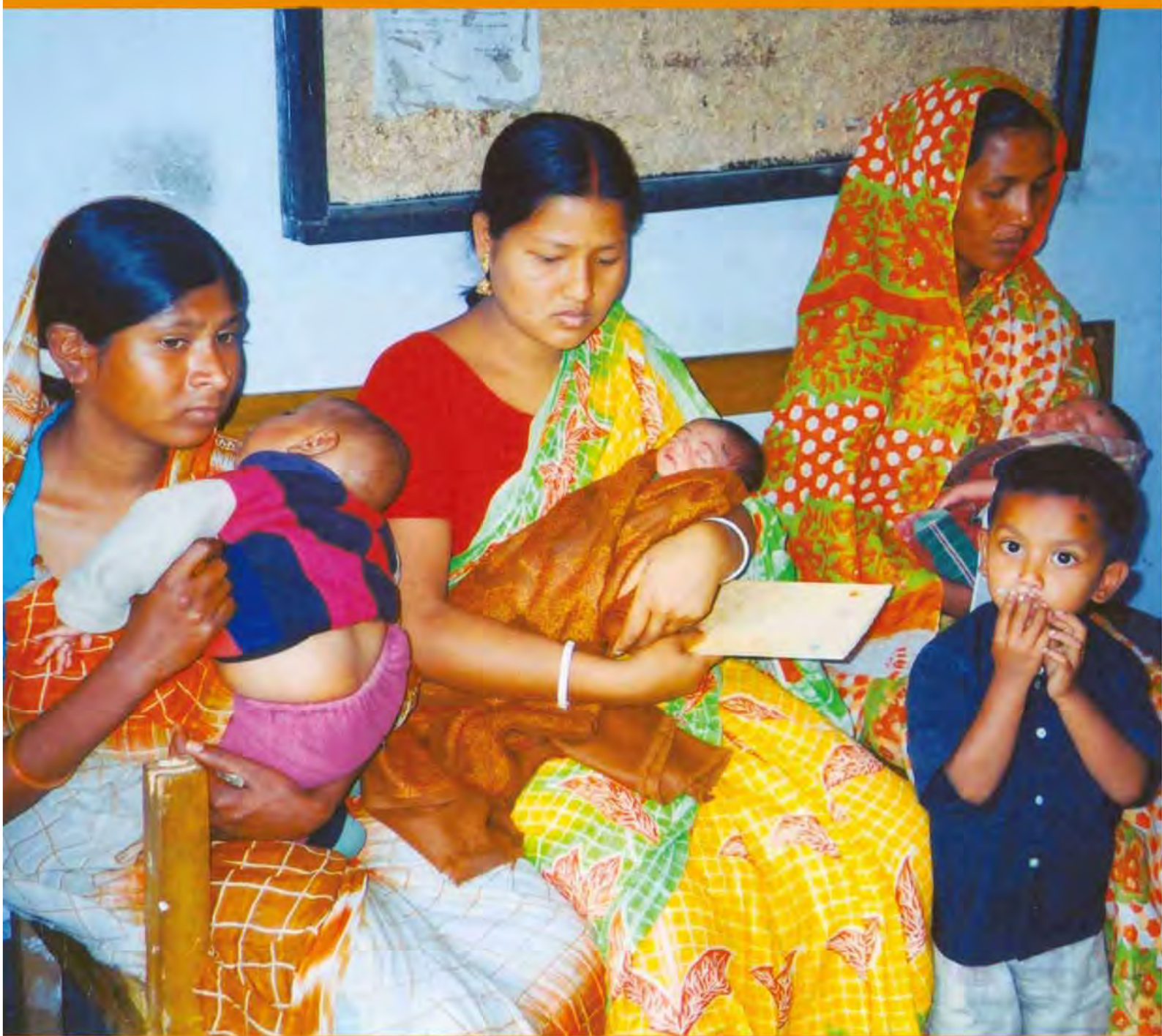
Rapid Assessment of Demand-side Financing Experiences in Bangladesh



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Rapid Assessment of Demand-side Financing Experiences in Bangladesh

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ABSTRACT

Towards the attainment of maternal health-related Millennium Development Goals (MDGs), the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoHFW), Government of Bangladesh, under the Health, Nutrition and Population Sector Programme (HNPSP), embarked on piloting a demand-side financing (DSF) scheme in 33 upazilas during 2005-2007. Some upazilas offered universal coverage, and others used means-testing to target the poor. A rapid assessment was undertaken in March 2008 of three upazilas using quantitative and qualitative methods, including in-depth interviews and focus-group discussions. The assessment showed the operation of the DSF scheme, the number of beneficiaries served, and the impressions of the voucher scheme from various key stakeholders. The findings indicated an increase in institutional delivery. Concerns were expressed by all stakeholders about the availability of higher financial incentives for institutional deliveries compared to current financial incentives for sterilization, which many fear will negate the success of the national family-planning programme. Further improvement in the physical infrastructure of the existing public-sector facilities is likely to contribute to higher use. The opportunity exists to further engage the non-state sector providers and facilities for involvement with the scheme. The potential for an increase in the use of caesarian sections, changes in the physical infrastructure, and appropriate posting of human resources in the public sector should be monitored. The existence of financial incentives and the availability of technical assistance by a third party in the DSF scheme require a close examination in terms of sustainability and scale-up.

In response to the Millennium Development Goals and to meet the needs of women and infants of Bangladesh, the Government of Bangladesh (GoB) implemented a consumer-led demand-side finance scheme. As possibly the largest health-sector programme in the world, with an estimated budget of US$ 4 billion, the GoB and the development partners in the first Sector-wide Approach (SWAp) had long expressed interest in applying a voucher scheme to improve key health indicators (1). Thus, a demand-side finance (DSF) voucher scheme was initiated through orientation beginning in 2005 and was further implemented during 2007.

Through the Health, Nutrition and Population Sector Programme (HNPSP), the GoB seeks to increase skilled attendance at birth from the present 19% to 50% by 2015. The most recent Essential Services Delivery Utilization Survey (ESD) from 2006 showed that the average skilled attendance at birth was 18.8% with gaps between the rich and the poor. The lowest quintile showed 5.2% use, and the second lowest quintile 10.1% (2). The Bangladesh Demographic and Health Survey (BDHS) 2004 showed that, apart from doctors, trained nurses, or midwives, trained traditional birth attendants (TTBAs) assisted 14% of births (3). The highest attendance of deliveries by trained personnel was 29.4% in Khulna, and the lowest was 21.5% in Sylhet (4). The poorest households are one-tenth as likely to be attended by a medically-trained person (4.5% vs 46.7%). Antenatal care (ANC) is an acknowledged measure for the reduction of maternal mortality (5). ANC-seeking behaviour is a crucial factor that affects the use of ANC facilities. A study conducted in India showed apathy of pregnant women to avail of ANC although available even when offered free of charge (6). The ESD 2006 also showed that ANC in the lowest quintile was 23.4% and 37.7% in the second lowest quintile. Demographic, socioeconomic, cultural and programmatic factors are significantly associated with ANC-seeking behaviour of rural women in Bangladesh. Poor women are less likely to seek ANC and to consult a qualified person, e.g. doctor, nurse, and paramedic, for ANC. This lack of service-use is typical of rural Bangladeshi society because consulting a qualified person involves some cost on the part of clients. A poor rural woman will have to meet the consultation fees for qualified practitioners, the cost of medicines prescribed by them, and transportation costs. Opportunity costs to rural woman, given the status of daughter-in-law and wife, the woman has to make alternative arrangements for the completion of usual household activities, looking after other children and seeking approval of in-laws (6). The BDHS 2004 data showed that only 18% of mothers received postnatal care (PNC) from a trained provider within six weeks after delivery, most (15 %) of which was received within 0-2 day(s). Among mothers who did not deliver at a health facility, only 8% received PNC from a medically-trained provider. A recent analysis of data from the DHS provides clear evidence of the gap between the rich and the poor in a range of health and population indicators, including fertility and the use of family-planning and other reproductive health services (7). Poorer women have more children than better-off women, with a total fertility rate (TFR) of 4.2 in 1999-2000 among the poorest income quintile and 2.5 among the richest quintile. The poorest quintiles are also one-fifth as likely as the richest to make two or more ANC visits (13.9% vs 63.7%) (7).

To influence the demand and to increase access of the poor to health services, particularly maternal health services, has been emphasized under the framework of the HNPSP so that the Government would initiate the piloting of demand-side approaches towards these goals. The Sector Investment Plan (SIP) of the HNPSP emphasized four main areas for reforms in the health sector with the goal to overcome and reduce the existing inequities in health in Bangladesh. The development of DSF mechanisms is one of these four areas of health-sector reform, and the following is a rapid assessment of the voucher scheme for maternal health services across three upazilas in Bangladesh.

PURPOSE OF RAPID ASSESSMENT

With the aim of increasing access to and the coverage range of maternal health services among poor women through the use of vouchers, the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoHFW), GoB, has embarked on piloting a DSF scheme initially in 21 upazilas with plans to expand it to 33 upazilas by the end of 2007 and to 64 upazilas by early 2008 (8). In nine upazilas, there is universal targeting so that all pregnant women are able to participate in the voucher programme; in 12 upazilas, there is means-testing under which, the following nationally-determined criteria of targeting poor pregnant women (9) are being used:

a. Must be a resident of same union, either with 1st pregnancy and those who have practised contraceptives before their 2nd pregnanc;
b. Family income is not more than Tk 2,500.00 per month;
c. Owns less than 0.15 acres of land; and
d. Have no income sources from cow/poultry/fisheries/fruit garden/rickshaw/van, etc.

Of these upazilas, 19 are supported from the government pool funds with technical assistance (TA) from the World Health Organization (WHO) and two upazilas by the United Nations Population Fund (UNFPA) and WHO. For administrative reasons, the planned implementation of the DSF voucher scheme was delayed.

A multi-level management structure has been developed to guide the implementation and monitor the execution of the voucher scheme. The guidance comes from several committees at the national level, an Upazila DSF (UzDSF) committee with a number of Union DSF (UnDSF) committees. The composition of UzDSF and UnDSF committees as recommended from the national level consists of the following:

UzDSF Committee

a. Upazila Nirbahi Officer (UNO), Chairperson
b. Upazila Health and Family Planning Officer (UHFPO), Member
c. Resident Medical Officer (RMO), UzHC, Member-Secretary
d. Upazila Family Planning Officer (UFPO), Member
e. Upazila Social Welfare Officer (USWO), Member
f. Upazila Women and Children Affairs Officer (UWCAO), Member
g. Medical Officer, Maternal and Child Health–Family Planning (MO-MCH-FP), Member
h. Representative, Upazila Parishad (UzP), Member
i. Representative, Non-governmental Organization (NGO)
j. All Chairpersons, UnDSF committees

UnDSF Committee

a. Chairman, Union Parishad (UP), Chairperson
b. All members of UP, Members
c. Assistant Health Inspector (AHI), Member
d. Family Planning Inspector (FPI), Member
e. Family Welfare Visitor (FWV), Member
f. Health Assistant (HA), Member
g. Family Welfare Assistant (FWA), Member

h. Representative, NGO, Member

i. A female Primary/Secondary School Teacher, Member

j. 3 Vulnerable Group Feeding (VGF) cardholders—one from each ward, Member

In the absence of guidelines from the national level, the UnDSF Committee has been entrusted with the responsibility to self-select the Member-Secretary (9), who will organize meetings and keep track of minutes. Officially, the following activities were to be accomplished by June 2007 at the implementation level:

- Designated maternal health service providers identified and contracted
- UzDSF committee formed and orientation of all members completed
- UnDSF committees formed and orientation of all members completed
- A bank account in the name of DSF seed fund with local Sonali Bank with UHFPO and RMO as signatories should be operational
- Orientation of all voucher distributors and service providers completed
- Registration of pregnant women and voucher distribution should be operational
- Designated cash amount for beneficiaries and service providers is operational

Under the DSF scheme, various levels of designated service providers of both means tested and universal upazilas are entitled to financial incentives. The service providers include skilled birth attendant (SBA) with a six-month training on safe delivery, FWV, Senior Staff Nurse, any MBBS-qualified doctors, Surgeons, and Anaesthetists. The *Aya* (female aid), MLSS (male aid), and Pathologist of UzHC are also entitled to financial incentives. The national level established the financial incentive structures (Table 1).

Table 1. Structures of financial incentives

Entitlement of beneficiaries	Taka
3 ANC check-ups (@ Tk 100/visit)	300
Transport cost for having institutional delivery	100
Safe delivery (institutional/SBA at home)	2,000
1 PNC check-up	100
Gift box (baby soap, big towel, baby attire, and Horlicks)	500
Entitlement of voucher distributors/service providers	
Registration per pregnant woman	10
2 haemoglobin tests before delivery (@ Tk 35/test)	70
2 urine tests before delivery (@ Tk 35/test)	70
3 ANC check-ups (@ Tk 50/visit)	150
1 PNC check-up	100
Conduct of safe delivery	300
Other associated expendable costs	
Medicine cost	100
Cost subsidy for ambulance if referred from UzHC to a designated service provider in the case of complications	500
Forceps delivery/vacuum extraction/placenta removal by hand/dilatation & curettage (d&c)/eclampsia	1,000
Caesarian section	6,000

ANC=Antenatal care; PNC=Postnatal care

According to the DSF guideline, a gift box containing a large Horlicks bottle, a big towel, and two sets of baby attire and baby soap to be distributed in kind to the beneficiaries for safe delivery by SBA or in a facility. The cost of gift box will be equivalent to Tk 500. The payment structures for the service providers are proportionately divided depending on the type of service provided and the category of service provider. Of alloted amount for other associated expendable costs for forceps delivery/vacuum extraction/placenta removal by hand/D&C/eclampsia done in the UzHC, 50% will be deposited to the DSF seed fund.

OBJECTIVES

The overall objectives of this rapid assessment were to measure progress in terms of registration of pregnant women and distribution of vouchers, use of services using maternal health voucher, identify barriers to disbursement of DSF money to beneficiaries and service providers, and collect recommendation on possible solutions to overcome those barriers. The specific objectives were to examine:

a. Adherence to the DSF guidelines during implementation;
b. Use of maternal health services by programme participants (beneficiaries) and their sociodemographic and economic characteristics;
c. Management issues relating to disbursement of DSF money to beneficiaries and designated service providers to reach the goals of DSF; and
d. Provide recommendations on issues to be addressed before nationwide scaling up of the DSF scheme and for larger evaluation.

METHODOLOGY

Prior to the start of the assessment, German Technical Cooperation (GTZ) organized a meeting with ICDDR,B professionals. Following the meeting, a series of discussions between GTZ representatives and ICDDR,B professionals were held to finalize the assessment methodology. GTZ recruited Data International (DI), a local consulting firm, to be a part of this assessment to cover at least two upazilas under each intervention design within the shortest possible time. Due to the scarcity of data on the progress of the DSF scheme, only 16 upazilas were found to be valid for this assessment, from which six upazilas were selected. The selected upazilas were equally divided between DI and ICDDR,B so that each research agency could conduct the rapid assessment in three upazilas. This report presents data collected by ICDDR,B in three selected upazilas. All involved parties jointly finalized the assessment instruments, including the questionnaires for structured interviews of beneficiaries, formats, guidelines for focus-group discussions (FGDs), and in-depth interviews. Given the allotted time for this assessment, it was agreed by all parties to cover one-third of the total number of unions of the six selected upazilas as described in Table 2.

Table 2. Research sampling by institution

Intervention design	Total number of upazilas, districts, and unions to be covered					
	Data International			ICDDR,B		
	Upazilas	No. of unions		Upazilas	No. of unions	
		Total	Sampled		Total	Sampled
Universal	Tarail, Kishoreganj	7	3	Ramu, Cox's Bazaar	11	3
				Khanshama, Dinajpur	6	3
Means-tested	Shakhipur, Tangail	6	3	Mirsarai, Chittagong	16	3
	Banaripara, Barisal	8	3			
Total		21	9		33	9

The Health Economics Unit (HEU) of the MoHFW issued a letter to Civil Surgeons (CSs) and Deputy Directors (DDs), Family Planning (FP) of concerned districts describing the importance of this assessment and to inform relevant upazila officials to allow access to relevant data and documents relating to the DSF scheme. Prior contact with relevant UHFPO and UFPO of the designated upazila was made by the rapid assessment agency to ensure the availability of relevant voucher distributors (FWAs and HAs) and service providers (FWVs and Senior Staff Nurses) on the mutually-agreed date of assessment. This was also needed to hold FGDs with the voucher distributors and service providers in the training room of the Upazila Health Complex (UzHC) or Health and Family Welfare Centre (HFWC). The rapid assessment agency also hand-carried the same letter from the MoHFW.

The researchers considered the performance in terms of registration of pregnant women and voucher distribution daily, union-wise performance available with either UHFPO or RMO or Health Inspector (HI) or locally-deployed WHO representative for the DSF scheme when selecting a minimum of three unions per selected upazila. After the selection of the unions, assistance of the HI or his authorized person was sought to introduce the data-collection team of one male supervisor and four female interviewers with concerned voucher distributors of the selected unions for locating the sampled beneficiaries. Both quantitative and qualitative methods were used for capturing the current situation of the DSF scheme as much as in the selected upazilas.

A. Quantitative methods

Operational status of DSF scheme: While selecting the unions for assessment, information on the operational status in terms of formation of committees, orientation of voucher distributors and service providers, behaviour change communication (BCC) strategy, beneficiaries already served, and status of payment disbursed for the upazila were collected to get an impression of the functioning of DSF at the implementation level.

Structured interview of beneficiaries: Depending on the size of population, the number of pregnant women in each union is likely to vary. Using the number of pregnant women registered and voucher distributed, the unions were categorized as highest, second highest, and third highest. A minimum of 13 beneficiaries per selected upazila were included in structured interviews. An equal number of extra beneficiaries was purposely selected from all the three unions per selected upazila to compensate for absenteeism/refusals and access difficulty.

B. Qualitative methods

Using qualitative methodology, in-depth interviews were conducted with the local GoB managers (UHFPO, RMO, MO-MCH, and UFPO), an NGO manager, a school teacher, the chairperson of the UnDSF Committee, the executives of the designated private for-profit sector service provider, and the locally-based WHO representative for the DSF scheme. Further, we conducted FGDs with voucher distributors (HAs and FWAs) and service providers (FWVs and Senior Staff Nurses) in the selected upazilas.

B1. The flexible guidelines theme for in-depth interviews included the areas of attitude and practices relating to the DSF scheme, implementation problems relating to BCC strategy, disbursement of payment process, conflicts and confusions, advantages and disadvantages of the DSF scheme, and recommendations for improvement. In-depth interviews also included case studies purposely selected graduated beneficiaries; one case of safe delivery and one case of caesarian section in each of the upazilas.

B2. The flexible guidelines theme for FGD was laid out in the area of registration of pregnant women, distribution of vouchers and service provision, disbursement of payment, and advantages and disadvantages of the DSF scheme. Although the details of each interviewer and FDG questions and key players are detailed in the following section, a summary of all informants is presented in Table 3.

1. Graduated beneficiaries: A graduated beneficiary is operationally defined as a woman who was registered, received the vouchers, and used the DSF benefits until completion of her pregnancy. Because of the logistical difficulty of gathering 6-8 graduate beneficiaries (who would be new mothers) at one place, the idea of holding FGD was abandoned. Instead, in-depth interviews of two purposively-selected most recently beneficiaries, excluding those participated in the structured interview per upazila, were conducted.

2. Voucher distributors: There were, on average, 15 FWAs and 9 HAs in the selected unions. As such, 50% of FWAs of the sampled unions were selected by the UFPO. In the absence of the UFPO, an MO-MCH was included to maintain the ideal number of participants (6-8). All the HAs of the sampled unions were selected for FGD. The FGDs were conducted separately.

3. Service providers: In addition to FWVs of the unions labeled as A, B, and C, the MO-MCH, in his absence UFPO, selected 3-4 FWVs in Mirsarai and Ramu to maintain the ideal number of participants. FGD with all the Senior Staff Nurses of the UzHC was conducted separately. FGD with

all the FWVs were conducted at the UzHC. There was no problem in Khansama to maintain the ideal number of participants for FGD.

4. Local DSF Committee members: The UHFPO plays an important role in the management and administration of the DSF scheme. The RMO and MO-MCH are not only members of the DSF Committee but also deliver services under the voucher scheme. As a member of the UzDSF Committee, the role of UFPO is more managerial in nature. Researchers of ICDDR,B conducted in-depth interviews with each of these key players to assess his/her attitudes about the DSF scheme, issues relating to disbursement of funds, monitoring and supervision, and implementation barriers and to solicit recommendations for the improved management of the scheme. In-depth interviews of six chairpersons of the UnDSF Committees of the unions labeled as A and C were conducted. In-depth interviews of two female primary school teachers were also conducted.

5. Administrators: In-depth interviews were limited to managers of local NGOs, the locally-based WHO representative for the DSF scheme, and the chief executive of the designated private for-profit sector service provider.

6. Health-financing expert on mid-term review: In-depth interviews were designed to focus on the advantages and disadvantages of the DSF scheme in terms of design, variation by TA or funding (WHO and UNFPA), management and administration, recommendations to overcome the disadvantages, improvements of the reimbursement procedures, implementation mechanism, and overall suggestion. This work was to be completed by co-investigators from DI or GTZ.

Table 3. Summary of completed structured interviews, in-depth interviews, and FGDs in three upazilas

Respondent/participant	Khanshama	Mirsarai	Ramu
Voucher distributors	2	2	2
FWA	FGD	FGD	FGD
HA	FGD	FGD	FGD
Beneficiaries	17	17	18
Structured interview	15	15	16
In-depth interview*	02	02	02
Service providers			
FWV	FGD	FGD	FGD
Senior Staff Nurse	FGD	FGD	FGD
RMO	0	0	1
MO (MCH-FP)	0	0	0
Committee members	4	4	4
UzDSF (UHFPO/UFPO)	2	1	1
UnDSF (Chairperson)	2	2	2
Administrator	2	2	1
DSF coordinator/organizer (WHO)	1	1	1
Head (designated non-state facility and NGO)	1	1	0
Community leaders	1	1	1
Female primary school teacher	0	1	1
Social leader	1	0	0

*For each upazila, one case of safe delivery and one case of caesarian section; DSF= Demand-side financing; FGD=Focus-group discussion; FWA=Family Welfare Assistant; FWV=Family Welfare Visitor; HA=Health Assistant; MO-Medical Officer; NGO=Non-governmental organization; RMO=Resident Medical Officer; UnDSF=Union demand-side financing; UzDSF= Upazila demand-side financing; WHO=World Health Organization

1. Current status of implementation: The official start date of the DSF scheme and implementation methodology used varied among the upazilas. There was variation in the manner that the national guidelines were followed in the introduction of the DSF scheme across upazilas. The role of the UzDSF and UnDSF Committees in the overall organization and management of the DSF scheme has been important since the inception of the programmes as they were responsible for the mobilization of the scheme at the upazila and union levels. Depending on the official start date of the DSF scheme, the UzDSF Committee was formed in all the three upazilas. The orientation of all members of the committee was held subsequently. Although the formation of UnDSF Committees in all the three upazilas has been completed, the orientation of committee members was still continuing in Mirsarai, Ramu, and Khansama as observed at the time of assessment. The meeting of already-formed committees has also not been very systematic, and the progress of DSF is reviewed in the regular meeting of the Upazila Parishad (UzP) and Union Parishad (UnP) in the three upazilas.

In Khanshama, a form of the DSF scheme was piloted in November 2004 but the official and revised start date was April 2007 as means tested and then changed to universal coverage from January 2008. Mirsarai piloted the project in March 2005, and then the voucher scheme was reintroduced in July 2007 using means-testing. In Ramu, the DSF scheme started under the leadership of a local NGO, named Family Development Services and Research (FDSR), in March 2005 as means tested; this test was ongoing when the Government introduced universal coverage and assumed management of the voucher scheme in August 2006.

2. Orientation of voucher distributors and service providers: The DSF guidelines have mandated both HAs and FWAs to register pregnant women and to distribute the vouchers. Also, the Senior Staff Nurses and FWVs were oriented because of their role as service providers. The duration of the orientation of voucher distributors and service providers varied from one to four days. The UHFPO, RMO, MO-MCH, and locally-posted WHO representative for the DSF scheme mostly conducted the orientation. The CS attended one orientation session in Khanshama. The national DSF guidelines were used as reading material. A number of posters on the walls of HFWCs and a billboard in the UzHC were found to be used as BCC material.

3. Registration of pregnant women, voucher distribution, and service provision: The registration of pregnant women and distribution of vouchers started in all the three upazilas following the orientation of distributors of vouchers and service providers. The HA and FWA in Khansama and Mirsarai distributed vouchers mostly at the household level; however, in Ramu, the FWA did not take an active role in the distribution of vouchers and registration. The HAs in Ramu accomplished the distribution of vouchers and registration task through the outreach immunization site (EPI site). Different practices were followed in the upazilas. Information was found to be conflicting depending on which local manager—either UHFPO or UFPO—was reporting about this issue. Moreover, there were cross-accusations of not being involved in the DSF scheme.

4. Status of distribution of vouchers, beneficiaries served, and payment disbursed: The national guidelines describe the availability of a financial incentive of Tk 30 for each work-day for a clerk to perform official formalities relating to the DSF scheme, in addition to regular job at the UzHC as designated by the UHFPO. The disbursement process of transportation cost to voucher holders varied among the DSF upazilas. The reported and observed systems of disbursement also varied among the upazilas. A clerk of Khansahma UzHC disburses all payments at the end of the month. In Mirsarai, the HI was designated by the UHFPO to disburse payments, along with the UnDSF

Committee, on a fixed date at the union level. In Ramu, a pharmacist and an office assistant have been designated by the UHFPO to disburse daily voucher payments from the upazila level. Since the majority of normal deliveries take place in the UzHC, the voucher holders are not released before the arrival of the pharmacist and office assistant in Ramu. On the day of assessment, it was observed that the pharmacist with assistance from one HA was making the disbursement in Ramu.

Performance data from the upazila level included the total number of pregnant women registered in the DSF scheme and the amount of cash disbursed for redeemed vouchers. That data revealed the following scenario in the three upazilas as described in Table 4.

Table 4. Total beneficiaries served and cash (Taka) disbursed

Service	Khanshama (May 2007–January 2008)		Mirsarai (July 2007–February 2008)		Ramu (August 2006–Febuary 2008)	
	Beneficiaries served	Cash disbursed	Beneficiaries served	Cash disbursed	Beneficiaries served	Cash disbursed
ANC1	1,264		817	49,580	1,801	201,790
ANC2	1,168		660	46,440	1,573	124,700
ANC3	538		379	27,580	988	88,800
Safe delivery	389		151	27,200	445	145,043
Caesarian section	75	Data unavailable	53	293,000	34	76,000
PNC	206		317	12,550	386	19,300
Delivery-related complications	09		02	2,000	12	3,000

ANC=Antenatal care; PNC=Postnatal care

Despite varied length of duration of the operation of the DSF scheme, the number of beneficiaries served ranged from 817 to 1,801 in all the three upazilas. This is low compared to the national pregnancy estimates. The total number of estimated pregnancies per annum in the pilot upazilas included in our assessment are: Khanshama–6,037, Mirsarai–14,249, and Ramu–8,087. The DSF scheme was expected to cover 50% of estimated pregnancies. This lower figure may be attributed to the number of beneficiaries registered who have yet to seek services and to changes during implementation.

There appears to be a mismatch between numbers of beneficiaries served and cash incentive disbursed to them such that, in Mirsarai, if 817 women received ANC1, Tk 81,700 should have been distributed. The reasons for the lower amount of cash distributed were illuminated in qualitative research. Ideally, the number of beneficiaries served and cash disbursed would be at par.

5. Results from structured interview with beneficiaries: Structured interviews of 46 registered beneficiaries were conducted. Locating the beneficiaries using the husband's name was difficult. Many beneficiaries reside in extended families, and the address details in voucher registration did not contain the name of her father-in-law or head of household, which would be useful in the rural setting. Each female data collector was given at least two additional questionnaires to compensate for refusal or non-availability of selected beneficiaries; however, the data collectors

did not encounter refusals, and the beneficiaries were eager to discuss their experience and participate in the research.

Of the 46 beneficiaries interviewed, 38 were aged 18-29 years. Six beneficiaries were married adolescents. In terms of education, nine beneficiaries and 12 husbands had no education; 29 beneficiaries and 27 of their husbands had completed primary education and above. The mean monthly income of the beneficiaries was Tk 4,902, which is nearly double the amount of Tk 2,500 determined for the means-tested upazila.

Although the nationally-determined guidelines call for the exclusion of women with more than two children in the means-tested upazilas, eight of the 46 beneficiaries interviewed had three or more children. Twenty-three women used contraceptives prior to their latest pregnancy. Almost half (24) were with one parity.

Of the 46 beneficiaries, 20 were pregnant at the time of interview, and 26 recently delivered. Of those 26 recently-delivered women, seven were conducted by a traditional birth attendant (TBA), 18 delivered in a facility, mostly at the UzHC, and one case of caesarian section in the district hospital. Combining 20 currently pregnant women and 26 recently delivered, 43 beneficiaries made ANC1 visit, 34 made ANC2 visit, 22 made ANC3 visit, and two did not make any ANC visit. The beneficiaries used the transportation vouchers as follows: 26 for ANC1 visit, nine for ANC2 visit, and four for ANC3 visit (Table 5). Five women used PNC services, and only four received transportation cost. Of the 18 women who delivered in a facility, 12 received the cash incentive to buy nutritious food.

Table 5. Services used by beneficiaries from structured interviews

Service	Service used	Number of beneficiaries		
		Transportation cost	Nutritious food	Gift box for baby
ANC1	43	26	N/A	N/A
ANC2	34	9	N/A	N/A
ANC3	22	4	N/A	N/A
Safe delivery (SBA/ institutional, including caesarian section)	18	0	12	9
PNC made	5	4	N/A	N/A

ANC=Antenatal care; N/A=Not Applicable; PNC=Postnatal care

Of those beneficiaries who were eligible but did not receive the mandated cash entitlement, each stated that she had been promised by the service provider that the cash entitlement would be available for collection at a later time.

1. Case studies of three safe deliveries: The three graduated beneficiaries were all aged over 20 years and have just delivered their second child. Two have completed above secondary grade education, and one completed primary grade education. Two are employed: one was a teacher and the other one was a sweeper. Service is the main occupation of their husbands. Their average monthly expenditure is Tk 5,300. Although one of the graduated beneficiaries owns land, all reported a deficiency in food supply at some point during the year. None of them holds a VGF card. The most recent pregnancy outcome of all occurred in the UzHC. Only one graduated beneficiary completed three ANC visits, one completed two, and the other one only one. None of them completed PNC visit. However, two beneficiaries received the amount allocated as transportation cost for ANC visits, and one was promised to be paid later. One woman received the safe delivery cash entitlement, and the same woman was the only one to receive a gift box for baby. The other two women were promised to be paid the cash entitlement later.

2. Case studies of three caesarian sections: All three women interviewed were aged less then 20 years; two of them were married adolescents; and all had just delivered their first child. All were housewives. Their husbands were manual labourers and bus helpers. Their average monthly expenditure was Tk 3,500. One of the graduated beneficiaries owns land. However, all the three reported deficiency in food supply at some point during the year. None holds a VGF card. Two of them delivered in the private for-profit sector and one in the district hospital. Two of them completed all the ANC visits, and one completed only one visit. None of them completed PNC visit. One of them received the transportation cost allocated for each ANC visit, and one was promised to be paid later. The summary of the in-depth case study of six graduated beneficiaries is presented in Table 6.

Table 6. Case studies of six graduated beneficiaries by sociodemographic characteristics

Characteristics	Safe delivery (n=3)			Caesarian section (n=3)		
	Khanshama	Mirsarai	Ramu	Khanshama	Mirsarai	Ramu
Age (years)	24	34	26	17	17	19
Parity	02	02	02	01	01	01
Education grade	14	05	12	06	04	00
FP used	Yes	No	Yes	No	Yes	N0
Occupation	Housewife	Sweeper	Teacher	Housewife	Housewife	Housewife
Occupation of husband	Services	Guard	Bus driver	Van puller	Day labor	Bus helper
Monthly expenditure (Tk)	6,000	4,000	6,000	3,000	9,000*	4,500
Food sufficiency	Sometimes	Sometimes	Sometimes	Sometimes	Sometimes	Sometimes
VGF card holder	No	No	No	No	No	No
Own land	No	No	Yes	Yes	No	No
ANC1 visit made	Yes	Yes	Yes	Yes	Yes	Yes
ANC2 visit made	Yes	Yes	No	Yes	Yes	No
ANC3 visit made	No	Yes	No	No	Yes	No
PNC visit made	No	No	No	Yes	No	No
Place of delivery	UzHC	UzHC	UzHC	Private	Private	DH
Cash/kind for ANC visit (transport)	No	Yes	Yes	No	Yes	Yes
Delivery	Yes	No	No	Yes	Yes	No
Gift box	Yes	No	No	Yes	Yes	No
PNC visit (transport)	No	No	No	No	No	No

*Member of extended nuclear family; ANC=Antenatal care; DH=District hospital; FP=Family planning; PNC=Postnatal care; UzHC=Upazila Health Complex; VGF=Vulnerable groups feeding

Based on their experiences, the graduated beneficiaries from Ramu commented about the quality of the physical infrastructure of both UzHC and district hospital. They emphasized the need for cleanliness of the delivery room and a separate toilet adjacent to the delivery room and suggested increasing the number of beds for women in labour. Both the graduated beneficiaries recommended that the disbursement of money should be made before delivery. They said that, while in labour, many women and their families have to borrow money to meet immediate expenses. They suggested that the cost of the full course of medicines before and after delivery and newborn child healthcare needs should be included in the DSF scheme. The beneficiaries of Mirsarai recommended that the Government should provide a cow to new mothers, which they can raise to make milk available for children. The wrong entry of detailed particulars in the voucher caused a delay in receiving entitlement money. One graduated beneficiary commented:

"My child has become two months old but I have not yet received the money."

All the women recommended that the DSF scheme should be continued and felt that it should be expanded to support the healthcare needs and feeding/nutrition support from birth to five years of age.

3. Views of local manager of GoB: All the in-depth interviews of the local managers with the public-healthcare system were repeatedly interrupted due to other official business. Because of his/her coordinating role for all activities relating to registration and distribution of vouchers, service provision, and disbursement of transportation cost to the beneficiaries and service providers, the UHFPO is a key actor in the overall organization and management of the DSF scheme. As a drawing and disbursing officer (DDO) of the programme, none of the UHFPOs mentioned any major problems with the availability of funds. The positions of RMO in Khanshama and UFPO in Mirsarai and Ramu were vacant at the time of the assessment. The temporarily-assigned MO was on leave, the MO-MCH in Khanshama was out of station on official duty, and the MO-MCH in Mirsarai was on leave during the assessment period.

UHFPO, Khanshama: The UHFPO informed that the present DSF scheme was first launched in Khanshama in late April 2007 and that the universal coverage began in late January 2008 under the revised MoHFW guidelines. Over this period, he attended a series of orientation workshops at the national and district levels and, after training, conducted local-level workshops on the DSF modalities. The District Designation Body headed by the CS of Dinajpur, the district that houses Khanshama, identified the service providers and concerned organizations. Plan International, Lamb Hospital, and Kanchan Samity were identified as partners of the government health and family-planning workers and institutions (UHC, FWC, MCWC, Sadar hospital). At the time of the assessment, all the six unions of the upazila had been covered by the scheme, although meetings of the UnDSF Committees were not regularly held due to other preoccupations of the UP chairmen. However; meetings of the UzDSF Committee were held once a month.

The UHFPO claimed that all pregnant women in the area have been brought under the scheme, and the performance had improved remarkably in ANC, safe delivery, and PNC since the programme was launched (Table 4).

Regarding the structure and delegation of authority of the UzDSF Committee, he pointed out that he was neither president nor secretary but served as a member of the committee. According to the official guideline, UNO was designated as President and RMO as Member-Secretary of the UzDSF Committee. Despite this structural reality, he has the responsibility to supervise and monitor DSF activities as head of the UzHC.

With regard to staff incentive, the UHFPO said that provision should be made for incentive for the UHFPO, RMO, and UFPO. He further mentioned that he had to work beyond office hours to cope with this additional assignment.

With regard to the needs of the programme, the UHFPO suggested starting an emergency obstetric care (EOC) programme immediately at Khanshama with the placement of an Obstetrician/ Gynaecologist and an Anaesthesiologist. Other vacant positions of doctors and nurses should be filled-in to ensure smooth operations of the scheme. Provisions should be made for the reimbursement of ultrasonogram charges for poor pregnant women. He also emphasized the need of a contingency fund to meet the expenses for his own telecommunications and fuel for field visits.

UHFPO, Mirsarai: The UHFPO arrived in Mirsarai in November 2007 and inherited most activities relating to the identification of designated service providers and NGOs. He reported that the orientation session for the UnDSF members was divided in two groups in Mirsarai—one group in the UzP and the other group in the UzHC—because of the number of unions and the total number of service providers. He did not see a strong role for the UnDSF Committee and opined that organizing meetings of this committee is very difficult. The Chairperson of the UnDSF Committee had a tendency to arrive late at the meetings. He did not perceive any additional workload and thought that the voucher scheme was running well. There is no opportunity for doing caesarian section in the UHC as an Obstetrician/Gynaecologist and an Anaesthesiologist are not available. The pregnant women coming for services were very unhappy when they were referred to other facilities from this institution for safe delivery. He felt that this is a problem of mindset of our service providers. He cited an example of his own initiative through which he used DSF funds to repair the endotracheal tubes used for anaesthesia when they were out of order for a long time, and the facility could not wait to receive money from a higher level. For a better functioning of the DSF scheme, the posting of an Obstetrician/Gynaecologist and an Anaesthesiologist pair would be necessary. He opined that the DSF scheme should be universal because reduction of maternal mortality is the MDG goal. Therefore, all mothers should be brought under coverage of the DSF scheme. He cited the example of a fisherman community having more mothers with more than two children but the present definition of poor does not allow them to have access to the DSF scheme. However, there has to be a balance because the cash incentive for safe delivery is greater than the cash incentive for sterilization and could produce a perverse outcome. He said:

"We are promoting delivery with incentives but we also provided incentive for family-planning sterilization in the past."

He expressed his distress with the designated facility hospital in Mirsarai.

UHFPO, Ramu: When the researchers interviewed the UHFPO of Ramu, he was readying himself for a meeting of the UnDSF Committee and preparing to disburse money to the beneficiaries. He was found to be advising his staff to draw fewer amounts than his requirement as a large number of women with institutional delivery were waiting to receive the payment. This was done mainly for security reasons and to comply with the ceiling of Tk 15,000 as per the Public Procurement Rule (PPR). The UHFPO felt that the PPR should be revisited to increase the monthly ceiling from Tk 15,000 to Tk 20,000 per month. With the current rate of ceiling, it is possible to disburse only 30 beneficiaries per month where the number of institutional deliveries is on the rise in Ramu. He

also felt that the use of SBA is contrary to the DSF guidelines because the spirit of DSF is to promote institutional delivery. Moreover, the chance of mutual agreement between beneficiaries and SBA in over-reporting of any delivery in the home cannot be ruled out.

He felt that, despite an increase in his workload, he is not entitled to any token honourarium. He felt that, if the DSF scheme is expanded to other places, there is a need to assign an additional full-time DSF clerk. There is no fund allocation for a UHFPO to fill the job of a resource person (trainer) under the DSF scheme whereas BRAC provides Tk 450 per lecture for a resource person.

He also opined that the financial allocation for the care of newborns should be available until at least the mother completes PNC. The non-availability of an Obstetrician/Gynaecologist and an Anaesthesiologist is increasing the burden on beneficiaries to travel from home to the UzHC, then to a designated provider. Since the FWVs do not stay in the HFWC, it is not possible to provide any service from there. He also recommended against the system of disbursement from the HFWC fearing the chance of payment being deferred. He recommended that the vouchers should cover Venereal Disease Research Laboratory (VDRL) tests, blood-grouping, and test for HIV for all pregnant women. Since the medical technologist is male, he addressed concerns that pregnant women might feel inhibited about giving blood and urine to a male technologist.

He did not see a strong role for the UnDSF Committee and opined that organizing meetings of the UnDSF Committee is difficult. He expressed that the UNO has been made chairperson of the UzDSF Committee, but he has no responsibilities for the functioning of DSF activities. He was concerned that the UzDSF Committee gives approval of expenses for the DSF scheme, but with the exception of the UHFPO, no other members are likely to be questioned by an audit. This could be a potential problem. However, he opined that absolute power and the absence of oversight have the potential to make someone authoritarian and possibly corrupt. He repeatedly expressed his concerns about not having a DSF coordinator/organizer if the GoB should decide to expand the DSF scheme throughout Bangladesh.

UFPO, Khansama: The UFPO expressed his concerns over the three different types of persons leading the district, upazila, and union DSF Committees (CS, UNO, and UP Chairman). He categorically pointed out the potential risk of the scheme to the current family-planning programme. He reported that the field workers were more engaged in DSF activities as they were attracted by financial benefit. This has resulted in reduction of routine home-visits and satellite clinics (SCs), thereby affecting the family-planning performance.

He mentioned that the non-availability of printed vouchers often created unwanted delays in the disbursement of payments to clients, followed by dissatisfaction among them.

The UFPO suggested adopting a doable check-and-balance approach between family planning and the maternal voucher scheme.

RMO, Ramu: Although the RMO was appreciative of the DSF scheme, he appears to have inadequate knowledge about it. He only knew that there is a DSF scheme, and he has to countersign vouchers brought to him. He felt that the financial incentives for the beneficiary are high. This is likely to encourage more pregnancy. However, he felt that the poor women would receive benefits from the DSF scheme. He had never attended a meeting of the UzDSF Committee, as he did not see its importance. He was not aware of the option for pregnant women to receive ANC from the HFWC, which could reduce the workload of service providers of UzHC.

4. Views of Chairpersons of UnDSF Committee

A. Khanshama (Angarpara and Alokjhari unions): Both the chairpersons of the UnDSF committee of Angarpara and Aloljhari unions were interviewed separately about the DSF scheme. Both had been involved in the programme since its inception.

The common concern raised by them was related to the cash incentives of Tk 2,000 being distributed to mothers after institutional delivery. They informed us that the mothers did not actually use this money. Neither the mothers nor their babies consumed this benefit, it was rather being spent for other household purposes or by their husbands. They suggested providing necessary commodities worth of Tk 2,000 (e.g. food, medicines, clothing, etc.) instead of post-delivery cash incentives. The commodities should be supplied at a periodic interval to the recipients. They suggested introduction of something similar to the World Food Programme's (WFP) VGF model for this purpose.

Both of them further added that the family-planning programme of the Government was at stake because of a growing misunderstanding within the local community that compares the cash incentive of Tk 500 for surgical sterilization with that of Tk 2,000 for safe delivery under the DSF scheme. This difference in cash incentive has been perceived as negatively affecting the family-planning programme in the area. Since the programme began, the poor and low-income people have been showing more interest in conception than in contraception for it offered better incentives in cash and kind for delivering a child.

Since the DSF scheme in Khanshama was declared as a universal coverage area, married women of adolescent age and the aged multipara, poor, and non-poor have been actively registering their pregnancies. This was contradictory to the national campaign against adolescent pregnancy and two-child norm of the family-planning programme. Both the chairmen opined that the eligibility criteria for incentives for mothers should be revised to incorporate age at marriage and first pregnancy (>18 years) birth spacing, number of children, and use of contraceptives for keeping logical links with relevant national agendas (e.g. family planning, age at first marriage, age at first pregnancy, etc.)

Both the chairmen noted the positive outcomes of the DSF scheme, such as pregnant mothers receiving regular ANC check-ups, safe delivery with referral facility, PNC check-ups, nutrition for mother and baby, and travel allowance for each visit. However, the built-in threats of the current voucher programme to family planning, adolescent pregnancy, and more children for cash benefit must be carefully addressed considering the local social context.

Meeting of the UnDSF Committee is held monthly in Alokjhari union and less regularly in Angarpara union. However, the Chairperson of Angarpara union informed that the UzDSF Committee is consulted as and when required (Please see comments of UHFPO).

B. Mirsarai (Mirsarai and Mithanala unions): Both the Chairmen of Mirsarai and Mithanala unions were interviewed separately for collecting their observations about the DSF scheme. Both of them have been involved in the full-swing implementation of the scheme.

Both of them told us that the service providers should properly follow the DSF guidelines and that a system of checks might be developed. The benefits of the DSF scheme should extend to the newborn at least up to two months of age. Field supervision by the local officials should be

increased. The amount of money for medicines used during a caesarian section and/or as a result of pregnancy-related complication should also be included. They observed that most clients were required to purchase medicines from their own pocket at the time of delivery.

C. Ramu (Rajarkul and Joarianala unions): Both the Chairmen of Rajarkul and Joarianala unions, involved in the programme since its inception, were interviewed separately about the DSF voucher scheme. They expressed concerns that, as an upazila with a universal coverage, the possibility exists that married women would be motivated to not use contraceptives. Moreover, the inclusion of rich people under the DSF scheme was a mistake. They suggested the involvement of all UP members in DSF activities for advocacy work on the importance of ANC and safe delivery. All field-level staff of the GoB at the union level should report to the UnP for DSF activities. They recommended that the provision of a photograph of beneficiaries on the DSF voucher should be included to avoid duplication. They also felt that the current level of reimbursement for transportation cost (Tk 100) should be increased to Tk 200 because many women spend a higher amount to reach the UzHC in Ramu.

5. Views of schoolteachers: Two school teachers—one in Mirsarai and one in Ramu—were interviewed. The schoolteacher from Mirsarai was found to have insufficient knowledge about the DSF scheme. However, she commented that the benefits of the DSF scheme should be limited to pregnant women with up to two children and that the programme should target only poor women. The schoolteacher from Ramu appeared to be knowledgeable about certain aspects of the DSF scheme because of her involvement in women's issues at the upazila level. She felt that the scheme had implications on the national family-planning programme as such, and the target should be limited to two children. On the other hand, she felt the need to reduce maternal mortality so that all pregnant women should come under the DSF scheme. She also felt that the current incentive of Tk 2,000 is attractive and might encourage more women to become pregnant. She pointed out that the DSF scheme should be extended to women who are residing as tenants for employment-related reasons but currently cannot be included under the DSF scheme because they are not residents of the area.

6. Views of local NGO managers: Partner NGOs, Khansama: The Service Promotion Officer (SPO) in Kanchan Samity and the Programme Coordinator of Plan International in Dinajpur were interviewed separately to assess their experiences about the partnership with the Government on the voucher scheme.

Kanchan Samity was engaged in managing referred cases at its clinic located in Dinajpur town. The SPO revealed that his organization was subsidizing the cost of caesarian sections performed under the DSF scheme. He suggested future additions of fund allocations for ambulance, ultrasonogram, and blood transfusions for DSF beneficiaries. He also emphasized the need for EOC training for their medical officers and paramedics.

The Programme Coordinator from Plan International said that, in collaboration with the Lamb Hospital, his organization has been supporting the DSF scheme through four of its safe-delivery units in four unions in Khanshama. This activity has been formalized through an agreement signed with the UzDSF Committee. However, the Coordinator claimed that Plan was receiving 50% of all charges from the UzDSF Committee. The organization was providing subsidy from its project money to meet the deficit. He claimed that, by doing this, the Upazila DSF Committee has clearly violated the agreement and the government guidelines.

7. Views of chief executive of a private for-profit maternity hospital in Mirsarai: The informant was a former Associate Professor of Obstetrics and Gynaecology and currently owns and operates a private for-profit, small 10-bed maternity hospital in Mirsarai. Although he was generally supportive of the DSF scheme, he felt that it would negate the success of the family-planning programme in Bangladesh. He stated that he had not been properly informed about the activities of the DSF scheme and that he should have been included in the UzDSF Committee. He expressed his frustration that the local GoB officials were critical about the services provided from his facility. Locally-based service providers should be included as members of the UzDSF Committee. He expressed his surprise about the inclusion of the head of a local NGO and wondered how the involved NGO will contribute to the DSF scheme as the scope of their services traditionally has not been focused on safe motherhood. He stated that he often received referred clients after improper handling by untrained delivery attendants at home. He also felt that the delivery in the home by the SBA should be promoted. When asked whether locally-based service providers could perform full services for a caesarian section at the current rate of Tk 6,000, he stated that the rate was too low and that it should be increased to a minimum of Tk 8,000.

8. Views of locally-based WHO representative for the DSF scheme: A WHO representative for the DSF scheme is posted by the WHO in Mirsarai and Ramu. There is no such person in Khanshama. Both of them actively provide support to the UHFPO. The WHO representative for the DSF scheme is actively engaged in the mobilization of DSF activities and regularly liaise with the UNO, UHFPO, RMO, government service providers, NGO, private for-profit sector providers, and Chairperson, UnDSF Committee. They made regular field visits to monitor registration and distribution of vouchers.

The WHO representative for the DSF scheme in Mirsarai felt that the activities of DSF are hampered due to the inadequate number of distributors of vouchers. He thought that the recruitment of volunteers could be one option to improve the situation. He has to regularly liaise with the full range of service providers to collect vouchers for from the RMO counter-signature before sending them to the bank. He observed that there is no voucher for the beneficiaries to buy medicines and that the voucher scheme should be expanded to support the healthcare needs of children up to one year of age. He also thought that the lack of available SBAs is a problem.

The WHO representative for the DSF scheme in Ramu felt that had the HFWC been used, the number of beneficiaries for ANC could have increased. He was not sure about SBAs and felt that there is a chance of false reporting by them. He stated that the SBAs can motivate a voucher-holder who has had a delivery in the home attended by a TBA but use the voucher to report the delivery by the SBA so that all involved can receive the benefits of the DSF. He recommended that the incentive amount for service providers should be increased to Tk 1,000 for normal delivery at the HFWC. One of the representatives felt that, for caesarian section, the amount should be increased from Tk 6,000 to Tk 8,000 which would include the cost of medicines. He felt that the UHFPO should also be entitled to some kind of honorarium.

Both of them strongly stated that the lack of an Obstetrician/Gynaecologist and an Anaesthesiologist is a hindrance to health services and tremendously increases the burden of beneficiaries to travel from home to the UzHC. They were not sure what will happen if the GoB decides to expand the DSF scheme throughout Bangladesh if there is no DSF coordinator/organizer.

All the FGDs with distributors (HAs and FWAs) of vouchers and service providers (FWVs and Senior Staff Nurses) were conducted in the afternoon so that routine service provision would not be hampered. Each of the four research informant groups was included in separate FGDs. There was an average of 6-8 participants in each FGD.

Findings from Khanshama HAs and FWAs

Knowledge and training: Most participants categorically discussed their responsibilities in relation to the scheme. All of them received one-day formal training relating to the scheme. However, the participants mentioned concerns about changes in the selection criteria of voucher recipients. One common comment was:

"At the beginning, we learnt that we should select the pregnant women having one child who must be poor, but now we are instructed to give the voucher to every pregnant mother."

The participants stated that they have received a booklet with instructions and were working as per the instructions outlined in the booklet.

Programmatic changes: Since the introduction of the scheme, the participants observed a general increase in the reporting of pregnancies. One comment was:

"Now, we don't need to find them (pregnant mothers), rather they search for us."

The participants also perceived that the overall number of hospital deliveries has increased since the introduction of the voucher scheme.

Workload: The participants stated that their workload has increased considerably due to the introduction of the scheme. They opined that their incentives are very small compared to amount of additional responsibilities for the scheme.

Supply of vouchers: The participants stated that the supply of vouchers was not sufficient for covering all pregnant mothers who had been identified. Thus, some pregnant women who did not receive the vouchers were very upset. However, the staff members took action to assure the upset pregnant women that they would receive the vouchers as soon as these are available.

Benefit payment system for pregnant women: The participants stated that the recipients of vouchers directly collect their payments from the UzHC office, and other staff members are not involved with the payment system. However, they came to know that the pregnant women often did not receive the due amount when they went to collect it but were asked to come again to collect the rest of the money.

Payment systems for staff: Most participants in the focus group mentioned that they have overdue payments. They opined that their payments for registration and distribution of vouchers should be increased from Tk 10 to Tk 25, and they prefer to obtain remuneration on a monthly basis. The participants thought that the payment system is discriminatory against them. One comment was:

"We receive only 10 taka whereas they (FWVs) get more, they get 25 taka, they (FWVs) are very interested to give services to the mothers under the scheme as they earn per check-up; now-a-days they are reluctant to deal with family-planning clients."

Reporting system: The participants noticed insufficiencies regarding the reporting systems under

the scheme. They do not have any format to report pregnant women in the routine MIS as they often used blank pages, thus creating a mismatch of information with their estimates and the official one. They stated that they even paid for photocopies needed for reporting.

Supervision: The participants expected more supervision at all levels for this scheme.

Suggestions for improvement: The participants commonly stated:

"for a successful scheme, the EOC facilities in the THC are mandatory."

The scarcity of general supplies (vouchers) was identified as a barrier to providing good-quality services for recipients. Some participants mentioned that the hospital authority should try to recruit female doctors and should offer ultrasonogram for recipients of vouchers.

Findings from Mirsarai HAs and FWAs

Knowledge and training: Most participants could categorically discuss their responsibilities in relation to the DSF scheme. Each had received three days of formal training provided by the UHFPO and the WHO representative for the DSF scheme. All of them received the DSF guidelines.

Programmatic changes: Since the introduction of the DSF scheme, they claim to have started to follow the DSF guidelines and were instructed by the UHFPO and WHO representative for the DSF scheme to include women with a monthly income of Tk 6,000. They commented:

"A rickshaw-puller earns Tk 6,000 in a month now-a-days, isn't he poor"?

They also noted that women who were not currently pregnant were interested in becoming pregnant because of the DSF scheme.

Workload: The HAs stated that their workload has increased considerably as they have to perform EPI, satellite clinic, geographical reconnaissance (GR), and other routine home-visits. They opined that their incentives are very small compared to amount of additional responsibilities for the scheme.

Supply of vouchers: There was no reported shortage of vouchers. Those who were excluded from the DSF services were unhappy because they did not receive vouchers like other women.

Benefit payment system for pregnant women: The HAs and FWAs stated that the system of payment to holders of vouchers is done on a fixed day and that it was the task of distributors of vouchers to inform those women. The task was reported to be quite cumbersome. They expressed confusion that the incentive of Tk 2,000 after delivery for buying nutritious food is not something practical for the mother because she would not consume that much food alone in a family situation.

Payment systems for staff: Most participants in the discussion group mentioned that they have received their payments. They recommended that their payments should be increased from Tk 10 to Tk 25.

Reporting system: The HI collects the report separately. If the HA has a low voucher distribution, the HI asks for the reason. The workers have reported spending their own money to develop and copy reporting formats. They suggested that a standard voucher-registration format should be supplied.

Supervision: The WHO representative for the DSF scheme and the HI mostly supervise them.

Suggestions for improvement: The participants said that the quality of services and behaviour of service providers in all the facilities should be improved. They observed that the tendency of service providers in the UzHC is to make referrals to private facilities because of low incentives.

They also discussed that a local NGO—Operation for Poor Community Assistance (OPCA)—provides rice (12 kg), cooking-oil (1.5 litre), and pulse (1/2 kg) for all women regardless of the number of children in the household. The local manager of OPCA is a member of the UzDSF Committee. The participants felt that these additional benefits from the NGO were causing a great hindrance to the family-planning programme.

They acknowledged that the coverage of registration and distribution of vouchers is low and felt that the coverage would increase gradually. They opined that the selection criterion of poor pregnant women was contributing to the low coverage of registration and distribution of vouchers. They felt that the service providers in the public and private for-profit sectors are not respectful to the holders of vouchers and do not give adequate advice to them about available services and facilities. They were critical of behaviour of the service providers in the UzHC.

The FGD participants felt that funds should be made available for refreshment in meetings of the UnDSF Committee. They recommended that the registration fee should be increased from Tk 10 to Tk 25. Depending on the type of services required by each of the beneficiaries, they should be properly guided about all the stages of pregnancy and delivery. They were very critical of the UnDSF Committee. They felt that the Chairperson of the UnDSF Committee spoke favourably of the DSF scheme but did not play a supportive role. They perceived this absence of support to translate into creating unnecessary delays in the authentication of vouchers. They perceived themselves as having to meet many members of the UnDSF Committee to authenticate the residential status of holders of vouchers.

Findings from HAs and FWAs, Ramu

Knowledge and training: Most participants could categorically discuss their responsibilities in relation to the DSF scheme. They received four days of formal training provided by the CS, UHFPO, UNO, and the WHO representative for the DSF scheme. All of them received the DSF guidelines.

Programmatic changes: There was confusion because the DSF scheme had been initiated as means tested but later had changed to universal distribution. They felt that the scheme would promote neglect of the family-planning programme.

Workload: The participants did not have any major complaints about the workload but demanded at least a bicycle to help assist with maneuvering through the terrain of the upazila. They stated that they had to spend a great deal of time motivating pregnant women to participate in the voucher scheme because of rumors in the area about women delivering at the UzHC having been unwittingly sterilized. They opined that their incentives are very small compared to amount of additional responsibilities for the scheme. Because of the strong emphasis on pregnant women and safe delivery, they are finding it difficult to promote family planning now. Moreover, some women who are daughters-in-law residing outside the DSF-covered upazila are returning to deliver their babies to take advantage of the scheme, thus creating a larger population and increasing the workload of the FGD participants. Moreover, the Chairperson of the UnDSF Committee is pressing the HAs to distribute DSF vouchers, which they feel is contrary to the DSF policy.

Supply of vouchers: There was no reported shortage in the supply of vouchers.

Payment system for pregnant women: They stated that the system of payment to the voucher holders is conducted from the UzHC on a daily basis.

Payment systems for staff: Most participants in the discussion group mentioned that they have received payments for collected vouchers. The HAs recommended that the registration fee should be increased from Tk 10 to Tk 25. However, some FWAs commented:

"We have been working with mothers for years but we are ignored, and more opportunity is given to the HA for the distribution of vouchers. We inform the HA about pregnant women for the distribution of vouchers."

"Now the women do not pay heed to our advice rather they listen to the HA", some FWAs mentioned.

Reporting system: Reporting is done by the individual HA. As the HI is not involved with the DSF scheme, there is no pressure.

Supervision: The UHFPO and DSF coordinator mostly visit the field.

Suggestions for improvement: The participants said that the quality of services and good behaviour from service providers of all the facilities would be a big improvement. They observed the tendency among service providers in the UzHC to make more referrals to private facilities because of low incentives. The HA should be provided with a bicycle, given the nature of terrain in Ramu. The ratio of worker to population is unmanageable. They worried that multipara women would be motivated to become pregnant to receive the benefits of the voucher scheme. They felt that women who delivered on the way to the hospital should be entitled to DSF benefits. They recommended that the registration fee should be increased from Tk 10 to Tk 25.

Views of service providers

The FWVs and Senior Staff Nurses are mandated to provide all the three ANC services and conduct normal vaginal delivery at the HFWC and UzHC, manage delivery-related complications, such as D&C, manage eclampsia and vacuum, extraction, and provide PNC service. Separate FGDs with FWVs and Senior Staff Nurses revealed that there was some level of reluctance among Senior Staff Nurses towards the DSF scheme so that they prefer to make referrals in light of perceived low financial incentives.

Perspectives of Service providers (FWVs and Senior Staff Nurses), Khansama

Programmatic changes: All the participants mentioned that deliveries in the hospital have increased since the introduction of the DSF scheme.

Job responsibilities/workload: All the participants mentioned that their workload has increased considerably since the introduction of the scheme. The FWAs stated that they provide services to 40-50 mothers daily under the scheme whereas the Senior Staff Nurses now see, on average, 20-25 pregnant women per day. One comment about their additional task since the introduction of the scheme was:

"The workload has increased a lot; we are getting more patients; we need to talk more and write on the cards; and the nature of services to be provided are now different."

Enrollment of pregnant women: Some participants informed that they started initially to maintain a register to keep an estimate of the total number of enrollments but the office authority had instructed them not to do so as all records would be maintained officially.

Payments systems: The participants, in general, were satisfied with the amount of money they receive for their services under the scheme but they are interested to obtain the money on a regular basis as their payments were often delayed for extended periods. Some participants stated that they received less than the amount of money that they should have actually obtained because the office deducted 10% from their payments, which they consider irregularity. However, the participants were not aware of a similar irregularity regarding payment systems for voucher beneficiaries (pregnant women). They opined that reimbursements to ambulance-users should be prompt.

General supply: Most participants stated that, despite the increased number of clients/patients since the introduction of the scheme, the hospital supplies have remained unchanged. Thus, they could not even perform some laboratory tests due to the scarcity of supplies.

Referral: The participants stated that they refer cases to an NGO. In absence of formal referral slips, they had to refer clients using simple pages.

Reporting system: The participants informed that there is no format for reporting in the current MIS. They felt that a register should be in place to keep good records on recipients of services.

Suggestions for improvement: The participants expressed that they should receive refresher training on the voucher scheme and would prefer more oversight in this area from their supervisors. They mentioned that the UzHC needs more manpower to handle the higher caseload and should offer EOC facilities for a successful scheme.

Findings from Mirsarai (FWVs and Senior Staff Nurses)

Knowledge and training: Most participants could categorically mention their responsibilities in relation to the DSF scheme. The UHFPO, RMO, MO-MCH, and WHO representative received a three-day formal training for the DSF scheme . All of them reported receiving the DSF guidelines. However, they were found to be generally uninformed about the registration, voucher-distribution and entitlement-disbursement process.

Workload: They have noticed a sizeable increase in their client-volume and noted that the holders of vouchers want preferential attention. They stated that the physicians do seem not as interested in attending to the holders of vouchers because of low financial incentives.

Payment system for pregnant women: Generally, the FGD participants seemed unaware of the financial disbursement system for pregnant women. One FGD participant commented:

"We are being pressed by the TBA in [the] case [of] home-delivery for a voucher holder to put our signature on the voucher to confirm that the delivery occurred in HFWC [so that] the client will be benefited by getting Tk 2,000."

Payment systems for staff: Most participants in the group mentioned that they are receiving their share more or less regularly. However, they felt that their allowances for ANC and PNC are too low and should be increased.

Reporting system: This group did not appear to be well-informed in this area. The most commonly-cited complaints were the unavailability of any financial incentives and lack of adequate cooperation of the attending physician.

Supervision: The UHFPO and RMO mostly supervise them.

Suggestions for improvement: There are no drug benefits for delivery-related condition, and there should be an adequate amount included in the scheme. Some HFWCs are lacking basic instruments, and they should be made available before bringing in more clients. More motivational work is needed to bring women in for institutional delivery. There is a need to provide caesarian sections at the UzHC. There is a dearth of supporting staff. The participants said that they would like to see that the physicians behave more actively in their role as service providers. They observed the tendency of the physician of the UzHC to make more referrals to private facilities because of low incentives.

Findings from Ramu (FWVs and Senior Staff Nurses)

Knowledge and training: Most participants could categorically mention about their responsibilities in relation to the DSF scheme and received a two-day formal training provided by the UHFPO, MO-MCH, and DSF coordinator. All of them received the DSF guidelines. However, they were unaware of the whole process of registration, distribution of vouchers, and disbursement.

Workload: The FWV reported that they do not attend DSF clients as most of them are going for care at the UzHC. They felt that they have been providing ANC and PNC services for a long time but, after the introduction of the DSF scheme, their workload has reduced. There are two kinds of rumors spread here that they must combat daily: (a) Women using the UzHC for delivery are likely to tubectomized and (b) Fear that the voucher scheme encouraged women to having more children so that the Christians will ultimately take them away.

Payment system for pregnant women: Alhough the Senior Staff Nurses appeared to be more informed about the payment system for pregnant women; however, the FWVs were not informed.

Payment systems for staff: Although officially involved in the voucher scheme, one FWV mentioned that she and her colleagues have been subtly excluded because the voucher beneficiaries are being referred primarily to the UzHC instead of HFWC. One FWV stated:

"We have to attend non-voucher clients for ANC and PNC check-ups at the same time my other colleagues (Senior Staff Nurse) are getting extra payment."

The FWVs felt that they were deliberately ignored despite having appropriate facilities in some HFWCs. The Senior Staff Nurses felt that the amount of incentive is too low.

Reporting system: The research participants reported that there was a lack of financial incentive to report the DSF scheme. It is not part of the regular reporting systems and may not be adequately supervised. The attending physicians do not assist with reporting requirements.

Supervision: The UHFPO and RMO mostly supervise them.

Suggestions for improvement: The participants stated that their clients complained of having to travel far for delivery-related reason whereas the delivery could have easily been conducted at the HFWC. Despite having years of experience in delivery, the DSF scheme has put all the focus on the UzHC. The FWVs want their skills to be use. The Senior Staff Nurse stated that the labour room is too small, there is not a hand-wash facility, and the toilet is quite far and mentioned the need to arrange for caesarian sections and incubators for newborns.

Many common themes emerged across the spectrum of interviews. There are successes and challenges that were highlighted during the course of the study. The greatest success is that the increase in demand for maternal health services was the aim of the DSF voucher scheme, and to that end, all respondents reported an increase in demand. Further, beneficiaries are generally satisfied with the DSF voucher scheme. Based upon the DSF voucher scheme plan to cover 50% of pregnant women per pilot upazila, there is a shortfall in registrations and voucher-use despite the study participants' discussion of increased workload. Further, a huge discrepancy remains between women registered for vouchers who then redeem the voucher for ANC1, which is the first programme indicator and the steep decline in voucher-use for safe delivery.

A general framework for further responses is to divide the issues into supply-side problems, governance and management issues, and perverse incentives. These factors include the increased demand for services, administration of the voucher scheme, and concerns about the impact of the DSF scheme on the national family-planning programme. Supply-side constraints, such as the appropriate number of providers and facilities in place to meet the increased demand created by the scheme, were recurrent issues. Appropriate remuneration of providers and various issues relating to payment of providers and beneficiaries and role of the non-state sector were also highlighted. Further, the respondents highlighted items that should be considered in an expanded form of the scheme.

Supply-side constraints

The overall increase in demand for services for both ANC and institutional delivery was a factor across the three upazilas. The enhanced demand for services is being met without any expansion in staff, physical capacity, or accompanying increases in the supply chain. Several respondents relayed information about the lack of tests, equipment, and related drugs for providing services that fall under the DSF scheme. Specific physical improvements to accommodate the surge in demand that were revealed in the case studies of the six graduated beneficiaries and from providers in FGDs included the need for government facilities to improve cleanliness, hold more beds for pregnant women, and establish/build easy-to-reach toilet facilities for women in labour.

An additional supply-side issue that was raised across upazilas and among various participants was the shortage of facilities with an available Obstetrician/Gynaecologist and an Anaesthesiologist at each UzHC.

In addition to what is currently included in the DSF voucher scheme, many participants suggested its expansion to include newborn and/or child-health needs.

Governance and management issues

One management concern that was highlighted at several levels was that programmatic changes in the upazilas from means tested to universal availability created confusion among distributors of vouchers. Further, there were variations in the amount of training on the DSF scheme received across the upazilas. Further, the eligibility requirements, particularly having less than two children, have not been strictly enforced. The respondents reported that there should be a steady supply of vouchers at all times to avoid delays in the enrollment of pregnant women and that a routine schedule for reimbursements of vouchers should be developed and maintained for the voucher scheme to fulfill the needs of both providers and clients. The MIS or registration of the voucher

scheme beneficiaries presented another challenge to the HAs and other providers in the system who received vouchers. The current MIS does not include reporting requirements for the DSF scheme.

Further, one manager pointed out that the PPR monthly ceiling of Tk 15,000 limited disbursement to only 30 beneficiaries per month. He stated that the need exists for more cash to be available for disbursement, especially with institutional deliveries on the rise in across the upazilas covered by the DSF programme. This issue was addressed in only one upazila but may emerge as a cross-cutting issue.

The informants perceived that there are high transaction costs in the DSF scheme. The providers and administrators may not be fully recompensed for their time and resources. Further, the deferred and/or irregular disbursement of payment becomes an issue for both providers and beneficiaries of the DSF scheme. Some provider-participants reported irregularities of a 10% reduction in the reimbursement rate of their cash entitlements by the distributor although this is not part of the DSF scheme.

The organization and management of the DSF scheme was supported by an external agency (WHO) in two upazilas. The implications of the lack of an external agency could not be systematically assessed through this methodology.

Perverse incentives

The financial incentive of Tk 2,000 for an institutional delivery has created near-universal concerns among the participants. The concerns focused on two main areas: the impact on the family-planning programme in Bangladesh and the practicality of awarding cash for nutritious food to graduated beneficiaries. The respondents pointed out that the cash benefit for cases of sterilization is set at a rate lower than the DSF scheme amount for an institutional delivery and may create a perverse incentive in favour of producing more pregnancies. Further, the discussion among upazila leaders, service providers, and civil society members was that the mothers of newborns receiving Tk 2,000 may not have the power within the family environment to determine how the money is spent, and mother and newborn may not, thus, benefit from the cash incentive.

In general discussion outside the interviews, the respondents expressed confusion over the purpose of Tk 2,000 cash incentive for an institutional delivery being awarded to all women in some areas regardless of location of delivery. In general, the respondents noted that, if the DSF scheme emphasizes the promotion of institutional deliveries by skilled attendants to reduce maternal deaths, benefit should not have been extended to home-delivery.

Several participants noted that the universal coverage under the DSF scheme extends the benefit to the non-poor and appears to promote an interest or fear of an increase in pregnancies at all levels of society.

The following recommendations are arranged by common themes as described in the preceding discussions. We will address supply-side constraints, management and governance issues, and perverse incentives.

Supply-side constraints

1. Consideration should be given to the use of means-testing versus universal coverage. Once a decision is made, it should be applied uniformly across all areas to avoid confusion.
2. Facilities and the supply-chain should continue to improve meeting the increased demand for services.
3. In the absence of an Obstetrician/Gynaecologist and an Anaesthesiologist within the UzHC, consideration should be given to the non-state sector (both NGO and private-for-profit) to meet the EmOC needs of voucher scheme beneficiaries.
4. Consideration should be given to expanding future versions of the DSF scheme to include newborn healthcare needs, such as postnatal visits, to further promote the achievement of the MDGs.

Governance and management issues

1. A standard distribution system should be developed and implemented. Consideration should be given to employing a third party account-management system or to creating a dedicated DSF voucher scheme position prior to scaling up.
2. The PPR monthly ceiling of Tk 15,000 per month should be re-evaluated and possibly expanded to meet the needs of the DSF voucher scheme.
3. The DSF scheme factors should be included in the existing MIS before scaling up.
4. Remuneration amounts should be evaluated in terms of actual transaction costs for providers, distributors, administrators, and clients.
5. The residential requirements should be reconsidered and monitored so that pregnant tenants can have access to the DSF voucher scheme.
6. The holding of separate UnDSF meetings was found to be problematic because of the excessive demands on those serving both as members and as committee chairs. The UnDSF meeting should be merged with the monthly UnP meeting.
7. The UzDSF and UnDSF Committees should be expanded to include non-state sector service providers who participate in the scheme—whether NGO or private-for-profit.

Perverse incentives

1. The purpose and form of Tk 2,000 cash incentive for an institutional delivery should be clarified and implemented before further scaling up of the DSF scheme.
2. The incentive for sterilization should be re-evaluated in light of the institutional delivery incentive.
3. The provision of incentives for distributors of vouchers and service providers via the DSF scheme must be monitored so that there is no detrimental impact on other vital tasks of service provision and motivational work, such as for immunization services, family planning, distribution of oral rehydration sachets (ORS), and family-planning commodities.
4. The impact of the DSF scheme on the use of or on the increased use of caesarian sections remains a factor worthy of continued monitoring.

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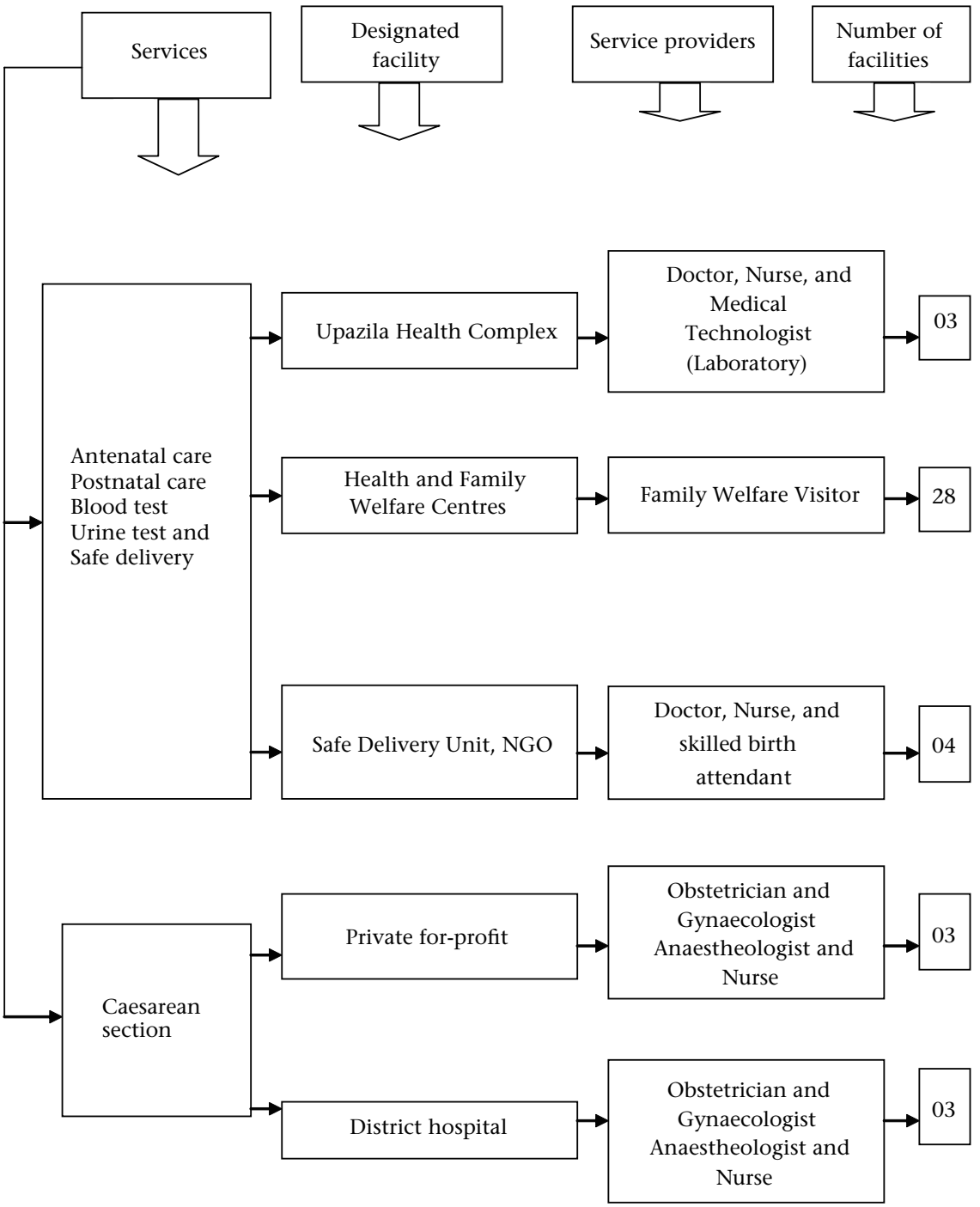
Sociodemographic characteristics of beneficiaries in three upazilas

Characteristics	Number
Age-group (years)	
<18	6
18-24	28
25-29	10
30+	2
Parity	
0	5
1	24
2	9
3+	8
Education (mean)	5.50
Education of husband (mean)	5.15
Currently pregnant	20
Used contraceptive	23
Hold VGF card	7
Received voucher	46
Income (Taka)	
≤2,500	4
2,501-4,500	22
4,501-6500	11
6,501+	9
Mean income	4,902
Received transport cost	
ANC1	26
ANC2	9
ANC3	4
Delivery	13
PNC	5
Received gift box	7

ANC=Antenatal care; PNC=Postnatal care; VGF=Vulnerable groups feeding

Schematic diagram of services and designated facilities for three upazilas



TERMS OF REFERENCE
Rapid Assessment/Situation Analysis of Demand-side Financing Experiences in Bangladesh

- Review of currently existing experiences, lessons learnt and recommendations for future modifications -

Background Together with Development Partners the Government of Bangladesh (GoB) is implementing the Health, Nutrition and Population Sector Programme (HNPSP) which was officially started in 2005. The HNPSP is probably the largest health sector programme in the world, with an estimated $4 billion budget when pooled funds and parallel funds are included. The goal of the HNPSP is to help Bangladesh advance towards the attainment of its health-related Millennium Development Goals (MDGs) and linked health policy objectives.

The basis of the planning of the HNPSP in the year 2004 was the Sector Investment Plan (SIP). SIP identified 4 main areas for reforms in the health sector with the goal to overcome and reduce existing inequities in health in Bangladesh. One of these four areas of health reform focuses on the development of demand-side financing mechanisms giving thus this area a particular importance. So far, the concept of demand-side financing has been done through the introduction of voucher schemes mostly, much less in the area of health insurance albeit the option has also been mentioned in the SIP, HNPSP as well as in the Operational Plan of the Health Economics Unit . to mentions of insurance in the SIP, HNPSP and is in the HEU OP. Currently, WHO supports in Kaliganj Upazila a pilot insurance scheme, expecting to cover 905 poor households (criterion: landlessness) which is expected to start in April, 2008.

Status of demand-side financing initiatives given the relevance of this area, GoB has started to implement pilots of innovative health financing strategies based on strengthening the demand side.

Vouchers One demand-side financing mechanism explored so far has been in the area of vouchers: GoB implemented with the TA of WHO and UNFPA demand-side financing initiatives in 21 Upazilas with plans to expand this to 33 Upazilas by the end of the 2007 and to 64 Upazilas by early 2008. The vouchers schemes are not quite uniform as there is some (limited) variation in the design of the pilot experiences: in nine Upazilas there is universal targeting of safe delivery vouchers, i.e. all pregnant women can receive the vouchers from the providers; in 12 Upazilas the distribution of vouchers is coupled with means-testing targeting, i.e. only women who have been identified as poor (this being based on criteria such as land ownership/household assets) will receive a voucher, but only for the first and second pregnancy.

First results Though still in its early stages, anecdotal evidence points to satisfaction from users and providers with the pilot. Initial data indicates an increase in deliveries at health care facilities. At the same time the Cesarean section rate has increased.

Open issues & questions The aide-mémoire of the mid-year stock take exercise recommends following areas for further analytical and programmatic interventions: 1) tracking c-sections rates to ensure program does not lead to perverse incentives; 2) expanding provider choice to include public, private and NGO facilities, 3) developing voucher distribution mechanisms that empower

consumers to make their own choice of provider and 4) addressing issues such as the need for public facilities to revert to MOF all funds under the program at the end of each calendar year as this causes disruption of services. Recent developments, such as the December 12, 2007 Government Order on retention of voucher reimbursements at the facility level (Public Providers are allowed to use 50% of the voucher's value, e.g. 3000 Tk, for a delivery by Cesarean section in the context of this particular pilot scheme), address some of the program bottlenecks but may not suffice. Also, the services ("benefit package") covered by the voucher need to be explored, whether the services covered by the vouchers really cater to the needs of the target population and where they could be improved by adding services surrounding safe motherhood & delivery.

Before any further upscaling of these experiences can be done, further research is needed and steps need to be taken to assure that vouchers indeed increase the choice available for voucher holders as the aide-mémoire of the Mid Year Stock Take observes. An evaluation of the voucher program is currently in the planning stages.

To inform the evaluation, it will be useful to conduct a rapid assessment of the situation on the ground regarding implementation of the voucher program, in its multiple variants.

Objectives of the rapid assessment/situation analysis:

The consultants should bear in mind that ultimately the idea is to address crucial questions which impede scaling-up and that this exercise is a first step into this direction. The four questions asked by the Mid Year Stock Take Aide Mémoire (see above) cannot be answered in-depth by this assessment equally but should be kept in mind as guiding framework for analysis and data collection.

To provide as a fast-track analysis a current and updated assessment of the demand-side financing initiatives, including all currently implemented voucher schemes.

To give an overview about experienced bottlenecks in the implementation of the vouchers in the different areas and assess possible bottlenecks in the planned implementation of the insurance scheme

Assess fiduciary and other accountability risks of the current schemes.

To inform the MTR process up to the Aide Mémoire drafting start of April and the updating of the Operational Plans on this demand-side financing scheme

Assess institutional and managerial arrangements of other countries' experiences and give recommendations how to improve existing.

Give recommendations on aspects to focus on for an evaluation in the longer run.

Activities of the consultant

The consultants will collect available data on the numbers of women using the scheme, preferably by month obtain any estimates of skilled attendance and examine monthly or quarterly trends compare with national trends assess financial procedures undertaken to ensure that the money is properly accounted for an disbursed assess the administrative procedures for qualifying women for exemption and ensuring money is disbursed to facilities. Are the procedures over-complex?

attempt to understand the incentives in the scheme for surgical delivery

In order to be able to do the above mentioned activities in a proper way, the consultants will develop a semi-structured questionnaire or other relevant methodology for that and submit the methodology for approval. The groups to be surveyed are key informants, including facilities, DSF committees, women/community groups, scheme administrators and target groups/beneficiaries of the vouchers. Go to the field for rapid assessment of various voucher schemes and qualitative interviews with stakeholders; come up with a conceptual analysis of bottlenecks and remedies how to remove these

Time Frame

It is expected that this work would be completed by end of March 2008. The MTR report will come out on 7 March, so the outcomes cannot be taken up immediately. However, the report could point out to the rapid assessment and it could be possible to include major insights into the aide-mémoire which will be drafted beginning of April.

Consultant qualification

The consultants selected for this assignment should have extensive experience in the area of innovative health financing mechanisms, as well as insight into the health system structure of Bangladesh, both the public as well as the private one. Consultants should provide specific examples and references from previous related work.

Expected Output: Structured report on the qualitative interviews (plus annexes):

While the conceptual part is important for the further planning and programming this will be taken care of by GTZ, the effort of the consultant should go into the empirical data analysis giving a comprehensive and accurate picture of what is going on in the field (as far as possible in the short time) rather than into the conceptual part. (Please refer to Annex 1)

Empirical part

Overview about main schemes (table with criteria)

when did the program start there

what services are covered

who distributes the vouchers

how are they distributed

how are beneficiaries identified

who are the beneficiaries

who are the service providers

how are providers paid

what data is collected on the program

who is it reported to

administrative processes and financial flows: who gets paid for what when by whom

Some of the data may be universal (can easily be reflected in a table), but some could be Upazila and scheme specific.

The report should contain:

key service deliver statistics on ANC, vaginal and C-sections, postnatal care (preferably before and after the scheme)

information on what works and what doesn't collected from various key informants: women's groups, beneficiaries, community leaders, administrators, providers, TA agencies, etc.

Observations on management and institutional issues

Observations on quality of care constraints, taking into account the various dimensions of quality of care, but most notably to provide information on availability of select equipment, personnel and medical supplies in the facilities providing voucher services

Summary monthly data on use of scheme and reported deliveries at facility level

Conceptual part

Lessons learnt from the schemes

Main bottlenecks – how can they be addressed

Possible solutions also taking into account international experiences gained in the administration of voucher schemes (ref. Annex)

Documents

Analytical work done so far:

Workshop on Health Financing Experiences (HEU Workshop July 2007)

Reports by EC, ILO (if available)

Voucher Schemes East Africa (KfW documentation)

World Bank (2005). A guide to competitive vouchers in health.

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