivery options, and the best approaches for addressing the specific inequalities and barriers in the given context. ITAP places strong emphasis on strategic information and use for evidence-based decisionmaking, planning, and monitoring (Box 1). As part of the consultations with state stakeholders that ultimately led to the decision to pilot the voucher scheme approach, ITAP carried out or contracted local organizations to undertake in-depth baseline analyzes of the selected districts and blocks in the three states. In some cases, this is the first time such thorough data and analysis has been made available regarding FP/RH needs at the block level. In addition, the project mapped the distribution of private sector providers.

Key findings from the baseline studies are summarized below.

2.1 PROFILE OF PILOT AREAS

The pilot areas include Agra District, Uttar Pradesh (seven blocks); Kanpur Nagar District, Uttar Pradesh (Kanpur City urban slums); Haridwar District, Uttarakhand (two blocks); and Gumla District, Jharkhand (two blocks). These sites vary in key demographic characteristics (Table 1).

Agra District. The capital city of Agra is located along the banks of the Yamuna River and is among the largest cities in Uttar Pradesh. According to the 2011 Census, Agra has a population of 4.4 million people. The district has experienced a rapidly growing population and increasing population density over the past decade. More than half of the population lives in rural areas. In Agra, the voucher scheme targeted seven blocks: Akola, Barauli Ahir, Bichpuri, Etmadpur, Fatehabad, Khandauli, and Shamsabad.

Kanpur Nagar District. Kanpur Nagar is an important industrial center in Uttar Pradesh. About 7 in 10 people in Kanpur Nagar live in urban areas. With a population of 4.6 million in 2011, Kanpur Nagar, like Agra, is among the most populous districts in the state. Given the large urban population, the Kanpur Nagar voucher scheme was designed to reach the district's urban poor (accordingly, data are presented by area of residence rather than income or Standard of Living Index [SLI] quintiles).

Haridwar District. The state of Uttarakhand, formed from the northwestern portion of Uttar Pradesh in 2000, has three distinct regions: Upper Himalayas, mid-Himalayas, and the foothills/plains. Located in the plains, Haridwar District alone accounts for nearly one-fifth of the state's population. In 2001, Haridwar District had the highest estimated total fertility rate of 4.1 in the state, which was higher than the national average. Haridwar also has a much higher population density when compared to the rest of the state. The Haridwar voucher focused on the Imlikheda and Bahadrabad blocks.

BOX 1: EVIDENCE-BASED PLANNING

Under the IFPS Project, ITAP provides support for strategic information and use. The project conducted secondary analyzes of existing data—such as the Census, National Family Health Survey (NFHS), District-Level Household Survey (DLHS), Sample Registration System (SRS), and National Sample Survey. ITAP also collected additional data, including conducting the *Reproductive Health Indicator Survey for Uttar Pradesh, 2005*; maternal and infant death audits in Jharkhand and Uttarakhand; and a survey of all First Referral Units/24x7 facilities in Uttar Pradesh, Uttarakhand, and Jharkhand.

TABLE 1: DEMOGRAPHIC PROFILE OF PILOT DISTRICTS, 2001 AND 2011

	Agra District (UTTAR PRADESH)		Kanpur Nagar District (UTTAR PRADESH)		Haridwar District (UTTARAKHAND)		Gumla District (JHARKHAND)	
	2001	2011	2001	2011	2001	2011	2001	2011
Population	3.6 mil	4.4 mil	4.2 mil	4.6 mil	1.4 mil	1.9 mil	832,447	1.0 mil
Area (sq. km.)		4,041		3,156		2,360		5,315
Density (persons per sq. km.)	896	1,084	1,321	1,449	613	817	157	193
Literacy (total)	62.6%	69.4%	74.4%	81.3%	63.6%	74.6%	50.1%	66.9%
Female	48.4%	59.2%	67.5%	76.9%	52.1%	66.0%	38.4%	57.0%
Male	74.6%	78.3%	80.3%	85.0%	73.8%	82.3%	63.4%	76.9%
Sex ratio (females per 1,000 males)	846	859	852	855	865	879	988	993
Urban population	43%	N/A	68%	N/A	30%	N/A	6.43%	N/A

Source: Census of India, 2001 and 2011 (data for 2011 include provisional data, see: http://www.censusindia.gov.in).
N/A = not available.

Gumla District. Jharkhand emerged as a newly formed state in 2000, carved out of the eastern portion of Bihar. Jharkhand has one of the highest levels of poverty in the country. Gumla is one of 24 districts in the state. The terrain is covered by dense forest, hills, and rivers, with a comparatively low population density spread across a wide area—hindering accessibility of health services and health workers. It is a primarily rural area with a majority tribal population. The Gumla voucher pilot was carried out in the blocks of Gumla Sadar and Sisai.

2.2 BASELINE ASSESSMENT FINDINGS

ITAP carried out detailed surveys that served as baseline assessments and informed project design. The surveys in Agra, Kanpur Nagar, and Haridwar (two blocks) each included a Women's Questionnaire for currently married women aged 15–49 years and a Children's Questionnaire to gather information pertaining to the health of children in the household under age five. The Children's Questionnaire was typically answered by the mother or other primary caregiver. The Gumla District study in the blocks of Gumla and Sisai followed a different design, given the focus of the voucher scheme on FP (and not maternal and child health). The survey covered currently married women aged 15–49 years and currently married men ages 20–54. See Annex A for specific details of the survey samples.

Tables 2 and 3 present data on modern contraceptive use, unmet need for FP, and maternal health services across the pilot sites. Data are presented by wealth quintiles, geographic residence, and SLI, as appropriate. Depending on the survey design, data are presented by district or block.

2.2.1 Use of modern methods of FP and unmet need

In general, fewer poor women—defined as women from the lower wealth quintiles, the low SLI category, and urban slums areas—used modern contraceptive methods than their counterparts in the high quintile/SLI and non-slum urban areas (Table 2). In Agra, modern contraceptive use is nearly twice as high among the highest quintile women (42.3%) when compared to women from the lowest quintile (21.8%). Further, nearly one in three women (32.6%) from the lowest quintile have unmet need for FP. In Kanpur Nagar, unmet need for FP among the urban poor (21.3%) is similar to that found among rural populations (21.1%). Also modern contraceptive use is more than five percentage points higher among non-slum urban women (44.0%) when compared to women in urban slums (38.5%). In Gumla, women in the high SLI category are three times more likely to use modern spacing methods than women in the low SLI category (280.0% vs. 9.3%, respectively). Large differences are also seen among poor and wealthier women in Haridwar, with especially high unmet need for FP among the

TABLE 2: FAMILY PLANNING AMONG CURRENTLY MARRIED WOMEN OF REPRODUCTIVE AGE AT BASELINE

	Modern Contraceptive Use		Unmet Need for FP		
	Any Modern Methods	Any Spacing Methods	Unmet Need for Spacing	Unmet Need for Limiting	Total Unmet Need
AGRA DISTRICT (UTTAR PRADESH) (2006)					
Quintile					
Q1	21.8	3.5	13.5	19.1	32.6
Q2	24.9	4.3	14.5	19.7	34.2
Q3	31.7	9.0	11.0	14.2	25.2
Q4	32.6	10.2	11.5	13.8	25.3
Q5	42.3	16.4	8.2	10.7	18.9
Total	31.1	9.1	11.6	15.2	26.8
Number of women	4742	4742	4742	4742	4742
KANPUR NAGAR DISTRICT (UTTAR PRADESH) (2006)					
Residence					
Rural	28.7	15.0	9.1	12.0	21.1
Urban slum	38.5	23.6	8.7	12.6	21.3
Urban non-slum	44.0	26.1	6.6	11.1	17.7
Urban (all)	42.2	25.3	7.3	11.6	18.9
Total	37.7	21.8	7.9	11.7	19.6
Number of women	4806	4806	4806	4806	4806
IMLIKHEDA BLOCK (HARIDWAR DISTRICT, UTTARAKHAND) (2006)					
Quintile					
Q1	19.7	13.1	18.0	24.9	42.8
Q2	27.6	18.0	12.9	14.4	27.3
Q3	29.2	20.3	16.2	15.8	32.0
Q4	41.6	21.8	10.2	16.1	26.3
Q5	42.3	25.4	11.7	9.2	20.9
Total	33.3	20.3	13.5	15.5	29.0
Number of women	1087	1087	1087	1087	1087
BAHADRABAD BLOCK (HARIDWAR DISTRICT, UTTARAKHAND) (2006)					
Quintile					
Q1	24.5	13.4	8.8	23.1	31.9
Q2	36.8	16.8	14.6	19.0	33.6
Q3	30.9	14.4	10.7	21.2	31.9
Q4	42.0	21.3	8.6	8.4	17.0
Q5	54.9	33.2	8.9	7.2	16.0
Total	39.8	21.1	10.1	14.5	24.6
Number of women	1036	1036	1036	1036	1036
GUMLA AND SISAI BLOCKS COMBINED (GUMLA DISTRICT, JHARKHAND) (2009/10)					
Standard of Living Index					
Low	31.1	9.3	N/A	N/A	N/A
Medium	51.5	20.1	N/A	N/A	N/A
High	52.0	28.0	N/A	N/A	N/A
Total	35.0	11.8	N/A	N/A	N/A
Number of women	841	841	841	841	841

Source: ITAP, Baseline Agra (2006), Baseline Kanpur Nagar (2006), Baseline Haridwar (2006), and Baseline Gumla District (2009)

lowest quintile women in Imlikheda Block (42.8%).

Box 2 highlights FP attitudes and behaviors among men from the Gumla baseline study.

2.2.2 Antenatal and postnatal care

The majority of women in the pilot areas had at least one ANC visit; however, in most cases, poor women were much less likely to receive full ANC care than women from higher wealth/SLI groups and urban non-slum areas (Table 3). For example, in Kanpur Nagar, 18 percent of women in urban slum areas received full ANC care, compared with 36.3 percent of women in urban non-slum areas. Use of PNC care was relatively low in all pilot areas and across groups, with the highest use of PNC services found in Imlikheda Block in Haridwar (32.6%).

2.2.3 Place of delivery

As shown in Table 3, poor women are significantly more likely to give birth at home than women of higher wealth status. In all of the rural pilot areas, more than eight in ten rural poor women gave birth at home. The largest differences in home delivery between low- and high-income groups are found in Agra District (81.2% vs. 31.1%) and Bahadrabad Block in Haridwar (82.9% vs. 31.7%). In Kanpur Nagar, 64 percent of women in urban slum areas give birth at home, compared with 38.6 percent of women residing in urban non-slum areas. Among women who do deliver in facilities, there is a strong preference for private or nongovernmental organization (NGO) facilities, which is consistent across all wealth groups, SLI categories, and areas of residence. For example, in Agra, among women from the lowest quintile, 15.4 percent delivered in a private or NGO facility, compared with 3.4 percent who delivered in a government health facility. However, women from the highest quintile are more than four times more likely to deliver in a private or NGO facility than women from the lowest quintile (64.1% vs. 15.4%, respectively).

BOX 2: GUMLA: MEN AND FAMILY PLANNING

Constructive engagement of men is essential—both for their own reproductive health and for supporting reproductive, maternal, and child health of their wives and children. As a result, the Gumla baseline assessment in the Gumla Sadar and Sisai blocks explored men's attitudes and behaviors regarding FP. Among male respondents (n=830), 44 percent reported current use of any FP methods (including 6.7% reporting condom use and 2.2% reporting male sterilization). About three-fourths of men (73.3%) agreed that FP is beneficial for both maternal and child health, resulting in better nutrition for mothers and babies, lower anemia among women, and better attention to care of the child. More than one-third of men (37%) reported wanting another child at some point in the future, with five percent of men saying they would like to wait at least two years after the birth of their baby.

2.3 BARRIERS TO SERVICE ACCESS AND USE

The baseline assessments explored reasons for non-use (and/or discontinuation) of FP/RH services, which encompassed both monetary and non-monetary reasons. Key barriers included traditional beliefs and practices, illiteracy or low levels of literacy, limited awareness of the value and availability of services, limited transportation, and lack of prioritization of women's health issues. Other major barriers identified by the analyzes included the high monetary costs of receiving institutional delivery services and the high time costs for poor women to travel to a facility with the capacity to provide delivery assistance. An additional analysis, examining data from the National Sample Survey 60th Round, revealed that poor women incur substantial out-of-pocket expenses on reproductive, maternal, and child health services in Uttar Pradesh (Winfrey et al., 2006). Only 34.7 percent of the poorest women paid nothing or reported no expenditures for prenatal care; only 5.5 percent said the same for delivery services and 6.9 percent for PNC.

2.4 IMPLICATIONS FOR INTERVENTION

The baseline assessments and related studies reveal that poor women in rural areas and urban slums are less likely to access FP/RH services than women from higher income groups. More than eight in ten women in rural areas and nearly two out of three women in urban slums give birth at home, with limited assistance from trained providers. Poor women also have a high unmet need for FP and high out-of-pocket expenses when

TABLE 3: ANTENATAL CARE, POSTNATAL CARE, PLACE OF DELIVERY, AND ASSISTANCE AT BIRTH

	Antenatal and Postnatal Care			Place of Delivery			Assistance by any Health Professional
	Any ANC	Full ANC	PNC for Home Deliveries	Govt. Health Facility	Pvt. or NGO Facility	Home	
AGRA DISTRICT (UTTAR PRADESH)							
Quintile							
Q1	69.6	2.4	8.4	3.4	15.4	81.2	23.3
Q2	73.3	5.1	6.6	7.0	19.0	74.1	31.4
Q3	79.6	7.8	7.0	9.6	26.4	64.3	39.6
Q4	85.9	13.7	4.8	9.7	45.9	44.5	62.0
Q5	93.1	21.7	12.7	4.9	64.1	31.1	72.5
Total	79.8	9.8	7.5	6.8	33.1	60.0	44.8
Number of mothers	1401	1400	841	1401	1401	1401	1401
KANPUR NAGAR DISTRICT (UTTAR PRADESH)							
Residence							
Rural	80.9	4.0	17.5	3.3	9.2	87.5	16.8
Urban Slum	87.0	18.0	13.2	10.1	25.9	64.0	44.2
Urban Non-slum	90.3	36.3	9.8	13.6	47.8	38.6	68.4
Urban (all)	88.9	28.9	11.7	12.2	39.0	48.9	58.6
Total	85.7	18.9	14.9	8.6	27.0	64.4	41.8
Number of mothers	831	831	625	831	831	831	831
IMLIKHEDA BLOCK (HARIDWAR DISTRICT, UTTARAKHAND)							
Quintile							
Q1	80.0	6.8	30.7	2.4	16.2	81.3	22.6
Q2	91.6	3.8	26.0	1.0	12.5	86.5	19.7
Q3	90.9	3.6	42.7	1.9	22.2	75.9	29.2
Q4	78.7	9.0	37.5	3.7	33.1	63.1	45.1
Q5	86.7	25.5	26.9	5.1	36.2	58.7	45.8
Total	85.7	10.1	32.6	2.9	24.2	72.9	32.6
Number of mothers	340	340	248	340	340	340	340
BAHADRABAD BLOCK (HARIDWAR DISTRICT, UTTARAKHAND)							
Quintile							
Q1	74.6	4.9	24.3	6.5	10.6	82.9	24.7
Q2	86.1	6.9	25.6	3.1	20.9	76.1	32.7
Q3	93.1	5.4	22.1	5.3	18.5	76.3	32.8
Q4	94.7	15.4	33.7	5.1	37.6	57.3	53.4
Q5	96.7	30.7	27.1	16.1	52.2	31.7	71.0
Total	89.2	12.3	26.4	6.8	27.9	65.3	42.8
Number of mothers	304	304	199	304	304	304	304

Source: ITAP, Baseline Agra (2006), Baseline Kanpur Nagar (2006), and Baseline Haridwar (2006)

accessing RH services. Among clients who do seek health services, there is high dependence on the private sector among both poor and non-poor groups.

Against the backdrop of low service use and health status among the rural and urban poor, high out-of-pocket expenses for those who do access services, an overwhelmed public health sector, and a growing private health sector, stakeholders in north Indian states engaged by the ITAP Project decided to pilot PPP voucher scheme models.

Chapter 3

RATIONALE FOR THE VOUCHER SCHEMES

Interest in the voucher scheme approach was first expressed during a meeting on PPPs in Agra, Uttar Pradesh, in December 2005. The meeting, organized by ITAP in collaboration with SIFPSA, brought together representatives of government agencies, private sector providers and associations, NGOs, medical colleges, and others. Similar consultations were organized for the other pilot areas. After exploring different PPP models, the private sector representatives identified several approaches in which they would be interested in participating—one being the voucher scheme.

Essentially, a voucher is a "token that can be used in exchange for a restricted range of goods or services. Health vouchers are used in exchange for services (e.g., medical consultations or laboratory tests) or consumables (e.g., drugs, vitamins)" (World Bank, 2005, p. 17). Vouchers may be provided for free or at a highly subsidized rate to eligible populations; the vouchers are redeemed at participating providers, with whom the specific package of services to be offered and reimbursement rate for each service has been negotiated.

Prior to designing the Agra pilot—the first of the *Sambhav* voucher scheme models—ITAP reviewed the literature on demand-side financing, as well as international and Indian experiences with vouchers for health. Representatives of the project also went on a study tour to Gujarat in 2006 to learn more about the state's *Chiranjeevi Yojana* scheme. Since that time, additional demand-side financing and voucher schemes have been reviewed and documented (Gupta et al., 2010; Bellows et al., 2011; and Meyers et al., 2011).

3.1 RISE OF DEMAND-SIDE FINANCING

3.1.1 Health sector financing reform

Finance and payment mechanisms are two of the five key "control knobs" in the health sector—that is, policy levers that governments can adjust to influence the equity and performance of the health system (Roberts et al., 2003). Some common financing alternatives for reaching the poor with health services include

- Allocating resources (e.g., funding, facilities, staff) to areas dominated by the poor populations to encourage health service access and use.
- Designing social/community-based health insurance schemes to minimize financial shocks.
- Promoting consumer-led demand-side financing schemes, such as vouchers, to target specific populations and offer a choice of health providers.

Strategic development and reform of the health system requires a mix of approaches appropriate for the given context. While additional funding may be desired, better use of existing funding is also essential, especially in the short to medium term and in cases where funds are limited.

3.1.2 Supply- vs. demand-side financing

Traditionally, healthcare policies in developing countries have focused on subsidizing the public sector. In countries such as India, the system is tax-financed and adheres to norms set by the government. Free and comprehensive basic healthcare services are provided to benefit the entire population. In supply-side financing, the public sector/donor funding goes directly to suppliers/providers. While this approach strives to make services as widely available as possible, some of the limitations of supply-side financing are the inability to target the poor, lack of user choice, and absence of linkages between provider payments and performance (World Bank, 2005; Gupta et al., 2010).

Supply-side financing can be complemented by demand-side financing mechanisms. The World Bank (2005) states that the "key defining feature of a demand-side subsidy is the direct link between the intended beneficiary, the subsidy, and

the desired output" (p. 8). Consumer-led, demand-side financing puts the purchasing power in the hands of consumers, often the poor, and aims to reduce their financial barriers to seeking and receiving services (World Bank, 2005). The consumer has a choice of service providers, and costs are curtailed by encouraging competitive market strategies. These types of financing methods include vouchers, conditional cash transfers, and in-kind transfers. Demand-side subsidies are not only better at targeting subsidies to the poor, but by linking subsidies with output, they also provide incentives for quality and efficiency (Bhatia et al., 2006).

Beyond targeting a specific population and transferring subsidies directly to the beneficiaries, Gupta and others (2010) further elaborate an additional characteristic of demand-side financing: the rationale for the services covered. Demand-side financing often seeks to increase use of services that have "large positive externalities," which are services that have benefits for the wider population beyond the direct beneficiaries. Reproductive, maternal, and child healthcare that help promote healthy families and communities—along with FP, which slows the society's population growth and strain on resources—are considered health services with positive externalities.

3.1.3 Vouchers as demand-side financing

Depending on the nature of the design and implementation of the voucher scheme, the potential advantages and disadvantages of the approach, as summarized by Donaldson and others (2008), include the following:

- Advantages
  - Targeting a specific segment of the population with specific services/subsidy to promote a desired health behavior.
  - Reducing price constraints that hinder use of specific health services.
  - Enabling choice for recipients by engaging private as well as public providers.
  - Mobilizing the private sector's capacity for providing public goods.
  - Improving the efficiency and quality of service provision through increased competition and performance-based financing.

- Disadvantages
  - May not be possible to cover all health needs of the target population under one scheme.
  - Insufficient reimbursement to either provide a significant subsidy for the poor and/or encourage private providers to accept vouchers as payments in full.
  - Potential for misuse/abuse through voucher re-sale and/or counterfeiting.
  - Need for supply-side capacity close to the household to provide covered services.

3.2 INTERNATIONAL AND INDIAN EXPERIENCES WITH VOUCHER SCHEMES

In recent years, the use of vouchers has been on the rise in the education and health sectors, especially for malaria prevention; reproductive, maternal, and child health; and prevention of HIV and sexually transmitted infections (STIs). Systematic reviews of voucher schemes within the health sector find moderate to robust evidence that vouchers increase use of services, improve quality of services, and target resources to intended beneficiaries (Bellows et al., 2011; Meyerset al., 2011). Less evidence is available on the longer term impact of vouchers on health outcomes and the cost-effectiveness of vouchers compared with other interventions. Vouchers have also been found to be most appropriate in cases where financial constraints hinder service access and may need to be supplemented by other strategies to address a range of barriers (Gupta et al., 2010).

In India, the competitive voucher scheme has gained ground for reaching the poor with FP/RH services (Bhatia et al., 2006). In 1999, under the Local Initiatives Program funded by the Bill & Melinda Gates Foundation, the Children in Need Institute initiated a reproductive and child health scheme for populations living in slums in Kolkata. A referral slip enabled clients to have two visits (initial and follow-up) to a private provider through a qualified network of providers. Other key features included development of protocols for doctors to follow while treating common ailments and free provision of prescribed essential drugs. In 2003, the program covered approximately 250,000 people and had 30 private practitioners serving as referral doctors. A review found that use of "existing infrastructure to develop health posts has not only been cost effective but has, more importantly, increased access for the slum community by having service delivery centers within/nearby the slum areas" (Gorter et al., 2003, p. 23). Two other NGOs that have experience in management of voucher schemes are *Sewa Mandir* in Rajasthan and *Janani* in Bihar. *Sewa Mandir* works with the tribal population and

uses vouchers to provide maternal and child health services to the underserved populations. In Bihar and Jharkhand, *Janani* targets low-income groups to provide contraceptives and RH services free of cost. Non-voucher recipients pay a small user fee to receive the same services from private sector providers organized under a franchising scheme.

In December 2005, the Government of Gujarat launched a pilot voucher scheme, *Chiranjeevi Yojana*, to facilitate institutional deliveries among BPL women. The scheme, which began in five districts, was scaled up statewide in 2007. Under the scheme, BPL households are eligible to receive free institutional delivery services by showing their BPL card or, if they do not have a card, by obtaining an authorization letter from the *Sarpanch* or Municipal Corporation.The district health authorities manage administration of the scheme while private obstetricians/gynecologists provide the services. By October 2009, more than 800 providers participated in the program and more than 384,920 deliveries had been supported through the scheme (UNICEF, 2009).

Determining private provider reimbursement rates for services is a key design issue for voucher schemes. In Gujarat, the government obtained quotations from representatives of the Federation of Obstetric and Gynecologists Societies of India (FOGSI) to arrive at a uniform reimbursement for each service (Bhat et al., 2006). To eliminate financial incentive for providers to "induce demand" for cesarean sections, each delivery was reimbursed at the same amount. At the start of the program,[8] the average reimbursement per delivery was estimated as Rs. 179,000 for 100 deliveries, assuming 85 percent would be normal deliveries and 15 percent would be complicated deliveries or cesarean sections. Thus, providers were paid Rs. 1,790 for each delivery they performed in a private facility. In cases where the private practitioners provided the delivery service in a public facility, they were reimbursed Rs. 440. Plus, Rs. 50 was provided for the *dai* and Rs. 200 to the patient for transportation. A study of *Chiranjeevi Yojana* found that BPL clients enjoyed considerable savings and were satisfied with the scheme. BPL clients using the vouchers were found to spend, on average, about Rs. 727 on transportation and medicines when seeking institutional delivery. In contrast, BPL women not using vouchers spent about Rs. 4,000 (weighted average) (Bhat et al., 2009). Expenses incurred by BPL women not using vouchers ranged from Rs. 2,319 for normal deliveries to Rs. 13,524 for complicated deliveries.

In August 2006, a team from ITAP visited Gujarat to learn about *Chiranjeevi Yojana*. The scheme included several positive aspects for replication, such as flexibility for BPL certification by the *Sarpanch*. The scheme also gave private providers an advance amount for service delivery, which alleviated delays in payment and encouraged the private providers to partner with the government. The team also identified some areas for refinement.

Recommended actions included:

- Ensuring accreditation of the private providers and strengthening mechanisms for quality assurance, including medical audits.
- Establishing a limit on the number of participating providers to help ensure they are able to attract a sufficient volume of BPL clients to compensate for offering services at reduced rates (and thus helping to retain providers in the scheme).
- Negotiating the reimbursement package in close consultation with the private providers, including pricing normal and cesarean deliveries separately so that cesarean sections are not referred to other public facilities.
- Developing marketing and information, education, and communication (IEC) strategies to generate increased awareness and demand among BPL women for the package of voucher services.
- Ensuring that reimbursement rates covered costs such as the fees of consulting anesthetists and pediatricians, medicines, and/or hospitalization of premature infants.

These considerations informed the design of the *Sambhav* voucher schemes.

[8] Note: The reimbursement rates have been revised over time—now Rs. 2,800 for all types of deliveries, Rs. 865 to the private provider for deliveries performed in public facilities, and Rs. 200 for the ASHA.

Chapter 4

SAMBHAV: VOUCHER SCHEME DESIGN AND IMPLEMENTATION EXPERIENCES

To reduce the inequities in health among the rural and urban poor populations, state and local partners, with support from ITAP, introduced a demand-side financing mechanism, the voucher system. Under the name *Sambhav*, the vouchers aim to make affordable, accessible, and high-quality FP/RH services possible for BPL families, while empowering them to choose their own providers. Accredited private facilities provided the services at negotiated rates through the voucher distribution system. A general model for the pilot voucher system was developed in Agra and then adapted as needed for Kanpur Nagar, Haridwar, and Gumla (Table 4).

4.1 CONSULTATION WITH STAKEHOLDERS

Active consultation with all the relevant stakeholders throughout the process was essential for the design, implementation, and monitoring of the voucher system. PPP models for health were an emerging strategy in the country, making it essential to facilitate dialogue and trust among the key players. While NGOs and community-level functionaries were being mobilized through central and state health programs, such as the new NRHM, in many cases, the private providers had not worked in partnership with the government. Representatives on both sides had concerns. For example, would the bureaucratic government system cause delays for private providers? Alternatively, could the private providers be held accountable for providing services in compliance with government standards and technical guidelines? Involvement of ITAP and the state health societies, such as SIFPSA in Uttar Pradesh and UKHFWS in Uttarakhand, helped to build a bridge across the sectors and encourage participation in the voucher system.

TABLE 4: OVERVIEW OF THE VOUCHER SCHEME MODELS BY PILOT AREA

Area	Agra (UTTAR PRADESH) Rural	Kanpur City (UTTAR PRADESH) Urban slums	Haridwar (UTTARAKHAND) Rural	Gumla (JHARKHAND) Rural
Coverage	7 blocks (Akola, Bichpuri, Barauli Ahir, Etmadpur, Fatehabad, Khandauli, Shamsabad)	368 slums	2 blocks (Imlikheda and Bahadrabad)	2 blocks (Gumla Sadar and Sisai)
Population	1.07 million	0.56 million	0.51 million	0.22 million
Voucher Management Unit (VMU)	CMO, PMU, NGOs	NGO	CMO, DPMU, NGO	NGO
Voucher distribution	NGOs through ASHAs	NGOs through CHVs	ANMs through ASHAs	NGOs through *Sahiyyas*
Services	Maternal health, clinical FP services, RTI/STI	Maternal health, clinical FP services, RTI/STI	Maternal health, neonatal health, clinical FP services	FP services: female sterilization, NSV, IUCDs, injectables
No. of accredited nursing homes/hospitals	15	16	8	2
Timeframe for service delivery	March 2007–June 2008	Nov 2008–Aug 2010	May 2007–March 2009	Sept 2009–June 2010; Sept 2010–Dec 2011[9]

[9] The Gumla voucher scheme pilot faced a break in service delivery due to the gap between the end of ITAP in June 2010 and initiation of its follow-on phase. The scheme faced additional challenges throughout implementation due to the Naxalite situation in the district, which, at times, limited the ability of *sahiyyas* to carry out their work.

Lack of providers is also a challenge in the hilly districts of Uttarakhand. As part of the scale-up plan, the state decided to allow all BPL card holders, not only those residing in the five scale-up districts but from other districts as well, to use their cards to access voucher services at accredited private facilities.

A series of consultation meetings was organized throughout the preparatory phase for each pilot, first in Agra and subsequently in Kanpur Nagar, Haridwar, and Gumla before the launch of each scheme. Participants included state, district, and block health officials; major civil society groups; private sector providers and associations, such as the Nursing Homes' Association in Kanpur Nagar; medical colleges, such as Sarojini Naidu Medical College in Agra; the state health societies; and ITAP, among others. The process typically involved an initial meeting with a group of stakeholders to review the health situation in the proposed districts, explore opportunities for partnership, and build consensus on the need for and utility of PPPs for the delivery of FP/RH services. The process also helped ascertain the willingness and suitability of potential partners. The meetings were followed by in-depth workshops with the interested parties on the specific design and parameters of the voucher system. Consultations continued throughout implementation and scale-up, including through regular meetings of project advisory groups (PAGs). Together, the various consultations helped to

- Generate interest in participating in the voucher system.
- Articulate each group's roles and responsibilities.
- Determine the package of services and reimbursement rates.
- Set the accreditation standards and procedures.
- Identify and address roadblocks as the schemes rolled out (Box 3).
- Establish feedback loops for monitoring service provision and quality.
- Ensure flexibility for adapting approaches to the local context.

BOX 3: ACTIVE PROBLEM SOLVING

The voucher scheme models maintained flexibility to adjust to conditions in each site. For example, Gumla District is a dense forest area with limited high-quality providers and even more limited transportation. As a result, stakeholders discussed possible solutions and decided that funds would be allocated to hire two full-time ambulances to transport BPL clients to and from facilities to seek clinical FP methods.

4.2 VOUCHER SCHEME PROPOSAL DEVELOPMENT

As part of the preparatory phase, as described in Section 2 above, ITAP supported detailed analyzes of the pilot areas by analyzing existing data sets and conducting baseline surveys on FP/RH issues and access to health services. As noted in Section 3, ITAP also reviewed demand-side financing and voucher schemes, including the study tour to Gujarat. In addition, ITAP assessed the public and private sector health systems in each area. For example, one study surveyed private sector facilities in the Agra District to analyze their capacity and service use. A different study examined performance of the public sector in the Imlikheda and Bahadrabad blocks in Haridwar to ascertain any gaps in services. These assessments shed light on health needs; availability of, access to, and use of services; barriers to access, including out-of-pocket expenses; and strengths and weaknesses of various voucher models.

Based on a review of these studies and discussions with stakeholders, ITAP provided assistance to the state health societies—SIFPSA for Agra and Kanpur Nagar and UKHFWS for Haridwar—to draft a proposal for each pilot voucher scheme. In Gumla, ITAP supported an NGO, Vikas Bharti, to prepare the proposal in a joint workshop. The proposals outlined the project goal; provided the rationale for piloting a PPP scheme; discussed linkages with other programs, such as *Janani Suraksha Yojana* (JSY); [10] reviewed the blocks for the pilot interventions and estimated service requirements; identified key stakeholders for implementation and their respective roles and responsibilities; and outlined steps to be completed in the pre-implementation phase.

4.3 SELECTION OF BENEFICIARIES

In each of the pilot areas, the voucher schemes aimed to target resources to those most in need. While rural areas have lower health status and access when compared to urban areas, there are wide disparities even within rural

[10] The JSY initiative, under the NRHM and entirely financed by the Central Government, links the provision of cash assistance with use of ANC during pregnancy, institutional delivery, and immediate post-partum visits in a government health center. Motivation of households to use these services is coordinated by the ASHA, who receives payments linked to performance.

areas in terms of standard of living and household assets. Similarly, while the urban population as a whole tends to be better-off, those living in slum areas have limited access to health services. Thus, the pilot blocks in rural areas employed *individual/household* targeting: members of all BPL households in rural areas were eligible to use the vouchers. In Agra, Kanpur Nagar, and Haridwar, the scheme primarily targeted married women of reproductive age (15–49 years old), pregnant women, and infants. A secondary target group included men. In Gumla, which focused on FP, target groups included women and men of reproductive age. Since the most disadvantaged populations in urban areas tend to live in slums, the pilot in Kanpur City used *geographic* targeting in which inhabitants of the selected slums were eligible for the vouchers.

Proof of eligibility to participate in the voucher program is the BPL card. Identifying and ensuring inclusion of the poorest families remained a challenge throughout implementation as many did not have the BPL cards. In these cases, eligibility could be established through issuance of a certificate and/or verification that the family is on the government's BPL list. The approvals required for certification varied by site, for example, requiring the signature of the *Pradhan* in rural areas or the municipal corporation in the urban areas. In the case of Haridwar, stakeholders found the process of obtaining the certificates cumbersome and eventually decided to provide vouchers only to those with the BPL cards. In the case of Kanpur City, some flexibility was introduced so that individuals could use their ration cards as proof of residence in the designated slums and, thus, become eligible for the vouchers. Such flexibility in program implementation improved the likelihood of reaching out to those in need.

4.4 DESIGN OF THE VOUCHER SCHEME MODEL

Figure 3 presents the general operational model for the pilot voucher schemes. Key players include the government health system, led by the district chief medical officer (CMO); the voucher management unit (VMU); NGOs and community-level health workers; beneficiaries; private providers; and other supportive organizations enlisted for quality assurance, accreditation, and training. ITAP provided technical assistance for capacity building, development of systems (including clarifying partner roles and responsibilities), project design, and evaluation. The state health societies, including SIFPSA and UKHFWS, facilitated the flow of government and donor funds to the VMU; supported the VMU; and fostered linkages between the government and private providers. Multisectoral PAGs were also established.

4.5 ROLE OF THE VOUCHER MANAGEMENT UNIT

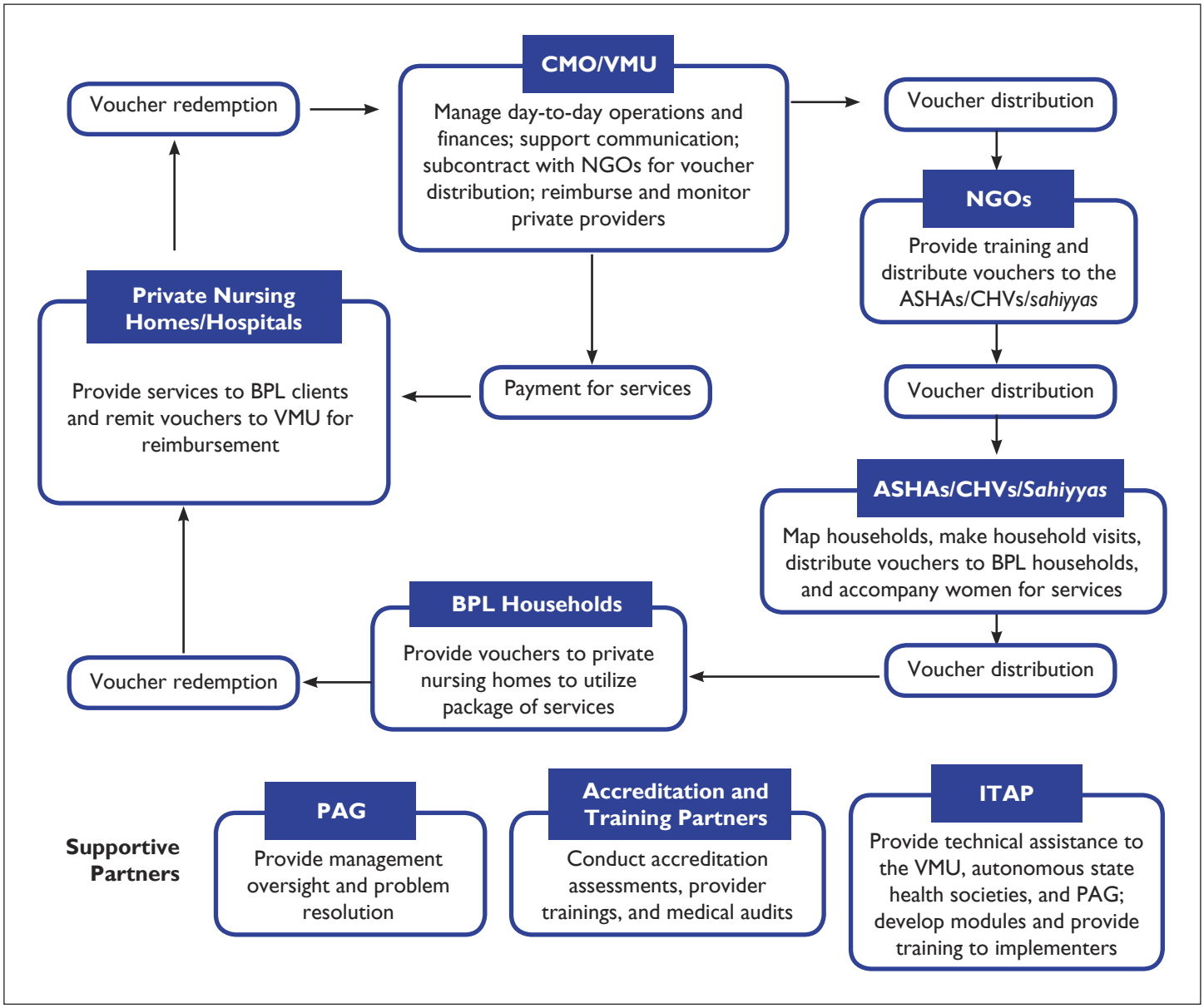
The VMUs managed the day-to-day operations of the pilot voucher programs. These responsibilities include coordinating implementing partners, building linkages with the government system, establishing quality assurance systems, distributing the vouchers, facilitating communication efforts to encourage use of services by the targeted clients, promoting continued participation of private service providers, reimbursing the providers, and collecting and analyzing data for monitoring and evaluation purposes. For effective implementation and coordination, the VMU consulted each stakeholder to determine its respective roles and responsibilities and agreements were formalized in memoranda of understanding.

The VMUs were typically headed by the CMO of the district. In Agra, the District Project Management Unit (DPMU) under DIFPSA served as the VMU. In the other sites, NGOs filled the role of or supported the VMU, including Hindustan Latex Family Planning Promotion Trust (HLFPPT) in Kanpur City; the NGO Dharam Gramin Utthan Sansthan (DGUS) in Haridwar (until the time the VMU was operationalized); and the NGO Vikas Bharti in Gumla. In Jharkhand, due to political instability and frequent transfers and changes in leadership, there was limited time to fully engage the Jharkhand Health Society and government counterparts in implementing the pilot; these are key steps for future action.

4.6 ROLE OF THE PROJECT ADVISORY GROUP

The PAGs comprised representatives of the government health system, state health societies/VMUs, private facilities, NGOs, accreditation/training partners, ITAP, and USAID/India. The PAGs met at regular intervals to review implementation progress, discuss achievements and barriers, and resolve roadblocks. They also monitored progress and ensured that high-quality services were provided to the BPL population. Based on their recommendations, course corrections were carried out as required; for example, establishing corpus funds (Box 4), organizing fixed days for sterilization at facilities to increase uptake of FP, and strengthening linkages with blood banks for emergency situations.

FIGURE 3: BASIC VOUCHER SCHEME MODEL



BOX 4: INNOVATIVE FUNDING ARRANGEMENTS TO IMPROVE CARE

To avoid delays in reimbursement, the private nursing homes/hospitals received an advance payment (e.g., Rs. 15,000) when they signed the formal memorandum of understanding with the VMU. When their services to voucher clients equaled a certain amount (e.g., Rs. 10,000), they submitted their claims to the VMU and received reimbursement for the approved claims. This approach helped to build confidence of private providers and was a key factor in encouraging them to participate in the partnership with the government.

In addition, because the poor often delay or avoid seeking preventive care, they may experience other ailments or be at higher risk for complications when they come in to avail the voucher services. To ensure treatment for emergency situations not covered by the vouchers, corpus funds (e.g., Rs. 500,000) were established at the district level to reimburse providers for unexpected, emergency expenses. Private providers could submit expenses to the VMU, which were approved by the CMO.

4.7 PROVIDER ACCREDITATION AND TRAINING PROCEDURES

Partners in the voucher scheme agreed on the need for an accreditation process. This process set standards for private providers to be eligible to participate in the scheme and served as a means for monitoring quality over time. During the initial pilot design in Agra, the Sarojini Naidu Medical College (SNMC)—with input from ITAP—played an important role in adapting accreditation guidelines based on National Accreditation Board for Hospitals and Health Care Providers (NABH) standards and evaluating providers against the criteria. SNMC reviewed and adapted government and private sector hospital accreditation standards to be more appropriate for 5–10 bedded nursing homes.[11] The accreditation assessed facilities for (1) obstetric facilities/equipment and personnel, (2) pediatric facilities/equipment and personnel, (3) display of services, (4) transportation facilities, and (5) hygiene and record keeping. A facility could receive a maximum score of 20 for each of the five areas. A nursing home/hospital was judged to have adequate quality for accreditation if it received a score of 75 out of 100.

In Agra, SNMC shared and finalized the standards in consultation with the Agra Nursing Homes Association (ANHA) and its members and other experts. SNMC was responsible for carrying out accreditation visits, developing working definitions and treatment protocols for each service in the voucher package, providing clinical training to nursing home staff, and creating a methodology for conducting clinical audits of the performance of voucher services. Building on these early efforts, ITAP assisted partners to adapt and apply the standards, training, and monitoring materials in the other pilot sites. Accreditation was undertaken by SNMC in Agra and experts from Chhatrapati Shahuji Maharaj Medical University (Lucknow) for Kanpur Nagar. In Haridwar, the District Quality Assurance Group (DQAG) conducted the accreditation visits.

4.8 ROLE AND SELECTION OF PRIVATE PROVIDERS

The providers encompass private nursing homes and hospitals that, after the accreditation process and training, offer a set package of services for free to the BPL clients. The private providers are responsible for providing high-quality services, remitting vouchers to the VMU for reimbursement, and maintaining records and reporting requirements. While selecting service providers, right at the outset, the voucher system hoped to ensure a choice for the poor by having multiple providers to choose from and using competition among them to minimize costs and maximize quality. Providers were selected based on expressed interest, ability to offer services in the benefits package for the negotiated prices, quality according to the accreditation criteria, and location/accessibility (for example, facilities near the edges of Agra City would be more accessible to rural populations in neighboring blocks).

Providers varied in size from small private nursing homes to large hospitals, as in the case of Kanpur Nagar. In most cases, providers were for-profit facilities; in a few instances, faith-based providers also participated (Kanpur Nagar and Haridwar). Some members of the Merry Gold Network—a social franchising initiative under IFPS to provide subsidized, high-quality services to the poor in Uttar Pradesh—participated

In Uttar Pradesh, a private provider is explaining a voucher to a beneficiary under the supervision of an ASHA

[11] Government guidelines exist for the quality assessment of 30 bedded community health centers and 100 bedded district hospitals. Private sector guidelines include those of the NABH.

as well. In Gumla District, where there was a dearth of private providers that could meet the quality standards, the two accredited facilities were located in Gumla Block; thus, clients from Sisai went to these facilities to avail services.

In addition to the accreditation standards, the element of competition among the providers was also intended to enhance quality as they sought to attract more clients. At times, the schemes expanded the panel of accredited facilities to additional providers to meet demand. In most pilot districts—as they saw the benefits of participation in terms of increased clientele, revenue, and social standing—more facilities were interested in joining the schemes than could be accommodated. In a few cases, facilities were replaced during implementation due to inability to meet quality standards. Thus, the specific mix and number of accredited facilities varied over time.

4.9 BENEFITS PACKAGES

The voucher system design involved a consultative process with private providers to determine the package of services to be offered through each pilot program (Table 5). The package of services was selected based on the FP/RH needs of beneficiary households, as well as the nursing homes'/hospitals' willingness and qualifications to provide services at a negotiated price. In Agra, Kanpur Nagar, and Haridwar, common elements of the packages included ANC visits, institutional delivery, PNC visits, clinical FP services (such as male/female sterilization and intrauterine contraceptive devices [IUCDs]), diagnosis tests, and treatment of reproductive tract infections (RTIs)/STIs. These packages also included immunizations, iron-folic acid (IFA) tablets, tetanus toxoid (TT), ultrasounds, and condoms and oral pills from government supplies. In addition, women (post-delivery) and the accredited social health activists (ASHAs) who accompanied them were given reimbursements to cover transportation costs. In Haridwar, it was agreed that if a case was too complicated for the provider

TABLE 5: BENEFITS PACKAGES

	Agra	Kanpur Nagar	Haridwar	Gumla
ANC	3 ANC check-ups, TT injection, IFA tablets, nutritional advice	3 ANC check-ups, TT injection, IFA tablets, nutritional advice	Minimum 3 ANC visits, inclusive of TT injection and IFA tablets; plus complications during ANC period	--
Ultrasound	Ultrasound	Ultrasound	Ultrasound	--
Delivery	Deliveries (normal, cesarean, and complicated)	Deliveries (normal, cesarean, and complicated)	Deliveries (normal, cesarean, and complicated)	--
PNC	2 PNC check-ups, breastfeeding, counseling	2 PNC check-ups	2 PNC check-ups visits inclusive of BCG, polio, pills, condoms, and counseling	--
FP	Pills, condoms, IUCDs, and male/female sterilization	Pills, condoms, IUCDs, and male/female sterilization	Pills, condoms, IUCDs, and male/female sterilization	FP services, including NSV, female sterilization, IUCD, injectables, SDM
RTI/STI	Check-ups, treatment, partner counseling	Check-ups, treatment	--	--
Neonatal and child care	Expanded Program of Immunization (EPI)	EPI	RDS, phototherapy, neonatal complication	--
Diagnostic tests	Pregnancy test, Hb test, blood group with Rh factor, blood sugar, urine examination, WR VDRL test	Hb, blood group with Rh factor, urine examination, VDRL	Hb, urine examination, VDRL, blood sugar	Urine examination and pregnancy test

TABLE 6: AGRA: BENEFITS PACKAGE NEGOTIATED RATES

	ANHA Facility Fee Range	Agra Voucher Scheme Negotiated Prices[1]
FP services:		
IUCD insertion	Rs. 0–2,000	Rs. 100 [2]
Sterilization (female)	Rs. 700–7,000	Rs. 1,000
ANC: ANC visit including IFA tablets, nutritional counseling, and TT injections as needed	Rs. 50–700/visit	Rs. 25 per visit [2] IFA and TT provided free-of-charge from CMO
Normal delivery: Supervised delivery, medicines, 3 days of hospitalization, and pediatrician fee	Rs. 800–5000	Rs. 1,500 for package
Complicated delivery: Supervised delivery, medicines, 5–6 days of hospitalization, pediatrician fee	Rs. 1,500–15,000	Rs. 3,500 for package
Cesarean delivery: Supervised delivery, medicines, 5–6 days hospitalization, anesthetist and pediatrician fee	Rs. 3,500–10,000	Rs. 5,000 for package
PNC: PNC visits, with breastfeeding and FP counseling	Rs. 50–250	Rs. 25 per visit
Other:		
Ultrasound examination, RTI/STI treatment, laboratory tests		
Blood transfusions	Rs. 100–5,000	

Source: [1] Memorandum of understanding between the CMO and nursing home (uniform format).

[2] FP and ANC supplies provided free of charge from the district CMO. Laboratory tests provided by the SNMC include Hb level, blood group and Rh factor, urinalysis, and VDRL.

to manage, it would be referred to a higher institution and travel would be arranged and reimbursed by the government.

In the case of Gumla, where improved FP was deemed the priority, the voucher scheme focused on FP services, including female sterilization, no-scalpel vasectomy (NSV), IUCD, injectables, oral pills and condoms,[12] and the Standard Days Method (SDM). In addition, the voucher program supported two full-time ambulances to provide transport to and from villages to the health facilities to seek clinical FP methods.

4.10 VOUCHER DISTRIBUTION AND REIMBURSEMENT PROCEDURES

After determining the package of services, reimbursement amounts had to be negotiated with the selected private nursing homes and hospitals. The example from Agra, the first pilot, illustrates how the process unfolded. Pricing schedules from government and private sector facilities were collected to inform the negotiating parties through a consultative meeting of the state chapter of FOGSI. The final set of negotiated prices for the voucher scheme constituted only 13 to 87 percent of the weighted average rates reported to be charged by the ANHA nursing homes (Table 6). The then Principal of the SNMC, a well-known and highly respected community medicine specialist, was a key figure in organizing meetings with ANHA members, wherein they could raise concerns related to reimbursement levels.

Decisions about the benefits packages and reimbursement rates had to consider the needs of the clients, government and donor, and providers or else the PPP model would not have been sustained. While seeking maximum value for money for the government and donor, it was also important to

[12] Oral pills and condoms were supplied during the first phase of the voucher scheme in Gumla (Sept. 2009–June 2010). During the second phase of the pilot, the government began to provide these methods for free through auxiliary nurse midwives (ANMs) and *sahiyyas*, and thus, they were no longer included in the voucher pilot.

TABLE 7: BENEFITS PACKAGE AND PROVIDER REIMBURSEMENT RATES ACROSS SITES

Type of Service	Agra Rate	Kanpur Nagar Rate	Haridwar Rate	Gumla
ANC (three visits)	Rs. 75	Rs. 75	Rs. 100	
PNC (two visits)	Rs. 50	Rs. 50	Rs. 100	
Normal deliveries	Rs. 1,500	Rs. 1,500	Rs. 2,200	
Complicated deliveries	Rs. 3,500	Rs. 3,500		
Cesarean deliveries	Rs. 5,000	Rs. 5,000	Rs. 8,000	
Ultrasound examination		Rs. 100	Rs. 150	
RTI/STI treatment		Rs. 150		
Sterilization	Rs. 1,000	Rs. 1,000	Rs. 1,500 (sterilization) Rs. 2,000 (ligation)	Rs. 2,000
IUCD	Rs. 100	Rs. 100	Rs. 100	Rs. 200
Injectables				Rs. 95
Standard Days Method				Rs. 25
Neonatal care				
RDS			Rs. 2,500	
Phototherapy			Rs. 1,000	
Neonatal complication			Rs. 500	
Incubator cost			Rs. 500/day	

Note: Vouchers also covered a range of lab tests, including Hb level, blood group and Rh factor, urinalysis, and VDRL.

ensure that the private providers did not take a loss by participating in the scheme, which most likely would cause them to drop out of the program. To reach agreement on the lower prices, it was essential to limit the number of participating private providers to ensure that each facility would be likely to attract a sufficient number of clients to offset their concerns about providing services at lower than market prices. In addition, in contrast to *Chiranjeevi Yojana*, normal and cesarean/complicated deliveries were reimbursed at different rates—recognizing the higher cost of the latter and that the 85/15 percent split used in the Gujarat scheme (based on the national average) was not necessarily applicable to the poor, who often delayed seeking assistance and thus may be more likely to face complications. Further, during the implementation phase, providers shared that it was not efficient to offer some services, such as sterilizations, on an isolated, case-by-case basis. It was agreed that designated days would be devoted to these services, thus realizing cost savings. Similar consultative processes were organized to determine rates for the other sites (Table 7). In addition, the ASHAs, CHVs, and *sahiyyas* receive remuneration for promoting services and reimbursement for their travel expenses.

The VMU managed the distribution and payment of vouchers. As shown in Figure 3, the VMU supplied the vouchers to the NGOs based on their requests. Due to lag times for printing, the VMU asked that NGOs request new vouchers when they had distributed 75 percent of their existing stock. The NGOs sent the VMU quarterly statements of progress and expenditure, which were reviewed and paid if found satisfactory.

4.11 ROLE OF THE NGOS AND COMMUNITY-LEVEL HEALTH WORKERS

4.11.1 NGO Activities

Given the importance of reaching BPL families in the communities where they live, voucher programs typically mobilize NGOs and/or community-level health workers. Under the voucher scheme, primary responsibilities of the NGOs included

- Training community-level health workers to implement the voucher scheme.
- Conducting monthly meetings with them to provide support, distribute vouchers, collect records, and pay remuneration appropriate to reported levels of performance.

- Facilitating communication and community mobilization events.
- Reporting to the VMU on block-level performance.

ITAP organized training-of-trainers courses for the NGOs and distributed a training module to provide them with the knowledge and skills needed to train community-level health workers about their role in the voucher scheme. ITAP also prepared and distributed to the NGOs a software program and forms to facilitate tracking of the NGOs' distribution of vouchers.

In Agra, the VMU contracted two NGOs that were already implementing SIFPSA-supported activities (except in Shamsabad, where there was no SIFPSA NGO)[13]. In Kanpur Nagar, HLFPPT was the VMU and served as a nodal NGO managing the activities of three NGOs, each covering about 120 slums. In the case of Haridwar, DGUS was selected to support the VMU, until the time the VMU was operationalized. DGUS performed all the functions of the VMU, including managing relationships with the government and providers, as well as distributed vouchers to and supported the ASHAs. Similarly, in Gumla, the NGO Vikas Bharti, after a competitive process, was selected as the VMU and also served as the link to community-level health workers.

4.11.2 ASHAs, CHVs, and *Sahiyyas*

The community-level health workers—women drawn from the communities they serve—are the backbone of the voucher programs. Their involvement is crucial for motivating clients to seek services, especially for services such as PNC and FP, which often are not perceived as essential by women and their families in rural, urban slum, and tribal areas. The pilot voucher schemes mobilized ASHAs, CHVs, and *sahiyyas*.

At the start of the first pilot, India had recently begun to recruit and train ASHAs under the new NRHM program to promote health services among the poor, including institutional delivery in public health facilities through the JSY scheme. ASHAs are women who have completed at least eight grades of education and are interested in providing motivation and support services to BPL women. The pilot voucher system sought to complement JSY and leverage the existing cadre of ASHAs to also encourage uptake of FP/RH services through the private sector. This process aimed to facilitate later mainstreaming of the voucher PPP model within the NRHM. As a result, ASHAs were mobilized for the voucher schemes in rural Agra and Haridwar. In Gumla, the voucher scheme oriented and trained the s*ahiyyas* (the name of ASHAs in Jharkhand), who promoted the uptake of FP services. In Kanpur Nagar urban slums, which did not have ASHAs, the voucher system relied on NGOs and CHVs. Both the ASHAs (under NRHM and the voucher scheme) and *sahiyyas* (under the voucher scheme) worked closely with ANMs. For example, in Gumla, two ANMs were posted at the accredited private health facilities, to provide counseling and support to clients referred for clinical FP services by the *sahiyyas*.

To prepare for their role in the voucher program, the ASHAs, CHVs, and *sahiyyas* received training from the NGOs and ITAP. Under the existing JSY scheme, the MOIC of the primary health center provides training to ASHAs, covering clinical and communication skills needed to build the ASHAs' overall capacity to perform. ITAP developed an additional training module to prepare the community-level health workers for participating in the voucher schemes. The training, organized by the NGOs, covered (1) how to identify BPL households; (2) the process for obtaining a *Pradhan* or (other certificate in lieu of a BPL card); (3) descriptions of services in the voucher service package and how to distribute vouchers for each service; and (4) ways to inform BPL households about the scheme and motivate them to use the complete package of voucher services. The trainings used participatory methods, such as employing role plays; and training aids, such as vouchers, empty and filled MIS formats, copies of patient record cards, guidelines for ASHAs/CHVs/*sahiyyas*, and handbills with the addresses of all the hospitals accredited.

The ASHAs/CHVs/*sahiyyas* under the voucher scheme receive remuneration, for example, for accompanying women for institutional deliveries and/or referring clients for clinical FP services.

[13] Because SIFPSA did not have an NGO program in Shamsabad Block in Agra, the medical officer in-charge of the Shamsabad primary health center distributed the vouchers to ASHAs, who distributed them to beneficiaries. The officer paid the ASHAs remuneration according to the JSY scheme.

An ASHA explains the voucher scheme to a young eligible woman

ROLES AND RESPONSIBILITIES OF ASHAs/CHVs/*SAHIYYAS*

Depending on the type of services covered by the vouchers, the ASHAs/CHVs/*sahiyyas*

- Receive BPL lists to identify BPL households in their villages and map households to identify pregnant women and other women who are married or of reproductive age.
- Raise awareness of the voucher scheme benefits and provide information on the nursing home/hospital providers and facilities.
- Encourage eligible women to use voucher services, including FP.
- Prepare a micro-plan for the timing of health system inputs during a women's pregnancy.
- Distribute the appropriate voucher at each point in a woman's pregnancy.
- Arrange transportation and accompany beneficiaries to a nursing home on the day of delivery.
- Work in collaboration with other partners such as elected representatives, community-based organizations, *anganwadi* workers, and ANMs.
- Report client perspectives and other implementation feedback to the NGOs on the quality of services.

4.12 DESIGN OF THE VOUCHER AND PATIENT RECORD

ITAP designed the voucher booklets for each type of service, and the color on the voucher coupons indicated the type of service covered. Each voucher has three parts: one retained by the ASHA/CHV/*sahiyya*, the second retained by the nursing home/hospital, and the third provided to the VMU with the claims for reimbursement. To prevent counterfeiting and misuse, holographic stickers and watermarks were added to each voucher. In addition, an eight-digit code was assigned to each voucher, enabling the VMU to identify duplicate vouchers. The numbering of the vouchers corresponded to the district and block where the vouchers were distributed. The addresses of the panel of eligible nursing homes/hospital and the VMU are provided on the back of each voucher for easy reference. NGOs distributed the voucher booklets to the community-level health workers during their weekly meetings.

ASHAs/CHVs/*sahiyyas* complete the vouchers with the names of the client, the ASHA/CHV who distributed the voucher, and the nursing home/hospital that provided the service.

Each client also received a *Jachcha Bachcha* card—or patient-held record of FP/RH information and services. ITAP designed and pre-tested the patient record for the voucher scheme with ASHAs. The card contains a record of (1) the outreach contacts made by the ASHAs/CHVs/*sahiyyas*; (2) ANC and PNC visit notes regarding findings from physical and laboratory examinations with ANMs or doctors at government and private facilities; (3) the date, place, and type of delivery; (4) the sex and birth weight of the newborn; (5) maternal and child immunizations; and (6) a growth chart to be completed by *anganwadi* workers. A pretest provided important feedback for the improvement of terminology and layout of the card. ITAP also adapted the card for Gumla, which focused on FP services.

4.13 COMMUNICATION STRATEGIES

A key finding from the review of the international and Indian experiences with voucher schemes was the need for increased awareness of not only the voucher schemes but also the importance of availing the services covered by them. This is especially true for FP, PNC, and other underutilized services, for which there may not be a perceived need among eligible families. A crucial component of the *Sambhav* voucher schemes was the development of communication strategies to create awareness about the schemes, motivate beneficiaries to use FP, generate demand for high-quality FP/RH services, and maximize use of institutional delivery benefits.

Based on the framework and assessment findings, key communications mechanisms included:

- Creating the program name, logo, and branding to identify and popularize the voucher scheme.
- Providing training and supportive supervision to strengthen the interpersonal communication (IPC) skills of the ASHAs, CHVs, and *sahiyyas*.
- Carrying out home visits and personal information-sharing sessions with households.
- Promoting community mobilization through village health days/camps and a range of mid-media, including folk media, magic shows, and theater programs.
- Distributing posters and other printed materials in priority areas.
- Reinforcing messages through selective use of mass media, such as TV and radio (especially during scale-up).

4.14 MONITORING SYSTEMS

Regular monitoring and corrective action was essential throughout the voucher system implementation process. The main mechanisms for monitoring included the following:

In Uttarakhand, a beneficiary is accompanied by an ASHA to submit a voucher at a PNH to access services

TABLE 8: MANAGEMENT INFORMATION SYSTEM FOR THE AGRA VOUCHER SCHEME

Name	Information	Origin and Recipient	Date Due
A. PMU Voucher Issuing Record	Vouchers distributed by the VMU to each NGO project coordinator. Identifies vouchers to each block and tracking ID numbers.	VMU > NGO	7th
B. NGO Voucher Issuing Record	Report by the NGO project coordinator to the VMU of the vouchers distributed by block and tracking ID numbers.	NGO > VMU	10th
C. Record of subcenter-wise ASHA recruited and trained	ASHA code.	NGOs > NGO	Updated 6th
D. Record of distribution of vouchers to ASHA	Vouchers distributed by the NGO block supervisor to each ASHA and tracking ID numbers.	NGOs > NGO	25th
E. Record of distribution of vouchers by ASHAs to beneficiaries	Vouchers distributed by a single ASHA to beneficiaries in her villages. This form is retained by the ASHA and documents her name; the name, age, sex, and spouse's name of each beneficiary; the voucher numbers; and names of the nursing homes providing the specific voucher service. This record is checked by the NGO block supervisor associated with the area in which the ASHA works.	ASHAs, with review by NGO block supervisors	25th
F. Record of services provided to BPL families in private nursing homes	Date, name of beneficiary/spouse, sex, BPL number, voucher number, type of services provided. If delivery, sex of newborn and alive or stillbirth.	Nursing home > VMU	25th
G. PMU monthly block-wise report of total beneficiaries for different services	Summary of specific services provided by block and per month.	VMU > CMO	7th
H. PMU monthly private nursing home-wise report of total beneficiaries and amount paid for services	Summary of specific services provided by nursing home and per month.	VMU > CMO	7th
I. PMU consolidated monthly report	Summary of specific services provided in district, reimbursement per service, and amount paid.	VMU > CMO & VMU > SIFPSA	

Voucher management information system. ITAP designed data entry and MIS for the NGOs and VMUs to meet the voucher system's monitoring and evaluation needs. Nine data entry forms were designed to track the distribution of vouchers to the NGOs, ASHAs/CHVs, and beneficiaries, as well as use of vouchers for each service by provider and by month (Table 8). The VMUs further compiled information from the NGOs and nursing homes to develop (1) a block-wise report of beneficiaries for different services, (2) a report of total beneficiaries for different services for each private nursing home, and (3) a consolidated report on the number of beneficiaries accessing each service. Providers completed paper records for all care provided to each beneficiary (case sheet), as well as information related to each delivery (discharge sheet).

Medical audits. Medical audits of private nursing homes/hospitals helped ensure accountability for maintaining quality standards. ITAP designed tools for the audits that assessed delivery of clinical services against the standards outlined in the accreditation criteria and protocols for each service. The audit teams comprised medical specialists, such as gynecologists and pediatricians, public health and community-based specialists, and representatives from ITAP. At periodic intervals, the audit teams investigated a sample of cases at each facility, considering the completeness of patient records, types of tests and

services provided, adherence to national standards and guidelines, the nature of complications and how they were managed, and the impact on health outcomes (e.g., maternal and neonatal deaths averted), among others. The assessment team shared feedback with facilities for corrective action, and those that could not maintain accreditation standards were discontinued from the voucher program.

Client satisfaction surveys. In Kanpur Nagar and Haridwar, ITAP conducted client satisfaction surveys with voucher beneficiaries. The surveys aimed to identify any problems in access to or availability of vouchers; assess the quality of services being provided to the beneficiaries under the voucher system; determine whether voucher beneficiaries faced discrimination or other challenges availing services at private facilities; and explore whether the beneficiaries had to make any payments for the voucher services availed at the private health facility.

Regular feedback loops. In addition to the formal monitoring mechanisms, the voucher system design encouraged feedback through a variety of mechanisms. These included the periodic meetings of the PAGs to review progress and resolve roadblocks; VMU follow-up with at least five percent of clients each month to verify the services used and enquire about quality; and feedback from the NGOs' monthly meetings where the community health workers could raise concerns and report back on the clients' perspectives. In the case of Haridwar, a rapid assessment was also undertaken to review implementation of the voucher scheme; assess the strengths and challenges of the private providers in delivering services; identify facilitating factors and barriers faced by BPL clients when accessing services; and understand the experiences of the clients who utilized the services.

Endline surveys. At the conclusion of each pilot program, ITAP conducted detailed endline surveys. The surveys, focusing on the targeted blocks, considered women's knowledge of the voucher schemes, use of various services, and to the extent possible, the effect of the voucher schemes on key health indicators. These endline surveys helped ITAP to fulfill its mission of demonstrating and documenting innovative PPP approaches.

Cost-effectiveness analysis. In addition to understanding the impact of the pilot programs, it is also crucial to understand its cost-effectiveness because this knowledge can enable governments, donors, and program planners make informed decisions about use of resources for reaching the poor. Following the Haridwar pilot, a cost-effectiveness study was undertaken, considering issues such as direct and indirect expenses incurred by the poor in seeking FP/RH services, effectiveness of the voucher scheme in expanding coverage, and efficiency of management and monitoring processes.

Together, the use of evidence, engagement of and dialogue among diverse partners, and strong mechanisms for monitoring and accountability helped to increase access to services, improve quality, and identify and address implementation challenges.

A CLOSER LOOK

BEHAVIOR CHANGE COMMUNICATION TO ENCOURAGE HEALTH-SEEKING BEHAVIOR AMONG THE POOR

The behavior change communication (BCC) strategies for the voucher schemes in Uttar Pradesh, Uttarakhand, and Jharkhand employed the same basic theoretical model, with variations based on the needs of the state, barriers and enabling factors, program interventions, and services offered. The strategies built on proven communication theories and models. The BCC strategies segmented audiences and aimed to reach them through multiple activities to reduce barriers, focus on the enabling factors, and use "positive deviants" to model desired behavior change. Through proper harmonization of interpersonal, community-based, health facility-level, and mass media activities, beneficiaries (at different life stages) could be exposed to multi-layered opportunities to understand, observe, and practice the recommended FP/RH behaviors and seek services under the voucher schemes.

Communication Needs Assessment and Barriers Analysis

The Trans-Theoretical Model of Behavior Change served as the framework for the communication needs studies. In the model, behavior change is conceptualized as a five-stage process or continuum related to a person's readiness to change: pre-contemplation, contemplation, preparation, action, and maintenance. Communication needs research attempted to map the current behavior of beneficiaries on the continuum of behavior change. Further, barriers analysis was used as a rapid assessment tool to identify behavioral determinants associated with proposed behaviors for adoption of and access to FP/RH services. For example, the barriers analysis considered the behaviors of users and non-users of services and assessed the most important determinants to address during communication strategy design. Focus group discussions and in-depth interviews with women, men, and physicians were carried out to determine beneficiary needs and their knowledge, attitudes, behaviors, and practices relating to FP/RH issues. For example, in Agra, village women and men reported that physicians are too far and services are too expensive; ANMs are seen as primarily a resource for child health services only (such as immunizations); and alternative providers (e.g., *Hakims*, "*jholla chaap* doctor") who charge lower fees are used when care is needed during pregnancy. The physicians reported that less literate women came in only when there was an emergency and often did not follow advice on maternal or child care. In Gumla, the assessment revealed various misperceptions about FP methods, explored barriers to FP use, and identified other influential audiences who must be reached to support uptake of FP, including in-laws and community leaders.

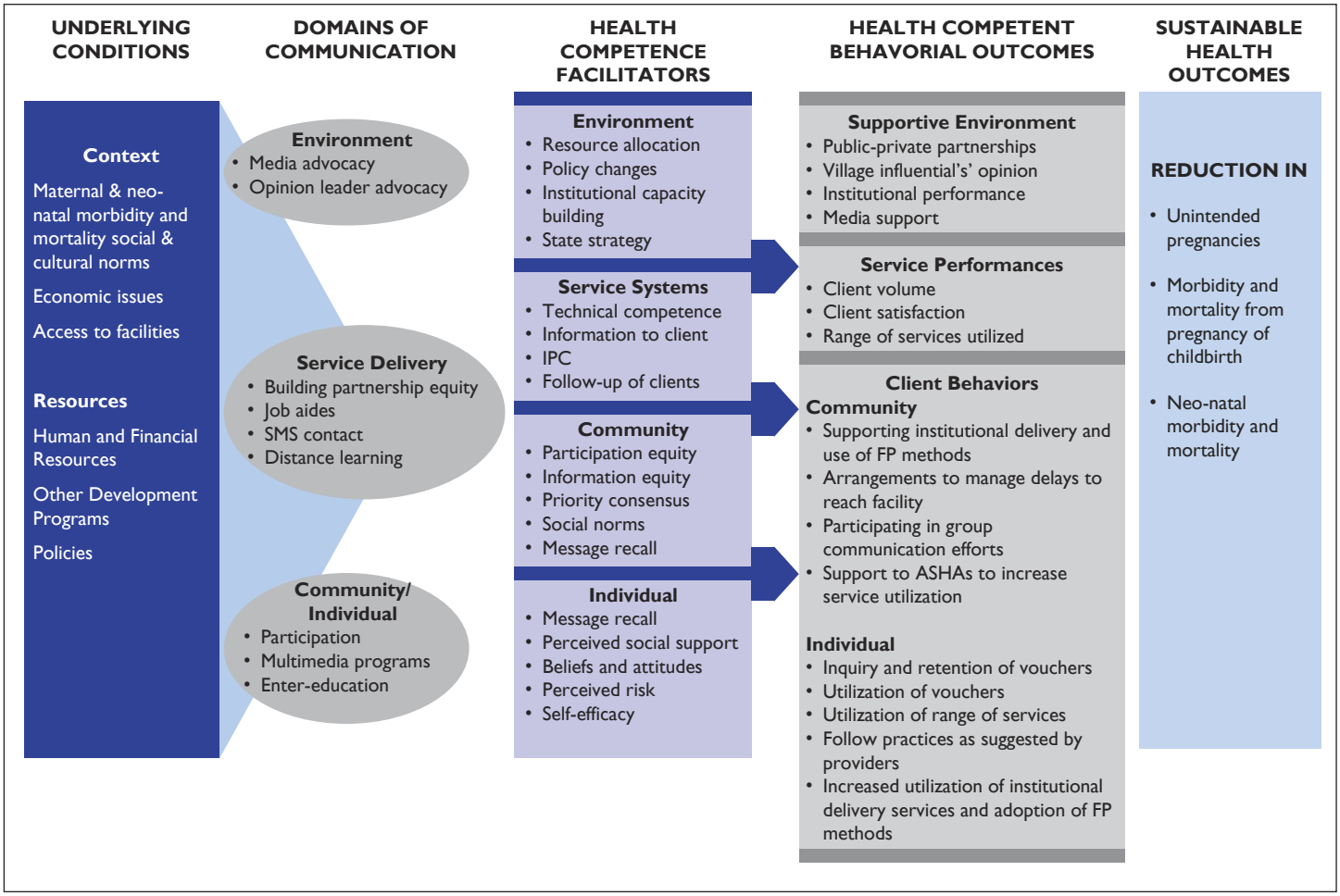
BCC Campaigns for the Voucher Schemes

Based on the assessment findings, and recognizing that behaviors are difficult to change, the communications strategies used a variety of mutually reinforcing approaches. The voucher programs adapted the "Pathways to a Health Competent Society"[14] conceptual framework to consider appropriate communication interventions at the environmental, service delivery, community, and household/individual levels and foster sustainability (Figure 4). This approach seeks to widen "the scope of behavior change communication to include creation of a supportive environment and promote improved health services, in addition to changing behaviors at the individual and community levels" (ITAP, 2011, p. 13). A health competent behavior can be defined as a behavior that individuals engage in consistently and appropriately to address the health challenges they face. This is affected by personal, social, and structural factors.

The overall objectives of the BCC campaigns in all three states remained the same, while differences were in the imagery of the materials, barriers that needed to be addressed, and media consumption patterns of

[14] This framework was developed by ITAP implementing partner, Johns Hopkins University/Center for Communication Programs.

FIGURE 4: PATHWAY TO A HEALTH COMPETENT SOCIETY: ENTRY POINTS FOR COMMUNICATION INTERVENTIONS



the beneficiaries in each state. The strategies were also adapted depending on the stage of the program (e.g., greater emphasis on mass media during scale-up and the need to reach wider populations). Overall objectives included:

- Increase adoption of positive attitudes and health behaviors related to FP/RH.
- Increase the awareness and knowledge about the *Sambhav* voucher scheme, including processes involved, services available, facilities offering services, and the awareness of the *Sambhav* brand among BPL families.
- Promote uptake of vouchers by BPL families for FP/RH services, as per their life stage and family needs.

Priority Behaviors

The needs assessments and barriers analyzes helped to identify priority behaviors for communication interventions (Table 9).

MEDIA APPROACH

Strategic Media Mix

The BCC strategies used multiple and reinforcing media channels to disseminate messages to intended audiences, including: IPC by ASHAs/CHVs/*sahiyyas*, ANMs, other healthcare providers, and influencers within the family and community; community media at the village level to ensure localization of activities and messages; facility-level media to improve service-related processes; and mass media to inform and shape social norms. The proposed media mix was based on media consumption patterns in each state, key points of contact, and the strengths and shortcomings of different approaches. The chart below displays the media mix of the campaign.

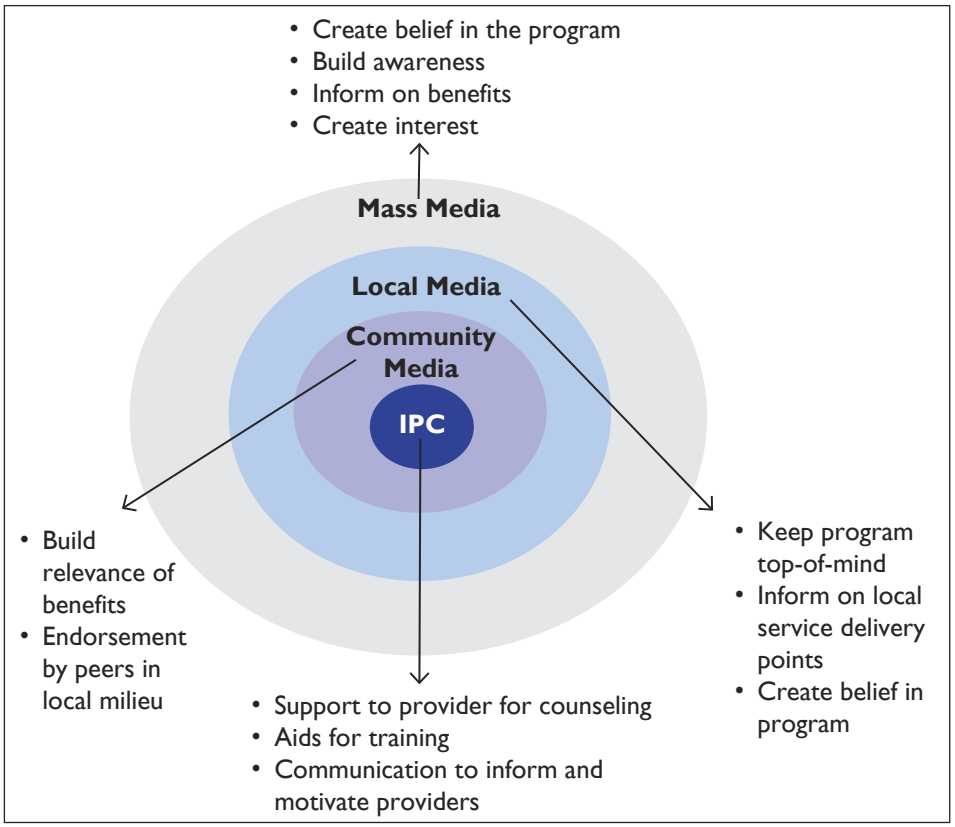
Capacity Building for BCC

The capacity-building efforts aimed to integrate BCC efforts for the voucher scheme with localized

TABLE 9: PRIORITY BEHAVIORS FOR COMMUNICATION INTERVENTIONS

Audience	Priority Behaviors	Specific Behaviors
Married women of reproductive age, from BPL families	Related to services for institutional delivery	Complete 3 ANC visits.
	Obtain a voucher of the *Sambhav* scheme from the ASHA if pregnant.	Deliver in an institution.
	Utilize the voucher to avail services of ANC, institutional delivery, and PNC under the scheme.	Register birth of child.
		Complete 2 PNC visits.
	Related to FP services	Adoption of spacing or limiting methods, as appropriate.
	Obtain a voucher of the *Sambhav* scheme from the ASHA for FP services.	If pregnant, adoption of postpartum contraception after delivery, as appropriate.
	Utilize the voucher to avail FP service under the scheme.	
Married men, 18–49 years old, from BPL families	Related to services for institutional delivery	Wife completes 3 ANC visits.
	Obtain a voucher of the *Sambhav* scheme from the ASHA if partner is pregnant.	Wife delivers in an institution.
	Utilize the voucher to avail services of ANC, institutional delivery and PNC under the scheme.	Register birth of child.
		Wife completes 2 PNC visits.
		Interaction with wife on maternal health and FP issues.
	Related to FP services	Adoption of FP methods, as appropriate.
	Obtain a voucher of the *Sambhav* scheme from the ASHA for FP services.	Communication with wife on FP issues.
	Utilize the voucher to avail FP service under the scheme.	

FIGURE 5: MUTUALLY-REINFORCING COMMUNICATION STRATEGIES



BCC initiatives of other health programs and thereby aligned with existing BCC training calendars. Training content was based on participatory, adult learning methods with techniques such as experience sharing, role plays, and games. Table 10 outlines the major training topics, trainees, and objectives.

FIGURE 6: COMMUNICATION ACTIVITIES AT MULTIPLE LEVELS

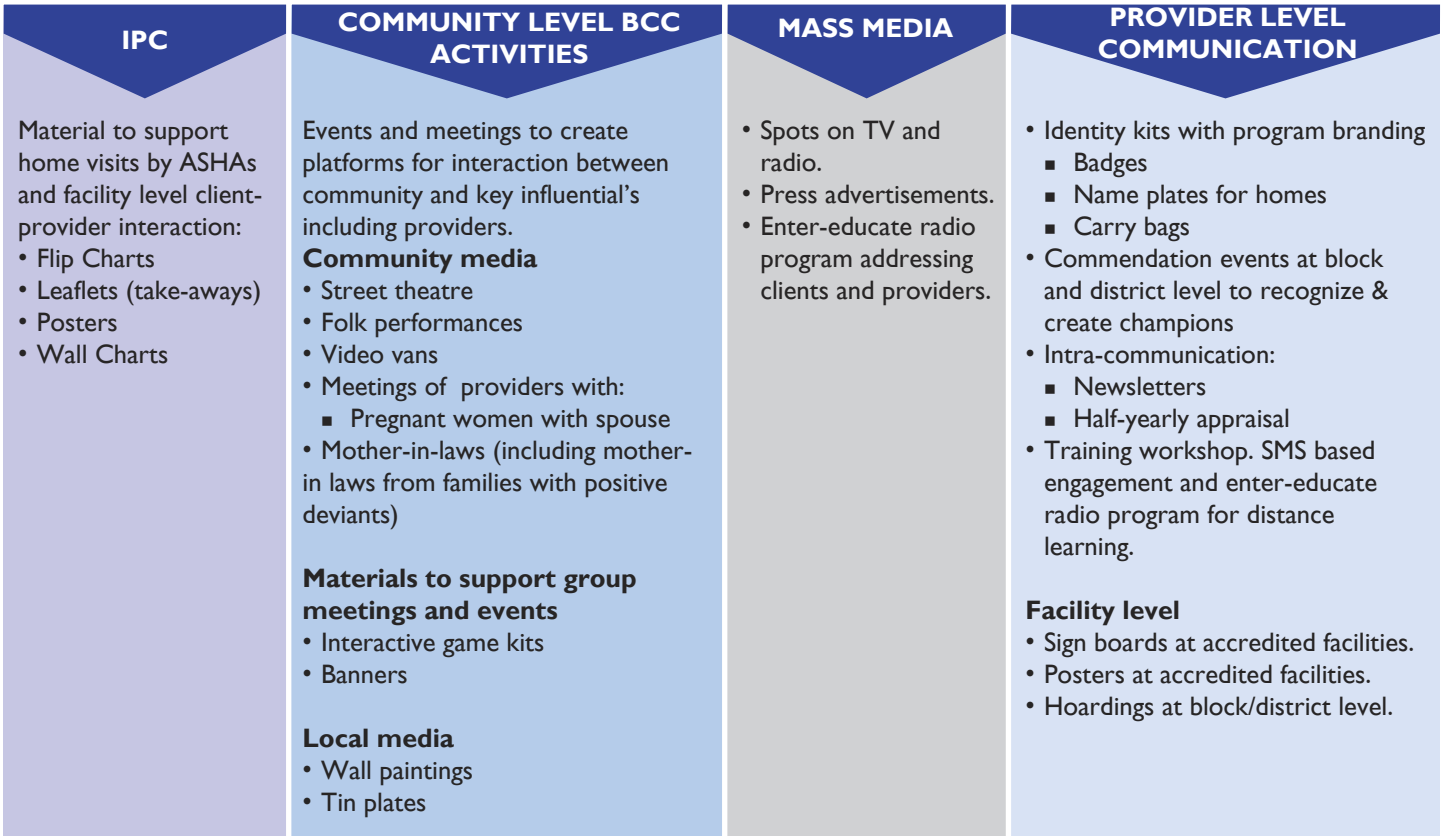


TABLE 10: BCC TRAINING COMPONENTS

Training	Objectives
BCC strategy dissemination	Appraise implementing agency and the government on the significance and content of the BCC strategy.
Training of ASHAs/CHVs/*sahiyyas* in IPC and community mobilization	Strengthen current knowledge and skills in IPC and community mobilization. Build familiarity and skills with use of facilitation materials and monitoring formats.
Training of BCC implementers	Increase knowledge about the *Sambhav* voucher scheme. Build skills in community mobilization, announcements, and communication to large audiences. Enhance familiarity and skills with use of facilitation materials and monitoring formats.
Training of private clinic staff in client-provider communication	Strengthen current knowledge and skills in client-provider communication using the GATHER[15] Approach and facilitation tools.
Training in M&E and supervision	Strengthen knowledge and skills in monitoring and supervision. Build capacity in working with research agencies for evaluations. Build familiarity and skills with use of monitoring formats.

[15] GATHER is a well-accepted approach for IPC in which the counselors are trained to greet the client (establish rapport), ask the client (gather information), tell the client (provide information), help the client (with problem solving and decisionmaking), explain to the client (key information for the decision), and return/refer/reality check. (Rinehart, Rudy, and Drennan, 1998)

Campaign Materials

Mass Media
One television and radio commercial series tracked a young couple using the multiple vouchers according to life stage using a catchy, folksy jingle. These aired on state-level television and radio channels and were used during community health fairs and other events.

Film on the Sambhav Voucher Scheme
A 10-minute film was developed on the voucher scheme to be displayed in a mid-media level activity, such as mobile video vans and the waiting areas of the health facility. This film contained the details about the scheme, how to avail vouchers, and the benefits of services for the clients.

Street Plays
In Gumla District, local folk troupes—trained in theater for change techniques and entertainment-education approaches—performed 180 street plays and 50 *haat* (weekly markets) activities to promote adoption of contraceptives and increase demand for voucher scheme services. These included dramatic stories, songs, folk music, and puppetry. Similar activities were organized in the Kanpur Nagar urban slum areas.

TIAHRT poster on FP basket of choice

Tin plates or posters on the coupons and the services offered placed at strategic places within the hospitals

Scrolls for Local Cable Television

Animated scrolls at the bottom of the television screen were developed to be displayed through local cable network channels. These scrolls were district-specific, providing contact details of the hospitals accredited under the voucher scheme.

Branding Materials for Accredited Nursing Homes and Hospitals

A range of branding materials highlighted the *Sambhav* brand and the voucher scheme.

In addition, clients needed to recognize the entire range of vouchers available for the different services offered; thus, tailored tin plates/posters were developed and placed at different locations in the hospitals.

This poster was displayed in all facilities to inform beneficiaries about the basket of contraceptives corresponding to USAID's commitment to ensure informed choice of a range of contraceptive options.

Hoardings in strategic locations in each city/town

Wall painting

Flipbook for facilitation during IPC

Outdoor Mid-Media

Hoardings and wall paintings were displayed at strategic locations in the town and cities participating in the voucher scheme.

IPC Materials

Materials were designed for facilitation by community-level workers and healthcare providers on the benefits of various services and details of the voucher scheme.

Chapter 5

ACHIEVEMENTS

The four pilot *Sambhav* voucher schemes each showed success by increasing access to services among the poor and demonstrating effective PPP models that were appreciated by policymakers, government health authorities, private nursing homes, NGOs, community-level health workers, and clients.

- Policymakers in states with the pilot voucher schemes increasingly recognize the value of partnering with the private sector to expand health services, including by integrating PPP initiatives into state health policies, budgets, and PIPs.
- For the government, the voucher schemes help to meet public health goals and reduce strain on public sector human resources and facilities. As the MOIC of the primary health center in Bichpuri Block explains, "The voucher scheme is very good in helping poor people in the villages get good-quality services."
- Private nursing homes and hospitals are willing to offer services at reduced rates in return for increased client volumes—which provides a more stable flow of resources. This is especially desirable for small C (e.g., 5–10 bed) private nursing homes that may experience fluctuations in clients from month to month. Managers of private nursing homes also report that the association with a PPP model for improving health equity was one of the salient reasons for joining the pilot scheme.
- Among ASHAs and other community-level health workers, in addition to remuneration for promoting services, they report a feeling of empowerment. The added training and supportive NGO supervision enables the ASHAs to develop skills and perform better at their jobs. The ASHAs also feel a sense of pride due to their ability to help fellow community members address health issues and gain access to high-quality services.
- Client satisfaction surveys and case studies reveal that clients, by and large, are satisfied with the quality of services received and feel that they are treated with respect. Most importantly, clients did not have to go into debt to have institutional deliveries, get treated for complications, and access FP services.

The pilot voucher programs also helped to build capacity of local counterparts through (1) training and mentoring in program management (e.g., the CMO office, state health societies); (2) accreditation monitoring, training on service standards, and upgrades to private facilities to maintain accreditation; and (3) training and mentoring of the community-level health workers. In doing so, the pilot voucher programs sought to enhance sustainability by building on existing systems in the public, private, and NGO sectors. As discussed in Section 6, the success of the pilot voucher schemes resulted in leveraging additional resources to scale up the approach in two states. Key achievements of the pilot programs are presented below.

5.1 EXPANDED SERVICE DELIVERY

Together, the pilot *Sambhav* PPP voucher schemes covered 11 rural blocks in three districts and 368 urban slums in one city, with implementation time periods ranging from about 1–2 years. In total, the vouchers enabled nearly 12,500 babies to be born in private health facilities (Table 11). The voucher schemes promoted maternal and neonatal health by supporting approximately 47,600 ANC visits and 10,300 PNC visits. In addition, the vouchers provided treatment for 6,750 RTIs/STIs. Families also availed a range of FP methods, including 2,007 sterilizations, 1,744 IUCDs, and 3,051 injectables.

ACCESS TO NEW FP METHODS IN GUMLA

Usha Devi, wife of a farmer in Bargaon village of the Gumla District, married at the age of 17 years. After marriage, she had three children in quick succession, with all deliveries taking place at home with the help of traditional birth attendants. Though she was aware of the benefits of FP, she was not able to adopt any contraceptive method due to family pressure and limited accessibility of health services in her area. Her husband is a petty cash cropper and the family struggles to make ends meet.

One day, Indu Devi, the *sahiyya* of her village, described the *Sambhav* voucher scheme, its benefits, and the basket of services for FP. Usha discussed the options available under the scheme with her husband and together they made the decision to opt for the quarterly injectables offered.

With support and guidance from the *sahiyya* and the ANMs, Usha was successfully able to obtain the injectables at a private hospital. She valued being counseled on their potential side effects and their duration. To date, she has completed three doses at the regularly prescribed intervals. The ease with which Usha could obtain services had prompted her to motivate others in the village about the benefits of FP and the *Sambhav* voucher scheme.

TABLE 11. MAJOR SERVICES DELIVERED BY PILOT AREA

	Agra (UTTAR PRADESH) Mar 2007–Jun 2008	Kanpur City (UTTAR PRADESH) Nov 2008–Aug 2010	Haridwar (UTTARAKHAND) May 2007–Mar 2009	Gumla (JHARKHAND) Sep 2009–Dec 2011 (in two phases)	TOTAL
ANC check-ups	7,771	31,413	8,407	--	47,591
Institutional deliveries	1,863	7,263	3,359	--	12,485
PNC check-ups	826	7,414	2,082	--	10,322
RTIs/STIs	1,520	5,230	--	--	6,750
Neonatal care	--	--	453	--	453
Sterilization	229	1,396	187	195	2,007
IUCDs	45	836	32	831	1,744
Injectables	--	--	--	3,051	3,051
SDM	--	--	--	165	165

Source: ITAP MIS Reports

The voucher programs helped contribute to government goals for increasing service access. For example, in the context of very low FP uptake in the Gumla District, the PPP voucher scheme contributed an additional 1.5–13.8 percentage points toward reaching block-level FP service coverage goals from April 2011–August 2011. Looking at government health system performance in another way, the PPP voucher scheme accounted for about two in five IUCDs in Sisai and nearly one in six IUCDs in Gumla Sadar. The voucher scheme also revealed strong interest in other modern methods of family planning, with injectables accounting for about 43 percent of the FP methods availed through the vouchers from October 2010–September 2011 (Box 5).

5.2 IMPROVED HEALTH INDICATORS

Key interventions for improving maternal health include (1) use of modern FP methods to prevent unintended pregnancy as well as promote healthy timing and spacing of pregnancies; (2) access to antenatal and postnatal care; and (3) delivery in a health facility assisted by trained personnel. Figure 7 presents changes in utilization of these services among currently married women in Agra, based on the district-wide baseline survey (n=1983) and the endline assessment (n=1463) that focused on the seven pilot districts.The increase in service utilization is found to be statistically significant ($p < 0.01$). (ITAP, 2009b)

The impact assessment undertaken for Haridwar enabled the disaggregation of data by BPL/non-BPL status of households in the two pilot blocks in the district.[16] This analysis shows large increases in access to ANC care, institutional delivery, and use of modern contraceptive methods among women from BPL households (Figure 8).

Beyond expanding access, choice, and quality, a major concern for the voucher programs is to promote equitable access to services for the poor. As shown in Figures 7 and 8, not only has service access among BPL households increased, but the voucher program also helped to reduce inequities in access between BPL and non-BPL households. Thus, at the endline assessment in 2009, both BPL and non-BPL households in the pilot blocks have similar levels of institutional delivery, modern FP use, and unmet need for FP.

It is clear that the voucher programs, and the quality of services in the private sector, played a key role in increasing service uptake, especially for maternal health services, such as institutional delivery. From the baseline to endline in Haridwar, even with the public sector JSY scheme, delivery in government institutions by BPL women decreased slightly (from 12.1% to 9.5%). In contrast, delivery in the private sector among BPL women more than doubled (from 15.0% to 37.5%) during the same time period, suggesting that the poor

[16] While the impact or "endline" assessment was carried out in 2009, the pilot was ultimately extended into 2010.

FIGURE 7. CHANGES IN SERVICE UTILIZATION AMONG CURRENTLY MARRIED WOMEN IN AGRA DISTRICT

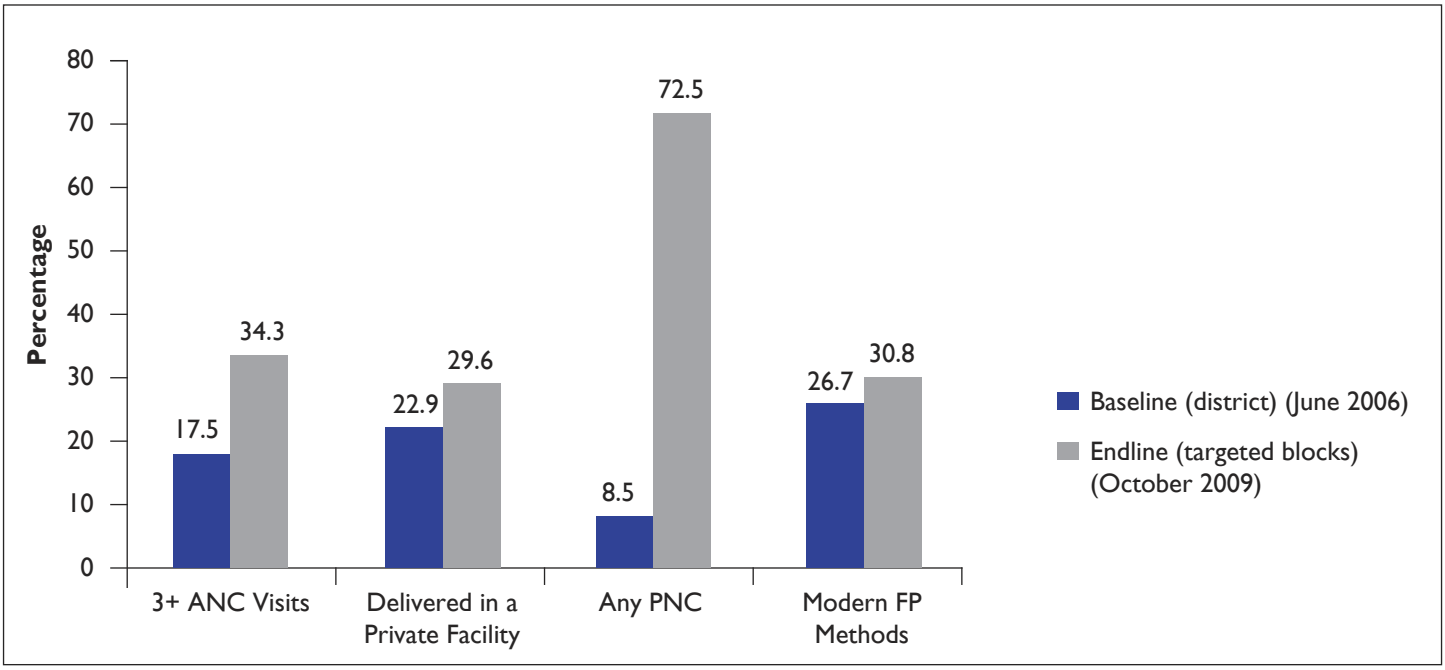
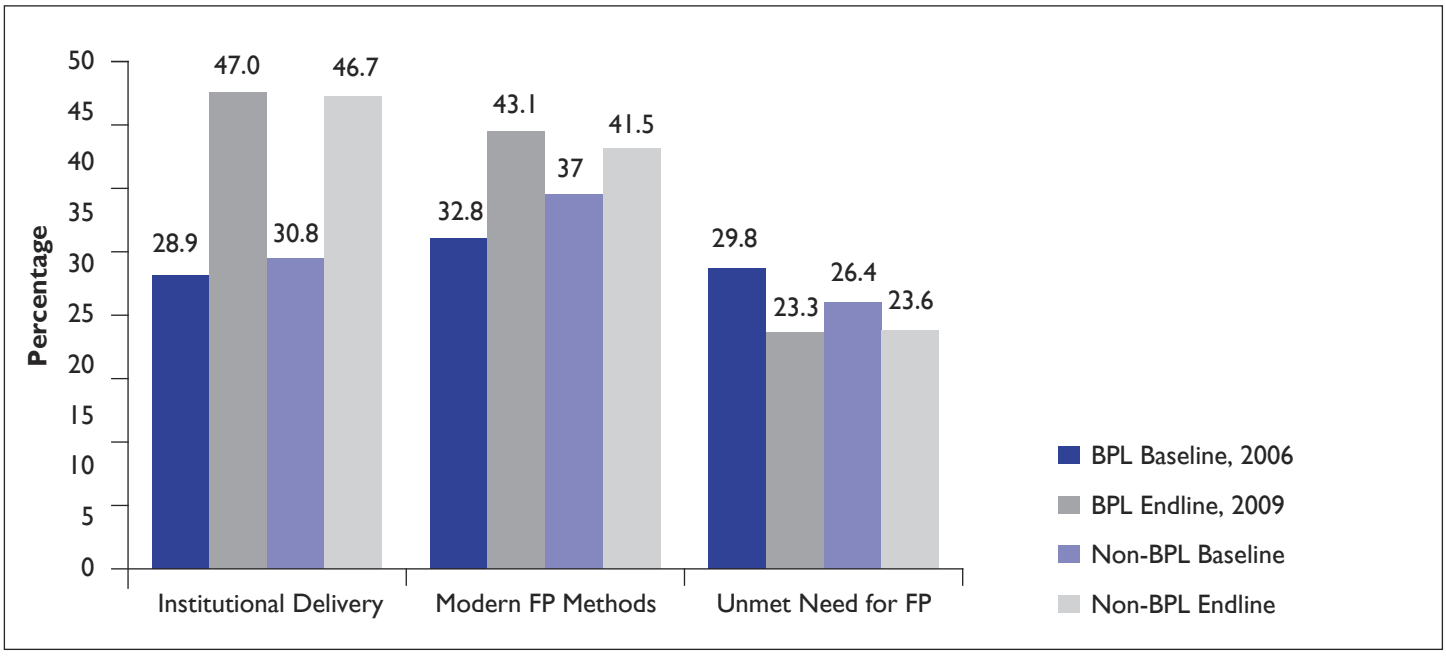


FIGURE 8. CHANGES IN SERVICE UTILIZATION AMONG CURRENTLY MARRIED WOMEN IN HARIDWAR



valued the quality of services offered by private providers. Thus, the overall increase in institutional deliveries among BPL women presented above can be attributed in large part to the *Sambhav* voucher program, which promoted deliveries in the private sector.

Similarly, the urban slums in Kanpur City do not have the benefit of programs that seek to increase institutional delivery in rural areas, such as JSY. Even so, in the slums covered by the *Sambhav* voucher scheme, there was a marked decline in home deliveries and concomitant increase in institutional deliveries.

5.3 ENHANCED CLIENT SATISFACTION

Client satisfaction surveys (in Kanpur Nagar and Haridwar), regular client follow-up, and case studies reveal that BPL clients and populations from urban slums were able to access high-quality services from private providers, felt respected by the providers, appreciated the information and support from community-level health workers, and could seek health services without incurring large debts (Box 6).

The Kanpur Nagar client satisfaction survey (ITAP, 2009c), carried out in October/November 2009, covered 699 beneficiaries in urban slum areas. The findings reveal that clients availed a variety of services through the vouchers, with the greatest interest in ANC (71.7%) and institutional delivery (55.4%), followed by PNC (42.5%) and FP (17.3%). More than eight in ten clients used the vouchers within one day (43.2%) or less than a week (37.3%) after receiving the vouchers, suggesting high demand for services and effective motivation and support for seeking services provided by the community-level health workers. Few clients reported not using the vouchers; this finding is consistent with the voucher distribution tracking MIS data for all pilot schemes, which confirm a high level of use of distributed voucher. The high uptake of the vouchers also reveals the importance of the regular contact and communication between clients and ASHAs/CHVs/*sahiyyas*, especially for encouraging typically under utilized services.

BOX 5: DELIVERY WITHOUT DEBT

Abha, a 25-year-old married woman living in the Khandauli Block had her first delivery in a private hospital by cesarean section, in 2005. Her family had to borrow Rs. 20,000 at an interest rate of five percent per month to pay for the physician's fees and hospitalization charges. Abha's husband is a day laborer with low wages, and they are still paying this debt. Abha delivered her second child by cesarean section using a voucher at one of the accredited nursing homes. She was happy with the care provided and relieved that no additional debt resulted from the delivery.

In the Kanpur Nagar client satisfaction survey, clients were also asked to rank services based on convenience, personal manner of the health professional, personal manner of the other staff, technical skills and quality of the health professionals, explanations of what was being done, cleanliness, and duration of waiting time. Overall, in nearly all cases, clients reported a satisfaction level of acceptable or higher (e.g., 2.5–5.0 on the scale) for these aspects when rating ANC, institutional delivery, PNC, FP, and treatment for RTIs/STIs. The one area that fell below this mark related to explanations of what was being done for the treatment of RTIs/STIs (~2.47).

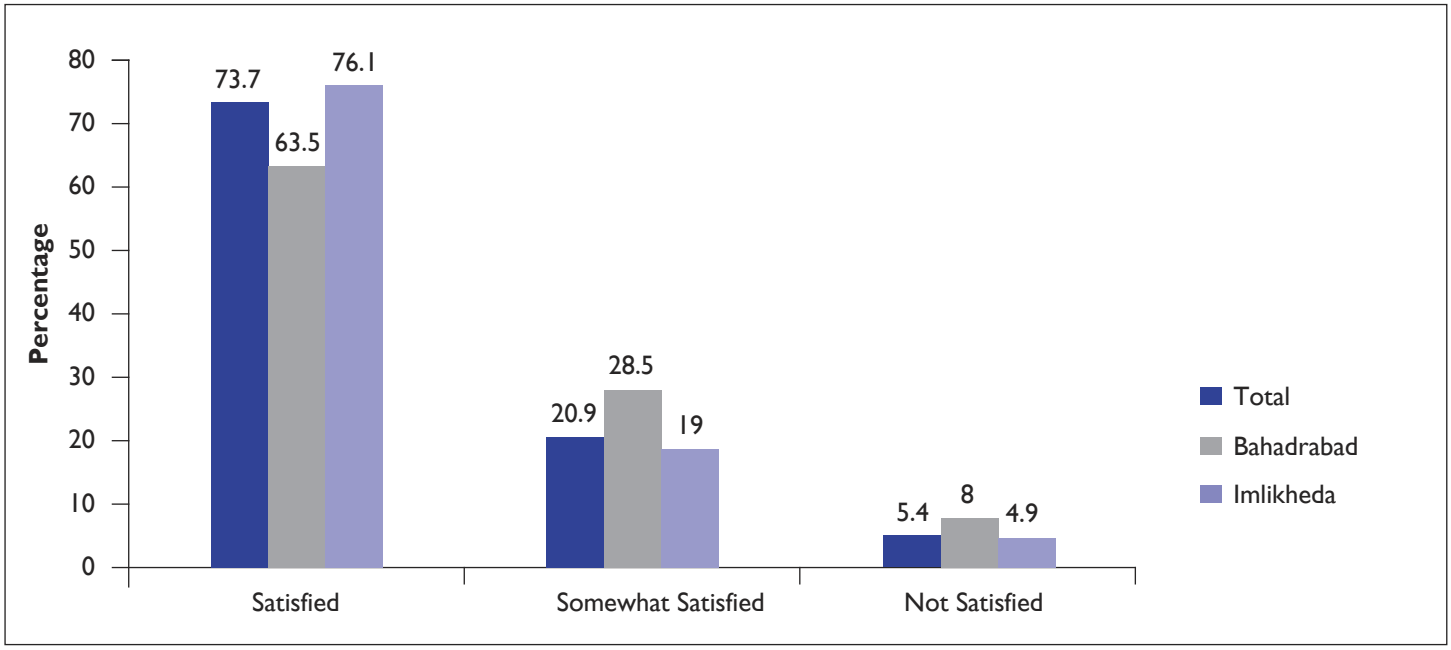
In Haridwar, the client satisfaction survey covered 320 beneficiaries in the two pilot blocks, with additional focus group discussions and interviews carried out with beneficiaries, NGOs, and ASHAs. Nearly all clients reported being satisfied (73.7%) or somewhat satisfied (20.9%) with services availed (Figure 9).

5.4 IMPROVED QUALITY, CAPACITY, AND SUSTAINABILITY

The voucher schemes encouraged quality improvement through various mechanisms including the initial accreditation assessment; improvements undertaken by private nursing homes to become accredited; periodic medical audits and corrective action to ensure standards are maintained; client satisfaction surveys; and training for service providers (e.g., on service provision standards, on infection prevention) and ASHAs (e.g., IPC skills).

Capacity building was done at three levels (Table 12) for community-level health workers (ASHAs/CHVs/*sahiyyas*), private providers (PNHs), and implementers (VMUs, voucher distribution agencies, and NGOs). The capacity-building exercise was done at regular intervals for PNHs (to continue to provide high-quality services); VMU, voucher distribution agency, and NGO staff (to continue efficient voucher management and stay up to date on FP/RH, BCC, MIS); and community-level workers (to continue their support at the field level, building on the clinical and communication skills).

FIGURE 9. LEVEL OF SATISFACTION WITH VOUCHER SERVICES AVAILED IN HARIDWAR



Source: Haridwar Client Satisfaction Survey (ITAP, June 2009).

TABLE 12. TRAINING BY NUMBERS IN AGRA, HARIDWAR, KANPUR NAGAR, AND GUMLA PILOTS

	Number Trained
Community-level Workers (ASHA/CHVs/*sahiyyas*)	
Haridwar	
Bahadrabad	259
Imlikheda	211
Kanpur Nagar (Nov. 2007–Sept. 2009)	593
Gumla (2009–2011)	830
Providers (PNHs)	
Agra	80
Haridwar	8 private nursing homes
Kanpur Nagar (Nov. 2007–Sept. 2009)	10 private nursing homes
	13 private nursing homes
Gumla (2009–2011)	29
Implementers (VMU, Voucher Distribution Agency, Field NGOs)	
Agra	120
Kanpur Nagar (Nov. 2007–Sept. 2009)	69
Gumla (2009–2011)	80

*Source: ITAP, Process Documentation of training workshops and attendance sheets

A CLOSER LOOK

COST-EFFECTIVENESS OF THE HARIDWAR PILOT VOUCHER SCHEME

A key area of interest regarding voucher schemes is their cost-effectiveness. ITAP carried out a Process-Based Cost-Effectiveness Analysis for the Haridwar pilot voucher scheme. This process-based analysis combines qualitative and quantitative data and obviates the need for normative assumptions. It is particularly useful in complex socioeconomic situations with many related but independently acting players contributing to the eventual outcome. It breaks up the complex system into identifiable independent activities. Each activity is then analyzed for its performance and impact on other interrelated activities.

The analysis and conclusions in this study were drawn from primary and secondary sources of data. Primary data were collected by interviewing health administrators and staff of the voucher management unit, administrators of seven empanelled private nursing homes, ANMs, and PRI members in August 2011. In addition, focus group discussions were conducted with ASHA and beneficiaries of the scheme. The secondary data pertaining to impact of the pilot, client satisfaction, baseline and endline surveys, as well as budget and expenditure statements were provided by the CMO office, Uttarakhand, and the voucher management unit. All qualitative and quantitative data were analyzed, and the findings were triangulated. The field visits provided an opportunity to interact with the various stakeholders involved in the pilot during 2007–2009 (Table 13) and to gain their perspectives on the program and its effectiveness in retrospect.

The effectiveness analysis focused on awareness generation, service provision, utilization of voucher services, monitoring, and quality assurance. The cost analysis used the following approaches:

- Costing analysis based on the calculation of full costs after the allocation of all indirect costs incurred in establishing and delivering the services in the pilot.
- Examining the behavior of costs and analyzing whether the pilot could cross the crash stage[17] and the implications of costs if extended beyond the achieved utilization.
- Estimating the weighted average cost of vouchers and analyzing utilization at these costs.

Two main cost centers considered while arriving at the costs are the service providers and VMU. For each cost center, total costs were accumulated and allocated to the type of voucher, which is the cost unit. Estimation of the cost of vouchers was carried out for four cost units: ANC, delivery, PNC, and FP. For the purpose of analysis, the following classifications were used:

- **Direct costs** are driven by voucher type, and use of services

TABLE 13. PRIMARY DATA COLLECTION FOR THE COST-EFFECTIVENESS ANALYSIS

No.	Stakeholders	No. of Interviews	Study Tools
1	State/district /block health administrators	12	Semi-structured interview schedule
2	Administrators of empanelled private nursing homes	7	• Semi-structured interview schedule, checklist
3	Voucher management agency (DGUS)	1	• Semi-structured interview schedule, checklist
4	PRI members	12	• Semi-structured interview schedule
5	ASHAs	76	• Individual interview schedule, checklist
6	ANMs	10	• Semi-structured interview schedule
7	Beneficiaries (mothers who availed services)	128	FGD checklist

[17] The crash stage is when the activity or project is accomplished in the shortest time possible in relation to the costs.

under the voucher can be directly attributed to the voucher. For example, the cost of the voucher paid to the hospital for normal delivery is identified as being directly attributable to the delivery voucher.

- **Indirect costs are** not directly allocated to a particular cost unit but can usually be shared/ allocated over these cost units. Indirect costs need to be allocated to the relevant cost units. For example, there may be no method of directly allocating IEC or voucher printing costs to a particular cost unit or voucher, and, therefore, these costs are an indirect cost to the different types of vouchers.
- **Overhead costs** support services that contribute to implementation of the voucher scheme. Overhead costs may include costs for planning, personnel, advisory services, and general maintenance of the voucher management office. These costs also need to be apportioned on a consistent and logical basis.
- **Pilot pre-start and research costs:** Costs incurred before the pilot began and other research costs to initiate various surveys and studies were not included in the analysis.

To evaluate the cost-effectiveness of the voucher scheme, another classification of costs was used and, for this purpose, the costs are divided among three categories:

- **Fixed costs** are not affected by the number of vouchers used by the beneficiaries in the pilot area. Initially, the per-unit fixed costs are high. As the pilot effort increases utilization of the scheme, the per-unit costs decreases. The rate at which per-unit fixed costs decrease indicates the success in utilization of these costs. These costs will include, for example, the salary of people managing the VMU.
- **Semi-fixed costs** are fixed for a given level of activity but change in steps, when activity levels exceed or fall below these given levels. For example, costs such as IEC may increase after a certain level of utilization of voucher services by beneficiaries.
- **Variable costs** fluctuate directly with the number of vouchers in the pilot scheme. For example, costs reimbursed to hospitals for the use of a particular voucher is a variable cost.

TABLE 14. WEIGHTED AVERAGE COST OF SERVICES

Types of Services	ANC	Delivery	PNC	FP	Total
Total utilization	8,407	3,359	2,082	219	14,067
Total cost (Rs)	2,319,386	11,867,203	360,888	418,838	14,966,315
Weighted average cost of services (Rs.)	276	3,533	173	1,913	1,064

Table 14 presents the weighted average cost of various services.

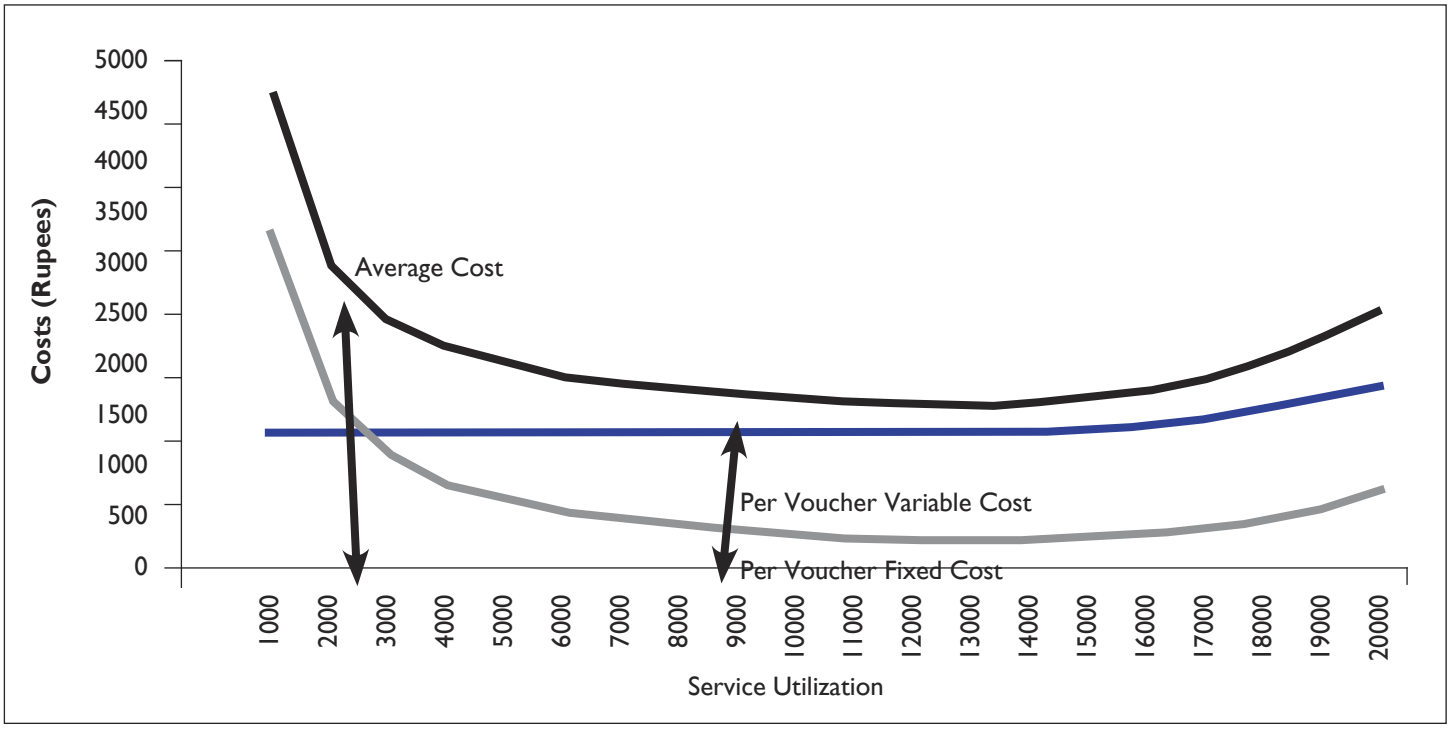
Key findings on the costing of the four services are as follows:

- The total utilization of ANC vouchers was 8,407. The number of beneficiaries using these vouchers was 5,624. The weighted average cost of one voucher is estimated as Rs. 276.
- The total utilization of delivery vouchers was 3,359. The weighted average cost of one voucher was Rs. 3,533.
- The total utilization of PNC vouchers was 2,082. The weighted average cost of one voucher was Rs. 173.
- The total utilization FP vouchers was 219. The weighted average cost of one voucher was Rs. 1,913. FP services included only surgical interventions.

These costs were substantially less than the market prices of the services. The overall utilization during the Haridwar phase was more than 14,000 vouchers, which is close to optimal levels of utilization. The pilot achieved its crash period in the first year, as use increased to 5,000. As evident from Figure 10, analysis shows that service use in the pilot phase was almost at the optimal level, where service use was at the maximum level and costs incurred were at the minimum level. The uptrend in costs would start again if utilization went up beyond 14,000. This would be due to rising fixed and variable costs that would be inevitable if more beneficiaries are reached. The costing analysis indicated that, at this point, the service use was at its peak and average per-unit costs were at their lowest.

It is observed that, beyond this level of utilization, the uptrend in costs would have started, as some of these costs are semi-fixed costs

FIGURE 10. OPTIMAL UTILIZATION GRAPH



in nature (such as IEC). Beyond a certain level of use, the program may need to provide more support to beneficiaries for availing services or cover transportation costs to enlarge the catchment area. The implications of these expenditures are that the average unit costs would rise.

Chapter 6

GOING TO SCALE

The success of the pilot voucher schemes garnered interest from the state governments in Uttarakhand and Uttar Pradesh, each taking steps to scale up the programs. Scale-up refers to "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis" (Simmons et al., 2007, p. 2). As this definition suggests, scale-up involves *horizontal* aspects (by expanding coverage and reach), as well as *vertical* aspects (by integrating innovations into national/state policies and guidelines). Planning for scale-up involves several considerations that influence the nature of how the intervention rolls out:

- *What is being scaled up?* The *Sambhav* pilot voucher schemes provided strong models to replicate, with the design informed by evidence, broad stakeholder engagement, clear roles and responsibilities, and various monitoring and feedback systems. Ideally, when scaling up, programs should adhere closely to the interventions proven to be effective during the pilot stage; however, it may be deemed necessary to make alterations to the model.
- *Who will implement the scale-up?* The pilots sought to build on existing local-level structures and systems, including the district health system, state health societies, private providers, NGOs, and community-level health workers. During scale-up, the role of the different partners needs to be clearly defined and shared; moreover, service providers mobilized during the pilot phase might not be available or appropriate in all areas where the program will be expanded, and new arrangements may be needed.
- *What is the environment?* The *Sambhav* pilot voucher schemes sought to create a conducive environment for implementation through stakeholder dialogue, formation of the PAG to address barriers, communication activities within communities, and links to technical assistance through ITAP. Taking a health program from pilot to scale requires maintaining key design elements and standards, while also having flexibility to adapt to and address local contexts. Various factors—economic, political, sociocultural, environmental, and others—affect how the scale-up efforts will unfold.
- *What technical support is required?* During the pilot, ITAP provided technical support for local institutions, including the state health societies and other implementing partners. Several barriers and challenges can be encountered during scale-up; thus, it is essential to ensure that needed support systems are in place. Setting up a program advisory group can provide a mechanism for discussing implementation challenges and exploring potential solutions.
- *What is level of scale-up needed/desired?* Key decisions relate to how scale-up is defined—for example:
  - Geographic coverage (e.g., all districts, priority districts, rural areas, urban slums).
  - Segment of the population to be targeted (e.g., women, men, all BPL cardholders, all people living in a particular slum, households falling low on the SLI).
  - Desired proportion of the targeted population to be reached (e.g., all, 80 percent, 50 percent, etc.).

These decisions will affect the resources required for and complexity involved in scale-up.

- *Are there any existing programs or models that can be built upon for scale-up?* Sustainability of promising practices can be aided

by integrating them into and building on existing policies, programs, structures, and resources. The pilot voucher schemes were designed to foster integration with India's NRHM, PIPs and state health policies, and local partners—from DQAGs to ASHAs and other community-level health workers—to help promote cost-efficiency, scale-up, and sustainability.

Throughout the scale-up process, there is also a need to advocate for buy-in among stakeholders; involve relevant parties in decisionmaking; anticipate costs and mobilize sufficient resources (human, financial, infrastructure); and carry out close monitoring to identify roadblocks, guard against unintended consequences, and refine the program. The scale-up experiences in Uttarakhand and Uttar Pradesh reflect some of the challenges inherent in scaling up promising practices and highlight the steps taken to overcome them.

6.1 UTTARAKHAND: SCALING UP VOUCHERS ACROSS THE STATE

Building on the pilot voucher scheme in two blocks of Haridwar District, the Government of Uttarakhand decided to expand the approach to five districts—Almora, Dehradun, Haridwar, Nainital, and Udham Singh Nagar. These districts encompass more than 50 percent of the state's rural population and have a large presence of private providers, which are nearly absent in the upper Himalayan regions of the state. Recognizing the limited number of private providers in those areas, the state also decided to make all BPL card holders, regardless of their district of residence, eligible for services provided by the accredited private nursing homes in the five districts. Clients in the hilly areas can receive vouchers from ASHAs in their districts or at the service sites by showing their BPL cards. Thus, the BPL population covered by vouchers has increased from an estimated 150,000 people in the pilot districts to 2.58 million people living below the poverty line across the state.

In the scaled-up model, the district program manager under the CMO serves as the district voucher scheme manager, or VMU. Rather than NGOs as in the pilot, the district MOIC facilitates voucher distribution through block coordinators and ASHAs. Clients with BPL cards can also receive vouchers directly from the private nursing points at the time of service delivery. The UKHFWS continues to facilitate the flow of funds from the Central Government and USAID to the CMO offices. The VMU signs memoranda of understanding with private providers that clearly outline the services to be provided and avenues for seeking reimbursement (Box 7). As in the pilot, the DQAGs assess private nursing homes against the accreditation standards. Medical audits and client satisfaction surveys are also carried out periodically, with the findings shared with the private

BOX 6: CLARIFYING ROLES AND RESPONSIBILITIES

A key element in the success of the voucher program has been the development of clear, mutually agreed roles. The memorandum of understanding signed by the VMU and private nursing homes in Uttarakhand sheds light on some of the ways the voucher scheme has been structured to ensure free, high-quality services for the poor.

As outlined in the memorandum, key roles of providers include the following:

- Provide "Cashless" package of services under voucher scheme completely, holistically, and without charging any monetary amount from the beneficiary.
- Provide "Cashless" package of services … ensuring quality standards and equity to BPL clients under the scheme.
- Provide "Cashless" package of services by following standard treatment protocols for basic and emergency obstetric care.

Key roles for the VMU include the following:

- Use the network of ASHAs already available in the district to identify women requiring reproductive health and eligible couples seeking FP services.
- Constitute a PAG and hold meetings at periodic intervals to discuss issues related to the voucher scheme and address grievances of the private facilities.
- Strengthen the existing financial systems for advancing and/or reimbursement of funds to private hospitals for services rendered.
- Ensure de-listing of accredited health facilities not following guidelines or violating accepted principles.

nursing homes for corrective action as needed. The remuneration for ASHAs, to reimburse for promoting services and for travel expenses, is paid by the private nursing homes directly to the ASHAs.

To date, scale-up has been carried out in two phases: April 2009–March 2011 and April 2011–March 2012.

Phase I. During the Haridwar pilot, reimbursement rates for institutional delivery had been set at Rs. 2,200 for normal deliveries and Rs. 8,000 for cesarean sections. While the pilot did not indicate an unexpectedly high proportion of cesarean sections being performed,[18] GoI had concerns that such rates would encourage private providers to perform unnecessary procedures. There were also concerns about cost-effectiveness and sustainability. Thus, after deliberations between the GoI and Government of Uttarakhand, a decision was taken to modify the rates that had been piloted. In the case of institutional deliveries, the program adopted the national average (85% normal deliveries and 15% cesarean sections) to set a reimbursement amount per delivery (Rs. 2,690). Remuneration rates for ASHAs were also set at rates lower than the pilot.

With this model in place, the scale-up commenced. Yet, an assessment of the first four months of the scaled-up program revealed that service use fell far short of the anticipated results.

Phase II. In response—feeling that scale-up could work with the proper design—state government health officials, ITAP representatives, and private nursing homes came together in district-level workshops to share feedback on the scale-up initiative. The lower rates for providers and remuneration for ASHAs, as well as the challenges in promoting the scheme to a larger client base, were identified as among the reasons for poor performance. Because reimbursement and remuneration rates were not commensurate with costs, the private nursing homes and ASHAs did not actively promote the voucher schemes as was done effectively under the pilot. Based on the discussions, the UKHFWS, USAID, and ITAP designed a new scale-up proposal in September 2010 that revised the reimbursement rates and placed greater emphasis on IPC between the ASHAs and BPL clients through home visits, village health and sanitation days, and health camps.

In revising the plan, the team considered the provider reimbursement and ASHA remuneration rates from different central and state government schemes to determine more appropriate rates for the voucher scale-up. As in the pilot, under Phase II, providers receive reimbursement for the type of delivery provided rather than an averaged amount. The amounts set at the state level are at Rs. 3,200 for normal deliveries and Rs. 5,500 for cesarean sections, with an additional Rs. 2,000 for any complications during either type of delivery. These rates are consistent with the rates determined for the state-level implementation of insurance scheme for the poor, *Rashtriya Swasthya Bima Yojana* (RSBY). Under the revised voucher scheme, itemized rates are also provided for ANC and PNC check-ups and infant care (Table 15). In addition, an emergency fund of Rs. 40,000 per district helps cover costs for unanticipated complications and medical emergencies. Further, the revised proposal raised remuneration rates for ASHAs. The revised proposal also included guidelines, such as recommended length of hospital stays for normal and complicated deliveries, and covered costs for communication activities.

Addressing the government's concerns, the margin for profit (e.g., costs incurred for providing the service vs. potential for profit) on normal deliveries is actually higher than for cesarean sections

TABLE 15: COMPARISON OF PHASE I AND II BENEFITS PACKAGES AND REIMBURSEMENT RATES

	Phase I (Rs.)	Phase II (Rs.)
ANC (3 visits) and all tests	2,690 (inclusive of all services)	450
PNC (2 visits)		100
Normal delivery		3,200
Cesarean delivery		5,500
Complications during delivery		2,000
Infant health		2,000
FP—sterilization (female)	1,200	1,500
FP—sterilization (male)	1,500	1,500
FP—IUCD	300	300

[18] From May 2007–March 2009, the Haridwar pilot voucher scheme supported 3,359 institutional deliveries—of which, 19.5 percent were cesarean sections.

under the new reimbursement scheme—thus, there is no financial reason for the private nursing homes to unnecessarily promote cesarean sections. Addressing the private sector's concerns, the new rates are more in line with the costs of providing the services without incurring losses.

> "Home delivery is the norm in my village, and my home is not an exception. In fact, my elder sister-in-law delivered her three children here at home. Following the advice of the ASHA of our village, we opted for the accredited hospital for my delivery. I was fortunate that it was a normal delivery."
>
> *— Beneficiary, Haldwani*

Results under Phase II. According to the UKHFWS, the state government recognizes "the voucher scheme is a PPP project to reduce the IMR and MMR of the state through demand-side financing and it provides an extra option to avail services in private nursing homes other than the government health facilities." Therefore, the state continued the voucher scheme, reintroducing key elements from the original design. Set up of the scheme began in April 2011, with the launch of the new package of services and reimbursement rates in July 2011. The voucher scheme has gained increasing attention from private nursing homes, which have sent requests to the district CMOs to join the program. The number of accredited providers has expanded from 25 at the start of the program to 31 as of October 2011. Another 10 private nursing homes are under accreditation assessment by the DQAGs and, once approved, this will bring the total number of providers to 41.

Early data from the implementation of the new package show an increase in the delivery of nearly all services (Table 16). Neonatal care services, which were added under the new package in May 2011, also show rapid uptake.

To ensure quality, the private nursing homes maintain a separate registry and case sheets for all voucher scheme beneficiaries, submitting monthly reports to the VMU. The VMU tracks vouchers distributed to the private nursing homes and ASHAs. It also seeks feedback on services availed through follow-up on all cesarean section cases and a proportion of ANC, PNC, neonatal, and FP clients. Periodic client satisfaction surveys and medical audits are also conducted.

The medical audits (June 2009 and June 2011) corroborated reasons

TABLE 16: TOTAL SERVICES DELIVERED UNDER PHASES I AND II

	Phase I						Transition Period	Phase II (Revised Package)		
	Oct–Dec 2009*	Jan–Mar 2010	Apr–Jun 2010	Jul–Sept 2010	Oct–Dec 2010	Jan–Mar 2011	Apr–Jun 2011	Jul–Sept 2011	Oct–Dec 2011	Total
ANC	71	168	197	296	205	267	374	1,596	1,933	5,107
Normal delivery	18	106	93	143	99	111	101	389	490	1,550
Complicated/ C-section	13	17	23	48	30	16	52	201	239	639
Eclampsia	0	2	0	3	0	0	0	0	7	12
Postpartum hemorrhage	0	6	11	13	7	4	4	8	1	54
Routine lab investigation	34	97	268	772	431	624	1,076	3,407	4,057	10,766
Ultrasound	2	18	38	37	36	40	50	632	1,057	1,910
PNC	8	42	43	74	47	76	97	569	820	1,776
Sterilizations	1	5	11	10	6	4	5	29	69	140
IUCDs	0	1	2	2	4	7	4	10	4	34
Neonatal care	--	--	--	--	--	--	89	558	752	1,372
Total	147	462	686	1,398	865	1,149	1,852	7,399	9,402	23,360

Note: * Phase I implementation planning began in April 2009. However, service delivery did not begin until December 2009.

for complicated deliveries and cesarean sections, suggesting that procedures performed were medically required. During the 2009 and 2011 audits, 65 and 56 cesarean sections were performed at the accredited facilities, respectively. Investigations into individual cases found that the indications for carrying out the procedures were justified. Reasons for performing cesarean sections included previous history of LSCS, drained out liquor with non-progress of labor, mal-presentation, mainly premature infants with breech presentation, and scar tenderness. Of the total cesarean section cases, a majority were deemed emergency cases (89% in 2009 and 80% in 2011), with the main reason being fetal distress.

Other reasons for cesarean sections performed include the following:

- Limited or delayed health-seeking behavior of the poor families, giving rise to complicated cases. It is possible that regular ANC check-ups could have helped to identify and address risk factors earlier in the pregnancies.
- Preference in rural communities for delivering at home. This preference is due to traditional beliefs and customs as well as inadequate and/or costly transportation, especially in hilly areas such as Uttarakhand.[19] Often, women and their families decide to opt for delivery in facilities only when they experience a complicated pregnancy.
- Cesarean section cases were referred from public facilities due to the lack of infrastructure and manpower in the public facilities.
- BPL families prefer public health facilities to take advantage of the JSY benefits; however, they report refraining from availing the public health facilities for complicated and cesarean section cases due to lack of faith in public facilities—as a result, they turned to the private sector in these cases.[20]

The medical audit carried out in 2011 also showed that various quality standards were being met. Capacity building and quality improvement continue to be important aspects of the scaled-up voucher program through various mechanisms, including training for service providers and implementation agencies and community-level workers is encouraged. During Phase I and II, 5,302 community-level workers, 142 private nursing home providers, and 258 implementers (VMU, voucher distribution agency, District ASHA Resource Center (DARC), DPMUs, and DQACs) were trained.

Regarding infection prevention, 50 percent of private nursing homes scored 90 points or higher, another 25 percent received 75–89 points, and the remaining quarter received 65–74 points. In addition, the client satisfaction surveys showed improvements in wait times for seeking services—which studies have identified as a barrier to women seeking services, especially when they have difficulty obtaining childcare and getting time off from work and household responsibilities.

Sustainability Plan. Facing the end of the IFPS Project in March 2012, the UKHFWS is devising a sustainability plan for the scaled-up voucher scheme. Informed by the positive developments in the uptake in services under Phase II and growing participation by providers, the UKHFWS will advocate to the state central and governments for inclusion of the voucher scheme in the next annual PIP for NRHM. Commitment for promoting PPPs, including vouchers, is already included in the new state *Health and Population Policy for Uttarakhand*, currently under review.

6.2 UTTAR PRADESH: MEETING NEEDS OF THE URBAN POOR

The urban poor population in Uttar Pradesh has grown rapidly in

A young beneficiary from an urban slum collecting medication from a private nursing home in Uttar Pradesh

[19] Baseline (ITAP, 2009).
[20] Haridwar Client Satisfaction Survey (ITAP, 2009) and Client Satisfaction Survey (ITAP, 2011).

recent decades, along with rapid urbanization. Despite close proximity to health services, the urban poor lack access to high-quality services—often, their access is as low as or lower than access among those living in rural areas. This limited access has a significant impact on the health status of the urban poor. According to the NFHS 2005-06,

- One in 10 urban poor children in Uttar Pradesh do not live to see their fifth birthday (which is even higher than in rural areas of the state).
- Only about one in five urban poor women receives the recommended three ANC checkups.
- Only 16.7 percent of urban poor newborns are born in health facilities (this contributes to high maternal and neonatal mortality among the urban poor).
- Less than one quarter (24.4%) of urban poor couples use modern contraceptive methods (an urban poor woman gives birth to an average of 4.25 children during her lifetime, which is higher than the total fertility rates in some rural areas).
- Only 15.3 percent of urban poor children receive full immunization, resulting in a high number of vaccine-preventable illnesses and deaths among the urban poor.

And, unlike rural poverty, which has declined in recent decades, the number of urban inhabitants living below the poverty line is increasing in Uttar Pradesh. The percentage of urban poor population in major towns is presented in Table 17.

TABLE 17: URBAN POOR (SLUM) POPULATION IN MAJOR TOWNS/CITIES OF UTTAR PRADESH, NFHS 2005-06

Town/ City	Total Population	Estimated Slum Population	Slum Population in %
Kanpur	2.53 million	367,000	14.5
Lucknow	2.21 million	180,000	8.2
Agra	1.26 million	121,000	9.67
Varanasi	1.10 million	138,000	12.54
Allahabad	990,000	126,000	12.72

In Uttar Pradesh, the Government of Uttar Pradesh, along with SIFPSA, scaled up vouchers in five cities for reaching the urban poor. The scale-up expands the urban slum voucher scheme from 368 slums in one city (Kanpur) to 1,562 slums in five cities (Kanpur, Allahabad, Varanasi, Agra, and Lucknow). The scaled-up voucher system was effectively launched in October 2010 in Allahabad and Varanasi, in December 2010 in Lucknow, in August 2011 in Kanpur, and in December 2011 in Agra. The expanded program has accredited 53 private nursing homes/hospitals and mobilized about 1,300 CHVs to date, with NGOs and the District Urban Development Association (DUDA) supporting voucher distribution to the CHVs. In Kanpur and Allahabad, local NGOs support the program as the voucher distributing agencies.

The goals of the voucher scheme are to

- Make institutional delivery services accessible for vulnerable populations living in urban slums.
- Enhance RH services coverage among families living in urban slums.
- Ensure the quality of RH services for poor families.
- Establish systems for accreditation, quality of care, and financial and administrative management of the scheme.
- Increase health-seeking behavior of the people living in urban slums.

The urban slum voucher scheme covers an expanded package of services, including ANC; institutional delivery (normal, complicated, and cesarean); PNC; infant immunization; FP (IUCDs, male and female sterilization, pills, and condoms); and counseling and testing for STIs and RTIs. Moreover, while the rural poor benefit from a range of health programs under the NRHM, there is currently no large scale, organized effort to meet the health needs of the urban poor. Thus, a new voucher to cover general health check-ups has been incorporated into the voucher program for the urban poor.

The vouchers are provided to vulnerable families living in urban slums through CHVs who are identified and trained by implementing agencies. In urban areas, the private sector ranges from small clinics and nursing homes to large corporate healthcare facilities. The voucher scheme encourages accessing services from facilities that have been accredited after following a due process. The facilities are accredited on various parameters such as infrastructure, trained personnel, policies, and protocols adopted for providing health

services. The accreditation guidelines also feed into the operating procedures.

The scaled-up voucher system continues to encourage quality improvement through various mechanisms such as training for service providers and implementation agencies and community-level workers. In five cities (Kanpur, Allahabad, Varanasi, Agra, and Lucknow), 898 community-level health workers, 49 private nursing home providers, and implementers (VMU and voucher distribution agency) were trained.

Vouchers serve as a tool for behavior change and initiate families into accessing high-quality services at accredited health facilities. Continuous interaction with the CHVs for each voucher helps to address doubts that the beneficiary might have. In addition, various demand-generation activities at the community level increase awareness and help motivate voucher use in communities.

Chapter 7

DISCUSSION AND WAY FORWARD

In September 2010, the GoI and United States Government (USG) signed a five-year, bilateral Health Partnership Program. USAID/India "envisions that its technical cooperation, coupled with resources from the GoI and the private sector, will continue to catalyze India's ability to improve the health system and increase access for its vulnerable populations to quality healthcare." This emphasis on meeting the needs of vulnerable populations is also reflected in the USG's Global Health Initiative, launched in 2009, which marks the latest chapter in U.S. efforts to promote health and development worldwide. The initiative calls for "making the most of every dollar to improve the health of the poorest families around the world." Innovative PPPs, such as voucher schemes for FP/RH services, present opportunities for mobilizing additional resources, expanding the service delivery network for underserved populations, targeting resources to reach the poor, and achieving economies of scale.

7.1 ELEMENTS OF SUCCESS

Several factors contributed to the achievements of the *Sambhav* voucher programs in Uttar Pradesh, Uttarakhand, and Jharkhand:

- **Evidence-based process to inform design, implementation, and monitoring.** The program implementers gathered and analyzed quantitative and qualitative data throughout the program cycle, including baseline surveys and focus group discussions with clients, analysis of existing data sets, accreditation and medical audits of private providers, close tracking of voucher distribution and use, client satisfaction surveys, PAG meetings, and other feedback mechanisms to identify and resolve implementation challenges.
- **Strengthening of existing systems to foster sustainability and ownership for implementation and scale-up.** From the onset, the voucher schemes were designed with an eye toward future scale-up and sustainability. The programs mobilized existing systems, providers, and cadre, including CMOs and DPMUs, private providers, DQAGs, medical colleges, and local NGOs and community-level health workers, such as the ASHAs trained under the NRHM. Efforts were also undertaken to integrate the PPP models into state action plans (e.g., annual PIPs) and health and population policies. This approach enhanced efficiencies and reduced costs, while helping to lay the groundwork for local ownership and sustainability.
- **Steps to build trust among all stakeholders.** The PPP model cannot work if the various partners do not live up to their obligations under the partnership; for example, if the government does not reimburse providers or ensure consistent supplies for service delivery, if the private providers fail to offer high-quality services and respect clients, or if ASHAs do not provide correct and accurate information about health issues and service options. Thus, beyond mobilizing different partners, regular dialogue and other strategies were undertaken to build trust and confidence among the key stakeholders. For example, the accreditation process addressed government concerns about quality within the private sector. For the private sector, allocation of the imprest amount at the time of signing the contract proved to be a game-changer, alleviating private sector concerns about delays in reimbursement. Plus, the transparent process of involving the private sector in the program design and pricing decision was

"PPPs are one of the strategies under the NRHM, and this scheme gives us the opportunity to engage private nursing homes for not only providing services to the needy, but also helps government institutions by sharing the case loads … The community has the advantage of getting facilities from private nursing homes situated near their homes and also has the advantage of getting services free of cost."

— CMO, Nainital

crucial. The PAG meetings, plus the monthly meetings for the community-level health workers, allowed for sharing the perspectives of the local implementing partners. Moreover, the client satisfaction surveys and regular client follow-up ensured that experiences and insights of BPL households informed the continual improvement of the program because the long-term success of the voucher scheme hinges on the quality of services provided by the health institution and satisfaction of the beneficiaries.

- **Genuine commitment for the goals of the voucher scheme.** The success of partnerships also depends on partners' genuine commitment for achieving the goals of the program. Beyond financial remuneration, both private providers and ASHAs/CHVs/*sahiyyas* were committed to meeting the needs of the poor and cited this as one major reason for participating in the program. District government officials also came to view the partnership with the private providers as a way to reach the poor and improve the overall health system performance in their districts.
- **Clear contractual guidelines and predetermined pricing for package of benefits.** Memoranda of understanding between the government and private providers outlined clear contractual roles and responsibilities for each partner. Packages including costs of services, medicines, and stay were negotiated with the private providers in advance and included in contracts ensuring free services to beneficiaries. This ensures cashless transactions. Also, the prices negotiated were set at rates below the prevailing market prices because the margins are driven by volumes.
- **Targeting of subsidies to the most vulnerable groups.** Demand-side financing mechanisms such as vouchers enable the targeting of scarce resources to groups most in need. The *Sambhav* voucher programs under the IFPS Project aimed to reach BPL households and populations living in urban slums. In most cases, vouchers were provided at the time of intended use and, where relevant, community-level health workers accompanied clients to avail services (such as institutional delivery and FP clinical methods). These strategies helped to ensure efficient use of subsidies, reduce wastage (e.g., vouchers going unused), and prevent leakage. The design of the vouchers, with tracking numbers and use of holographic images, also discouraged counterfeiting.
- **Accreditation and monitoring for quality improvement and assurance.** It is essential that high-quality services are provided through the private sector to vulnerable populations. Therefore, only those facilities that met minimum qualifying criteria (developed using the NABH standards) were included in the voucher system. Further, medical education related to infection prevention practices and service delivery protocols raised quality of services provided through the private sector. Medical audits and corrective action at the facility level also helped ensure adherence to guidelines and address gaps.
- **Choice of providers for beneficiaries.** Under the voucher system, the beneficiary can choose from a group of accredited providers to avail services. Thus, the beneficiary has the choice to go to another provider in case he/she is not satisfied with the services. Grievance redressal mechanisms through the VMU were also available, thus empowering the vulnerable populations. Further, because volume maximization is of interest to private providers, they sought to improve the quality of services to attract and retain beneficiaries. This leads to publicity for the facility through word-of-mouth, as well as ensures repeat visits of clients to avail other services.
- **Multiple communication strategies to promote demand for services.** BCC strategies were designed and IPC trainings for community workers were carried out in the pilot areas. Communication activities included airing of TV and radio spots, street plays, village-level meetings, display of wall paintings, and household visits and counseling to address myths and misconceptions about FP, institutional delivery, and other services.
- **Engagement between community-level health workers and clients.** The continuous engagement between the community-level health workers and BPL clients increased use of the vouchers. As described above, vouchers were provided right at the time of need (reducing delays or non-use of vouchers). The workers also accompanied clients to seek services and

provided significant follow-up. This engagement was essential for changing attitudes and behaviors toward underutilized services, such as ANC, PNC, and FP.

7.2 OTHER INSIGHTS FROM IMPLEMENTATION EXPERIENCES

While voucher schemes are one option for improving access of the poor to health services, some questions have been raised, both in India and internationally, about the implementation of these programs. The pilots and scale-up experiences from Uttar Pradesh, Uttarakhand, and Jharkhand shed light on some of these debates.

7.2.1 Complementarity or competition among different approaches for reaching the poor

Some contend that vouchers may be redundant or have limited impact due to competition with other programs. In India, the GoI has designed several approaches for reaching the poor; chief among these are JSY and RSBY. JSY is a conditional cash transfer program in which pregnant BPL women who avail at least three ANC visits and have an institutional delivery in a public sector facility receive a specified amount of money. RSBY is a health insurance program that provides Rs. 30,000 to a BPL family to cover treatment and preventive services related to more than 700 health conditions; one limitation of this program is that a severe illness or health problem can use up most of the family's insurance for the year.

Common feedback from the *Sambhav* voucher scheme implementers and clients is that these various programs are complementary, rather than competitive, and that all are necessary given the very large population living below the poverty line (Box 8). For example, studies show that the health of women—including reproductive and maternal health needs—are often de-prioritized in families. JSY and vouchers can enable women and children to access services, saving RSBY to cover other health needs of the family. Further, poor families in need of the cash transfer can avail JSY in the public sector while other families may decide that the shorter wait times and improved quality are more important and, thus, opt for using vouchers for private providers.

To ensure complementarity, however, proper training of ASHAs, other community-level health workers, NGO functionaries, and healthcare providers in both the public and private sectors is required so that they are knowledgeable of the various schemes available to the poor. Rather than promoting one scheme or another, the primary aim should be to encourage the poor to seek health services and provide them adequate counseling about their options. This will enable the poor to decide for themselves which program is right for them. In this way, the presence of different programs can help to respond to the varied needs of BPL families.

7.2.2 Identification of eligible clients

Demand-side financing mechanisms seek to improve the equity and efficiency of health expenditures by targeting subsidies directly to the clients most in need, thus preventing leakage of benefits to non-poor clients who can afford to pay for services. Targeting resources to the poor, by design, requires a way of identifying eligible clients and preventing misuse by non-eligible clients. To that end, the *Sambhav* voucher schemes were effective in limiting leakage of benefits to non-poor families, for example, by using the holographic images on vouchers, close tracking of each voucher, accompanying voucher clients to avail services, ensuring follow-up with clients (both by the VMU and ASHA interactions), and distributing vouchers at the point of time when the service will be availed (thus limiting opportunities to sell or re-distribute the vouchers to others). The rare cases of leakages (e.g., non-poor families demanding vouchers from ASHAs) were reported to and redressed by the VMU.

The greater challenge is ensuring that all families who are indeed poor can access the program. As some way of determining eligibility is required, the *Sambhav* vouchers sought to reach BPL families in rural

BOX 7: DIFFERENT OPTIONS FOR BPL CLIENTS

Sudha, a beneficiary from a BPL household in the Bichpuri Block, indicated that she had used vouchers for three ANC visits and that she was extremely happy with the services she had received from the nursing home. However, she has decided to have her delivery at a public institution, as the Rs. 1,400 incentive under JSY will provide more financial support for her family. Thus, in this case, even though Sudha did not use all of the services in the benefit package, she did receive good-quality ANC with a trained provider and will have an institutional delivery—a primary objective of the JSY and *Sambhav* voucher system.

areas and inhabitants of urban slums. Eligibility was based on having the government-issued BPL card, a ration card (for those living in slum areas), or certificates from the community leaders or municipal authority. In doing so, the vouchers were able to reach a significant proportion of the poor. However, many families may lack the BPL cards and seeking certificates can cause added delays. Thus, the success of the scale-up of vouchers and other programs depends on a strong government system to accurately map poor households, regularly update BPL lists, and issue BPL cards to those who qualify. Other methods can also be introduced for setting eligibility criteria—for example, geographic targeting (e.g., all slum inhabitants) or targeting based on a standard of living index (e.g., considering the type of dwelling and other households assets).

7.2.3 Influence of Reimbursement Rates on Service Delivery

Encouraging institutional delivery among the poor is often a primary goal of FP/RH voucher programs. Two primary concerns have been raised with regard to vouchers and institutional delivery: (1) higher reimbursement rates for cesarean section may encourage private provides to perform unnecessary procedures; and (2) the private sector may be more likely to refer complicated cases to the public sector so that they avoid incurring extra costs that cannot be reimbursed.

As described in Sections 4 and 6, design of the benefits packages and reimbursement rates had to consider the needs and interests of various stakeholders, including the government and donors, private providers, ASHAs, and clients. The voucher implementation experiences showed the following:

- Rates that are set too low will discourage providers from promoting or actively participating in the voucher program, as in the first phase of the Uttarakhand scale-up experience. Rates must consider the actual costs for different types of deliveries, yet be set so that potential profit margins are similar regardless of the type of delivery (this approach is adopted in the second phase of the Uttarakhand voucher scale-up).
- When rates are set too low or do not cover all costs incurred, then there could be cases where the private sector does refer clients to the public sector. However, the reverse has been witnessed under the *Sambhav* voucher programs, where public sector health officials report referring complicated cases to the private sector due to the shorter wait times and ability to respond to emergency situations. Moreover, innovative approaches—such as establishing the corpus funds for emergency expenses, linking private providers with hospitals to ensure supplies for blood transfusions, and regularly monitoring and following up with clients—can be set up to ensure proper treatment of complications by private providers.
- Higher reimbursement rates for cesarean section do not necessarily translate into unnecessary procedures being performed. To begin with, India's national average for type of institutional delivery is 85 percent for normal deliveries and 15 percent for cesarean sections. Without additional study, it is difficult to know whether this proportion is relevant for the poor because several factors could lead to a higher proportion of complications among this population. For example, the poor are more likely to seek services in a facility only when there is an emergency or complication (preferring to deliver at home for normal deliveries). In addition, when they do seek services, due to poor health and nutrition, BPL clients may be more likely to suffer from anemia and other conditions that put them at greater risk for complications. Plus, anecdotally, public sector providers and ASHAs in the *Sambhav* voucher blocks reported referring complicated cases to the private sector. All these factors can contribute to the proportion of cesarean sections performed being higher under the voucher schemes than the national averages.

That being said, data from the Haridwar pilot demonstrate that the higher reimbursement rate (e.g., Rs. 8,000) did not lead to an unexpectedly high proportion of cesarean sections. Quarter-wise data from May 2007–March 2009 indicate that the proportion of cesarean sections or complicated deliveries among voucher clients varied from a low of 19 percent to a high of 22 percent per quarter. Data from the 2008 client satisfaction survey in Haridwar also show that the proportion of cesarean sections among BPL families in the pilot blocks did not differ significantly and, in fact, was slightly lower than for non-BPL families in the same block (Figure 11).

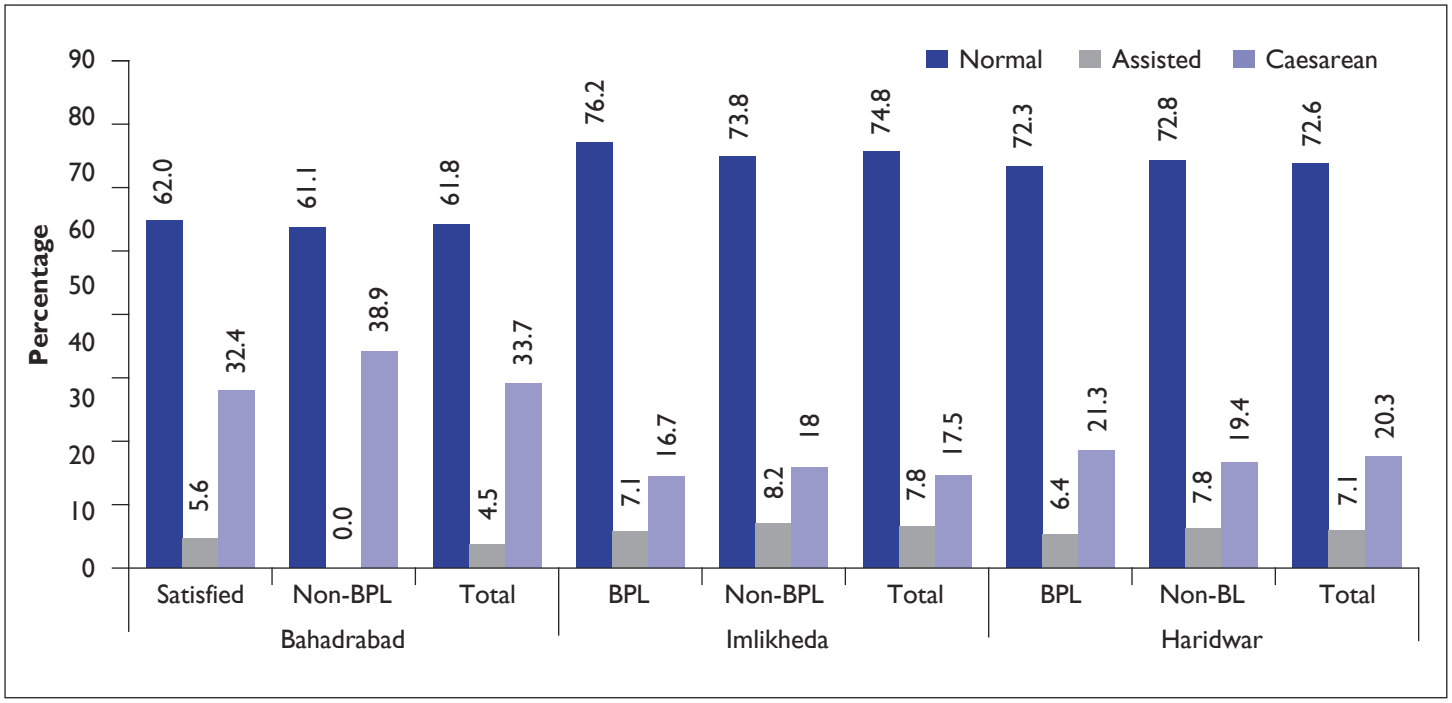
Additional research is needed to investigate the likelihood of delivery

complications among the poor, which can help establish a standard against which to assess programs. In addition, monitoring and evaluation is crucial. For example, in the Uttarakhand scale-up model, the VMU follows up all cases of cesarean sections to verify the diagnosis and adherence to guidelines.

7.3 RECOMMENDATIONS FOR STRENGTHENING VOUCHER PROGRAMS

- **Empowering the poor.** A key goal of the *Sambhav* voucher programs was to promote access, choice, and quality for the poor. The vouchers helped to do this by enabling access to free services in the private sector, accrediting a panel of private providers from which to choose, and employing various mechanisms to monitor and improve quality of services. Moreover, ASHAs and other outreach workers advised on services and provided an essential link between the poor and health services. Going forward, additional efforts are needed to empower the poor to make decisions regarding their health. These efforts should include provision of information on the full range of programs and schemes so that the poor can decide which program and provider is right for them.
- **Expanding services and avoiding missed opportunities.** Due to myraid barriers, the poor rarely seek health services in facilities and typically only do so in cases of emergencies. Thus, once a poor client reaches the health facility, the contact opportunity should not be lost. Since many factors influence whether the clients reach the facilities, providers should use each opportunity to counsel and advise the beneficiary about appropriate health-seeking behavior. Similarly, in cases of emergencies, there should be a cross-referral system to transfer the client on to another private nursing home or other facility that might be better suited to handle the situation. Such a system would prevent cases where BPL clients may be referred to external agencies and have to spend significant amounts of money. An internal referral would not only strengthen service quality within the voucher system but would also maintain a good reputation for the program. Because vouchers are modular in nature, it is relatively easy to add vouchers to the scheme (e.g., malaria or other services) as long as the appropriate service provision, referral, and follow-up mechanisms are in place. In Uttar Pradesh, for example, beyond FP/RH services, the scale-up voucher program for urban slums added a General Health

FIGURE 11: TYPE OF DELIVERY IN HARIDWAR, 2009



Source: Haridwar Client Satisfaction Survey (ITAP, June 2009).

Check-up voucher to promote preventive health-seeking behavior among the poor.

- **Sustainable financing.** The *Sambhav* voucher models demonstrated effective partnership mechanisms engaging the public and private sectors to meet the health needs of the poor. Demand-side financing mechanisms can help direct scarce government resources to those most in need. The design and implementation of the vouchers, as described above, sought to build on existing policies, plans, systems, and cadre to help support long-term sustainability. With the phase-out of donor funding, the continued success of the voucher scale-up depends on central and state policymakers ensuring sustainable financing for the program.
- **Research on implementation and impact of scale-up.** The pilot vouchers helped to expand FP/RH service access among BPL populations and improved health indicators, such as modern contraceptive use and institutional delivery. The early scale-up initiatives have also demonstrated challenges and successes in expanding the voucher beyond the initial pilot areas. Additional research will be needed to assess the impact of the scale-up on health outcomes, such as total fertility and maternal and child mortality. Close monitoring will also be needed to monitor quality of the scaled-up voucher programs, identify and document implementation challenges, and inform corrective action, as needed.

ANNEXURES

Annexure A

BASELINE AND ENDLINE SURVEYS

The four baseline and endline surveys include the following:

- *Haridwar Baseline Survey 2006: Imlikheda and Bahadrabad Blocks* (ITAP, 2007a).
- *Reproductive and Child Health Status in Slum, Non-slum, and Rural Areas of Agra: Baseline Survey, 2006* (ITAP, 2007b).
- *Reproductive and Child Health Status in Slum, Non-slum, and Rural Areas of Kanpur Nagar: Baseline Survey, 2006* (ITAP, 2007c).
- *Baseline Survey for Pilot Project of Voucher Scheme in Gumla District of Jharkhand: Final Report* (ITAP, 2010).

The sample populations for each survey are presented below.

SAMPLES FOR THE BASELINE AND ENDLINE SURVEYS

	Target No. of Households	No. of Households Completed	No. of Currently Married Women, aged 15–49 years	No. of Children Under 5	No. of Currently Married Men, aged 20–54 years	Fieldwork
Agra	5,000	4,777	4,742	4,545	NC	June–July 2006
Baseline (Rural)	2,000	1,919	1,983	3,091		
Endline (Rural)	2,000	1,398	1,463	NC	NC	Oct 2009
Kanpur Nagar	5,000	4,781	4,806	4,246	NC	June–July 2006
Baseline (Slum)	1,500	1,422	1,428	1,294		
Endline (Slum)	1,500	1,462	1,280	683		Jan–Feb 2012
Haridwar						
Imlikheda						
Baseline	1,200	1,144	1,087	1,007	NC	Nov–Dec 2006
Endline		701	684	351		June–July 2009
Bahadrabad						
Baseline	1,200	1,134	1,046	959	NC	Nov–Dec 2006
Endline		752	640	340		June – July 2009
Gumla*						
Baseline	1,270	1,181	512	NC	511	Dec 2009–Mar 2010
Sisai						
Baseline	930	841	393	NC	319	Dec 2009–Mar 2010

Note: NC – Not collected

* Details of endline for Gumla are awaited.

REFERENCES

Bellows, Nicole M., Ben W. Bellows, and Charlotte Warren. 2011. "The Use of Vouchers for Reproductive Health Services in Developing Countries: Systematic Review." *Tropical Medicine and International Health* 16 (1): 84–96.

Bhat, R., D.V. Mavalankar, P.V. Singh, and N. Singh. 2009. "Maternal Healthcare Financing: Gujarat's *Chiranjeevi* Scheme and Its Beneficiaries." *Journal of Health, Population, and Nutrition* 29: 249–258.

Bhat, R., A. Sinha, S. Maheswari, and S. Saha. 2006. "Maternal Health Financing: Issues and Options: A Study of Chiranjeevi Yojana in Gujarat." Ahmedabad: Indian Institute of Management.

Bhatia M.R., C.A. Yesudian, A. Gorter, and K.R.Thankappan. 2006. "Demand-Side Financing for Reproductive and Child Health Services in India." *Economic and Political Weekly* 41(3): 279–283.

Castro-Leal, F., J. Dayton, L. Demery, and K. Mehtra. 2000. "Public Spending on Health Care in Africa: Do the Poor Benefit?" *Bulletin of the World Health Organization* 78 (1): 66–74.

Donaldson, D., H. Sethi, and S. Sharma. 2008. *Vouchers to Improve Access by the Poor to Reproductive Health Services: Design and Early Implementation Experience of a Pilot Voucher Scheme in Agra District, Uttar Pradesh, India*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Gorter, A., P. Saniford, Z. Rojas., M. Salvetto. 2003. "Competitive Voucher Schemes for Health: Background Paper." Managua, Nicaragua: Instituto Centro Americano de la Salud.

Gupta, Indrani, William Joe, and Shalini Rudra. 2010. "Demand Side Financing in Health: How Far Can It Address the Issue of Low Utilization in Developing Countries?" *World Health Report Background Paper* No. 27. Washington, DC: World Bank.

Rinehart, W., Rudy, S., and Drennan, M. 1998. *GATHER Guide to Counseling. Population Reports, Series J, No. 48.* Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Innovations in Family Planning Services (IFPS) Technical Assistance Project (ITAP). 2007a. *Haridwar Baseline Survey 2006: Imlikheda and Bahadrabad Blocks*. Gurgaon: Futures Group.

International Institute for Population Sciences (IIPS), 2006. *District Level Household and Facility Survey (DLHS-2), 2002-04: India.* Mumbai: IIPS.

International Institute for Population Sciences (IIPS) and Macro International. 2007. *National Family Health Survey (NFHS-3), 2005–06:* India: Volume I. Mumbai: IIPS.

ITAP. 2007b. *Reproductive and Child Health Status in Slum, Non-slum, and Rural Areas of Agra: Baseline Survey, 2006*. Gurgaon: Futures Group.

ITAP. 2007c. *Reproductive and Child Health Status in Slum, Non-slum, and Rural Areas of Kanpur Nagar: Baseline Survey, 2006*. Gurgaon: Futures Group, ITAP.

ITAP. 2009. "Customer Satisfaction Survey for Voucher Scheme: Haridwar."Gurgaon: Futures Group, ITAP.

ITAP. 2009a.*The Accomplishment: Haridwar Voucher*. Gurgaon: Futures Group, ITAP.

ITAP. 2009b. "Endline Evaluation of Voucher Project, Agra-—Final Report." Gurgaon: Futures Group, ITAP.

ITAP. 2009c. "Final Report: Client Satisfaction Survey for Voucher System in Kanpur Nagar, 2009."Gurgaon: Futures Group, ITAP.

ITAP. 2010. "Baseline Survey for Pilot Project of Voucher Scheme in Gumla District of Jharkhand: Final Report." Compiled by GfK Mode Pvt Ltd. Gurgaon: Futures Group, ITAP.

ITAP. 2011. *Behavior Change Communication Strategy for Voucher Scheme: Uttar Pradesh*. Gurgaon: Futures Group, ITAP.

ITAP Forthcoming. *Customer Satisfaction Survey for Voucher System*: Haridwar: Draft Report.

Liberhan, T. 2011. *Sambhav Voucher Scheme: Jharkand.* Gurgaon: Futures Group, ITAP.

Marmot, M. 2007. "Achieving Health Equity: From Root Causes to Fair Outcomes." *The Lancet* 370: 1153–1163.

Meyer C., N. Bellows, M. Campbell, and M. Potts. 2011. *The Impact of Vouchers on the Use and Quality of Health Goods and Services in Developing Countries: A Systematic Review*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Planning Commission. 2009. *Economic Survey, 2008–09*. Delhi: Government of India, Planning Commission.

Registrar General, India. 2001. "Census of India, Provisional Totals, 2001." Delhi: Registrar General, India.

Registrar General, India. 2011. "Census of India, Provisional Totals, 2011." Delhi: Registrar General, India.

Shepherd, C. 2010. *Reducing Inequities in Reproductive Health Care through Voucher System: The Uttarakhand and Uttar Pradesh Experience.* Gurgaon: Futures Group, ITAP.

Simmons, R., P. Fajans, and L. Ghiron (Eds.). 2007. *Scaling Up Health Service Delivery: From Pilot Innovations to Policies and Programmes.* Geneva: World Health Organization.

United Nations Children's Fund (UNICEF). 2009. "MDG-5: Improve Maternal Health: MDG Target 5.A: Reduce by Three Quarters the Maternal Mortality Ratio." Gandhinagar, Gujarat, India: UNICEF Gujarat State Office.

Winfrey, W., V. Jayachandran, and R. Sanders. 2006. *Maternal Health and Vaccination Expenditures in Uttar Pradesh.* Gurgaon: Futures Group.

World Bank. 2005. *A Guide to Competitive Vouchers in Health*. Washington, DC: World Bank.

Editing, Design and Printing
New Concept Information Systems Pvt. Ltd.
Email: communication@newconceptinfosys.com

US Agency for International Development
American Embassy
Chanakyapuri
New Delhi – 110 021
INDIA
Tel: (91-11) 2419 8000
Fax: (91-11) 2419 8612
www.usaid.gov