

Are our voucher programmes working? Evaluating our methods and results in six countries

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Introduction

Marie Stopes International has been implementing family planning voucher programmes in 11 countries since 2005. Voucher schemes have the potential to expand women's access to family planning services, especially among poor and underserved populations.

To evaluate their effectiveness, we reviewed voucher interventions for family planning and sexual and reproductive health services across our country programmes. This brief presents a summary of results for the family planning voucher programmes.



Findings at a glance

- Uptake of contraceptive services increased from baseline by 67% on average across all participating facilities in Kenya and up to sevenfold at voucher intervention clinics in Sierra Leone.
- Voucher redemption rates ranged between 40% and 50% (in the four family planning voucher programmes with rate data) and reached 91.4% in Sierra Leone.
- Voucher clients are generally younger and poorer than non-voucher clients, and vouchers distributed with a means test were more effective at reaching specific groups.
- Client satisfaction levels were very high (around 90% or above) in all programmes.
- In Madagascar, couple years of protection (CYP) increased overall, but costs per CYP through the voucher programme were higher than through other delivery methods.

Summary

Increasing access to contraceptive services remains a critical goal for improving the health and well-being of women and children. Voucher programmes are a form of output-based aid (OBA) known as demand-side financing, where free or subsidised vouchers are distributed and redeemed for certain services. Voucher schemes are hypothesised to increase the use of certain goods and services, especially among hard-to-reach populations, and they are also expected to improve service quality and efficiency by increasing revenue and competition among providers.

This study sought to examine Marie Stopes International's experience in implementing voucher programmes and evaluate their effectiveness in achieving these goals. The results of six family planning voucher schemes with evaluation arms across Ethiopia, Kenya, Madagascar, Pakistan, Sierra Leone and Uganda were compared (Table 1).

It was found that vouchers increased uptake of family planning services and were generally effective in reaching specific groups. Clients were highly satisfied with voucher services. Voucher programmes were not uniformly more efficient than other mechanisms; this is an area that requires further study. With the increasing prevalence of voucher schemes, the results of this study can be used to inform the design of future programmes.

Background

An estimated 222 million women in developing countries who would like to delay or stop childbearing currently lack access to contraceptionⁱ. Evidence shows that improving access to contraception would improve public health outcomes. Furthermore, investment in family planning services has been shown to reduce costs to families and the health systemⁱⁱ and may contribute to poverty alleviation.

However, many barriers to accessing family planning services currently exist in developing countries. Due to the state of public health services, the lack of national insurance schemes and the profit incentive of private providers, cost remains an important barrier to access, especially since poor people have the highest unmet needⁱⁱⁱ. Many other barriers also exist, such as socio-cultural factors, perceptions of poor quality of services, and distance to services. Disadvantaged groups, especially the poor and young, are most likely to suffer long-term negative health impacts from unattended deliveries or unsafe abortions. They are the most

important groups to reach with family planning services.

In an attempt to address gaps in investment, service quality and access, OBA programmes with a focus on stimulating demand have been implemented in many countries^{iv}. These programmes tie funding to the achievements of specific goals or outputs. The distribution of subsidised vouchers that can be redeemed for contraceptive services is one such demand-side OBA mechanism.

Vouchers supplement the purchasing power of recipients and are theorised to increase the use of certain goods among target populations^{iv,v}. Increasing demand and making reimbursement consistent means greater revenue for service providers, who can then reinvest into their services to improve quality. By encouraging competition and creating incentives to meet voucher contracts, programmes can improve efficiency in healthcare.

The objective of this study was to assess whether Marie Stopes International's voucher schemes have been effective in achieving these goals: increasing contraceptive services uptake, particularly among specific groups, and improving quality and efficiency.

Methods

The study initially involved identifying Marie Stopes International programmes that use vouchers for some aspect of their family planning services. Voucher programmes covering only short-term methods or non-family planning or sexual and reproductive health services were excluded from this analysis. Marie Stopes International internal publications and descriptions of current and past voucher programmes were reviewed and internal stakeholders such as the Health Financing Team and programme officers were consulted. Background programmatic details and evaluation data, including studies with and without controls, were extracted from existing publications and reports. Results from robust evaluations with comparative arms in addition to routine client and monitoring data, where available, were analysed.

Findings

Marie Stopes International has implemented 16 family planning voucher programmes, acting as voucher management agency and/or service provider, in 11 countries since 2005. More than 200,000 vouchers have been distributed and over 100,000 clients have received

family planning services through our voucher programmes. The majority of the voucher programmes are located in sub-Saharan Africa (Uganda, Kenya, Madagascar, Ethiopia, Zimbabwe, Malawi and Sierra Leone), and a minority in Asia (Vietnam, Cambodia, Pakistan and Yemen). Voucher programmes varied in size and range from only a few clinics to multiple districts or regions within a country. In many countries, multiple voucher programmes ran simultaneously in different geographic areas. In 13 programmes, provision of vouchers was combined with social franchising efforts.

This study examined four outcomes of our voucher programmes: uptake, reaching specific groups, quality and efficiency. Process indicators, such as success of targeting approaches and redemption rates, were also considered. A selection of key findings is described below.

Uptake

Uptake was defined as an increase in the use of services among populations with access to vouchers compared to populations without access. All six voucher programmes increased uptake of family planning services. In Kenya, across all districts, uptake increased on average by 67% from the study baseline. In Sierra Leone, productivity increased sevenfold in participating clinics, from 200 family planning services per month before voucher distribution to a high of almost 1400 per month. Voucher redemption rates were 41% in Kenya, 45% in Madagascar and 51% in Ethiopia, but reached 91.4% in Sierra Leone, where substantial effort was made to re-contact clients who had accepted vouchers to encourage redemption.



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Reaching specific groups

Outcomes related to reaching specific groups included increased use of services by poor women and young people. Family planning voucher clients in Kenya were more likely to be in the poorest 40% of wealth profiles than non-voucher clients. In Uganda, 74% of voucher purchasers were defined as poor. Poverty assessments were conducted before voucher distribution in our Kenya, Pakistan and Uganda programmes. Our Sierra Leone programme used geographic targeting, while our Madagascar programme administered a poverty questionnaire only after voucher distribution.

In Pakistan, more than 60% of family planning voucher clients earned less than the national average daily wage. In Sierra Leone, family planning voucher clients were younger than non-voucher clients and more likely to be poor. In Madagascar, the percentage of family planning clients within the bottom 40% of household wealth profiles actually decreased following voucher distribution from 20.2% to 13.0%, although the proportion of young people among family planning clients increased from 27.5% to 35.4%.

Quality

Quality was defined as clients' satisfaction with the services received. In Uganda, 99% of family planning voucher recipients rated the programme as 'good' or 'very good'. In Madagascar, 95% of voucher recipients were satisfied with the overall programme. However, in Sierra Leone, family planning voucher clients were less satisfied with services than non-voucher clients (88.4% vs. 93.9%, $p=0.032$), and satisfaction actually decreased after voucher distribution began. Furthermore, the increased client flow in Sierra Leone led to contraceptive stock-outs, while service providers in both Sierra Leone and Uganda expressed concerns about excessive workload due to the introduction of vouchers.

Efficiency

Efficiency indicators differed across programmes. In Kenya, 24% of the programme's costs were spent on administration and evaluation, compared to 45% on administration alone for Kenya's National Hospital Insurance Fund. In Madagascar, while total CYPs increased by 15% after vouchers were introduced, the costs per CYP rose from 29,210 Ariary to 33,585 Ariary (£8.66 to £9.96 in April 2012), which is higher than the cost per CYP in Madagascar's social franchises without vouchers.

TABLE 1: Description of Marie Stopes International voucher interventions with evaluation arms

Country	Dates	Targeted population	Distribution channel	Service provider	Our role
Ethiopia	2012-present	Poor, young	Community health workers	Bluestar and other private clinics	Voucher Management Agency, Social Franchise and Service Provider
Kenya¹	2006-present	Rural and poor urban	Community based distributors	Private, public, and non-profit clinics	Service Provider and Social Franchise
Madagascar	2010-present	Poor, rural	Community health workers	Bluestar clinics	Voucher Management Agency and Social Franchise
Pakistan	2008-present	Poor	Local field worker marketing agent	Bluestar clinics	Voucher Management Agency and Social Franchise
Sierra Leone	2010-present	Poor, urban	MSI voucher distributors	Bluestar clinics	Voucher Management Agency and Social Franchise
Uganda	2010-2015	Peri-urban, high unmet need	Community health workers	Public and Bluestar clinics	Voucher Management Agency and Social Franchise

¹ A national programme Marie Stopes Kenya is accredited into

Conclusion

Evidence from all countries included in this review indicates that voucher schemes can increase the uptake of contraceptive services. In reaching specific populations and improving service quality, results were mixed. In countries that used poverty grading tools to assess potential clients and limit eligibility, voucher programmes were shown to be effective at reaching poor clients. Overall, voucher clients were satisfied with the service they received, although comparisons in Sierra Leone found that voucher clients – although overwhelmingly satisfied – were less satisfied than non-voucher clients. Results on efficiency are mixed; this aspect requires better data and further study. It would be useful to expand on Fry and Hanitriniaina's approach to compare the efficiency of voucher programmes and other health financing schemes.

This study had some limitations. We were limited to reviewing existing data, some of which were of poor quality; data on some topics were unavailable. We were limited to creating measures based on the existing data, and the indicators for quality and efficiency in particular were incomplete measures. Quality is a multi-dimensional indicator, and here we relied only on one aspect (client satisfaction). Measures of efficiency require accurate data on cost inputs which were rarely available. Because standardised indicators were not used, comparisons between programmes should be interpreted with caution. Further limitations included the exclusion of programmes offering vouchers for short-term methods such as condoms and oral contraceptive pills and non-family planning and sexual and reproductive health services, as well as the small number of programmes included.



Recommendations

Marie Stopes International country programmes can apply evidence presented in this paper to inform the design of voucher schemes. Careful consideration of the benefits and challenges of voucher schemes is needed in the feasibility and planning phase. The authors recommend the following steps:

Assess context

- Consider whether vouchers are the most appropriate method for your country. Voucher programmes are only appropriate for countries where price poses the biggest barrier to service uptake. Is there value in targeting if the majority of women in a country are poor? Could it be more efficient to target geographically and serve everyone free of charge?
- Evaluate the context in which voucher schemes will be operating, taking into consideration the availability of other providers and their target groups. For example, do government facilities already provide free family planning services? Is there a National Health Insurance Scheme and, if so, are family planning services included?

Programme design

- Have clear goals for voucher schemes, for instance, to increase uptake among youth, or to increase contraceptive access among those who cannot afford to pay.
- Justify why services should be aimed exclusively at certain groups.
- Consider sustainability and the long term. Voucher programmes are most valuable if they are a stepping stone to National Health Insurance Schemes.
- Voucher schemes require strong monitoring systems to reduce their susceptibility to fraud.

Practical considerations

- Prepare for common pitfalls ahead of time. Voucher programmes can greatly increase uptake of services and result in increased workload and stock-outs.



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Further Reading

This brief was extracted from a larger research study conducted by MSI's Research, Monitoring, and Evaluation Team. The full publication is:

Eva G, Quinn A, Ngo T. 2014. Vouchers for family planning and reproductive and sexual health services: a synthesis of results from Marie Stopes International's country programmes. In press.

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