



PAY FOR PERFORMANCE: IMPROVING MATERNAL HEALTH SERVICES IN PAKISTAN

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Pay for performance (P4P) in Pakistan consists of supply-side payments to providers and demand-side vouchers that subsidize the costs of a package of reproductive health care services and transportation for poor women. The aim is to reduce maternal and infant mortality by increasing utilization of antenatal care, skilled delivery, and postnatal care, as well as family planning services. P4P is being implemented within the framework of a social franchise network, Greenstar Social Marketing. Key features of this program include: strategies to reach women who have not previously delivered babies in health facilities and accreditation and training for private provider members of a social franchise network. This case study thus describes an example of a private sector P4P voucher program targeting reproductive health and offers lessons for countries that are considering implementing similar schemes.





ABOUT THE P4P CASE STUDIES SERIES

Pay-for-performance (P4P) is a strategy that links payment to results. Health sector stakeholders, from international donors to government and health system policymakers, program managers, and health care providers increasingly see P4P as an important complement to investing in inputs such as buildings, drugs, and training when working to strengthen health systems and achieve the Millennium Development Goals (MDGs) and other targets that represent better health status for people. By providing financial incentives that encourage work toward agreed-upon results, P4P helps solve challenges such as increasing the quality of, as well as access to and use of health services.

Many developing countries are piloting or scaling up P4P programs to meet MDGs and other health indicators. Each country's experience with P4P is different, but by sharing approaches and lessons learned, all stakeholders will better understand the processes and challenges involved in P4P program design, implementation, evaluation, and scale-up.

This Health System 20/20 case study series, which profiles maternal and child health-oriented P4P programs in countries in Africa, Asia, and the Americas, is intended to help those countries and donors already engaged in P4P to fine-tune their programs and those that are contemplating P4P to adopt such a program as part of their efforts to strengthen their health system and improve health outcomes.

Annexed to each case study are tools that the country used in its P4P program. The annexes appear in the electronic versions (CD-ROM and Health Systems 20/20 web site) of the case study.

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ACRONYMS

ANC	Antenatal Care
DG	Dera Ghazi
EMOC	Emergency Obstetrical Care
FP	Family Planning
GL	GoodLife (Sister of Greenstar Company, for non-FP part of Greenstar)
IPC	Interpersonal Communication
JD	Job Description
JSI	John Snow Inc.
LHW	Lady Health Worker
MCNH	Maternal, Child, Neonatal Health
MOU	Memorandum of Understanding
P4P	Pay for Performance
PAIMAN	Pakistani Initiative for Mothers and Newborns
PDHS	Pakistan Demographic and Health Survey
PSI	Population Services International
RH	Reproductive Health
TBA	Traditional Birth Attendant
UC	Union Council
VMS	Voucher Male Supervisor
VOW	Voucher Outreach Worker
W/O	Wife of



INTRODUCTION

This case study shows how vouchers have been used to improve poor women's access to and utilization of family planning (FP) and reproductive health (RH) services in Pakistan. In this case, poor women buy vouchers at a highly subsidized price, which entitles them to FP and RH services from private providers in the social franchise managed by the Greenstar Social Marketing network. The women also receive funds to subsidize the cost of transportation to access care. The voucher program is both a demand- and supply-side pay for performance (P4P) program: The subsidy (care plus funds for transport) is conditioned on the women accessing providers in the Greenstar network, making it a demand-side form of P4P. On the supply side, a fee paid for each service provided is a financial incentive for providers to deliver covered services to this previously underserved population.

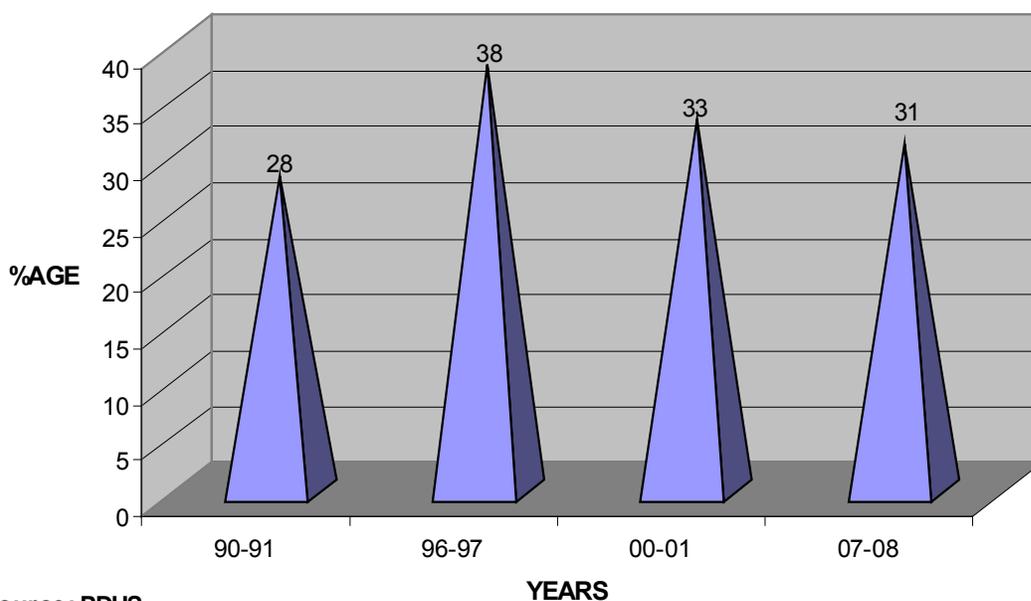
BACKGROUND: WHAT DROVE THE DECISION TO IMPLEMENT THE VOUCHER SCHEME IN PAKISTAN?

Pakistan has a large and growing population, estimated to double in the next 30 years. Of a population of 165 million, almost 29 million are women of reproductive age. Pakistan has alarmingly poor maternal and child health indicators and its progress toward attaining the health Millennium Development Goals is poor. According to the Pakistan



Demographic and Health Survey (PDHS)¹ conducted in 2006-07, maternal mortality is estimated at 279/100,000 babies born and infant mortality is 78/1,000 live births. Only 23 percent of births take place within a health facility, while the remaining 77 percent occur at home. Unqualified personnel conduct a large proportion – 82 percent – of deliveries. The contraceptive prevalence rate is 22 percent, while unmet need for FP is estimated to have hovered around 30 percent for the past two decades (see Figure 1).

FIGURE 1: UNMET NEED FOR FP IN PAKISTAN



Source: PDHS

Health services are less available and utilization levels lower in rural areas than in urban settings. For example, antenatal care (ANC) visits are significantly lower in rural areas, where only 20 percent of women make four or more ANC visits compared with 62 percent of women in major urban areas. Findings from the PDHS 2006-07 revealed that the main barriers to accessing care were low demand due to lack of awareness about the benefits of care (70 percent of women), high cost of access (30 percent), and transport/distance concerns (10 percent of cases).

What to do? It was clear that a multi-pronged approach to behavior change was required to encourage pregnant women to make ANC visits and seek delivery from a qualified birth attendant. At the client level, women, their husbands, and their families needed to understand

¹National Institute of Population Studies (NIPS) [Pakistan], and Macro International Inc. 2008. Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan



that ANC by a skilled provider and delivery in a health care facility with skilled providers are better for both the woman's and the newborn child's health. It also was recognized that both training and quality improvements, as well as compensation, were necessary to motivate health service providers to provide services to poor members of communities who were previously unable to pay.

Because the PDHS 2006-07 had also found that the private sector provides 68 percent of all ANC in Pakistan and 69 percent of births that occur at a facility occur in the private sector, it seemed that working with an existing network of private providers would be an opportunity to leverage the private sector to quickly and effectively address the low utilization of priority maternal health services: antenatal and postnatal care, deliveries, and FP. Therefore, to motivate and encourage pregnant women to visit health facilities for these services, the Pakistan Initiative for Mothers and Newborns (PAIMAN) project² approached its partner Greenstar Social Marketing,³ a private non-profit organization, to develop a voucher scheme that would increase utilization of the services.

Greenstar Social Marketing maintains one of the largest private sector networks in Pakistan and its operation is unique within the country. Greenstar is devoted to helping lower-income citizens improve their quality of life through better access and availability of health care. It addresses a wide variety of family health needs including maternal, child, and neonatal health (MCNH) and FP issues and it has built a network of FP service providers that offer high-quality and affordable FP services. The first network that focused on FP was the Sabz Sitara FP network, started in 1995 and currently comprising 8,000 providers – doctors and lady health workers (LHW). The GoodLife MCNH network, which started in 2005, has approximately 5,000 providers.

Greenstar has trained over 24,000⁴ doctors, nurses, and health workers within its network of facilities in emergency contraception, post-abortion care, antenatal and postnatal care, voluntary surgical contraception, and treatment of sexually transmitted infections, among other services. These providers are also supported to follow quality processes through visits from the Greenstar quality assurance team.

² PAIMAN is a United States Agency for International Development (USAID)-funded project led by John Snow International (JSI). See <http://www.paiman.org.pk/>

³ Greenstar was established by Population Services International (<http://www.psi.org>) in 1991. See <http://www.greenstar.org.pk>

⁴ Of which 8,000 have Bachelor of Medicine/Bachelor of Surgery (MBBS) degrees or are LHWs. The rest are midwives, nurses, hakim, homeopaths, etc.



ORGANIZATION OF THIS CASE STUDY

The following sections of this case study provide comprehensive look at the development and implementation of this Sehat (Urdu for “health”) Voucher Scheme. In particular, it describes the design of the initial pilot scheme, which ran from October 2008 to October 2009, identification of voucher recipients, scheme management, and results to date.⁵

⁵ Key materials reviewed and drawn upon to develop this case study include: Montagu, D. 2002. Franchising of health services in low-income countries. *Health Policy and Planning* 17(2):121-130; McBride J. and R.Ahmed. September 2001. Social Franchising as a Strategy for Expanding Access to Reproductive Health Services. A case study of the Greenstar service delivery network in Pakistan. *Commercial Market Strategies Technical Paper Series*; Kazmi, S. 2009. Greenstar Social Marketing Project. Presentation at a Population Services International Workshop, September.



VOUCHER SCHEME DESIGN

As noted above, the objective of the voucher scheme is to improve financial access to and utilization of priority RH services by subsidizing the price of these services through vouchers distributed among targeted populations, overcoming financial barriers posed by the cost of transportation, and reimbursing private providers to deliver services to a population they did not previously serve. That is, by largely eliminating the financial obstacle for poor households, it would provide access to care from private providers. And by paying network private providers to deliver the services to this population, it would create a viable new market.

With support from PAIMAN, the Sehat Voucher Scheme was designed and implemented by Greenstar's local Multan office team, specifically Mr. Hamid Bashir, Deputy General Manager, and Mr. Sarfaraz Kazmi, Manager of Operations. The team designed project modalities and an implementation plan, which they then shared and finalized with Greenstar management and JSI.

The design process comprised the following:

1. Selection of providers/development of provider agreements
2. Selection and training of interpersonal communications (IPC) team
3. Area mapping
4. IPC team job descriptions



5. Reporting process/back checks
6. Voucher design
7. Mode of payment
8. Verifications

SCOPE OF THE VOUCHER PROGRAM

In October 2008, Greenstar selected Dera Ghazi (DG) Khan district, a low-income district with the highest unmet need, to pilot the voucher intervention. This pilot sought to recruit 2,000 pregnant women living in DG Khan to utilize the voucher scheme within a 12-month period.

DG Khan is one of the most populous districts in Southern Punjab and the largest district in Punjab in terms of area (approximately 5,306m²) (see Figure 2). At the time of the voucher intervention, the district had a population of 2.2 million, of which 13.76 percent were living in urban areas. The population of women of reproductive age (between 15–49 years) was approximately 380,000. The contraceptive prevalence rate was 27 percent (all methods).

FIGURE 2: DISTRICTS OF SOUTHERN PUNJAB





The DG Khan district is divided into 60 union councils (UCs), which are both urban and rural. Greenstar selected six UCs for the pilot intervention. Selection criteria included participation in the Greenstar private provider network, availability of laboratories, availability of logistics, and urban areas with a prevalence of poor people and high maternal and infant mortality rates. The six UCs have a total population of approximately 216,000; assuming a 30 percent population increase, there are about 7,700 births annually. Within the UCs, 22 Greenstar providers were selected to participate in the pilot, on the basis of their participation in the network; training in emergency obstetric care (EMOC), antenatal, postnatal, and neonatal care, and FP; work in facilities equipped for natural delivery and for surgery; geographical accessibility to the population; and fulfillment of all criteria and standard operating procedures to conduct deliveries.

Before the pilot launch, the providers signed a provider's memorandum of understanding (MOU) to participate and attended a comprehensive training course that covered antenatal and postnatal care and FP issues and familiarized the providers with the voucher concept and process. In addition, one female voucher outreach worker and one male supervisor per UC were trained to perform door-to-door outreach visits. These visits served to identify pregnant women who had not previously delivered with a skilled health provider and to support geographical targeting of poverty by physically identifying low-income households.

GENERATING BUY-IN: FROM PROPOSAL TO DECISION TO IMPLEMENT P4P

At the outset, Greenstar management itself had to be convinced it could design and implement a successful pilot P4P voucher scheme. As a PAIMAN partner, Greenstar was expected to lead two project initiatives. After exploring different options with JSI, Greenstar agreed to implement the voucher scheme.

Then, Greenstar-trained providers had to be convinced that the voucher program was a good idea. This was important, because they provide the services and assume a degree of financial risk as they must serve clients (including reimbursing them for transportation) and await reimbursement from Greenstar. Provider interest in being involved in the Greenstar voucher scheme was driven by the following factors: opportunity for direct financial gain through payments from Greenstar for services delivered to voucher clients; potential for increased business resulting from the IPC and demand-creation activities in the voucher



catchment areas; quality assurance visits by the Greenstar quality assurance teams and training by Greenstar in FP, EMOC, antenatal and postnatal care, neonatal care, and child care. Fees to providers for services provided to voucher clients were determined based on the average fees charged to non-poor customers in the area with some discount.

Finally, Greenstar had to convince clients to access the services, which meant doing outreach; working with home-based decision makers; convincing clients not to use traditional birth attendants (TBAs), a break with a long-established tradition; and most importantly, selling the vouchers for a fee. IPC teams were very successful at counseling clients and their families. These were not one-off visits, however; IPC teams had to keep in touch with the identified client until she and her family were convinced to purchase the vouchers, which frequently required multiple visits.

HOW POOR WOMEN ARE IDENTIFIED AND RECRUITED

An essential selection criterion for voucher outreach workers is that they are familiar with and understand the area in which they work. As noted above, one female outreach worker and male supervisor per UC were trained to perform door-to-door outreach visits. (See Annexes A and B for job descriptions of workers and supervisors.) These visits serve to identify low-income households and “needy” pregnant women who have not previously delivered with a skilled health provider. Elected area counselors then verify the resources of the family identified for the voucher scheme. If there is disagreement, the voucher outreach worker or his/her supervisor coordinates with the local Zakat (government charity collected from the public in an Islamic arrangement) officer, who also has data on families. Once identified, women and their families are convinced to purchase a voucher booklet, they do so from the outreach worker, who completes a form admitting them to the scheme. (See Annex C for a sample form.) At that time, the first ANC visit to the nearest identified facility is planned, to which the outreach worker personally takes the woman.

Vouchers target women who have previously delivered at home – indeed, 97 percent of voucher recipients during the pilot had previous deliveries attended by TBAs (see Figure 3). Additionally, the voucher program targets recipients of low socioeconomic status – most voucher recipients’ husbands work as un-skilled laborers (see Figure 4) and the



median voucher recipient monthly household income during the pilot was US\$42.68. Finally, only 5 percent of voucher recipients who already had children reported having ever saved any money for delivery. This is a reflection of low income and/or of lack of knowledge about the importance of accessing health services for ANC and delivery.

FIGURE 3. PERCENTAGE OF WOMEN WHO RECEIVED A VOUCHER, BY SOURCE OF THEIR LAST DELIVERY

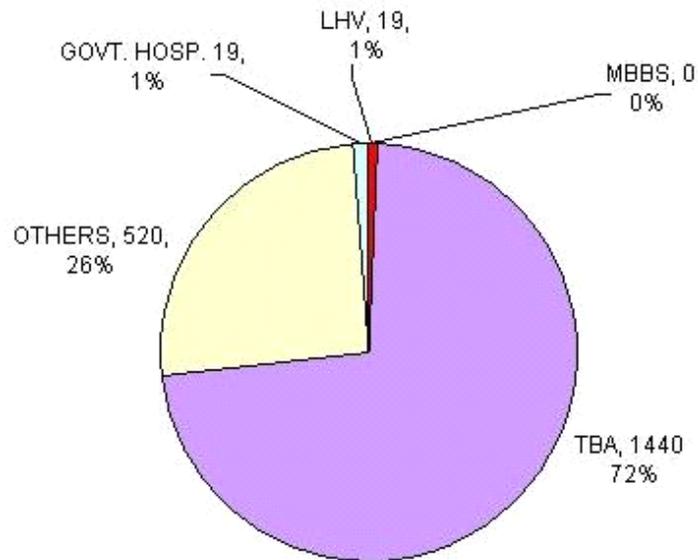
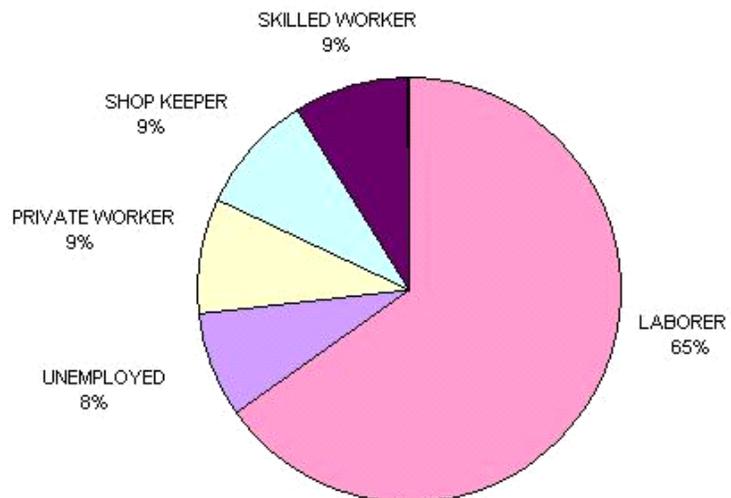


FIGURE 4. PERCENTAGE OF WOMEN WHO RECEIVED A VOUCHER, BY HUSBAND'S OCCUPATION





HOW THE VOUCHERS WORK

The vouchers have two components: a portion to pay providers for performing health services and a portion for client transport costs to reach a Greenstar provider. When the client reaches the clinic and receives the covered services, the health care provider gives the client funds to cover the transport costs incurred. The client pays nothing out of pocket for the health services delivered. Greenstar reimburses the provider for the transportation costs and pays for the services provided. Providers receive payment for each service provided to a voucher holder. It is a fee-for-service system and does not pay based on attainment of targets.

INDICATORS USED TO MEASURE SUCCESS

The intervention attempted to recruit 2,000 pregnant women living in DG Khan to utilize the voucher scheme within a 12-month period, to increase antenatal, institutional deliveries, postnatal visits, and access to FP services, and eventually to reduce maternal and infant mortality rates and increase utilization of FP services. Success of the program was measured by the number of voucher books sold and the redemption rate for covered services. The eight indicators (activities) are shown in Table I.

TABLE I:VOUCHER PROGRAM REIMBURSEMENT RATES

VS	Activity	Providers Services	Providers' Cost	Clients'	Total Cost
1.	1st ANC check-up	• ANC (fill the ANC card) Medicines: iron tab, anti-emetics, analgesics, and M/ vitamin	Rs 100/-	Rs 50/-	Rs 200/-
•		TT injection -	Rs 50/-		
2.	2nd ANC check-up	• ANC (fill the ANC card) Medicines: iron tab, anti-emetics, analgesics, and M/ vitamin	Rs 100/-	Rs 50/-	Rs 150/
3.	3rd ANC check-up	• ANC (fill the ANC card) Medicines: iron tab, anti-emetics, analgesics, and M/ vitamin	Rs 100/-	Rs 50/	Rs 200/-
•		-TT injection	Rs 50/-		
4.	Lab investigation	• Blood CP – Blood group – Urine RE – Blood HBs – Blood HCV	Rs 200/-		Rs 200/-
5.	Ultrasound	• Ultrasound	Rs 150/-	Rs 50/-	Rs 200/
6.	Simple vaginal delivery	• SVD with medicines (fill the ANC Card) (Rs 10,000/- for Cesarean section)	Rs 2,500/	Rs 250/	Rs 2,750/
7.	Postnatal check-up	• Postnatal care (fill the ANC card) Medicines, analgesics & M/vitamin	Rs 100/	Rs 50/	Rs 150/
8.	FP counseling	• FP counseling FP services (products i.e. injections, pills, or IUD)	Rs 100/-	Rs 50/-	Rs 150/
		Total	Rs 3,450/--	Rs 550/	Rs 4,000/

PAYMENT PROCESS AND AMOUNTS

The pregnant women recruited to visit the participating providers receive a voucher booklet worth US\$50.00, for which they pay the equivalent of US\$1.21 (Pakistani rupees 100.00). These booklets include a US\$31.00 coupon for the delivery, as well as coupons for four ANC visits, one postnatal care visit, and one visit for FP services. Health care providers reimburse each woman the equivalent of US\$3.00 for transportation for the delivery and US\$0.60 for all other visits.

Each month, Greenstar providers submit vouchers to Greenstar DG Khan staff for reimbursement. A team that manages the Greenstar social franchise verifies a sample of submitted vouchers to ensure that services were, in fact, provided to a certified voucher recipient selected and forwarded by IPC team. Once claims are approved, the finance department at the Greenstar head office transfers funds to each individual provider's bank account. This process is relatively efficient and health care providers are reimbursed by Greenstar within 35 days of the submission of part of voucher. A summary of the fees reimbursed by Greenstar is in Table I (above).



CONTRACTING

Contracts have been established between the individual health providers and Greenstar. Annexes D and E offer two sample MOUs, the first between surgical health care providers and Greenstar and the second between non-surgical health care providers and Greenstar.

VALIDATION

Following provider submission of vouchers for reimbursement, Greenstar supervisors verify the voucher serial numbers against client names. IPC teams also randomly check 10 percent of the vouchers during their regular visits to the clients. Additionally, supervisor managers verify clients on a random basis. Clients are also asked about services, care, and responses provided by health providers. Finally the Greenstar health office conducts quarterly audits.

Following validation, the vouchers are sent to the head office for reimbursement. There are quality visits also made by Greenstar health services department at regional level and head office level to check the quality standards of services.

START-UP: SYSTEMS AND PERSONNEL INVESTMENTS NEEDED TO GET THE VOUCHER PROGRAM UP AND RUNNING

Many investments were made prior to or at the start of pilot implementation, namely: mapping of GoodLife providers, interviews with providers to assess their willingness to be part of the voucher scheme, recruitment of field staff, and training of staff in communication, community mobilization, advocacy, pregnancy, and recognition of danger signs. An identification process was undertaken to determine both the area to include in the pilot and the potential clients.

Each IPC team, once hired, was allocated to a geographical area. An important first step was for each IPC team member to meet with the LHWs working in the same geographical area. LHWs, who are employed by the government health department, are responsible for raising health awareness among 2,000-2,500 community households. They know their communities well and were critical in the process of helping IPC teams identify pregnant women who are poor and who have not yet gone to a skilled birth attendant. Once the women were identified, IPC teams interviewed the women, collected data, and enrolled the women.



RESULTS OF PILOT VOUCHER SCHEME

The pilot voucher scheme in DG Khan district ended in October 2009. If the scheme is deemed successful once results are fully analyzed, the scheme will be scaled up.

Three initial findings are particularly promising:

- With 1,999 voucher booklets sold, the scheme was successful in selling virtually 100 percent of its target of 2,000 booklets sold.
- Interviews with participating providers show that in addition to increased service use by the voucher holders, there was a considerable positive spillover effect: nearly every voucher recipient and user brought 3–4 pregnant women from her family or neighborhood for care at the health facility. This is a very positive sign of behavior change, especially as these women had to pay for services out of pocket.
- Finally, the pilot will be repeated in a second district.

SPECIFIC RESULTS

As of October 2009, voucher booklets had been sold to 1,999 pregnant women (of the targeted 2,000) in DG Khan district. This suggests that vouchers increased the number of facility-based deliveries. Indeed, 1,968 of the women delivered in health facilities: 1,711 had natural deliveries and 257 had C-sections. Through interviews with clients and providers,



Greenstar also estimates that ANC visits increased by 20 percent over the 12 months of the voucher pilot.

Figure 5 shows the number of vouchers distributed and redeemed by type of ANC service during the pilot. Figure 6 shows where voucher holders delivered.

FIGURE 5. NUMBER OF VOUCHERS DISTRIBUTED AND REDEEMED BY TYPE OF HEALTH SERVICE DURING THE GREENSTAR PILOT IN DG KHAN DISTRICT

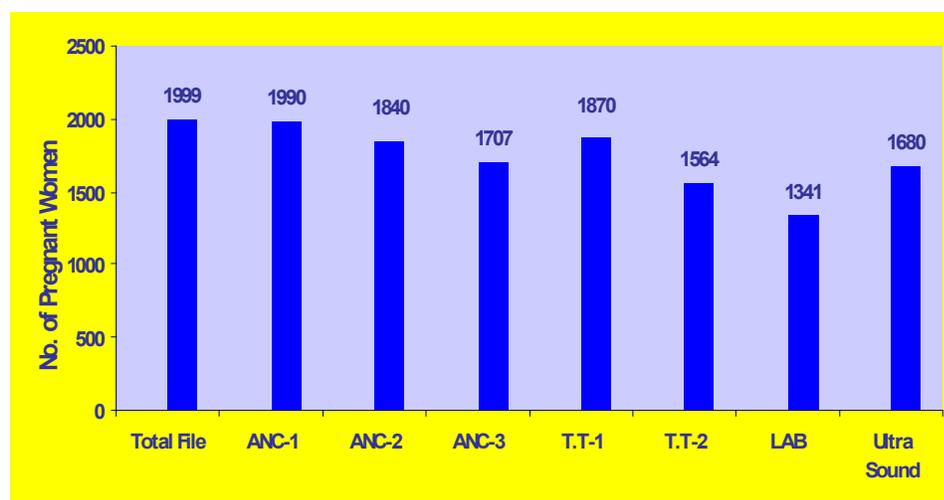
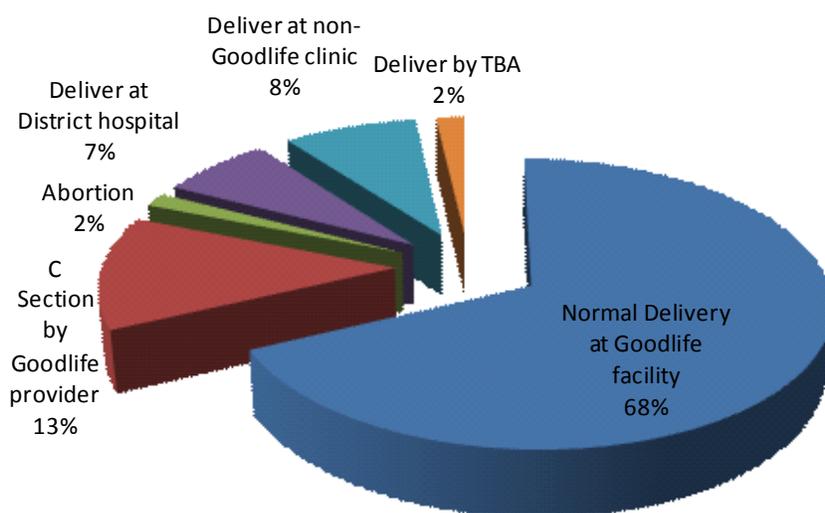


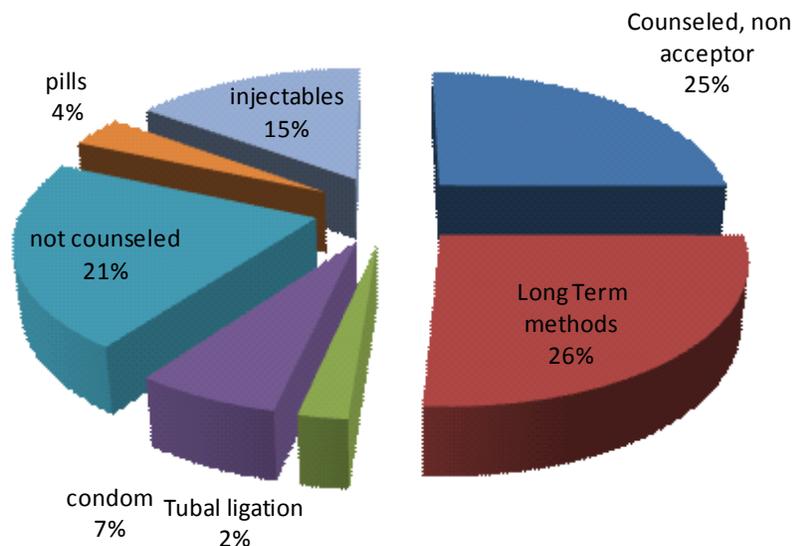
FIGURE 6. DELIVERIES AMONG VOUCHER RECIPIENTS IN THE DG KHAN PILOT





FP counseling and use was also a success: 79 percent (1,569) of voucher recipients returned to a GoodLife provider after delivering to receive FP counseling, 25 percent chose no method, and the other chose methods as shown in Figure 7.

FIGURE 7. FAMILY PLANNING RESULTS AMONG VOUCHER RECIPIENTS (N = 1,999)



EXPANDING THE VOUCHER SCHEME

Based on these initial findings, Greenstar decided to expand the voucher program. In November 2009, it launched a pilot project in Jhang district, also in Punjab province. Jhang differs from DG Khan in several respects:

- It is a purely rural area
- It has fewer providers and less competition
- The quality of service provision is poorer than in urban DG Khan
- There is a shortage of facilities that can provide C-sections
- There is low population density
- There are larger distances for the population to cover to access services



The PAIMAN project initially funded the D.G.Khan pilot. Since that project ended, another donor has agreed to partially fund the pilot for Jhang, along with the local government. In addition, the public sector, in particular the Punjab Director General-Health, has been very involved in and supportive of the scheme. A successful scheme will help in the behavior change of the public sector, which is considering introducing P4P in their facilities. This represents the beginning of a new era.



KEY CHALLENGES AND LESSONS LEARNED

Key design and operational challenges were as follows:

DESIGN CHALLENGES

While paying for services of a skilled medical provider is one barrier to seeking formal maternal health care services in Pakistan, social taboos are the biggest challenge to seeking care, especially among populations in peri-urban and rural areas. Pregnant women often do not make decisions about their own health, and husbands and in-laws resist the women going to clinics for deliveries and other services. Also, many TBAs have strong roots in these communities, and some have decades-long ties with families, so it can be a challenge to convince some women to use formal health services.

In response, IPC teams made frequent counseling visits to families, sharing examples of others in the community who had used voucher services, and discussing deaths and complications that had occurred during deliveries unassisted by skilled medical professionals. Testimonial meetings were held with women who had used the voucher. In some cases, influential community-level leaders (counselors, religious elders, etc.) were recruited to convince women and their families of the value of formal services with skilled practitioners.



Additionally, voucher scheme workers approached TBAs, encouraging them to take on a referral role rather than perform deliveries. The workers argued that in doing this, the TBAs would increase their credibility in the community once it was shown that women and babies have better health outcomes when births are attended by skilled health workers in a formal facility.

OPERATIONAL CHALLENGES

On a few occasions, Greenstar ran short of voucher booklets. As a result, pregnant women were ready to go to unqualified individuals for care. In such cases, the Greenstar team engaged clients who had benefited from skilled care to convince women and their families to pay for these services out of pocket.

The main lessons learned that will be incorporated into future voucher schemes designed by Greenstar include:

- Detailed baseline data are needed to demonstrate precise results/ outputs and change over the life of the voucher program. Gathering such data is included in the Jhang voucher scheme. The DG Khan scheme did not collect baseline data, and therefore it has not been possible to quantify its impact.
- Health facility data on quality in addition to quantity are needed. The Jhang voucher scheme will entail a quality component. It will also be mandatory for providers to submit partographs alongside vouchers for reimbursement. Additionally the Greenstar health service department will regularly conduct audits assessing the quality of services and of facility maintenance.
- Public sector providers should be included in the voucher scheme to encourage client use of free public facilities where available. Public sector facilities and providers are engaged in a part of the Jhang voucher scheme. Immunization will also be the responsibility of the government of Pakistan.
- Unemployed qualified health workers should be encouraged to participate in the scheme. Outreach visits identified a few unemployed/not-practicing providers (mostly LHVs). Greenstar will support them in establishing practices. It is anticipated that a different contract will be used to advance payment (rather than make reimbursement) for a certain number of clients once the LHV has a place of work.



- TBAs should be recruited to serve as allies of the voucher program, by referring women to skilled care. It may have be a good strategy to offer referral fees to TBAs to get them to play this role.
- Communities should be involved to the extent possible. Voluntary committees should be established to do fundraising to sustain the voucher scheme beyond the life of the project. In each area, there are a few higher-income individuals who have allocated some portion of their income to charity, and they can finance a certain number of subsidized services. Providers are also encouraged to provide some free or discounted services for patients referred by community workers.
- Transport companies/agents that are willing to offer subsidized transportation rates to voucher clients could be incorporated into the scheme. There are a few private ambulance services in different areas of the district; a referral system could be developed and, when transport is required, the community worker could contact the subsidized service.
- Voucher scheme implementation should be accompanied by education interventions, to increase the public's awareness about the importance of saving for health purposes, especially for deliveries and pregnancies. This was not the part of the original IPC material but will be incorporated into the Jhang voucher scheme.
- Education and building trust is also important when first discussing the voucher program with communities and individuals. For example, given the low literacy levels, it often requires 3–4 visits to develop trust, remove doubts, and sell a voucher booklet. Given serious financial constraints, even US\$1.21 can seem like an overwhelming expense unless the voucher purchaser understands the value of the voucher-subsidized care. Understanding often requires long and continuous sessions with the family members of the pregnant women. In some cases, they have to be taken to the providers to see firsthand the services they will be getting, what their future child will gain, and how the whole family will benefit.



SUCCESS STORIES

SUCCESS STORY I

FILE # 1939

CLIENT NAME: MRS. RABIA, WIFE OF (W/O) MR. ASIM

DATE: MAY 4, 2009

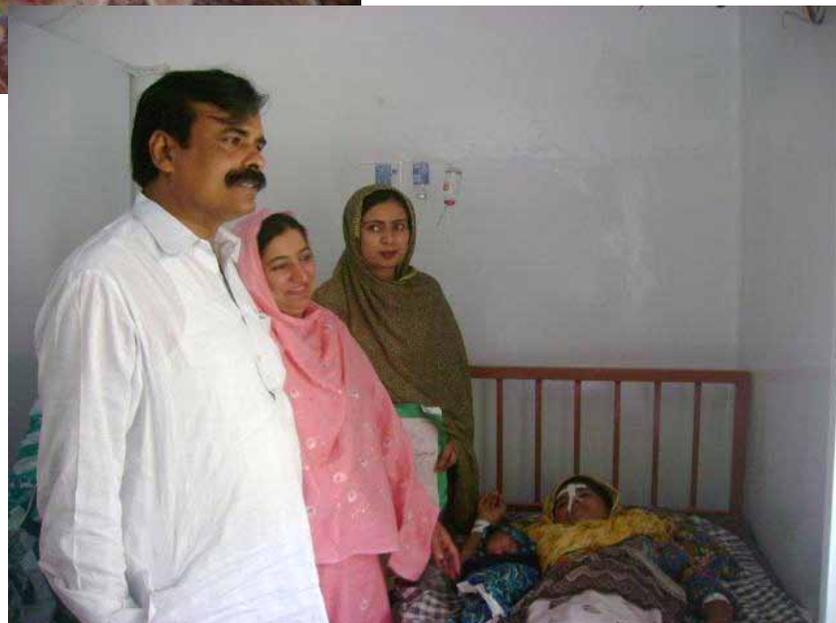
Mrs. Rabia has two children that she delivered at home with the assistance of a traditional birth attendant (TBA). During her third pregnancy, a voucher team approached her; she agreed to be enrolled in the voucher program and was assigned to Greenstar provider Miss Shaista Qazi, a lady health visitor (LHV). Due to the multiple pregnancies, Mrs. Rabia was very anemic; when she went into labor (May 4, 2009), her condition became critical, and Miss Shaista referred her to Dr. Maria Waseem, MBBS. Dr. Maria found her bleeding heavily, and her blood pressure was 70/40. Her family was able to for arrange blood for a transfusion. After stabilizing the patient, Dr. Maria performed a delivery by C-section, and the patient and baby both survived. Mrs. Rabia was discharged two days later (May 6). That midnight, due to improperly taking care at home, including moving around, Mrs. Rabia felt pain and found some of her stitches had torn. Her husband immediately arranged transport and took her to Dr. Maria, whom they found to be out of town. At that point, they called the Emergency Rescue 1122 and went to the district headquarters hospital at 1:30 am. Emergency staff refused to see Mrs. Rabia because no surgeon was on duty. The couple traveled to



several other hospitals, all of which refused to attend them. At 6 am, they contacted Greenstar. When Greenstar staff reached them and observed Mrs. Rabia in intense pain, they spoke with Dr. Maria, who still was out of town. Greenstar then contacted other network providers and finally found Dr. Numaira Naz and Dr. Sharafat Ali. Greenstar immediately took Mrs. Rabia to Ali Hospital. Both doctors arrived within 30 minutes and found Mrs. Rabia anemic and in critical condition, with her incision partially open. They briefed the family on the seriousness of her condition and secured their consent to re-open the incision. Dr. Jabbar Khosa, an anesthesia specialist, assisted in the surgery. They were able to save the patient. Mrs. Rabia's family was very thankful to Drs. Numera and Sharafat and especially to the Greenstar voucher scheme



The family of Mrs. Rabia were very thankful to Dr. Numera Naz, Dr. Sharafat Ali, and especially to the Greenstar voucher scheme.



SUCCESS STORY 2

FILE # 1349

CLIENT NAME: MRS. SAMINA, W/O MR. AMIR

DATE: MAY 23, 2009

Mrs. Samina was pregnant for the first time. Her husband, a laborer, lives in a periurban area. Mrs. Samina lives with her parents; her father is an office peon. On the evening of May 22, 2009, Mrs. Samina felt labor pains. But, as the women in her neighborhood do not usually contact health service providers, she did the same. The following morning (May 23), her mother contacted Ms. Nagma, the area's lady health worker. Ms. Nagma checked Mrs. Samina; when she saw Mrs. Samina's Greenstar voucher scheme file, she called Greenstar. Greenstar staff contacted Dr. Numera Naz, Mrs. Samina's assigned physician, advising her that they were taking Mrs. Samina to the hospital immediately. Dr. Numera also headed to the hospital, where she found Mrs. Samina in severe pain, lethargic, dehydrated, and very anemic. Upon examination, Dr. Numera diagnosed the patient with obstructed labor and her baby in severe distress. She performed an episiotomy, which allowed for a normal (vaginal) delivery. The baby was unconscious and didn't cry, so the staff immediately administered CPR and oxygen, which revived the baby. Meanwhile, Mrs. Samina developed a postpartum vaginal hemorrhage and was given emergency treatment; Greenstar staff found someone in the hospital willing to donate blood. In the end, both mother and baby survived. All attendants and other people expressed appreciation to Dr. Numera and the Greenstar voucher scheme.



Mrs. Samina and her family are very thankful to the Greenstar Voucher Scheme.





SUCCESS STORY 3

FILE # 1511

CLIENT NAME: MRS. WAZIRA, W/O MR. ABDUL HAMEED

DATE: MAY 14, 2009

On a voucher verification visit to Mrs. Wazira on the afternoon of May 14, 2009, Greenstar staff found her having labor pains, and very weak and anemic due to seven previous deliveries. The Greenstar representative knew that a small postpartum hemorrhage could be fatal and advised her to go to the health provider at the clinic. However, her husband was angry, called the voucher scheme a fraud, and refused to let his wife go anywhere to deliver. In any case, a second problem was that transport was not available, even had the husband relented. Third, Greenstar staff found that the nearest voucher scheme provider was not available.

The third one contacted, a lady health visitor named Miss Shazina Qureshi, agreed to attend the emergency case at the patient's home. Miss Shazina came with her father on their own conveyance, examined the patient, and prescribed medicines. Her father went to market to purchase the medicine. After 4–5 hours, Mrs. Wazira delivered at home; Miss Shazina stayed with her to keep her under observation for several hours. In the end, mother and baby were safe, and the whole family was happy. Greenstar made follow-up counseling visits to Mrs. Wazira, and she agreed to have a tubal ligation.



Mrs. Wazira and her husband were very happy and thankful to the Greenstar provider and the voucher scheme.





SUCCESS STORY 4

FILE # 72

CLIENT NAME: MRS. TASNEEM, W/O MR. IRFAN

DATE: MARCH 9, 2009

Mrs. Tasneem, a voucher scheme client, lives in Chocke Chorata, D.G. Khan district. On March 9, 2009, Mrs. Tasneem went into labor. Because it was the eve of a national holiday, it seemed that no provider would be available. Mrs. Tasneem called Greenstar for help. Greenstar staff started contacting nearby providers. As the time passed, Mrs. Tasneem started bleeding and, as she was already anemic, her condition quickly worsened. Finally, Greenstar reached Dr. Numera Waseem, who agreed to treat the patient. Transport was arranged and the patient was taken to the hospital. Dr. Numera examined her, observed her for some time, and ultimately decided to perform a C-section. Blood was arranged and the operation was performed. Mother and baby were saved and went home happy.



Greenstar client Mrs. Tasneem, shown here with the voucher scheme team, is very happy and thankful, first to God and to the USAID-funded Pakistan Initiative for Mothers and Newborns (PAIMAN) Project and Green Star.





SUCCESS STORY 5: EMERGENCY RESCUE | I 22

MRS. BANO W/O M. JAMEEL

During the client identification process, the Greenstar team met a TBA named Mrs. Sakina. Her daughter-in-law, Mrs. Bano, was pregnant, Mrs. Bano's husband was jobless, and they were a very poor family. As a TBA, Mrs. Sakina initially was unwilling to send her daughter-in-law to a formal health care provider. However, the Greenstar team counseled her on Pakistan Initiative for Mothers and Newborns (PAIMAN) objectives, especially the "three delays," and the advantages of the voucher scheme, explaining that it would cover the costs of pregnancy-related care and perhaps save the lives of the mother and infant. They were successful at convincing Mrs. Sakina to enroll her daughter-in-law in the scheme. Greenstar staff took both women to Mrs. Bano's first antenatal care (ANC) visit at Dr. Tahira's clinic; Mrs. Bano faithfully went to her follow-up ANC visits afterward.

When Mrs. Bano began labor one morning, Mrs. Sakina advised her to wait to seek care, because transportation to Dr. Tahira was not available. As the hours passed, Mrs. Bano's labor pains intensified, and she started bleeding. By 1:30 am of the following day, the family began to panic. They contacted Greenstar, which spoke with Emergency Rescue I 22 and gave the family their number; the family called the rescue services. The rescue team quickly reached the home and checked the voucher file for the name of the provider. They immediately called Dr. Tahira and took Mrs. Bano to the clinic at no cost. Dr. Tahira examined the patient and found she had placenta previa. Dr. Tahira tried a normal delivery, which resulted in hemorrhage, so she immediately transferred Mrs. Bano to the operating theater and performed a successful C-section. Mother and baby were safe.

Greenstar staff, ready to handle any situation, thanked the doctor and rescue I 22. The family was very happy and thankful to all. Mrs. Bano's husband told Greenstar that if they had not convinced his mother to enroll his wife in the voucher scheme, "today I might have lost my wife and child."



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