Vouchers:
Addressing inequities in access to contraceptive services

October 18, 2017

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Nandita Thatte, WHO/IBP, Facilitator

Nandita leads the WHO/IBP Secretariat based in Geneva. Her current portfolio includes institutionalizing the role of WHO/IBP to support dissemination, implementation, and scale up of WHO guidelines and strengthening the linkages between IBP partners and WHO researchers to inform new areas for implementation research. Prior to joining WHO, Nandita was a Technical Advisor in the Office of Population and Reproductive Health at USAID where she supported programs in West Africa, Haiti and Mozambique. She has a DrPH in Prevention and Community Health from the George Washington University School of Public Health.

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Agenda

- **Welcome and Introduction**
- **HIP brief**
  Nandita Thatte, WHO
- **Financing Mechanism/Programmatic Tool**
  Elaine Menotti, USAID
- **Increasing contraceptive access with vouchers in Uganda**
  Ben Bellows, Population Council - Zambia
- **Youth vouchers in Madagascar**
  Anna Mackay, MSI
- **Voucher Program in Punjab, Pakistan**
  Moazzam Ali, WHO
- **Questions and Answers**

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Vouchers Webinar

Objectives:

- Participants have a better understanding of the vouchers HIP
- Share implementation successes and challenges in voucher at global and country levels

Logistics:

- **Questions**

During presentations, please submit any questions using the question feature of the application. We have allotted time at the end of the webinar for Q&A

- **Webinar presentation and recording**

This webinar will be recorded and posted on the HIPs YouTube channel and the IBP channel. Links will be shared at the end of the webinar. The presentation will be shared with participants

- **Handouts**

There are handouts that you can download for your own viewing and reference

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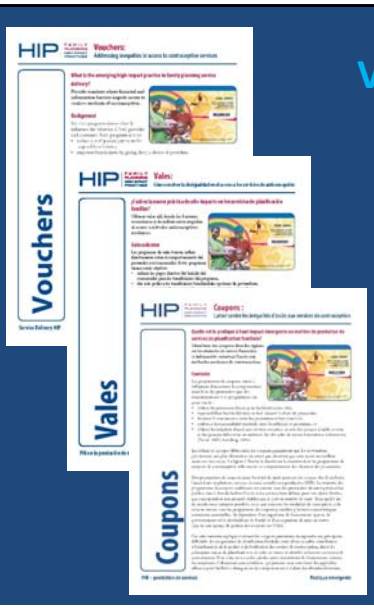

Vouchers HIP Brief

What is the high-impact practice in family planning service delivery?

Provide vouchers where financial and information barriers impede access to modern methods of contraceptives

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HIP Categories

Enabling Environment	Service Delivery	Social and Behavior Change
Systems or structural interventions which affect factors indirect to contraceptive use.	Changes in the organization of services which directly affect access, availability, and quality of family planning services.	Interventions which directly affect knowledge, attitudes, behavior, and social norms that influence contraceptive use.

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Service Delivery and Social and Behavior Change HIPs are further categorized according to the strength of the evidence base for each practice – proven, promising, and emerging. The darker the color used in the HIP brief, the stronger the evidence base for the practice.

Proven	Sufficient evidence exists to recommend widespread implementation, provided that there is careful monitoring of coverage, quality, and cost.
Promising	Good evidence exists that these interventions can lead to impact; more research is needed to fully document implementation experience and impact. These interventions should be implemented widely, provided they are carried out in a research context and evaluated for both impact and process.

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Vouchers:
Addressing inequities in access to contraceptive services

- Background
- Why is this practice important?
- What is the impact?
- How to do it: Tips from implementation experience
- Priority research questions
- References

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Today's Panelists

Elaine Menotti
USAID

Moazzam Ali
WHO

Ben Bellows
Population Council

Anna Mackay
MSI

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Elaine Menotti, USAID

Elaine is a Technical Advisor at USAID's Bureau for Global Health in the Office of Population and Reproductive Health where she works on the Private Sector team, manages health service delivery programs and supports public/private partnerships and strategic initiatives to implement total market approaches. Previously, she worked in USAID's Health, Infectious Disease and Nutrition Office on community based maternal and child health programming. She has an MPH in Health Behavior and Health Education and a Certificate in Reproductive and Women's Health from the University of Michigan and a BA in Anthropology from Duke University.

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Vouchers: What are they and what can they do?

- What? Paper or electronic tickets distributed or sold to select client segments who exchange them for products and/or services at accredited sites
- Why? To increase access to and use of high quality FP services for those who may otherwise face barriers

Why not just make services free?

- Despite high unmet need, the poorest often have lower rates of service utilization than their wealthier counterparts*
- Health systems are often stretched and face difficulties adequately financing and supporting health facilities and programs, especially lower levels

→ Need to address cost barriers and other factors affecting service utilization to reduce inequities

***EQUITY**: VOUCHERS FACILITATE TARGETING SUBSIDY TO*

1) THOSE SEGMENTS WHO NEED IT MOST (e.g. poor, youth, postpartum)

2) CRITICAL, HIGH IMPACT HEALTH SERVICES

And can reduce other barriers to seeking care, if implemented well.

*Wang et al. 2010. Who Benefits from Government Subsidies to Public Health Facilities in Liberia? HS2020

What are the key components to voucher programs?

1) Foundational structure
   - Funding (govt, donor, both)
   - Program Objectives
   - Governance structure
2) Management systems
   - Voucher management agency
   - Voucher design
   - Provider QA
   - Claims, fraud control, M&E
3) Providers / facilities
   - Which ones, how to engage, reimburse, support
4) Clients
   - Who, how to engage, what services

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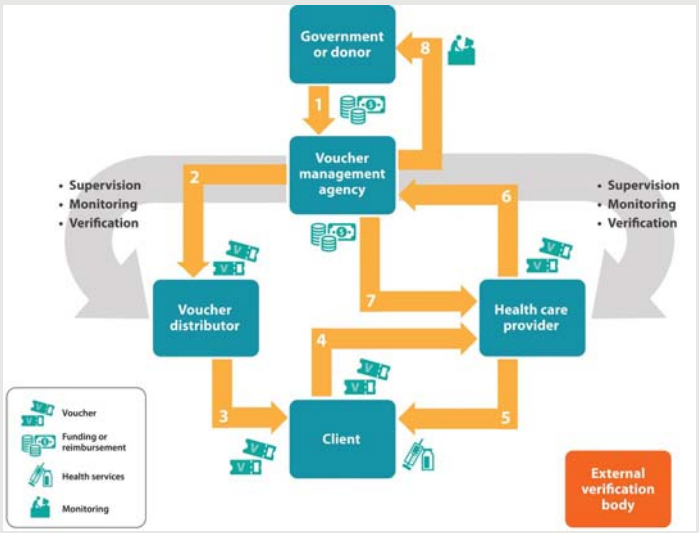
HOW DO THEY WORK IN PRACTICE?



Adapted from WB 2005, Islam 2006, Grainger et al 2014

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What Makes for better Voucher Programs?

- **Include Supply + Demand** related inputs
  - Inputs to providers and facilities to ensure strong FP quality
    - Training, monitoring, supportive supervision, site improvements
  - SBCC to reach desired population group
    - Promote FP services, create a "buzz"
    - Opportunity for counseling and interpersonal communication
- **Means testing** to ensure vouchers go to those who need them
- Voucher **revenue reinvested** at the facility level

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WHAT CAN THEY DO FOR FP?

- Increase **voluntary uptake** of modern contraceptive methods
- Improve **quality** and continuity of FP services
  - Can include follow up, removal services
- Enhance **method choice** by offering a broad range
  - Increase number and types of providers "network" offering quality FP
  - In many countries, gaps in LARC/PM access
  - Reimbursement rates can level playing field with less costly methods
- Enable **client purchasing power+ provider choice**
- Create **pathway** for **strategic purchasing**
  - Accustom providers to accreditation, reimbursement, oversight
  - Including FP as methods vary in provision costs
  - Including private providers

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Challenges we face, questions we ask

- Too heavy administrative lift to set up voucher programs?
- Integrated package or FP services alone?
- Are there unintended consequences on other service provision?
  - Increase service volume and overwhelm providers?
- How long to sustain them?
  - Creates quality assured provider network with FP service capacity
  - Platform for other financing mechanisms, like insurance
- What else can we ask/monitor? Can they help improve FP continuation?
- What are most important design features for success?

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Ben Bellows, Population Council – Zambia

Ben is an associate with the Population Council's Reproductive Health program in Lusaka, Zambia. He joined the Council in 2009 to lead a five-country, five-year initiative to measure the impact of reproductive health vouchers on health service uptake, equity, quality of care, cost-effectiveness, and sustainability in East Africa and South and Southeast Asia. Bellows received his MPH in epidemiology/biostatistics and social behavior and his PhD in epidemiology from the University of California, Berkeley, where his research focused on the impact of low-income subsidies for care on population health in East Africa.

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POPULATION COUNCIL — Ideas. Evidence. Impact.

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MARIE STOPES INTERNATIONAL — Children by choice, not chance

Increasing contraceptive access for hard-to-reach populations with vouchers and social franchising in Uganda

Ben Bellows

Vouchers: High Impact Practice in FP
HIPs Webinar Series
18 October 2017

Paper development supported by the Support for International Family Planning Organizations (SIFPO) program funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement No. AID-OAA-A-10-00059

Full study: Bellows, B., Mackay, A., Dingle, A., Tuyiragize, R., & Nnyombi, W. (2017). Increasing Contraceptive Access for Hard-to-Reach Populations With Vouchers and Social Franchising in Uganda. *Global Health Science and Practice*, 5(3), 446–455. http://www.ghspjournal.org/content/5/3/446

Background: Study

- Study objective: Estimate impact of services and program's contribution to national CPR and additional users
- 2011 DHS: 34% of married women of reproductive age indicated unmet need for FP services
- Inaccessible due to costs, lack of trained providers, lack of consumer awareness, weak supply chains

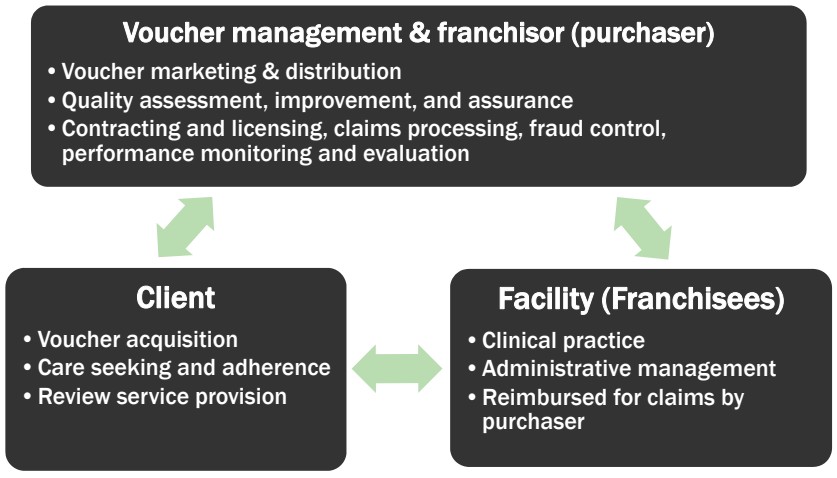
Background: Study

- +50% of Ugandan FP users access services through private sector
  - Lack of training
  - Where available, LARCs expensive

Background: Program design

- Combined social franchising & voucher program contracted 400 private facilities to increase access to LARCs and PMs March 2011–Dec. 2014
- FP voucher covered counseling, LARCs, PMs, and follow-up services as necessary
- Vouchers intended for poor women identified with poverty grading tool

Voucher programs and social franchising scheme



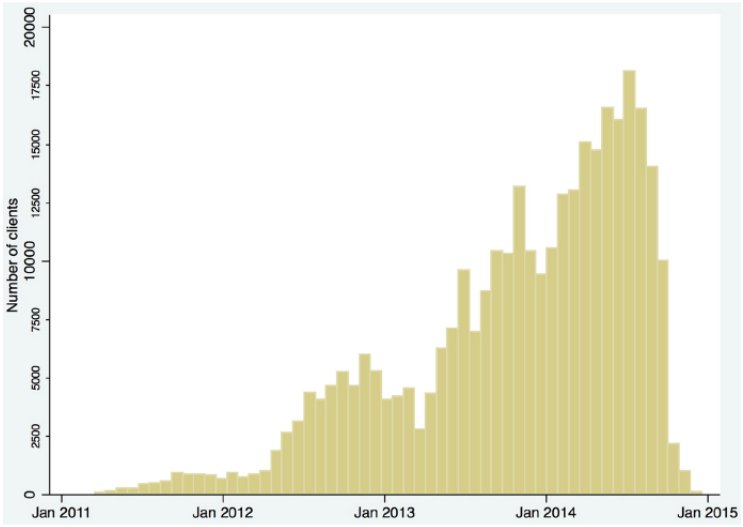
Study Methods

- Estimate program's health impact using Impact 2 Model
  - Number of pregnancies averted
  - Adverse health and financial outcomes averted
- Input client demographics and facility routine service delivery

Results: SF & voucher program

- 330,826 FP services provided to women
- 69.8% used vouchers to purchase implant
- 25.1% used vouchers to purchase IUD
- Noted increases in contraceptive uptake and client volume at franchised facilities

FIGURE 2. Date of Family Planning Voucher Clients' First Visit to a Marie Stopes Uganda Social Franchise Facility, January 2011 to January 2015



Results: Impact2

- 218,000 unintended pregnancies and 520 maternal deaths averted (2014 services)
- USD$14 million saved in direct costs
- 280,000 of Uganda's 8.6 million women of reproductive age using a method supplied by program
- 120,000 clients were additional users
- Program contributed 1.4% to national CPR within study period

Conclusions

- Existing private sector can be leveraged to expand FP access and method mix, particularly for marginalized populations
- CPR can be improved nationally when program is scaled up
- Future research: are higher clinical service quality scores associated with higher client volumes? Potential for positive feedback.

Full study: Bellows, B., Mackay, A., Dingle, A., Tuyiragize, R., & Nnyombi, W. (2017). Increasing Contraceptive Access for Hard-to-Reach Populations With Vouchers and Social Franchising in Uganda. *Global Health Science and Practice*, *5*(3), 446–455. http://www.ghspjournal.org/content/5/3/446

Ideas. Evidence. Impact.

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Anna Mackay, Marie Stopes International

Anna is the SIFPO 2 Director with Marie Stopes International (MSI). Anna has over ten years of public health program management experience, including seven years at MSI supporting SRH programming across sub-Saharan Africa and South Asia. During this time Anna supported the development and management of MSI's voucher programs in Madagascar and Uganda. Prior to working with MSI, Anna managed post-conflict health systems strengthening projects in West and Central Africa with Merlin. She holds an MSc in Violence, Conflict and Development from the University of London.

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MARIE STOPES INTERNATIONAL
Children by choice, not chance

Increasing FP access for young people through the private sector: Youth vouchers in Madagascar

Anna Mackay
Marie Stopes International

Youth voucher program: design & development

Rationale

- 1/3 of 15-19 year olds have children, 27% have unmet FP need
- Cost barrier for young people to access quality SRH services
- Only 12% of MSM franchisee clients 15-19
- MSM experienced in voucher programs

Preparation

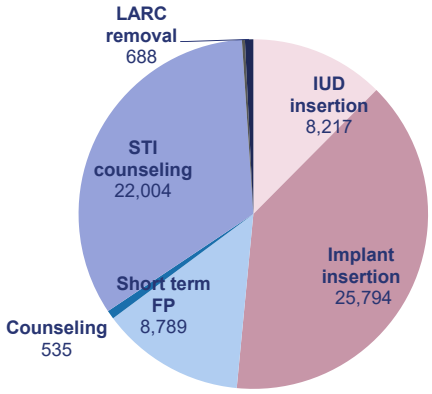
- Training CHWs and franchisees in youth friendly services
- Adapted existing voucher management software

Launch

- Launch of the youth voucher for FP and STI services for 15-19 year olds distributed by CHWs and available for redemption at franchisees

Results (18 month pilot phase)

- 58,417 vouchers distributed
- 43,352 young people used vouchers to take up a service
- 78% chose to take a LARC
- 51% had STI counselling



Who are the voucher clients?

69% had never previously used a method of family planning

96% of clients were aged 20 or younger

47% had one or more children

Lesson learned from the pilot: evolving the voucher format to include a paper voucher

- E-vouchers were not being frequently used due to:
  - a high number of young people interested in receiving a service but who did not own a mobile phone
  - Reluctance to provide mobile number due to the sensitive nature of the SMS content
- New distribution strategy was established:
  - Paper-based voucher distributed at community level
  - E-vouchers via MSM's Call Center (toll-free number)

Feedback from franchisees

- Youth-friendly training helped equip them to provide confidential, non-judgemental information and services
- Increased youth client load improved provider confidence and willingness to provide services, including voluntary LARCs, to young people

Conclusion

- Results demonstrate that **vouchers can be an effective tool to reach adolescents at scale**, provide them with FP choice, and leverage existing private health infrastructure
- MSI also operating adolescent vouchers in Kenya and Uganda
- When young people have the choice, many of them choose LARCs
- Holistic demand and supply side intervention key to success
- Mobile technology not always the right solution

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WANT TO HEAR MORE? JOIN US ON OCT 31

Scaling-up access for the underserved: The role of vouchers for family planning

Tuesday 31st October, 8.30am- 4pm

Whittemore House, 1526 New Hampshire Ave NW, Washington DC

RSVP: jenny.haydock@mariestopes.org

How can voluntary family planning vouchers help us reach FP2020 goals and pave the way for sustainable FP financing? MSI, FP2020 and USAID invite you to join us for a day of discussion and learning. Implementers, researchers and donors will share FP voucher programming results, insights and challenges, and explore the potential of vouchers in the future FP financing landscape.

41 Marie Stopes International

Moazzam Ali, WHO

Moazzam is a Medical Officer at the Department of Reproductive Health and Research at WHO Headquarters. He is physician by training and has masters and doctorate in public health. His main interest is in clinical trials, strengthening research capacity and health care financing modalities in family planning.

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October 18, 2017.

Effectiveness of a voucher program in meeting birth spacing needs of the underserved in Punjab, Pakistan

Department of Reproductive Health and Research

Moazzam Ali, Khurram Azmat, Waqas Hameed

World Health Organization

human reproduction programme hrp research for impact

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Background – Pakistan

- Approx. 210 million population - 6th largest (Census 2017)
- Overall Contraceptive Prevalence Rate (CPR) is 35%
  - Modern CPR is 26% - LARC methods lowest 2-3%
- Approx. 9 million pregnancies in 2012 - 4.2 million pregnancies unintended
- Inequities: rural and urban populations especially
- Narrowing gap - Increasing role of private sector in FP service provision
  - public sector 46%, and private sector 42%

44 Filename

Main objectives

- To assess the effectiveness of a single-purpose voucher approach (MSS model) in increasing the uptake, use and better targeting of modern contraceptives among women from the lowest two wealth quintiles in rural and urban communities of Punjab province, Pakistan

Single purpose free voucher by Marie Stopes Society Pakistan (MSI).

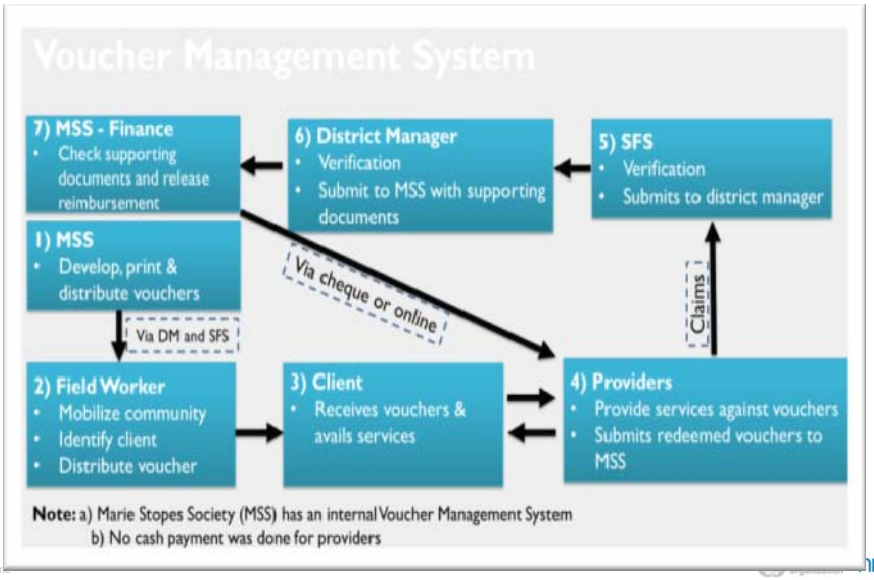
Three components:

- Services
- Follow up /side effect management
- Removal services for LARCs

Study design

- MSS used a combination of social franchising and voucher program to reach out to the underserved in selected areas in Punjab province, Pakistan to increase access to all methods with a special focus on LARCs (2011 to 2015)
- Quasi-experimental study (pre & post intervention)
- Intervention and control arm
  - Intervention district: Chakwal, Punjab
  - Control district: Bhakkar, Punjab
- Intervention time : Approx. 30 months
- Multi stage cluster sampling with 1276 clients each from Intervention and control areas
- Distance between districts at least 100 Km to minimize contamination

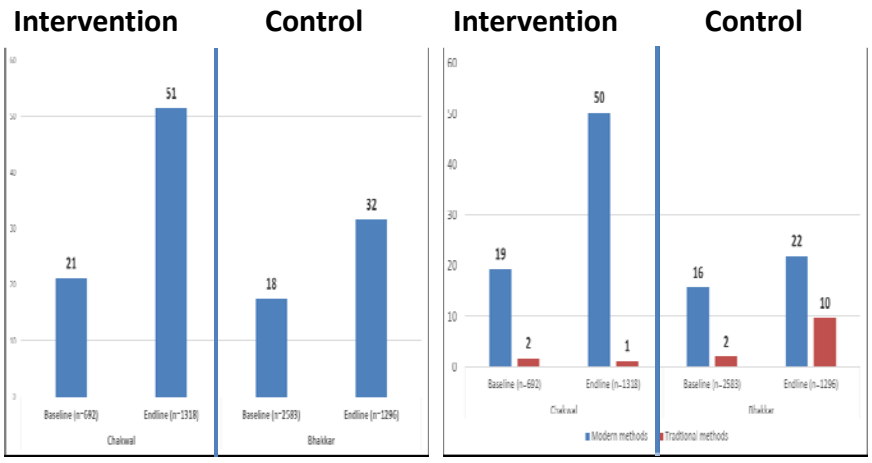
Voucher management system



Socio-demographic characteristics

- Age of MWRA : Similar between baseline and end line in both arms (average ± 31 and 30)
- Age of Husband: Similar between baseline and end line in both arms (average ± 37 and 34)
- Average household size: 6.5 to 4.9 in the intervention areas while no effect on control (6.2)

Utilization of contraceptives



a) Chakwal Current user p=<0.0001,
b) Bhakkar Current user p= <0.0001

a) Modern methods uptake
b) Traditional methods uptake

Utilization: FP method preferences

	Chakwal			Bhakkar		
	Baseline (n=692)	End line (n=1318)	p-value	Baseline (n=2583)	End line (n=1296)	p-value
	%	%		%	%	
Current users	21	51	<0.0001	18	32	<0.0001
Pill	2	3	0.1852	2	1	0.0217
IUD	2	20	<0.0001	2	4	0.0003
Injections	3	4	0.2564	2	2	1
Implants	-	2	-	-	0	-
Condom	7	13	<0.0001	7	9	0.0272
Female sterilization	5	8	0.0121	3	6	<0.0001
Male sterilization	0	0	-	0	0	-
Diaphragm/foam/Jelly	-	0	-	-	0	-
Periodic Abstinence	0	0	-	2	1	0.0217
Withdrawal	1	0	-	0	3	-
LAM	-	1	-	-	6	-

Utilization: Difference in Difference Analysis

	Control		Intervention		Absolute difference (% change)+		Net effect (% change) ^
	Baseline (%)	Endline (%)	Baseline (%)	Endline (%)	Control	Intervention	
Ever user	25	58	35	79	33	44	11
Current user [1]	18	32	21	51	14	30	16
Modern Method [2]	16	22	19	50	6	32	26
Pill	2	1	2	3	-1	1	2
IUD [a]	2	4	2	20	2	18	16
Injections	2	2	3	4	0	1	1
Implants		0		2	0	2	2
Condom	7	9	7	13	2	6	4
Female sterilization	3	6	5	8	3	3	0
Traditional Method [3]	2	10	1	1	8	0	-8
Periodic Abstinence	2	1	0	0	-1	0	1
Withdrawal	0	3	1	0	3	-1	-2
LAM [b]	0	6	0	1	6	1	-5

+Absolute difference is the percentage change from baseline to endline

^ Net effect is the percentage change in intervention group subtracting the percentage change in control group.

a) Intra uterine device, b) Lactational amenorrhea method

[1] Percentage totals % for 2 + 3

51 Filename

World Health Organization hrp

Method continuation and switching

(during study period)

	Intervention site (Chakwal)	Control site (Bhakkar)
	n=842 n (%)	n=354 n (%)
Discontinued modern method	115 (13.7)	95 (26.8)
Switched to different method	392 (46.6)	47 (13.3)

52 Filename

World Health Organization hrp

Key findings: Targeting

Multilevel logistic regression models identifying factors associated with contraceptive knowledge and use, MSS project area, Pakistan

Characteristics	Odds ratio (95% Confidence interval)				
	Contraceptive Knowledge any one method	Ever use (any method)	Current use (any method)	Modern method use	First time modern contraceptive use
Study area					
Intervention	0.72 (0.45-1.17)	**1.8 (1.44-2.24)**	**1.68 (1.31-2.16)**	**2.18 (1.67-2.84)**	0.87 (0.49–1.56)
Control	1.00	1.00	1.00	1.00	1.00
Household size	1.02 (0.99-1.06)	1.07 (1.03-1.11)	1.07 (1.03-1.10)	1.07 (1.04-1.11)	0.98 (0.92–1.04)
Wealth quintile					
Poorest	**1.78 (1.06-2.97)**	**1.68 (1.16-2.42)**	**1.67 (1.13-2.46)**	**1.69 (1.13-2.55)**	0.56 (0.27–1.19)
Poor	**1.26 (0.89-1.79)**	**1.58 (1.23-2.04)**	**1.37 (1.02-1.85)**	**1.39 (1.00-1.94)**	0.62 (0.27–1.43)
Average	1.27 (0.90-1.81)	1.29 (1.03-1.62)	1.29 (0.95-1.75)	1.29 (0.93-1.80)	0.61 (0.25–1.47)
Rich	0.97 (0.76-1.24)	0.96 (0.77-1.20)	0.98 (0.76-1.27)	0.94 (0.68-1.29)	0.48 (0.21–1.08)
Richest	1.00	1.00	1.00	1.00	1.00

Adjusted for respondent age and education, husband's age and education, baseline and endline time points

Conclusion

- Increase uptake and utilization of modern contraceptive
  - Client's empowerment
- Targeting the underserved
  - Reaching out to those who need the services
- Connecting clients with the facility
  - community field workers or LHWs
- Social franchising as tool to engage private sector
- Future directions
  - Poverty tool vs. geographical targeting
  - Sustainability and Scalability

Vouchers:
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Q & A

October 18, 2017

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Recording and presentation available at:

https://www.youtube.com/playlist?list=PLmc4ZL8DMckoSaVUuSDyaaYMCBJvuG-sl

&

https://channel.webinar.com/channel/965084607443925509

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For more information, please visit:

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www.ibpinitiative.org

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