2013

Cost estimation for scale-up of voucher services in Kenya

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COST ESTIMATION FOR SCALE-UP OF VOUCHER SERVICES IN KENYA

RESEARCH
REPORT

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APRIL 2013

COST ESTIMATION FOR SCALE-UP OF VOUCHER SERVICES IN KENYA

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Suggested citation: Kumar, Shubhra, Smita Sanghrajka, Ben Bellows. 2013. "Cost estimation for scale-up of voucher services in Kenya." Nairobi: Population Council.

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GLOSSARY

FBO	Faith-based organisation
FP	Family planning
GBVR	Gender-based violence recovery
IMR	Infant mortality rate
KDHS	Kenya Demographic and Health Survey
KfW	German Development Bank
KNBS	Kenya National Bureau of Statistics
MDG	Millennium Development Goals
MMR	Maternal mortality rate
MoPHS	Ministry of Public Health and Sanitation (2008–2013)
MOH	Ministry of Health (split into two Ministries during Grand Coalition)
NCAPD	National Coordinating Agency for Population and Development
NHA	National health accounts
NHSSP	National Health Sector Strategic Plan
NMR	Neonatal mortality rate
NRHS	National Reproductive Health Strategy
OBA	Output-based aid
PwC	PricewaterhouseCoopers
SMH	Safe motherhood
TFR	Total fertility rate
VMA	Voucher management agency
WRA	Women of reproductive age

EXECUTIVE SUMMARY

Despite an international commitment to improving maternal health through the Millennium Development Goals (Goal 5: Improve maternal health), the trends in Kenya have not been in a positive direction. The 2008-09 Kenya Demographic and Health Survey found that there was approximately the same number of women dying of pregnancy and childbirth related causes 2004-2009 as in 1998-2003, namely 488 deaths versus 412 deaths per 100,000 live births. This is a matter of great concern, as these deaths arise from well-known preventable causes.

The Output Based Aid (OBA) program commenced in Kenya in 2005 with the first vouchers issued in June 2006 and has shown promising results. This voucher scheme is co-funded by the German Development Bank (KfW) and the Kenyan government and offers three different services to poor clients: a safe motherhood package of antenatal services and attended delivery by qualified health workers, long-term family planning methods, and gender-based violence recovery (GBVR) services at accredited facilities.

The estimates for scaling up the OBA program by applying past trends to projected data, adjusting for inflation and exchange rates and with some rounding differences, are as follows for the period 2013 to 2015 under three coverage scenarios:

TABLE 1: Summary safe motherhood scale-up costs

	30% coverage			50% coverage			70% coverage		
<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	1,083	1,184	1,220	1,805	1,974	2,034	2,527	2,763	2,848
Admin costs	238	209	166	396	348	277	555	488	388
TOTAL COSTS	1,321	1,393	1,387	2,201	2,322	2,312	3,081	3,251	3,236
<i>US\$ millions:</i>									
Reimbursement costs	12	14	14	21	23	23	29	32	33
Admin costs	3	2	2	4	4	3	6	6	4
TOTAL COSTS	15	16	16	25	27	27	35	38	37

TABLE 2: Summary family planning scale-up costs

	30% coverage			50% coverage			70% coverage		
<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	582	645	733	970	1,076	1,222	1,357	1,506	1,711
Admin costs	128	114	100	213	190	167	298	266	233
TOTAL COSTS	709	759	833	1,182	1,265	1,389	1,655	1,771	1,945
<i>US\$ millions:</i>									
Reimbursement costs	7	8	8	11	13	14	16	17	20
Admin costs	1	1	1	2	2	2	3	3	3
TOTAL COSTS	8	9	10	14	15	16	19	20	22

The total government health budget for 2011/12 presented in Kenya National Bureau of Statistics' Classification of Expenditure by Purpose is KSh 69.13 billion. Using this and applying 2009/10 National Health Account (NHA)¹ trends with adjustments for inflation, the estimated potential Total Health Expenditure (THE) and reproductive health expenditure between 2013 and 2015 is as follows:

TABLE 3: Estimated health expenditure in Kenya, 2013–2015

Estimated (KSHs billions)	2013	2014	2015
Total health expenditure (THE)	273.42	295.76	327.11
Government health expenditure	78.75	85.18	94.21
Reproductive health expenditure	38.01	41.11	45.47
Government reproductive health expenditure	15.20	16.44	18.19

In the NHA 2009/10, reproductive health expenditure as a percentage of THE was 13.9% and this percentage has been applied to 2013 to 2015. NHA 2009/10 public sector proportions of THE (28.8%) and reproductive health (40%) have been applied to 2012 KNBS estimates and adjustments made for inflation to estimate government health expenditure between 2013 and 2015.

The figures show that, for example, in 2013 with 50% coverage, the total costs of KSh 3,383 million (safe motherhood, family planning and administrative costs) would comprise:

- 1.2% of estimated THE
- 4.3% of estimated government health expenditure
- 8.9% of estimated reproductive health expenditure
- 22.3% of estimated government reproductive health expenditure

The PwC Phase II evaluation report noted that reimbursement levels may be too low and there is a threat that service providers may withdraw. Program costs for 2013 would range from KSh 2.1 billion (30% coverage of poor) to KSh 4.9 billion (70% coverage of poor) if reimbursement rates were increased by 5% above forecast inflation.

¹ Jointly issued by Ministry of Public Health and Ministry of Medical Services with financial support from USAID, WHO and World Bank

TABLE 4: Summary safe motherhood scale-up costs with increased reimbursement rates

<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	1,137	1,243	1,282	1,895	2,072	2,136	2,653	2,901	2,990
Admin costs	250	219	175	416	366	291	582	512	408
TOTAL COSTS	1,387	1,463	1,456	2,311	2,438	2,427	3,235	3,413	3,398
<i>US\$ millions:</i>									
Reimbursement costs	13	14	15	22	24	25	30	34	34
Admin costs	3	3	2	5	4	3	7	6	5
TOTAL COSTS	16	17	17	27	28	28	37	40	39

TABLE 5: Summary family planning scale-up costs with increased reimbursement rates

	30% coverage			50% coverage			70% coverage		
<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	611	678	770	1,018	1,129	1,283	1,425	1,581	1,797
Admin costs	134	120	105	223	199	175	313	279	245
TOTAL COSTS	745	798	875	1,241	1,328	1,458	1,738	1,860	2,042
<i>US\$ millions:</i>									
Reimbursement costs	7	8	9	12	13	15	16	18	21
Admin costs	2	1	1	2	2	2	4	3	3
TOTAL COSTS	9	9	10	14	15	17	20	22	24

The change in reimbursement rates from the combined increase in 5% in reimbursement rates and increase in inflation leads to an overall increase in 20% between the reimbursement rates from 2012 to 2013. However, the safe motherhood, family planning and administration costs increase by 5% between the estimates before and after the reimbursement level increases.

Programmatic changes may impact the costs. For example, the introduction of transport reimbursements to patients could improve access to the OBA services but would increase costs due to transport expenses and a greater number of distributed vouchers being used. It is difficult to estimate how much and on what basis these reimbursements may be made so they have not been factored in the scale up cost estimates. However, if transport is added, then the above scenarios would again have higher programmatic costs. Scaling up nationally with many new geographical areas may also alter the logistical administration of the OBA program and impact on the administrative costs also. Therefore, using PwC administrative cost trends where administrative costs as a proportion of total costs were higher at the beginning of each Phase, the calculations have been assumed to be higher in 2013 and gradually decreasing in 2015 as a proportion of total costs.

1 CONTEXT: KENYA'S DEMOGRAPHIC INDICATORS AND HEALTH SPENDING

According to the Population Reference Bureau (2012), Kenya's population is approximately 43 million and is growing rapidly at the rate of 2.7% per annum. With fewer than 2 years left for achieving the Millennium Development Goals (MDG), Kenya has renewed its effort to meet goals 4 and 5 relating to maternal and child health. The last Kenya Demographic and Health Survey (KDHS) 2008/09 shows the following trends related to infant, neonatal and maternal mortality in the country (Table 6).

TABLE 6: Infant and maternal mortality data (KDHS 2008/09)

Indicator	2003	2008/09
Infant mortality rate (IMR) /1000 live births	77	52
Under-5 mortality rate /1000 live births	115	74
Neonatal mortality rate (NMR) /1000 live births	33	31
Maternal mortality rate (MMR) /100,000 live births	414	488

As can be seen from the table above, Kenya has made significant progress in tackling infant and under-5 mortality, but there has been only a marginal improvement in its neonatal mortality figures. The IMR MDG target for 2012 was 37 deaths/1000 live births and for MMR was an ambitious 147 deaths/100,000 live births. However, since 2003, the maternal mortality rate has largely remained unchanged and is still a major challenge.

In Kenya, the challenges posed by weak health systems are compounded by a vast gap in the provision of quality maternal and child health services between the economically better-off and the poor. Skilled attendance at birth is only 43.8% (KHDS 2008/09) and is a crucial contributing factor to the high levels of neonatal and maternal mortality. In rural areas the births attended by skilled health providers are as low as 36.8%. Among the bottom two quintiles, only 24% of women deliver in a facility.

Kenya's high population growth rate needs to be analysed through the lens of both levels of contraceptive prevalence and fertility trends. KDHS (2008/09) reports the following data (Table 7):

TABLE 7: Contraceptive prevalence and fertility data (KDHS 2008/09)

Indicator	2008/09
Total fertility rate (TFR) Avg. number of children a woman would have through her entire reproductive period	4.60
Contraceptive prevalence Proportion of all women of reproductive age (WRA) who are using (or whose partner is using) a contraceptive method at a given point in time	44%
Percentage of all WRA using:	
Sterilisation as a contraceptive method	3.2%
IUDs as a contraceptive method	4.0%
Implants as a contraceptive method	2.6%
FP unmet need: Married women	25%

The low uptake levels of long-term contraception methods, especially in the poorest two quintiles of the population, remain a challenge. The total fertility rate in Kenya was as high as 6 births in a woman's lifetime in the 1950s, falling to about 5 births in the mid-1990s and then in the 2000s failed to drop further with significant disparities by economic status as poor women on average had a significantly higher number of children. These figures indicate that family planning programs have to take into account the barriers to access faced by poor women.

In terms of national spending on health, Kenya's National Health Accounts 2009/10 provide the following information related to Total Health Expenditure (THE) which comprises both public and private sectors' health expenditures:

TABLE 8: Health expenditure in Kenya 2009/10 (NHA 2008/09)

Key results	2009/10
THE in absolute values	KSh 122.9 billion (US\$ 1,620 million)
THE per capita	KSh 3,203 (US\$ 42)
Government health expenditure	KSh 35.4 billion
Government health expenditure as % of total government expenditure	4.6%
Total reproductive health expenditure	KSh 17.1 billion (US\$ 225 million)
Reproductive health expenditure as % of THE	13.9%
Reproductive health financing sources:	
Public	40%
Private	38%
Donors	22%
Government reproductive health expenditure	KSh 6.8 billion

GIZ in its Health budget analysis report 2011 noted that the budget allocation to the health sector - Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation

(MoPHS) - for FY 2010/11 accumulated to a total of KSh 41.5 billion of government resources which represents 6.5% of the total estimated government budget and 1.5% of the Gross Domestic Product (GDP). This amounts to KSh 1,064 (13.1 USD) per capita.

2 OUTPUT-BASED AID (OBA) APPROACH IN KENYA

2.1 Context

The Second National Health Sector Strategic Plan in Kenya or NHSSP II (2005-2010) outlined reproductive health as one of the priority health packages. The core reproductive health services in NHSSP II include: family planning, unmet need for contraception, safe motherhood and child survival, management of STDs/HIV/AIDS, promotion of adolescent and youth health, management of infertility, gender issues & reproductive rights, and other issues including chronic illnesses and cancers of the reproductive system. The plan came to an end in June 2012 and preparations are underway to finalise the next plan: Kenya Health Sector Strategic Plan-KHSSP (2012-2017).

The government in partnership with external donors has recognised that despite significant investment in the supply side of the health sector, the uptake of services has remained low (for example, institutional deliveries constitute only 43% of all deliveries). The Kenya Vision 2030 is a government strategy that aims to transform Kenya into a middle-income country by 2030, advocating innovative output-based financing models for the health sector and the development of a national health insurance scheme. The OBA approach is highlighted as one of two priorities in Vision 2030 and has already helped create demand for health services by motivating providers to cater for the health needs of the poorest and most vulnerable sections of the population.

The goal of the National Reproductive Health Strategy (NRHS) 2009 to 2015 is to facilitate the operationalization of the National Reproductive Health Policy, launched in 2007, through a multi-sectoral approach. The goal of the Policy is to *enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs*. The main objective under the maternal and neonatal health component is to reduce rates of maternal, perinatal and neonatal morbidity and mortality in Kenya. The expected output of its implementation strategies is *increased availability, accessibility, acceptability, and utilisation of skilled attendance during pregnancy, childbirth and the postpartum period at all levels of the health care delivery system*. One of the strategies to address this is increasing

service availability by scaling up OBA voucher schemes². Overall, the reproductive health OBA program fits well under this strategy. It not only provides poor women access to reproductive health services, but also enhances the capacity and quality of services of the service providers by reimbursing service costs and allowing facilities to invest in expanding capacity.

2.2 Design of Voucher Scheme

A pilot Reproductive Health OBA program has been in operation in Kenya since 2005 with the first vouchers issued in June 2006 and has shown promising results. This voucher scheme is co-funded by the German Development Bank (KfW) and the Kenyan government and offers three different services to poor clients: a safe motherhood package of antenatal services and attended delivery by qualified health workers, long-term family planning methods, and gender-based violence recovery (GBVR) services at accredited facilities. These vouchers are priced at a heavily discounted rate of KSh 200 (\$2.70) for the safe motherhood services and KSh 100 (\$1.35) for family planning services and no cost for the GBVR services. The table below outlines in detail the design of this scheme (Table 9).

TABLE 9: Design of reproductive health OBA program in Kenya (2005–2012)

Feature	Observation
Funding	GoK/KfW
Phases	Phase 1: October 2005–October 2008 Phase 2: November 2008–October 2011 Phase 3: November 2011–October 2014
Government body	Phase 1: Ministry of Planning, National Agency Coordinating Agency for Population and Development (NCAPD) Phase 2 & 3: Ministry of Public Health and Sanitation, Department of Economic Policy and Planning
Project areas	Phase 1: Nairobi (Korogocho, Viwandani), Kiambu, Kisumu, Kitui districts) Phase 2 Addition of Kaloleni and Kilifi districts Phase 3: Nairobi (Korogocho, Viwandani), Kiambu, Kisumu, Kitui, and Kilifi counties, expanded beyond former districts) Potential for additional counties in 2014.
Governance	Steering committee Advisory board
Management	Pricewaterhouse Coopers (voucher management Agency)

² Section 2.3.1 Maternal and Neonatal Health, NRHS, STRATEGY 3: *Increase availability of Integrated Maternal and Neonatal Health Services, at all Levels*

Quality of services monitoring	Phase 1: NHIF Phase 2: MOH technical committee Phase 3: Contracted accreditation and quality assurance agency
Quality improvement	Checked at accreditation and reinforced where there is competition between providers
Targeting approach	Poverty grading tool, originally developed by MSI as a participatory mechanism, with indicators unique to each district or county
Referral	Covered
Cost of vouchers to clients	Ksh.200 for SMH services Ksh.100 for FP services Free for GBV
Reimbursement mechanism	Reimbursement based on fixed rates per service type plus allowances for treatment of complications
Distributors	Contracted distributors (CBO, FBO, NGO, and individuals)
Providers	Private, FBO, NGO, Public levels 3,4,5 ³ Phase 1: 54 facilities Phase 2: 83 facilities Phase 3: 150-200 facilities
Clients	Poor pregnant women, GBV victims, poor families

This scheme currently caters to a population of over 3 million in the five above-mentioned pilot districts with an additional two districts added in Phase II. It is being implemented in three phases: Phase I (Oct 2005- Oct 2008) with a budget of € 6.5 million; Phase II (Nov 2008- Oct 2011) budgeted at €10.00 million (KfW) and €0.3 million (MoPHS); and Phase III (Nov 2011-Oct 2014) budgeted at €13.7 million (KfW) and €1.5 million (MoH).

In Phase II, PwC reported that 83 facilities had been contracted as voucher service providers. A total of 166,064 Safe Motherhood vouchers and 67,087 Family planning vouchers had been sold in Phase I and Phase II. Total deliveries in Phase I and Phase II were 119,795 and a total 39,460 of family planning services had been provided in Phase I and Phase II. In its Phase I report (Oct 2008), PwC notes that lower utilization of sold safe motherhood vouchers is due to several factors such as large distances in rural areas, poor communication and lack of transport and household level dynamics. Family planning voucher utilisation is lower than sold vouchers due to contraceptive stock outs and household level dynamics regarding seeking family planning, particularly when women consult their partners.

³ This is based on health facility levels defined before the new Constitution.

Total project costs reported in Phase II were KShs 796,360,726, 15% of which related to operational costs. Total Safe Motherhood reimbursements at the end of Phase II were KShs 507,327,518 and family planning reimbursements were KShs 52,481,878.

2.3 Evaluation of Voucher Scheme

There have been several internal and external evaluations of the voucher program. The first was done internally by PwC. Population Council, IPE Global and KfW⁴ have carried out external evaluations to describe operational issues and measure the effect of the program on clients, providers and the general population.

A review of the scheme conducted by PwC in 2008 found that the voucher sales and utilization rates of the Safe Motherhood vouchers exceeded targets. The high uptake of the SMH voucher suggests that the program is popular and can significantly reduce economic barriers for poor pregnant women who previously did not deliver at facilities. PwC found that in Phase II, 80.25% of the sales forecast was achieved, attributed to disruption and resulting loss of momentum between Phase I and II. PwC (2011) reported that during Phase I of the project, there was slow uptake of family planning services across the project sites. In Phase II, the family planning services picked up significantly with community based outreach conducted by trained healthcare workers having a positive impact on family planning service uptake (PwC 2011).

A key recommendation made by PwC in its End of Phase II report was to expand the program further in other counties to spread OBA benefits to more Kenyans and to help shape a national healthcare financing scheme. Although the report does not specify which lessons, key learning that could result from expanding the program nationally could include: effective coordination and management of a national healthcare financing scheme with multiple stakeholders; logistical implementation differences between counties; urban versus rural comparisons; and variations in attitudes between different communities and between different generations. The report also recommends reviewing reimbursement levels to facilities as some private sector and FBO facilities have opted out of the OBA program due to low reimbursement levels. This scenario is further explored in Section 4.

In 2009, the Population Council began an external evaluation and conducted a baseline assessment of the reproductive health voucher program, measuring both program management and program outcomes (Population Council, 2011). The baseline assessment found several positive impacts of the program including:

- improved capital investment at the facility level;
- high levels of satisfaction among voucher clients regarding service provision;

⁴ Analysis of Kenya OBA programme data – phase 2, Anna Gorter (June 2012).

- reduced levels of out-of-pocket expenditures for voucher clients;
- improved level of knowledge regarding potential complications that could arise during pregnancy and child birth;
- higher use of reproductive health services among poor voucher holders than non-voucher holders;
- reduced socio-economic inequities in service utilisation among voucher clients; and
- a perceived decline in maternal deaths in the community as a result of the safe motherhood voucher.

The IPE Global Private Limited end of Phase II evaluation report⁵ found that Phase II was successful having impacted positively on the lives of the intended beneficiaries. By the end of Phase II, an estimated 234,886 WRA or 24% of the target population in the five regions were reached. This figure represented 27% of the estimated 857,993 WRAs at the start of Phase II. The success of Phase II was largely due to the relevance of the project design set up in Phase I and continuing in Phase II, which was an innovative and appropriate approach to health service delivery (IPE Global 2012). The greatest challenge to the project IPE Global reported in Phase II was in the area of efficiency in some aspects of management, which affected the timely use of human, financial and physical resources.

The KfW End of Phase II report analyses the Phase 1 and Phase 2 data. The analysis shows that compared to Phase 1, many more FP vouchers were used during Phase 2. Facilities introduced FP outreach activities during Phase 2 and women became more familiar with long term methods. The report noted that word-of-mouth advertising probably played an important role. SMH increases were observed as well between Phases 1 and 2. The report notes that the SMH increase seen between Phases 1 and 2 was not the result of the expansion to Kilifi, but due to an increased distribution and utilisation of SMH vouchers in the existing areas: the increase in use of SMH vouchers is most likely the result of increasing familiarity of the program. The report further analyses the total number of voucher service providers and WRA in the areas served under this program. It found that the number of VSPs in Kilifi needs to be increased and Kitui and Kisumu may benefit from contracting more facilities. When comparing data by facility type (NGO, FBO, private or public), the analysis in the report shows that there is a huge difference between the percentages of complications between facilities: ranging from 0% to 60%, with high frequencies of complications, not only in the private and NGO sector but also in the FBO sector, and in a few public facilities. This indicates that the problem is related to health facilities trying to maximise their benefits. Contracts have had to be terminated in the private and NGO sectors because of fraud.

⁵ End of Phase II Evaluation and Phase III Baseline Survey of the Reproductive Health – Output-Based Approach (OBA) Project (December 2012)

3 Cost of Scaling Up

Results show that the pilot OBA scheme in Kenya has not only enabled poor women to access health services that were initially out of their financial reach, but is likely to have had a direct positive impact on maternal mortality (Population Council, 2011). With these encouraging results, the OBA program can become a decisive tool in Kenya's crusade against maternal mortality if scaled up appropriately.

Scaling up of such a program must go hand in hand with the establishment of an appropriate institutional set up. The IPE Global End Of Phase II Evaluation & Phase III Baseline Survey (December 2012) report recommends realigning/reassigning new PMU staff to fit the RH-OBA project design. This will be even more necessary should the project scale up. It is assumed that the administrative costs will be higher in 2013 as a result of these changes (see section 4.4) and decrease as a proportion of total costs over the projected period.

The baseline evaluation paper (Population Council, 2011), also found that there was a need to improve coverage in remote areas. Even though targeting in this OBA scheme was pro-poor, other aspects of distribution could be improved. For instance, there was a need for greater community sensitization regarding the use of long-term family planning methods. A need for a transport subsidy also emerged, and all these issues may need to be considered as the program is scaled up. However, this scale up report does not include programmatic changes such as transport subsidies as it is difficult at this stage to know the criteria for implementing such a subsidy in a scaled-up program, and therefore, the financial outlay required to implement it.

The estimated costs of scaling up both safe motherhood and family planning services are elucidated in the sections below. The scale-up cost estimation considers the cost of scale-up over three years - 2013, 2014 and 2015. It also gives estimates using three coverage targets- 30% (low), 50% (medium) and 70% (high) of all deliveries attributed to the poor; and meeting 30%, 50% and 70% of the unmet need for long-term contraception in the poor as identified using the KDHS wealth index. KDHS developed⁶ a wealth index as a proxy for standard of living using characteristics⁷ related to a household's socio-economic status. The ranking of individuals was then divided into five wealth quintiles. The bottom two quintiles have been used as a basis for identifying the poor for the scale up calculations. The current OBA scheme uses a poverty grading tool to identify the poor and although the tool uses some similar criteria, it has not been validated and may not correspond 100% to the population in the bottom two quintiles, as measured in the KDHS reports.

⁶ Section 2.6 KDHS 2008/09

⁷ Characteristics included ownership of consumer goods; dwelling conditions; drinking water source; toilet facilities among others related to socio-economic status.

3.1 Assumptions

A forecasting exercise rests on various assumptions. The assumptions in this paper are divided into three broad categories:

- Demographic
 - Number of deliveries
 - Number of deliveries attributed to the poor
 - Number of expected home based deliveries amongst the poor
- Economic
 - Inflation rates
 - USD-KES exchange rates
- Program-related
 - Change in administrative costs
 - Change in reimbursement rates
 - Poverty identification by the program is comparable to national poverty scales

U.S. Census Bureau data were used to estimate the number of annual deliveries from 2013-2015. Trends using the KDHS 2008/09 data (Annex C) were applied to this to determine potential home based deliveries amongst the poor to define the unmet need attributed to the poor. The unmet need for family planning and the number of deliveries attributed to the poor were calculated based on figures from the KDHS (2008/09).

Forecast data from TradingEconomics was used for exchange rates and inflation rates for 2013 to 2015.

3.2 Administrative Costs

In the first phase, the PwC (2008) review found that till 2008, the administrative⁸ costs of running the voucher program had been 21% while the direct benefits to the clients were about 79%. In Phase two, PwC (2011) report states that 15% of the total costs are administrative. These specifically ranged from 18% in 2008/09, 15% in 2009/10 to 12% in 2010/11.

Proportionate calculations for program management costs may be made using the PwC reported costs in Phase II. Costs may be higher initially in 2013 and 2014 as the administration costs of scaling up may be higher, with a reduction from 2015. On this basis, 18% of administrative costs may be earmarked for 2013, 15% for 2014, and 12% for 2015.

⁸ In Phases I & II, OBA administrative costs included: accreditation; impact monitoring (quality assurance); training; marketing & distribution; process monitoring; advocacy; communications/public relations; distribution sensitization; distributors' commission; VMA costs; and bank charges.

These rates have been applied in sections 3.3 to 3.5 to show the administrative cost of the safe motherhood and family planning programmes.

3.3 Safe Motherhood Services

For the purpose of forecasting, U.S. Census Bureau data⁹ estimate that the number of births in Kenya in 2013 will be 1,325,000, in 2014 will be 1,272,000 and in 2015 will be 1,212,000. KDHS 2008/09 reported that the lowest quintile delivered 24.7% of babies in Kenya and nearly 80.9% of those births were at home, while the second lowest quintile produced 20.3% of all births with 68.3% of these deliveries at home (Annex C). Based on those figures, the following delivery estimates were calculated for each year:

TABLE 10: Estimate of number of deliveries (Source: US Census Bureau, 2011; KDHS 2008/09)

	2013	2014	2015
No. of deliveries	1,325,000	1,272,000	1,212,000
No. of home based deliveries (lowest quintile)	264,684	254,097	242,111
No. of home based deliveries (second quintile)	184,026	176,665	168,332
TOTAL PROJECTED HOME-BASED DELIVERIES AMONGST THE POOR	448,710	430,762	410,443
Low target (30%)	134,613	129,229	123,133
Medium target (50%)	224,355	215,381	205,221
High target (70%)	314,097	301,533	287,310

The table below outlines the unit cost of each of these services and the proportion of total numbers based on PwC 2012 claims data (Table 11).¹⁰ The cost data has been updated for the projected years by the projected inflation rates for those years. The table below summarises the results.

TABLE 11: Unit costs and proportion calculations (Source: PwC claims data 2012)

Service	Reimbursement rates 2013 (KSh)	Reimbursement rates 2014 (KSh)	Reimbursement rates 2015 (KSh)	Percentage of deliveries
ANC	1,113	1,204	1,331	99%
Normal delivery	5,225	5,652	6,251	89%
Caesarean section	23,864	25,814	28,550	11%
Complications	3,276	3,544	3,919	24%

⁹ <http://www.census.gov/population/international/data/idb/country.php>

¹⁰ Note that the calculations are based on vouchers that will be utilized as opposed to the number sold. As with the current OBA program, vouchers sold are likely to be higher than those utilized.

Unfortunately, poor women do not seem to make full use of their ANC entitlement, with most women only attending one ANC visit. Reasons cited include lack of transport and difficulty to travel as the pregnancy advances. It has been assumed that this trend will not change in the medium term.

From the data in the tables above, the cost for the three coverage targets were computed. The results were translated into US\$ using TradingEconomics exchange rate forecast data as follows:

2013: \$1= 86.94KSh

2014: \$1= 86.02KSh

2015: \$1= 86.69KSh

The calculations yield the following costs (in millions) including the administrative costs:

TABLE 12: Summary safe motherhood scale-up costs

	30% coverage			50% coverage			70% coverage		
<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	1,083	1,184	1,220	1,805	1,974	2,034	2,527	2,763	2,848
Admin costs	238	209	166	396	348	277	555	488	388
TOTAL COSTS	1,321	1,393	1,387	2,201	2,322	2,312	3,081	3,251	3,236
<i>US\$ millions:</i>									
Reimbursement costs	12	14	14	21	23	23	29	32	33
Admin costs	3	2	2	4	4	3	6	6	4
TOTAL COSTS	15	16	16	25	27	27	35	38	37

If US \$25 million (including administration costs) were available for the safe motherhood component in the OBA scheme in 2013, 50% of the deliveries by women in the lowest two quintiles would be by skilled attendants at a health facility. This would double the current number of poor women receiving qualified maternity care.

The total government health budget in 2011/12 was KSh 69.13 billion (KNBS¹¹). This represents 5.9% of the total government 2011/12 budget estimate. If this figure is used and extrapolated with the NHA proportions (see section 2), reproductive health expenditure is estimated at KSh 38.01 billion in 2013 (see Annex D for calculations). Therefore, the safe motherhood component of that to achieve 50% coverage would be 5.8% of total reproductive health expenditure (including the related administrative costs).

¹¹ Classification of Expenditure by Purpose
www.knbs.or.ke/sectoral/Pfinance/Classification%20of%20Expenditure%20by%20Purpose.pdf

3.4 Family Planning Services

US Census Data population projections have been used to determine the number of WRA in the 15 to 49 category in the table below.

TABLE 13: Forecast of total number of women or reproductive age and the number of women of reproductive age in the bottom two quintiles of the population

	2013	2014	2015
Total projected population ^	44,037,656	45,010,056	45,925,301
Total projected WRA^	10,607,808	10,877,750	11,177,158
Proportion of married women of WRA*	58.36%		
Married WRA	6,190,819	6,348,360	6,523,097
Married women lowest quintile - %**	17.65%		
Married women second quintile - %**	17.9%		
Poor married WRA lowest quintile	1,092,941	1,120,753	1,151,602
Poor married WRA second quintile	1,109,272	1,137,500	1,168,810
Unmet need in poor married WRA - lowest quintile %+	38%		
Unmet need in poor married WRA - second quintile %+	32.5%		
Unmet need in poor married WRA - lowest quintile	415,318	425,886	437,609
Unmet need in poor married WRA - second quintile	360,513	369,688	379,863
Total number of poor, married WRA with unmet need	775,831	795,574	817,472
Unmarried WRA	4,416,989	4,529,390	4,654,061
Poor unmarried women %**	17.79%		
Poor unmarried WRA	785,611	805,603	827,777
Unmet need in poor unmarried WRA&	4.42%		
Number of poor, unmarried women with unmet need	34,693	35,575	36,555
Total number of poor WRA with an unmet need	810,524	831,149	854,027

^ US Census Data

*Pg. 97, KDHS (2008/09) Table 7.3 Proportion of currently married women to all women

** Proportion of married women in each quintile to total married women

+ Pg 97, KDHS (2008/09) Table 7.3

++ Average of % of lowest two quintiles of married women

& KDHS (2008/09) estimates that average unmet need among unmarried WRA is 3.2%. Assuming unmet need in the bottom two quintiles of unmarried women is in the same proportion to the average unmet need as in married women, the figure has been adjusted

The unmet need¹² for contraception is fairly high in Kenya, with a quarter of women unable to meet their contraceptive needs (KDHS 2008/09). Among married women, the unmet need in the bottom two quintiles is an average of 35%. Among unmarried women, the KDHS estimates an average unmet need of 3.2%. Estimating (as detailed below the table) the unmet need in the

¹² Unmet need: Proportion of women wanting to space or limit births among all women of reproductive age (15-49 years). Women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method are said to have an unmet need for family planning.

bottom two quintiles of unmarried women at 4.42%, the total number of poor WRA with an unmet need for contraception in Kenya may be computed.

With this target population across three years, the FP component of the OBA program can be scaled up to meet 30%, 50% and 70% of the unmet need among poor Kenyan women (Table 14).

TABLE 14: Target population(s) for scale-up of FP services

Coverage target: Bottom two quintiles:	2013	2014	2015
Low (30%)	243,157	249,345	256,208
Medium (50%)	405,262	415,575	427,013
High (70%)	567,367	581,805	597,819

Four long-term FP services are part of the OBA package. Calculating the proportion of usage using PwC 2012 claims data, the proportions are as follows:

- Sterilisation: 3%
- IUDs: 6.0%
- Implants: 91%

Family planning services provided by the OBA scheme also include vasectomy services for men. However, the uptake of these services has been extremely low with only a handful of cases (in 2012 there were only 2). Therefore, for the purpose of projections, vasectomy services have not been factored in. Further research needs to be done to determine whether these services should be offered at all, and if they are, what sensitization activities would be more effective in creating demand.

For the purpose of this study, it is assumed that the women under the coverage target will use one of the three forms of available contraceptive method under the OBA program in proportion to 2012 trends.

The table below summarises the estimated reimbursement rates for each of the FP services adjusted for inflation using the 2012 reimbursement rates calculated from PwC 2012 claims data (see Annex A).

TABLE 15: Unit costs of FP services provided under the OBA voucher

Service	Reimbursement rates 2013 (KSh)	Reimbursement rates 2014 (KSh)	Reimbursement rates 2015 (KSh)
Sterilisation	3,728	4,033	4,460
IUDs	2,336	2,527	2,795
Implants	2,352	2,544	2,814

Using the data presented in the tables above, the costs of scaling up the OBA program to meet 30%, 50%, and 70% of the unmet need among poor Kenyan women are reported below. The administrative costs of the program have been calculated separately in Section 4.4.

The total family planning costs for each year with related administration costs are presented below (Table 16).

TABLE 16: Summary family planning scale-up costs

	30% coverage			50% coverage			70% coverage		
<i>KSh millions:</i>	2013	2014	2015	2013	2014	2015	2013	2014	2015
Reimbursement costs	582	645	733	970	1,076	1,222	1,357	1,506	1,711
Admin costs	128	114	100	213	190	167	298	266	233
TOTAL COSTS	709	759	833	1,182	1,265	1,389	1,655	1,771	1,945
<i>US\$ millions:</i>									
Reimbursement costs	7	8	8	11	13	14	16	17	20
Admin costs	1	1	1	2	2	2	3	3	3
TOTAL COSTS	8	9	10	14	15	16	19	20	22

With approximately US \$14 million in 2013, the OBA programme could cover 50% of the unmet need for contraception among poor Kenyan women.

Reproductive health expenditure is estimated at KShs 38.01 billion in 2013 (see Annex D for calculations). Therefore, the family planning component of that to achieve 50% coverage in 2013 (including related administration costs) would be 3.1% of total reproductive health expenditure.

3.5 Total Costs

The combined scale-up costs for the safe motherhood and family planning services in US\$ for three different coverage targets will be:

TABLE 17: Total cost of scale-up for three coverage targets across three years

	2013	2014	2015
	(USD \$)		
Total programme costs*			
Low	19,147,118	21,268,118	22,538,445
Medium	31,911,864	35,446,863	37,564,075
High	44,676,610	49,625,608	52,589,705
Administrative costs^			
Low	4,203,026	3,753,197	3,073,424
Medium	7,005,043	6,255,329	5,122,374
High	9,807,061	8,757,460	7,171,323
TOTAL COSTS (US\$)			
Low	23,350,144	25,021,315	25,611,869
Medium	38,916,907	41,702,192	42,686,448
High	54,483,670	58,383,069	59,761,028

* Safe motherhood and family planning representing 82% of total costs in 2013, 85% in 2014; and 88% in 2015

^ 18% in 2013; 15% in 2014; and 12% in 2015

In 2013, to achieve 50% coverage of institutional deliveries and meet the unmet need for contraception amongst poor Kenyan women, the total funding required will be approximately US\$ 38.9 million.

The NHA 2009/10 proportion of reproductive health expenditure as a percentage of THE was 13.9% and this percentage has been applied to 2013 to 2015. The figures show that, for example, in 2013 with 50% coverage, the above total costs of KSh 3,383 million (safe motherhood, family planning and administrative costs) would comprise 1.3% of THE and 9.2% of estimated reproductive health expenditure.

The gender-based violence recovery vouchers have still not gained a foothold in the target population and further research is required to estimate both its impact and potential for scale up in the future.

3.6 Increased Reimbursement Levels

One of the recommendations from the PWC review is to increase reimbursement levels as some facilities are opting out of the OBA scheme due to low reimbursements. If reimbursement levels are increased by 5% and year on year inflation rates applied, the total costs increase by 5% as follows:

TABLE 18: Total cost of scale-up for three coverage targets across three years with increased reimbursement levels (KShs)

<i>KSh millions</i>	30% coverage			50% coverage			70% coverage		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
Safe motherhood	1,137	1,243	1,282	1,895	2,072	2,136	2,653	2,901	2,990
Family planning	611	678	770	1,018	1,129	1,283	1,425	1,581	1,797
PROGRAM COSTS	1,748	1,921	2,052	2,913	3,201	3,419	4,078	4,482	4,787
Admin costs	384	339	280	639	565	466	895	791	653
TOTAL COSTS	2,132	2,260	2,331	3,552	3,766	3,885	4,973	5,273	5,440

The above figures reflected in US\$ (with some rounding differences) are:

TABLE 19: Total cost of scale-up for three coverage targets across three years with increased reimbursement levels (US\$)

<i>US\$ millions</i>	30% coverage			50% coverage			70% coverage		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
Safe motherhood	13	14	15	22	24	25	31	34	34
Family planning	7	8	9	12	13	15	16	18	21
PROGRAM COSTS	20	22	24	33	37	39	47	52	55
Admin costs	4	4	3	7	7	5	10	9	8
TOTAL COSTS	24	26	27	41	44	45	57	61	63

The change in reimbursement rates from the combined increase in 5% in reimbursement rates and increase in inflation leads to an overall increase in 20% between the reimbursement rates from 2012 to 2013. However, the safe motherhood, family planning and administration costs increase by 5% between the estimates before and after the reimbursement level increases. Annex E details the increased reimbursement rates that were applied to obtain the above estimates.

Therefore, 50% coverage in 2013 costing KSh 3,552 million, would represent 1.3% of THE and 9.3% of reproductive health expenditure.

4 CONCLUSION: WAY FORWARD

The Government of Kenya OBA vouchers program is an affordable strategy to meet the international and national objectives for improved maternal and reproductive health. Maternal health has received significant attention in Kenya both at a national as well as international level. To help achieve the global MDGs related to maternal and child health, especially MDG 5, the Kenya government has launched several initiatives including NHSSP II, Maternal and Newborn

health (MNH) roadmap, Contraceptive Security Strategy and the National Reproductive Health Strategy.

Nationally, the Kenya Vision 2030 strives to achieve middle-income country status by the year 2030. Health is a key component of this Vision with a focus on developing equitable financing mechanisms that channel output-based funds directly to healthcare facilities. This output-based approach will help strengthen the evolution of a national social health insurance scheme that serves the informal sector and the destitute.

As a Vision 2030 flagship program, the OBA scheme harmonizes global and national objectives by improving access and enhancing equity in health service delivery. The three maternal health MDG indicators: maternal mortality rate, rate of institutional deliveries and contraceptive prevalence can all be improved substantially by scaling up the OBA program.

The cost of scaling OBA will increase the number of new users and poor women accessing reproductive healthcare with significant contribution to the achievement of the MDGs in Kenya, particularly by contributing to the reduction of maternal mortality. In addition, with the increased efficiency and availability of resources at healthcare facilities, the quality of health care is likely to improve. There will, however, be several challenges to managing such a large-scale program. The MOH and PMU will have to have greater capacity and robust management systems to ensure the program runs smoothly. There may be logistical challenges, especially to accredit and monitor a large number of service providers and verify service delivery. As part of the drive to improve efficiency, utilization of distributed vouchers will need to be improved. Complementary services could be added to improve utilization, such as including a transport subsidy and increasing sensitization activities. This will, however, lead to higher program costs. Finding the right reimbursement rate for facilities will be an important activity that will need to be repeated on a periodic basis. The risk of losing health care facilities due to low reimbursement levels will need continuous monitoring to ensure there are a suitable number of participating facilities in all areas to ensure access. Routine performance monitoring of utilization, quality, costs, equity and health status will allow program managers to respond and improve operations over time. Overall, planning for a scaled up program should take account of the valuable lessons from the pilot OBA scheme to enhance the scaled up program as far as possible and minimize potential risks and challenges.

Annex A

Cost calculations and proportions for 2012 (PwC claims data)

Safe motherhood	ANC		Normal		Caesarean		Complication	
	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)
	35,586	34,784,007	32,046	146,993,260	3,857	80,803,793	8,738	25,126,750
Total deliveries	Normal and Caesarean = 35,903							
Average cost 2012*		977		4,587		20,950		2,876
Percentages+	99%		89%		11%		24%	

* Amount divided by number of patients

+ Based on total deliveries of 35,903

Family planning	BTL		Vasectomy		Implants		IUCD	
	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)	Number of patients	Amount (KShs)
	549	1,797,150	2	6,000	18,261	37,706,950	1,162	2,383,150
Total patients								
Average cost 2012*		3,273		3,000		2,065		2,051
Proportions^		0.03		0.00		0.91		0.06

* Amount divided by number of patients

^ Number of patients under each service divided by total number of patients

Annex B

Division across quintiles, from Page 120, KDHS 2008/09

Table 9.6 Place of delivery								
Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, Kenya 2008-09								
Background characteristic	Health facility		Home	En route	Other/missing	Total	Percentage delivered in a health facility	Number of births
	Public sector	Private sector						
Mother's age at birth								
<20	37.3	9.3	52.6	0.6	0.3	100.0	46.6	953
20-34	32.0	10.7	56.2	0.8	0.3	100.0	42.7	4,234
35-49	27.2	9.0	61.4	1.8	0.5	100.0	36.2	665
Birth order								
1	47.2	13.9	37.7	0.9	0.3	100.0	61.1	1,310
2-3	33.8	11.9	53.5	0.7	0.2	100.0	45.7	2,225
4-5	23.6	9.3	65.8	1.1	0.2	100.0	32.9	1,252
6+	21.2	3.6	73.3	1.3	0.6	100.0	24.8	1,066
Antenatal care visits¹								
None	5.1	5.6	87.5	1.2	0.6	100.0	10.7	290
1-3	29.7	8.5	60.7	1.1	0.1	100.0	38.2	1,730
4+	44.6	15.7	38.4	1.3	0.1	100.0	60.3	1,872
Residence								
Urban	51.6	23.1	24.5	0.3	0.6	100.0	74.7	1,074
Rural	28.0	7.4	63.3	1.1	0.3	100.0	35.4	4,777
Province								
Nairobi	45.7	43.7	9.9	0.0	0.7	100.0	89.4	334
Central	56.7	16.2	25.9	1.0	0.1	100.0	73.0	466
Coast	38.0	6.4	54.6	0.7	0.3	100.0	44.4	495
Eastern	33.5	9.3	54.8	2.0	0.4	100.0	42.8	890
Nyanza	34.7	9.4	54.9	0.9	0.0	100.0	44.2	1,145
Rift Valley	26.0	6.8	66.3	0.7	0.3	100.0	32.9	1,642
Western	19.1	6.3	73.3	0.9	0.5	100.0	25.3	703
North Eastern	16.6	0.7	81.3	0.0	1.4	100.0	17.3	178
Mother's education								
No education	12.3	2.8	83.5	0.7	0.6	100.0	15.0	763
Primary incomplete	23.6	4.4	70.8	0.9	0.3	100.0	28.0	1,952
Primary complete	37.1	10.9	51.0	0.9	0.1	100.0	48.1	1,761
Secondary+	49.6	22.0	27.0	1.0	0.3	100.0	71.6	1,375
Wealth quintile								
Lowest	16.0	2.1	80.9	0.8	0.3	100.0	18.0	1,445
Second	23.1	7.3	68.3	1.1	0.2	100.0	30.4	1,190
Middle	36.2	5.4	56.7	1.4	0.3	100.0	41.6	1,085
Fourth	39.9	11.6	47.2	1.2	0.2	100.0	51.4	1,038
Highest	52.9	28.0	18.4	0.1	0.6	100.0	80.9	1,095
Total	32.3	10.3	56.2	0.9	0.3	100.0	42.6	5,852
Note: Total includes 81 women with information missing on number of antenatal visits.								
¹ Includes only the most recent birth in the five years preceding the survey								

Annex C

Financial data, www.tradingeconomics.com/kenya/forecast

MARKETS	REFERENCE	PREVIOUS	ACTUAL	TREND	2013	2014	2015	
<u>GOVERNMENT BOND 10Y</u>	Mar/2013	13.50	12.30		12.32	11.57	11.83	View
<u>STOCK MARKET</u>	Mar/2013	4518.59	4721.23		4727.84	4762.05	4763.09	View
<u>CURRENCY</u>	Mar/2013	86.10	85.66		86.94	86.02	86.69	View
GDP	REFERENCE	PREVIOUS	ACTUAL	TREND	2013	2014	2015	
<u>GDP PER CAPITA</u>	Dec/2011	470.58	478.22		479.65	481.19	480.22	View
<u>GDP PER CAPITA PPP</u>	Dec/2011	1645.52	1709.50		1803.43	1836.86	1863.61	View
<u>GDP</u>	Dec/2011	32.19	33.62		35.14	35.63	35.99	View
<u>GDP GROWTH RATE</u>	Sep/2012	0.50	2.20		1.07	1.14	1.16	View
<u>GDP ANNUAL GROWTH RATE</u>	Sep/2012	3.30	4.70		4.38	4.11	4.17	View
LABOUR	REFERENCE	PREVIOUS	ACTUAL	TREND	2013	2014	2015	
<u>POPULATION</u>	Dec/2011	40.51	41.61		42.51	42.51	42.51	View
<u>UNEMPLOYMENT RATE</u>	Dec/2011	12.70	40.00		49.01	52.67	55.87	View
PRICES	REFERENCE	PREVIOUS	ACTUAL	TREND	2013	2014	2015	
<u>CONSUMER PRICE INDEX (CPI)</u>	Jan/2013	134.25	135.62		147.58	153.36	156.74	View
<u>INFLATION RATE</u>	Feb/2013	3.67	4.45		13.91	8.17	10.60	View
MONEY	REFERENCE	PREVIOUS	ACTUAL	TREND	2013	2014	2015	
<u>FOREIGN EXCHANGE RESERVES</u>	Jun/2012	411618.00	441861.00		472307.08	506038.58	527306.49	View
<u>INTEREST RATE</u>	Mar/2013	9.50	9.50		7.75	11.00	9.75	View
<u>MONEY SUPPLY M1</u>	Nov/2012	699.00	691.20		768.47	813.45	841.14	View

Annex D

Total health expenditure estimates for 2013–2015 using KDHS 2011/12 and applying trends shown in NHA 2009/10

(Using KNBS Classification of Expenditure by Purpose, 2009/10- 2011/12)							
							Billions KSHs
Total Government Outlay (estimate) 2011/12							1,165.53
Government health expenditure 2011/12							69.13
Government health expenditure as % total government expenditure							5.9%
Financing sources as % of THE Using 2009/10 NHA figures:							
			KSH billion				
			2012	2013*	2014*	2015*	
	Public	28.80%	69.13	78.75	85.18	94.21	
	Private	36.70%	88.09	100.35	108.54	120.05	
	Donors	34.50%	82.81	94.33	102.04	112.85	
	THE		240.03	273.42	295.76	327.11	
RH expenditure as % of THE (2009/10)					13.90%		
Therefore, estimated RH expenditure 2011/12					33.36	KSh billion	
Financing sources as % of RH expenditre (2009/10)							
	Public				40%		
	Private				38%		
	Donors				22%		
Applying to 2011/12 estimates:				2012	2013*	2014*	2015*
	Public			13.35	15.20	16.44	18.19
	Private			12.68	14.44	15.62	17.28
	Donors			7.34	8.36	9.04	10.00
				33.36	38.01	41.11	45.47
* - assume annual inflationary increase using TradingEconomics estimates							

Annex E

Safe motherhood

Service	Reimbursement rates 2012 (KSh) -5% increase	Reimbursement rates 2013 (KSh)	Reimbursement rates 2014 (KSh)	Reimbursement rates 2015 (KSh)
ANC	1,026	1,169	1,264	1,398
Normal delivery	4,816	5,486	5,935	6,564
Caesarean section	21,998	25,057	27,105	29,978
Complications	3,020	3,440	3,721	4,115

Family planning

Service	Reimbursement rates 2012 (KSh) -5% increase	Reimbursement rates 2013 (KSh)	Reimbursement rates 2014 (KSh)	Reimbursement rates 2015 (KSh)
Sterilisation	3,437	3,915	4,235	4,683
IUDs	2,154	2,453	2,654	2,935
Implants	2,168	2,470	2,672	2,955

Annex F

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