Reproductive Health Vouchers: from promise to practice

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Acknowledgements

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Executive Summary

Reproductive health is a fundamental human right and is pivotal to the well-being of women, men and their families. However, more than 200 million women who would like to delay or avoid pregnancy currently do not have access to modern contraception. A disproportionate number of these women are living in poverty.¹

The challenge for the health sector is how to increase access to reproductive health services in hard-to-reach areas where many communities can’t afford to access services through the private or public sector. Concurrently, donors and host governments are often interested in targeting international aid subsidies to the poorest and most marginalised communities.

In response to this problem, many public health-care professionals have become advocates for the use of vouchers, which can be targeted at poor people and then exchanged for a health service. However, the use of vouchers is still fairly new and there is little documentation from these programmes about their successes and failures.

Marie Stopes International (MSI) is a non-governmental organisation, providing family planning and sexual and reproductive health services to more than six million individuals a year in 43 countries. MSI believes in trying out new innovations in order to address the challenges of reaching hard-to-reach populations creatively. Over the last five years, MSI has been at the forefront of the drive to provide subsidised, targeted reproductive health vouchers. Our programme leaders have learnt firsthand some of the inherent challenges in running a voucher programme, as well as some of the common factors that can increase the likelihood of success.

This report brings together the views and experiences from three different countries – Pakistan, Sierra Leone and Uganda – in order to share more widely some of the important lessons that have been learnt. In parallel, MSI is committed to undertaking more robust evaluations of its programmes in order to shed further light on the main issues that this report attempts to answer.
SUMMARY

1) How can we successfully use voucher programmes to target the poor?

2) How can we ensure and maintain a high-quality service?

3) How can we reduce the likelihood of fraud, increase efficiency and reduce voucher administration costs?

Key lessons learned include:

1) Reaching the poor

Targeting vouchers to underserved or poor people can be an ongoing challenge for programme designers:

- distributing vouchers to an area with a high density of poor people is an efficient targeting method
- enlisting local community members to distribute the vouchers is important for increasing uptake and for overcoming any community resistance
- distribution of vouchers can also be a demand generating process that includes knowledge building around subsidised services (i.e. family planning) to encourage lasting behaviour change and to facilitate choice

2) Ensuring a high quality service

As a voucher management agency, MSI has ensured that all services provided through the voucher programme meet minimum quality standards. MSI goes much further and uses the accreditation process as a way of improving the general quality of the participating private healthcare providers:

- providing training at the beginning and ongoing, support with opportunities for refresher courses, helps to maintain high standards

- using a range of quality assurance tools, such as mystery clients, exit interviews and clinical audits, is important for checking quality and for reducing the likelihood of service provision fraud
- setting up strong referral and follow-up networks calls for public and private providers to develop partnerships, which can be challenging.

3) Reducing the likelihood of fraudulent behaviour

In all three countries in this report, the programme managers have set up systems to try and reduce the likelihood of fraud. Strategies that show promise include:

- investing in strong internal monitoring and evaluation (M&E) systems
- training extensively on data collection to improve the quality of data
- undertaking random checking and follow-up of voucher recipients in order to validate the service
- communicating zero tolerance for fraud to the service providers and being prepared to exclude non-compliant service providers from the network.

It is clear that running a voucher programme is complex and challenging. Each of the programme managers in Sierra Leone, Pakistan and Uganda has come up with creative ideas to overcome these challenges. The results of their efforts are beginning to show: the average cost per client provided with a STI service has reduced significantly in Uganda from US $53 to US $21 over the first four years of the programme.\(^1\) Across all three programmes, vouchers have enabled more than 71,000 hard-to-

\(^1\) Based on the total number of vouchers redeemed across the three voucher programmes as of August 2010.

\(^2\) Based on the total number of vouchers redeemed across the three voucher programmes as of August 2010.

By sharing some of the successes and failures of these programmes, we hope to show the potential of health vouchers in practice and to bring the health sector one step closer to turning the potential of this exciting innovation into a reality.
Chapter One: Introduction

Sexual and reproductive health services are essential to ensuring maternal and child health and controlling STIs. Sexual and reproductive health services in developing countries currently fail to reach all those in need, however. There are over 200 million women in developing countries who would like to delay or avoid pregnancy but who lack access to a modern method of contraception.¹

Despite some gains in contraceptive uptake in some countries, the highest unmet need remains concentrated amongst poor people.² Similarly for maternal and sexual health care, it is the poor who are least able to access services. It is therefore more vital than ever to find innovative approaches that specifically enable poor people to access sexual and reproductive health services.

For poor people in particular, cost is often the major barrier to accessing services. In response, the health sector has attempted to develop models of service delivery which specifically target the poor with highly subsidised services. Of the various models available, voucher programmes offer the greatest potential to provide targeted subsidies to poor people and improve the overall quality of service provision through better regulation and accreditation.³-⁵

The potential of voucher programmes

Over the last ten years, health care providers have increasingly advocated for the use of voucher programmes to target reproductive health services to underserved communities.³⁶ Voucher programmes are seen as an exciting innovation for the following reasons:

1. Vouchers ensure highly subsidised services target populations (usually poor people).
2. Vouchers are redeemed by service providers after a service has been provided. This means that the financing is contingent upon outputs rather than inputs and is therefore more results focused.

3. Voucher programmes often include the accreditation of private providers who join the network. This can help to regulate the private sector and improve the quality of service.

4. Vouchers enable men and women to choose where to seek healthcare. This in turn, creates competition between providers which is expected to improve the quality of care.

Historically, attempts to reach underserved and poor communities have focussed on providing subsidies to health providers so that they can serve those who are not able to finance their own care. There are a number of shortcomings to this approach. First, there is no guarantee that, once established, the subsidised services will be utilised by the target beneficiaries. Second, since the subsidy is provided directly to the service provider, patients have little choice as to which provider they go to for affordable care. This may leave target beneficiaries disempowered and leave providers with little incentive to improve their services.\textsuperscript{3,6}

An alternative approach is to finance the desired outputs - in this case reproductive health services provided to target groups. This approach is called output based aid (OBA). OBA helps ensure that there are incentives to service providers to achieve the desired outputs, since only by doing so will they receive funds. OBA is sometimes also referred to as results-based financing or performance-based financing.

The healthcare voucher model is a type of OBA, as the service provider is redeemed in monetary terms only after the service has been provided.\textsuperscript{2,7} Typically, a voucher programme involves the provision or sale of vouchers to target beneficiaries (for example, poor people) who can then use them at selected public or private facilities to receive free or discounted services. Once the selected facilities have provided a service, they can redeem the voucher they receive for cash from an agency managing the programme. This ‘Voucher Management Agency’ can also limit payments to services that satisfy certain quality criteria. Service providers subsequently receive payments according to the quantity and quality of the services provided to voucher holders.\textsuperscript{3,5}

Through the voucher model, demand for reproductive or sexual health services is stimulated since the subsidy is given directly to the service user. Service improvement is then achieved organically through competition between service providers seeking to attract voucher-holding clients.\textsuperscript{7,8} Quality can be further improved through the eligibility criteria used to select facilities for inclusion in the scheme and to vet reimbursement claims. The means to pay for services are provided directly to target beneficiaries, helping ensure that the right people use the subsidised services.\textsuperscript{9,10}

Output-based aid, in particular vouchers, encourages both efficiency and quality in services, and enables donors to target resources. In addition, it makes possible a more effective model much more competent model of project management for the donor agency, whereby the donor payment provides an instant and transparent measure of that institution’s achievements.\textsuperscript{2} This is very popular amongst donors in the current climate of aid transparency. A recent World Bank report describes voucher schemes as one of the few instruments that allow health planners any degree of certainty that their subsidies are reaching the intended population groups.\textsuperscript{7} In the long term, voucher programmes can also be a useful stepping stone to setting up large-scale health insurance schemes or output based contracting.\textsuperscript{2,3}

From potential to practice

Reproductive health vouchers offer great potential to target subsidised services to poor and underserved communities.

Voucher programmes can also have a significant impact upon health outcomes. An external evaluation of MSI’s Uganda programme, which was undertaken by Ben Bellows (Population Council) and funded by the German development bank, KfW\textsuperscript{9} examined the impact of vouchers on levels of knowledge, utilisation, cost and disease burden. It was based on two population surveys of the greater Mbarara region, conducted in July 2006 and November 2007. The results show a strong and sustained impact of vouchers: knowledge of STI symptoms increased 18\% between the first and second years (adjusted odds ratio, aOR=1.43; 95\% CI=1.22-1.68). Uptake of STI treatment among those who reported having had one or more STI symptoms increased 15\% in the same period; however, the increase was not statistically significant (aOR=1.14; 95\% CI=0.89-1.47). Most remarkably, the prevalence of syphilis decreased 42\% between the two surveys (aOR=0.63; 95\% CI=0.48-0.79).\textsuperscript{9}

There is however, little understanding of what works,
and of best practice in voucher programmes. In part this is due to the new and evolving nature of the schemes. The scant evidence that does exist suggests a number of recurring challenges across programmes related to quality, efficiency, equity and sustainability. In particular, critics question the ability of voucher programmes to target the poor effectively, as well as questioning how to ensure quality and how to reduce the risk of fraud.

This paper attempts to answer some of these practical questions by examining the success and failure stories of three of MSI’s voucher programmes in Uganda, Sierra Leone and Pakistan.

**MSI’s experience in voucher programmes**

MSI is a global, not-for-profit and non-governmental organisation (NGO) that is committed to upholding the fundamental right of women and couples to freely decide the number and spacing of their children. MSI provides sexual and reproductive health services to the poorest of the poor in over 43 countries worldwide. MSI is constantly striving to develop new and innovative ways in which to meet the unmet need amongst the world’s hardest-to-reach groups by ensuring affordable prices together with unalteringly high levels of service delivery.

As part of its commitment to reaching the poorest of the poor, MSI has introduced highly subsidised voucher programmes in five countries and is participating in a programme in a sixth country. In three countries (Uganda, Sierra Leone and Pakistan), MSI manages large-scale voucher programmes. In two countries (Malawi and South Africa), MSI is piloting male circumcision voucher programmes. MSI also participates as a service provider in voucher programmes managed by other organisations (Kenya).

MSI voucher schemes tend to follow a similar model, although this can be altered slightly depending on the country programme (see Figure 1 for the general operational procedure of MSI voucher schemes).

A voucher management agency (MSI country programme) typically receives funding to implement the programme. The same agency then provides vouchers to distributors. The target population is then approached through community sensitisation visits or other marketing events, which vary amongst the programmes. Once clients have a good understanding of the service offered, they receive the voucher from the distributor and redeem the voucher at health centres of their choice for the service specified.

Once the provider has completed the required service, they submit a claim to the management agency for reimbursement. The type of reimbursement depends on the programme. For example, some service providers may be entitled to claim for equipment, whilst others will claim for the service/treatment provided. Once the claims have been processed, the voucher management agency will then report back to the donor with clear and detailed results about the scheme.

**About this report**

MSI is committed to identifying, documenting and sharing best practice. As part of this commitment, MSI has set up an Innovations and Best Practice Team to document and share key lessons learned. Between April and July 2010, the team worked with the voucher programmes in Sierra Leone, Pakistan and Uganda to develop a better understanding of what works and best practice. The team analysed more than 20 internal MSI project documents. Many of these documents included research undertaken by research agencies and mid-term evaluation reports. In addition, telephone interviews were conducted with key project staff.

This report synthesises the findings of this process, highlighting the key lessons learned from MSI’s experiences in the three focus countries. The chapters are organised as follows:

- Chapter Two: How can voucher programmes best reach the poor and underserved?
- Chapter Three: How can voucher programmes ensure a high-quality service?

**Figure 1: MSI voucher procedure**

DONOR FUNDS OR GOVT

MONEY

REPORTS

VOUCHER MANAGEMENT AGENCY

VOUCHER DISTRIBUTERS

ACCREDITED HEALTHCARE PROVIDERS

VOUCHER

SERVICE

POTENTIAL FEE

VOUCHER

VOUCHER

VOUCHER

VOUCHER

CLIENTS
<table>
<thead>
<tr>
<th>Name of programme</th>
<th>Pakistan</th>
<th>Uganda</th>
<th>Sierra Leone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suraj Network</td>
<td>Reproductive health vouchers project Healthy Life Healthy Baby</td>
<td>Healthy Life (family planning) Healthy Baby (Safe Motherhood)</td>
<td></td>
</tr>
<tr>
<td>Year started</td>
<td>November 2008 August 2008 (safe motherhood &amp; STIs) May 2006 (STIs)</td>
<td>May 2009</td>
<td></td>
</tr>
<tr>
<td>Geographical reach</td>
<td>Sindh Province and Punjab Province 20 districts in Western and Southern Uganda Healthy Life – 15 slums in the Western Area: Healthy Baby – as above plus Northern and Southern regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of voucher</td>
<td>Free</td>
<td>3000 UGX/ US$1.50 – Healthy Baby &amp; 1500 UGX / US$0.75– Healthy Life Le1,500 /US$0.375 – Healthy Life Le3,000/US$0.75 – Healthy Baby</td>
<td></td>
</tr>
<tr>
<td>Services included in the voucher</td>
<td>Free voucher with three service coupons: insertion of intrauterine device (IUD), removals and follow-up service and counselling Treatment of STIs (Healthy Life): Cost of lab tests, treatment, a separate consultation fee, and three follow-up visits. Safe Motherhood (Healthy Baby): 4 antenatal care (ANC) visits, facility-based delivery and one post-natal care (PNC) visit, plus treatment of pregnancy related illnesses and management of complications One LAPM method of choice Safe delivery: 4 antenatal visits, delivery, 2 ultra sounds and 1 post-natal visit that includes long-term family planning (LTFP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement to service providers</td>
<td>On monthly basis, private providers (PPs) receive payments against redeemed vouchers; vouchers are reimbursed within 15 days of submission to Marie Stopes Pakistan Each voucher costs 200 Pakistan Rupees (PKR) (US$2.32), which is paid by MSS on behalf of clients against each voucher (PKR 150 is for IUD insertion, PKR 20 for follow-up visit and PKR 30 for removal) STI reimbursement rates range from 9000 UGX (US$4.5) to 38,000 UGX (US $19) for STD treatment. The rates include consultation fee, laboratory investigations and drugs from the agreed national treatment protocols for STD management. For Healthy Baby services, 4 Antenatal and 1 post natal care cost 130,000 UGX (US$58) for normal delivery and 314,000 UGX (US$140) for Caesarean Section – Emergency transport and other complications are reimbursed on cost Healthy Life voucher – LTFP services Le 40,500 (US$10) and Tubal Ligation Le 81,000 (US$20) Healthy Baby: Antenatal – Le 20,250 (US$5) each visit, delivery: vaginal – Le 405,000 (US$100), Caesarean Section – Le 1,620,000 (US$400), Ultrasound – US$10 each visit and post-natal (including LTFP) –US$15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role of MSI</td>
<td>Management agency and social franchiser: MSI provides training, quality assurance and vouchers Management agency: MSI provides accreditation, training, voucher distribution and marketing, behaviour change communication, quality assurance, claims management and provider reimbursement, monitoring and evaluation, fraud control Management agency and social franchiser: MSI provides accreditation, training, vouchers, quality assurance, claims management, monitoring and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection of service providers</td>
<td>All Suraj franchisees (private providers) • female private providers • willingness to provide FP services • prior training and experience • willingness to provide FP services • reputation in community • existing client volume • formal medical qualification. Private providers: two tier First tier for normal births and PNC and STI. Second tier are referral sites for complicated births 98 for STI &amp; basic obstetric care (some sites only offer STI services, whilst others are maternal health-care only) 19 for comprehensive emergency obstetric care (Healthy Baby) Process: mapping, contact, quality checking, training, accreditation Healthy Life: Randomly selected BlueStar franchisees (randomly selected because of ongoing operations research) Healthy Baby: Through a process that includes mapping, selection, induction, contract negotiations, accreditation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Vouchers in Context

<table>
<thead>
<tr>
<th>Pakistan</th>
<th>Uganda</th>
<th>Sierra Leone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training provided</strong></td>
<td>Five days:</td>
<td>Five days:</td>
</tr>
<tr>
<td>• FP, counselling, infection prevention, business management and IUD insertion and removal.</td>
<td>Business management, orientation on OBA scheme and principals, refresher training on the service packages and protocols to follow (STD management and safe motherhood), claims processing and reimbursement mechanisms, discussion on distribution, BCC and other associated activities, discussion on contract obligations and service fees.</td>
<td>Two days: Healthy Life: BlueStar providers had already received training in the range of LTFP methods, therefore training provided was: Orientation, customer service, claims Processing, and TL (TL training has been postponed until 2011).</td>
</tr>
<tr>
<td><strong>Marketing and distribution</strong></td>
<td>MSI hires a local field worker marketing (FWM) agent. This person undertakes door-to-door visits, referrals and voucher distribution</td>
<td>Developed a social marketing campaign including: a multimedia strategy, placard advertisements, radio advertisements on five regional stations, radio call-in shows, awareness stalls and roving educational films</td>
</tr>
<tr>
<td><strong>Target population and poverty targeting approach</strong></td>
<td>Poor women. Individual-based poverty ranking is based on consumption and assets, including a home visit.</td>
<td>Healthy Baby: Poor women identified through poverty grading tool and area-based targeting. Healthy Life: Sexually active men and women Anybody who buys from a participating partner</td>
</tr>
<tr>
<td><strong>Claims processing</strong></td>
<td>15 day turnaround, paid by cheque</td>
<td>30 day turnaround In-house software for claims processing and validation. To counteract a backlog of payments, MSU paid advances to providers and as claims are entered, deductions are made.</td>
</tr>
<tr>
<td><strong>Total number of vouchers redeemed</strong></td>
<td>8,642 From January to June 2010</td>
<td>38,595 for Healthy Baby 23,324 for Healthy Life From February 2009 to June 2010</td>
</tr>
<tr>
<td><strong>Total number of private providers as of September 2010</strong></td>
<td>100 partners in the 18 districts of Sindh and Punjab Provinces, five private partners in each district</td>
<td>30 STIs and 87 safe deliveries</td>
</tr>
</tbody>
</table>
Chapter Two: Reaching the poor and underserved

All three MSI voucher programmes that were analysed for this report have experimented with different approaches to targeting and reaching poor and underserved individuals. This chapter looks at some of the different approaches the programmes used for assessing poverty levels. It also reviews the evidence about how successful these approaches have been and some of the innovative approaches for increasing access to the vouchers.

Table 2: Three focus countries at a glance

<table>
<thead>
<tr>
<th></th>
<th>Uganda</th>
<th>Pakistan</th>
<th>Sierra Leone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size</td>
<td>31.6 million$^{10}$</td>
<td>166.1 million$^{11}$</td>
<td>5.5 million$^{12}$</td>
</tr>
<tr>
<td>% of population living below the poverty line</td>
<td>51.5%$^{13}$</td>
<td>22.6%$^{13}$</td>
<td>53.4%$^{13}$</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (CPR)</td>
<td>24%$^{14}$</td>
<td>30%$^{14}$</td>
<td>5%$^{14}$</td>
</tr>
<tr>
<td>% of deliveries that are facility-based</td>
<td>41%$^{15}$</td>
<td>34%$^{16}$</td>
<td>25%$^{17}$</td>
</tr>
</tbody>
</table>
2.1 Approaches to poverty targeting

In all three programmes, the target recipients for the highly subsidised vouchers are poor women and men (in the case of the STI programme). As the vouchers are highly subsidised, there is an incentive for individuals of all socio-economic backgrounds to try to obtain and use them. It was therefore imperative that the programme developed a strong evidence-based approach to target poor individuals or communities and that checks and balances were put in place to ensure that vouchers are really being used by the poorest of the poor.

Of the three voucher programmes, the KFW-funded Uganda programme is the most mature. The programme has an STI treatment component, which is not targeted but is available to anyone who wishes to buy the voucher at a distributing outlet. The programmes safe motherhood component is targeted at poor women.

During the first year of operations, the programme used a poverty grading tool that was developed by MSI and used in a similar voucher programme in Kenya. The poverty grading tool is highly participatory and the local communities themselves define poverty. In order to use the tool, the voucher distributor needs to physically go to the woman’s house and examine assets and services in their homestead. Although this tool has been adopted more broadly outside MSI, it is highly intensive in terms of both time and resources. A home visit is needed to distribute every single voucher. This is highly inefficient and very difficult to scale up.

As Christine Namayanja, voucher project director, points out:

“In some areas, homes are sparsely located meaning that community-based distributors wasted a lot of time moving between homes. The introduction of geographical targeting removed the need for a poverty grading tool and saved a huge amount of time, – allowing voucher distributors to reach more women in a day. Average enrolment of mothers increased from an average of 12 per day to 25. It also meant that distributors could easily mobilise mothers and carry out group education and voucher selling, thus leading to greater efficiencies.”

Ultimately, targeting specific individuals within a community will have high costs. On the one hand, a simple system without home visit verification is open to leakage (use of the subsidy by unintended beneficiaries) and yet a more complex system – like the one in Uganda – is very demanding on resources.

Given these challenges, the Uganda programme introduced additional area-based poverty targeting measures in the poorest sub-counties where poverty incidence is above 50% and poverty density is above 100 people per square km. Under this definition 25% of all available sub-counties were ‘poor’ and home visits were not required. In those sub-counties that are not considered to be the poorest, distributors continue to use the individual-based poverty grading tool and home visit verification.

The Ugandan programme undertook extensive secondary analysis of national and local poverty data to ensure that the choice of ‘poor’ communities was evidence-based and that the vast majority of inhabitants in each community were eligible for the voucher. In the 2002 Uganda census, a national poverty line was used to differentiate between poor and non-poor households. For example, a wage of 23,150 Ugandan shillings (US $10)\textsuperscript{v} per month or less in a central urban area is regarded as below the national poverty line.

Using geographical targeting to identify those who qualify for the vouchers will help more women qualify for the voucher, leading to a further increase in safe deliveries. As it is less complex to administer than individual poverty grading, area-based targeting can be facilitated through existing data collection processes. Using sub-counties rather than larger districts means the population is likely to be more homogenous. In order to minimise leakage of vouchers to clients outside the targeted areas, community-based marketing agents ensure that all women are registered by name and address before they access vouchers.

Even though communities are never entirely homogenous in terms of socio-economic status, given the high levels of poverty across the country, the problem of a small number of somewhat richer individuals accessing the vouchers within an area can be far outweighed by the cost savings in using the area-based approach. To be more certain of these assumptions, the Uganda programme will undertake exit interviews or home visits to check that the percentage of poor voucher recipients does actually match their expectations.

Although the Uganda programme has not yet undertaken this type of evaluation, both the Pakistan and Sierra Leone programmes have a rigorous evaluation component running in parallel to programme

\textsuperscript{ii} Individual-based poverty targeting includes assessing each client individually, usually using a poverty grading tool with indicators such as income and type of dwelling. It can also include individual home visits to further assess the client’s eligibility. Area-based targeting utilises geographical mapping techniques to designate whole areas as qualifying for the voucher scheme. Some programmes use individual poverty grading questions in addition to this. Nab. the shift from individual to area targeting has only taken place in certain select sub-counties.

\textsuperscript{iii} Based on current market value, September 2010.

\textsuperscript{iv} In Sierra Leone, MSI is collaborating with the World Health Organization (WHO) on a large quasi-experimental evaluation of the voucher programme. Baseline data collection was completed in May 2010 and the endline will be undertaken in early 2011. In Pakistan, evaluations have been contracted out and include provider surveys, focus group discussions and exit interviews with clients.
In Sierra Leone, exit interviews are used at both the beginning and the end of the process (baseline and endline) to assess whether the proportion of poor clients at participating social franchisees increases as a result of the voucher programme. These are also compared with control sites.

As in Uganda, the Sierra Leone programme uses government mapping statistics to identify the poorest geographic ‘slum’ areas in and around Freetown in order to distribute the family planning vouchers. There are seven areas in the present voucher scheme chosen within the Western area of Freetown. These represent the poorest dwellings according to statistical mapping. The marketing agent then conducts ‘asset’ based questions with the client to ascertain the woman’s access to sanitation and water, as well as factors such as the type of floor of the client’s dwelling. Although self-reported, this additional questionnaire acts as a further check that the woman really is eligible for the voucher. This dual approach is quicker to administer than a home visit.

Although the data are not yet available on the poverty levels of voucher recipients, the baseline data shows that 32.8% of family planning clients interviewed earned either the equivalent of or less than Le 120,000 (US$30) per month. This means they are categorised as poor. Importantly, 43% had never previously used a modern method of family planning. So before the vouchers have even been distributed, a high proportion of clients at the facilities are poor and underserved.

The programme director realised however that this type of area-based targeting, although effective in Freetown, is more difficult in rural areas where communities are more heterogeneous:

"In rural communities, land is not sold; there are no slums. You find communities of diverse socio-economic status, which impedes area-based targeting."

Manty Tarawalli, Private Sector Partnerships Director, Marie Stopes Sierra Leone (MSSL)

Since the safe motherhood vouchers are also distributed in rural areas and are of more monetary value than a family planning voucher, it was decided to undertake individual poverty grading through home visits for the safe motherhood voucher only.

Looking across all three types of programmes, the general approach taken is that the lower the monetary value of the voucher (e.g. STIs in Uganda), the less effort needs to go into assessing and checking poverty eligibility of target recipients. It still remains to be seen whether or not this approach is effective.

In Pakistan, marketing agents employ an individual poverty ranking tool with nine indicators, which include a mixture of assets, socio-economic profile and services. The marketing agent conducts door-to-door visits to identify which women qualify for vouchers as per the poverty ranking tool. Marie Stopes Pakistan consulted different poverty ranking tools already available for the Pakistan context and modified them as per the need and targeted population. Marie Stopes Pakistan is currently in the process of completing an 18 month study on the Suraj scheme in order to develop further evidence as to the effectiveness of the project.

If women score below a certain level, they are given a free voucher. Those women who are not eligible are referred to the nearest social franchisee, where they are expected to pay normal user fees. In order to ensure that this approach is working, an external agency is tasked with undertaking exit interviews. The national average ratio of female primary school attendance in Pakistan is 67%. Results from a round of data collection in 2010 shows that 48% of franchisee clients had no formal schooling at all, and only 21% had completed primary school (n=98). This suggests that the providers are reaching some of the most disadvantaged and poor populations (as education level is a strong indicator of poverty level).

The exit interview tool also includes a question on household income. Although self-reported, the results shows 25% of women at the voucher distributing providers stated their average household income at below 102 PKR (US$1.20) per day. A further 41% earned less than 205 PKR (US$2.40) a day, which is still below the national average.

Project staff are also aware that the vouchers provide an important means of reaching those who would not normally access services:

"It will be hard without the voucher system because only (those who can afford to) will be able to avail the services."

Female marketing agent, Punjab Province, Pakistan

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vi Based on current market value, September 2010.

vii The percentage of first-time family planning adopters is a good proxy for reaching underserved communities, as these individuals had never accessed modern FP before.

viii Client’s access to the number of meals per day, housing, fuel for cooking, daily income per family, earning members of family, dependent members of family, water source, sanitation and access to reproductive health services.

ix Based on current market value, September 2010.

x This is comparatively less than the average Gross Domestic Product (GDP) per capita of 86,415 PKR, which equates to 7,204 PKR or US$84 dollars per month.
“Removing the cost barrier has allowed poor women and men a chance to access expensive services they would never have thought of accessing. Private providers who normally see clients with money can now serve them.”
Christine Namayanja, Voucher Project Director, Uganda

“Vouchers are the ideal marketing tool to reach the poor, in present day Sierra Leone.”
Manty Tarawalli, Private Sector Partnerships Director, Sierra Leone

The preliminary findings suggest that vouchers are effectively targeting poor individuals. The more rigorous evaluation in Sierra Leone will be able to see the extent to which client profile changes with the introduction of the vouchers.

**DIRECT AND INDIRECT COSTS OF SERVICES**

What should vouchers include if the poorest of the poor are not to be excluded? At the moment, the voucher covers the direct cost of the health service. However, the Uganda programme has found that some women are so poor that they cannot afford the transport needed to bring them to the service provider. Although the vouchers do not currently include transport costs, these indirect costs are substantial and should possibly be considered as part of demand-side financing.

**2.2 Extending reach: marketing and distributing vouchers**

Poverty targeting is important to ensure that the vouchers are distributed to the correct target populations. In addition, the mechanism by which the voucher is marketed and distributed is key to ensuring effective targeting of underserved areas and to ensure that uptake is high. In Pakistan, the marketing agents made vouchers available to clients in their homes, whereas the vouchers in Uganda were initially available in retail outlets like pharmacies but were then brought closer to clients through a variety of community groups. Voucher distribution depends on the type of voucher and the level of subsidy included.

For example, in Pakistan the vouchers are free and offer a free family planning service. Similarly in Sierra Leone, the family planning service is very highly subsidised. In both these two programmes the demand is very high as a result and it is fairly easy to distribute the voucher.

In Uganda, the safe delivery voucher is not so easy to distribute, as the target population is smaller: poor and pregnant women. During the first year of roll out, the difficulty in finding eligible women to buy the voucher led to low uptake. The Uganda programme responded by undertaking a multi-faceted awareness raising campaign. The team used radio talk shows to discuss reproductive health issues and to advertise the voucher scheme. The reach is huge: in one three-month period, it is estimated that 12 radio sessions reached more than 3 million people in West and Southern Uganda. Combined with intensive community sensitisation activities and incentivising sales teams, the average number of vouchers distributed per marketing agent increased from 55 to 198 during a three-month period – a 360% increase.

Figure 2 denotes ‘HealthyBaby’ voucher sales in Uganda from 2009-2010. The vouchers are used to provide three visits to a centre for ante-natal care, delivery and postnatal care. The graph demonstrates a sharp and continual rise in voucher sales every month, reflecting the success of the programme so far.

For the STI vouchers, the Uganda programme decided to increase the range of partners selling the voucher. In 2006, when the STI programme first started, the vouchers were only distributed through drug shops and pharmacies. The marketing agents employed a face-to-face
approach to ensure that traders stocked the vouchers, but also to get feedback on market attitudes and perceptions of the scheme.\footnote{Given the stigma surrounding STIs, the Uganda programme has also been careful about how it recruits the marketing agents:}

In general, this approach was not deemed to be effective in reaching the large number of people needed to make a real difference to the incidence of STIs in the region. The programme therefore decided to be creative in the type of groups involved in raising awareness about the voucher and approached organisations working with the highly vulnerable or poor. The groups included youth groups, churches or sex workers.

"The use of local based organisations and opinion leaders or champions from churches, youth and women’s groups, political leaders and village health teams has not only been instrumental in promoting the project and vouchers services, but greatly reduced stigma, built confidence in health service provision and most importantly promoted community empowerment and uptake of STI treatment services."

Christine Namayanja, Voucher Project Director, Uganda

In Pakistan, the programme has also worked closely with communities in order to break down myths and misconceptions. In Pakistan, the challenge is to market and distribute the vouchers in highly rural communities that have not had much exposure to family planning or communication on sexual and reproductive health matters.

"Men are happy about the affordability of services and there is a visible improvement in male involvement as they now understand the benefits of safe motherhood and they do all they can do find money to buy the voucher."

Christine Namayanja, Voucher Project Director, Uganda

"From the start of the Suraj initiative we have involved men as key community stakeholders. When a husband is opposed to his wife using the family planning services, the marketing agent will arrange a joint meeting with the husband and the wife in order to try and explain the services fully."

Jamshaid Asghar, Manager Private Provider Partnership, Pakistan
ENSURING ACCESS

“The distribution of the vouchers has been complicated. The distances covered by the community-based distributors is wide, as rural communities tend to be sparsely distributed. This really impedes our ability to distribute large numbers of vouchers.”
Field worker marketing agent, Pakistan

In some instances, this lack of knowledge has led to community resistance, particularly from religious or community leaders and from husbands and mothers-in-law, to a lesser extent.23

As one marketing agent remarked:

“Some people still do not have positive views about a chala (IUD) and they share these rumours with their community without confirming as some believe that a chala moves up in (the) body and can reach to the neck and can lead to death.”
Field worker marketing agent, Sindh Province, Pakistan24

Marie Stopes Pakistan decided to employ local married women to act as the marketing and distribution agents who were viewed as trusted members of the community. The agent meets with the local leaders to gain their approval before starting distribution of the vouchers. As one marketing agent commented:

“If she (the marketing agent) is according to the criteria of the community, they will listen to her but if she is inappropriately dressed, then the women of the community will feel uncomfortable in talking with her and consider her a bad influence.”
Field worker marketing agent, Punjab Province, Pakistan24

The agent then visits each residence in turn, distributing leaflets, identifying potential clients, giving referral cards, holding follow-up visits before or after any service, and providing more information if necessary to raise awareness and change attitudes. The agent gives completely confidential and impartial counselling and ensures that the counselling is individual so as to minimise pressure from the family. If a woman chooses a family planning service that is not included in the voucher programme, then she is referred to the local Suraj franchisee for short-term methods and the Marie Stopes clinic where prices are highly subsidised for permanent methods and abortion care if necessary. Through this personalised counselling approach, most marketing agents report that they are able to challenge myths and change perceptions about family planning.24

This face-to-face marketing is supported by Suraj branded clinic wall murals and up to 150 posters that are pasted on walls in each community each month. The local Marie Stopes clinics supplement the marketing activities through advertisements on TV, radio and in community groups.

In Sierra Leone, there are far fewer challenges involved in distributing family planning vouchers than in Uganda or Pakistan. The main reason for this is that the vouchers are distributed in very densely populated slum areas. There are often queues of women who all want the voucher. The challenge in Sierra Leone is to ensure that all women hear about their family planning options, not just those who receive the voucher. Also, women that do not receive the voucher need to be informed where to go for quality services and encouraged to pay out of their own pocket to avail the services.

KEY LESSONS ON MARKETING

› develop targeted activities and address the myths and misconceptions related to each contraceptive method

› use satisfied clients to promote a voucher scheme

› aim marketing at potential clients and potential service providers so that they understand the value of the programme.
A complementary and crucial part of every voucher programme is quality assurance and accreditation. This chapter first explores how each voucher programme maintained a standard minimum level of quality across voucher service providers. It then looks at how voucher programmes have the potential to regulate and improve the quality of a private provider network.

Voucher programmes work by having a large number of private or public providers offering a standardised health service. Before vouchers are introduced, private providers may be operating in a less regulated environment or providing services of varying quality. As the voucher management agent, MSI has the responsibility to ensure that the participating providers are all operating at a minimum standard of quality.

There are three main ways in which these three MSI voucher programmes ensure and guarantee quality of care:

1) Providing training and accreditation (which becomes more important to verify the standards of the franchisees).

2) Undertaking continual quality audits and checking (internal and external).

3) Setting up and ensuring follow-up and referral networks.

3.1 The training and accreditation process

In all three countries analysed, any service provider that wishes to be involved in the voucher programme needs to be accredited. In order to be accredited, the provider needs to meet certain minimum quality standards and be trained on each element of service delivery related to the voucher.
MAINTAINING QUALITY

In Pakistan and Sierra Leone (for HealthyLife vouchers), the training and accreditation takes place as part of a social franchising model. Providers that pass the training and meet the quality standards are then branded as part of the MSI social franchise network (typically ‘BlueStar’). Being part of the network means that the provider meets the quality standards and men and women associate the brand with a high-quality service. The training improves standards and also confidence. As one provider commented:

“It (the training) has benefitted us a lot. Compared to before, we are now more confident. We are giving very good services to the people. Previously, we were also unaware and less confident that

BLUESTAR SOCIAL FRANCHISING

BlueStar is a social franchise developed by MSI to expand service delivery and contribute to national health goals through private providers. Social franchises create and support a network of existing private providers to offer high quality health services and contribute to improving service in the private sector as a whole.

BlueStar strategically selects private providers located in underserved areas where income levels are generally low. The aim is to meet the needs of harder to reach groups, who might not otherwise have access to family planning counselling, commodities and services. Most private providers apportion family planning as a low percentage of their sales. BlueStar aims to increase sales from an average of 3-7% to 10-15%, thus making the concept more appealing to vendors. In addition, BlueStar supports franchisees with branding, training, community demand creation events, as well as clinical and marketing assistance. This support is dependent on the franchisee agreeing to routine supervision, submission of monthly reports, adherence to specified quality standards and an annual franchise fee.

As of 2010, MSI has set up nine social franchising projects in Africa and Asia. These projects incorporate almost 1,100 social franchisees, and from January to August 2010 they served over 700,000 men and women.

MSI’s experience has demonstrated that social franchising can provide a stimulus to improving service provision in the private sector as a whole. This supply-side intervention makes services available that were previously non-existent or low in quality in the private sector. In addition, the availability of a recognisable brand with a reputation for high-quality services can increase clients’ interest in receiving care.

CHOICE AND INCENTIVES IN SIERRA LEONE

It is possible to offer a range of family planning services through vouchers and yet still have method-specific vouchers. In Sierra Leone, for example, the programme distributes specific vouchers for female sterilisation, implants and IUDs. Various measures are put in place to ensure that there is freedom of choice of family planning methods at all times. For example, voucher distributors are trained extensively on how to counsel each eligible woman on the various options. As part of this counselling process, the eligible woman and the voucher distributor identify which method best meets the woman’s needs and she will be given a voucher for that method. Since vouchers do not include short-term methods, women who would prefer a short-term method are given referral cards that will direct them to a recommended family planning provider. These referral cards also allow MSI to track and ensure choice.

The distributors are MSI staff and they are financially rewarded for their work, but this is not in any way based on the type of FP method, or number of FP acceptors, as this could restrict choice. Lastly, when a woman attends a clinic to redeem her voucher, measures are in place to ensure that freedom of choice remains intact. Women who change their mind – whether before or after the consultation – have the option to switch to a different method from the method specified on the voucher.
MAINTAINING QUALITY

whatever we were doing is either right or wrong. But now that we have done this training, we are more confident and it has helped us a lot.”

Voucher provider, Punjab Province, Pakistan

Training and accreditation is therefore the first step to ensuring a high-quality service.

3.2 Continual quality audits and checks

CHALLENGES TO PROVIDING A HIGH-QUALITY SERVICE

Challenges identified by programme teams include:

• high turnover of staff in health facilities can result in low-quality services and sub-standard documentation
• lack of stock/government supplies
• referral mechanisms, including government hospitals, can be bureaucratic and take a long time.

All three programmes undertake multiple checks to ensure that quality is maintained at participating service providers. Actual random spot checks at the facility play a central role. In addition, client satisfaction surveys, mystery client surveys and analysing claims data for correct diagnostics have been found to be useful tools. Although internal quality assurance systems need to be in place, all three programmes have recognised the importance to including external evaluations as well.

As the voucher management agency, MSI undertakes quality audits to ensure that services meet expected clinical standards in all three countries (Uganda, Pakistan and Sierra Leone). In Uganda, the audit tool is a simplified version of the tests that were used at the accreditation stage. This allows the project team to estimate whether or not quality standards at individual facilities have improved, stayed the same or declined. For example, at the pre-test phase, of seven providers, five had improved and two had declined in quality. Problem areas ranged from minor issues, such as irregular personnel hours, to major issues, such as poor or non-existent laboratory services. Following a minor negative quality assessment, service providers are given a chance to improve or else face exclusion from the programme. For major quality issues, facilities are further investigated and may be excluded, depending on the degree of deviation.

Observing client-provider interactions has also proved to be highly useful in assessing quality. In Uganda, MSI systematically observes service providers as they interact with mothers. In one highly rural area, the team found that newly hired providers were inexperienced and not technically competent. MSI subsequently worked with them to increase the general skills of the staff and to improve the quality of the whole facility. In addition to internal quality checks, in Pakistan, MSI contracted an external group to undertake a quality clinical audit. This helped to ensure that clinical practice met all of MSI’s standards. In some cases, individual providers were not meeting the standards and remedial action was taken. The Pakistan programme also undertook client exit interviews in order to gauge their views on quality. The latest 2010 survey suggests that 98.6% of new Suraj clients (franchise clients) and 100% of existing Suraj clients would recommend the facility to a friend. In terms of quality, clients were particularly satisfied by the friendliness of the service provider, with a mean score of 4.7 out of 5 for the Suraj clients.

The voucher programme in Sierra Leone is still very new, but MSI is currently undertaking an overall evaluation of the scheme. This will include exit interviews, monitoring the voucher distribution process, the rates of redemption and acceptability of vouchers in order to assess the overall effectiveness of the programme in reaching the underserved.

3.3 Referral and follow-up networks

As with any reproductive health service, it is important to have strong referral and follow-up mechanisms in place in case of complications or, for example, if the woman wishes to remove an IUD or implant.

In Uganda, where the vouchers are used for safe deliveries, severe complications requiring hospitalisation do occur occasionally. MSI has therefore set up a referral network with local government hospitals. Health providers who refer to government facilities are required to pay the hospital bills, and bill the project with all relevant documentation attached. Redeemable factors include a ‘mama kit’ (a clean, safe and affordable child delivery kit consisting of plastic sheet, sterile gloves, razor blades, cord ligature, cotton, sanitary pads, tetracycline and soap), accommodation, meals as well as other drugs and supplies used. Health providers referring to another comprehensive emergency obstetric care facility do not have

INNOVATIVE WAYS TO CHECK QUALITY: CHECKING DIAGNOSES

One way of indirectly assessing the quality of care is to analyse routinely collected claims data to see the extent to which the providers are prescribing the correct treatment or offering adequate family planning choice. This approach assumes that provider knowledge is related to healthcare quality and has been used in Uganda by researchers to check if STIs are being correctly diagnosed and treated. By analysing over 19,000 patient visits, Bellows et al found that 79% of balantias cases were correctly treated, compared with 98% of gonorrhoea cases. The overall numbers mask variation between providers. Although overall it appears that the vouchers are diagnosing and treating STIs correctly, there is clearly room for some improvement. This type of analysis allows MSI to work more closely with those providers who might be in need of more training or laboratory facilities.
to pay for any services. The specialised facility takes immediate responsibility for the bill. Referral to both government facilities and specialised facilities involved in the voucher programme require the referring health provider to fill in a referral form, which is also endorsed by the receiving facility. Mothers in emergency cases are given transport/ambulance services and the claim is sent to the reproductive health voucher programme for reimbursement.

In terms of family planning, the Pakistan programme has set up a somewhat simpler follow-up mechanism: the marketing agent gives her number to the clients in case of any questions. In addition, there is a toll-free number that is open 24 hours a day, seven days a week for free advice. This approach has proved to be very successful, with 60% of the clients using the follow-up service, and 68% of the vouchers being validated. In addition, the client exit interviews are used to check that clients have been given appropriate information on what to do in case of a problem or if they wish to change their choice of family planning method. The 2009 round of data shows that 95% of women reported that they knew where to go in case of a problem or side effect and 100% knew when and where they needed to go for the follow-up visit.

This continuum of care is seen as a distinct advantage of the voucher programme:

“The Suraj model’s best aspect is the voucher because people are very needy and because of this they get free services and we guarantee that there will be no problem and ask them to visit us if they are having any problems (after they have had the service).”

Female marketing agent, Punjab Province, Pakistan

THE POTENTIAL OF VOUCHERS TO IMPROVE QUALITY THROUGH COMPETITION AND ENTREPRENEURSHIP

The programme managers in Uganda see additional longer term benefits in the voucher programme including increased competition between providers, which can in turn increase quality. In Uganda, patients living in rural areas are often faced with fewer options relating to health provision. Claims data from the STI voucher scheme suggested that around 60% of patients visited a clinic within 10 kilometres of their village of residence, and 55% of these patients were visiting their nearest clinic.

“In some areas, the problem is that we don’t have enough competition so there is a monopoly in service provision. Competition enhances the quality of service.”

Christine Namayanja, Voucher Project Director, Uganda

In addition, anecdotal evidence suggests that some providers use the profits from the vouchers to reinvest into their facilities, thus improving the quality and access to services overall. As Christine Namayanja reflects “Angela is a private provider of STI management and safe delivery services, who essentially used her small household to provide basic health services. Angela joined the voucher programme and used the profits to reinvest into her business, taking on more staff and improving the facility. The voucher programme gave her the opportunity to develop her entrepreneurial side, which in turn has led to more women accessing services. Her monthly clientele for both STDs and safe delivery increased by over 90% leading to the centre’s income growing by over from $USD 1,000 a month to $USD 2,500.”
Chapter Four: Reducing fraud and improving efficiency

All voucher programmes are susceptible to fraud. All of the Uganda, Sierra Leone and Pakistan voucher programmes have had to learn how to combat fraudulent behaviour. This chapter looks at some of the checks and balances, and systems that the programmes have experimented with in order to reduce the likelihood of fraud, as well as to improve the overall efficiency of the programme.

4.1 Approaches to reducing the likelihood of fraudulent behaviour

In all three programmes, the programme managers have had to deal with the potential for corruption and fraud. Their role has been to work out systems to minimise this. In Uganda, the team has identified four main types of fraud which can occur at any stage of the process:

1. **Counterfeit voucher fraud**: this involves falsifying vouchers and then redeeming false vouchers.

2. **Distribution fraud**: this type of fraud is two-fold and includes both fraudulent behaviour between provider and distributor, as well as between distributor and client. Distribution fraud leads to vouchers being claimed for services that never occurred.

3. **Service provision fraud**: this type of fraud includes a range of possibilities, from over-charging for drugs to hiring under-qualified staff to non-compliance and charging extra fees to clients. In this situation, clients were provided with the service, but either quality was compromised or the service provider acted fraudulently to increase profits.
4. **Claims processing fraud**: this involves fraudulent behaviour within the management agency either internally or in collaboration with the service provider. This may include siphoning off funds by falsifying the number of claims or falsifying the accounts of voucher service providers.

**Tackling counterfeit vouchers (voucher fraud)**

In all three countries, the underlying principle for reducing voucher fraud has been to make the vouchers as difficult to copy as possible and also to track voucher serial numbers so that these can be cross-checked.

In MSI programmes, vouchers can either have original watermarks (as in Sierra Leone) or barcodes (as in Uganda), or unique code numbers (as in Pakistan). The watermarks act as a quick check for counterfeit vouchers, since they are more difficult to copy than a paper voucher. The barcode is an important unique identifier and helps to track how vouchers are used. Individual coding and numbering has been an effective method by which to discourage counterfeited vouchers.

**Validating claims (distribution fraud)**

**TIPS FOR CLAIMS PROCESSING**

Processing claims should be:

- **efficient** – payments should be made quickly and providers should be reimbursed on time
- **effective** – the system should allow the managing agent to check for accuracy and control fraud and dishonesty.

An essential part of any voucher programme is a robust and efficient system to validate claims and to ensure that the voucher being redeemed really does represent an individual who was provided with a service.

Of the three voucher programmes, the Pakistan programme has developed the most rigorous validation system, which involves intensive internal checks as well as contracting external agencies to undertake random spot checks.

The internal validation system is an integral part of the voucher design and relies very heavily on the role of the marketing agent and in-depth physical mapping. The marketing agent does more than...
just marketing and distributing the voucher and is involved in providing counselling and follow-up care.

The process which is undertaken in Pakistan is detailed below:

1. The marketing agent counsels the potential client and, depending on the contraceptive need and socio-economic status of the woman, either refers her to the Suraj network or offers her a free voucher.

2. The women eligible for the vouchers take the vouchers to the provider.

3. The provider sends a services report along with redeemed vouchers to the supervisor via the marketing agents on a weekly basis.

4. The supervisor then validates a minimum 20% of the vouchers using a systematic random sampling technique.

5. The supervisor visits the woman in her household to confirm that the service was provided as claimed.

6. The agent also checks whether there are any concerns or complications and encourages the woman to return for the free follow-up examination.

The ongoing support provided by the marketing agent has led to very high rates of follow-up, with over 60% of women returning for the three-day follow-up examination and very high levels of client satisfaction, as shown through the exit interviews (see 3.2).

Although this approach has been useful for multiple purposes, both in terms of ensuring a quality service and reducing the likelihood of fraud, it is highly resource intensive and the programme managers are now considering alternative approaches that are less expensive:

“The marketing agent has [a] key role in the marketing of family planning services and the Suraj brand, distribution of vouchers to poor clients, addressing myths and misconceptions, generating referrals and strong follow up of mobilized and served clients.”

Jamshaid Asghar, Manager Private Provider Partnership, Pakistan

Regardless of how robust the internal checks are, the three voucher programmes have also found it important to use independent external agencies to undertake additional random checking. In 2009, the Pakistan programme contracted an external agency to undertake some random checking. In 2009, the Pakistan programme contracted an external agency to undertake some random checking of vouchers.\(^\text{24}\) The agency undertook the evaluation across 18 districts, randomly selecting a total of 540 vouchers to follow up. Fieldworkers visited the household (up to two visits) to validate that the household and women actually existed. Women were then asked whether or not they still had the IUD and whether or not they had returned for a follow-up visit.

Of the 540 randomly selected women, only 68% were located and their voucher use validated. The remaining women either were not followed up because the household could not be located (11%) or the woman could not be located (19%). Unfortunately, the evaluation only collected a minimal amount of information and it is not entirely clear how many of the women or the households that could not be located were in fact due to fraudulent claims. The agency noted that the main reasons for not being able to locate the household were due to wrong addresses or un-numbered houses. Some women were not located due to economic migration (e.g. they had gone to work in a neighbouring village) or because they were working on the land. In Pakistan, the programme actually marks the households with chalk. This can lead to errors in household identification after the chalk washes away with the rain. GPS (global positioning system) mapping would be a far more accurate way to locate households and is something that the programme is now considering.

**Checking that quality is maintained**

As outlined in Chapter Three, all three programmes employ a wide array of options to ensure that quality is maintained. Random and unexpected quality audits are used across the countries, as are mystery client interviews. These are all explained in more detail in Chapter Three.

In Uganda, laboratory practice is the most challenging area of the voucher programme. Factors that have affected laboratory quality include: bad storage of reagents; under-qualified staff; and lack of continuous medical education. On the safe delivery project, health providers who were not complying with project guidelines, lack of qualified personnel (affected by high staff turnover) and those whose facilities and services were found to deteriorate were terminated. Since the beginning of the voucher programme, Marie Stopes Uganda have terminated the contracts of seven providers. In the pilot project, five providers were terminated and three dropped out due to significant losses in reimbursements because they were not following guidelines.
REDUCING FRAUD

Claims processing

All three countries have invested heavily in developing robust internal control systems in order to reduce the likelihood of fraud. Based on both successes and failures, the three programmes identify the following key elements to a successful internal control system:

- cheques, payments and vouchers need to be approved by authorised signatories in advance of payment
- there are clear roles and responsibilities in the cycle for approving payments
- supporting documents are well streamlined in order to reduce the possibility of fraud.

Choice and differential reimbursement for family planning vouchers

In many countries around the world, women and men are not able to access the full range of contraceptive options. In particular, long-acting and permanent methods of contraception remain prohibitively expensive, in both the public and private sectors, especially for poor people. Family planning vouchers are perhaps part of the answer.

Vouchers are often funded as an intermediate step towards social insurance schemes. Vouchers can therefore be viewed through the same lens as USAID-supported health insurance or social insurance programmes. In health insurance, including Medicare and many private insurance schemes in the US, contraceptives are often not reimbursed at all. When contraceptive methods are reimbursed by health or social insurance programmes or by host governments, including in the US or the UK’s National Health Service, they are reimbursed at differential rates to providers, based on the provider’s direct, indirect and commodity costs, complexity of the service, etc. Reimbursing providers at differential rates is done so that providers are not biased towards the use of one method over the other, thus protecting informed choice and consent.

It can therefore be important to reimburse for the provision of family planning services at differential rates, or to reimburse only one or a few more complex, expensive or underutilised family planning services. Vouchers are less likely to reimburse other, inexpensive and easy-to-provide methods such as condoms or oral contraceptives.

KEY LESSONS LEARNED: TRACKING AND FOLLOWING CLIENTS

- invest in strong internal M&E systems
- train staff extensively on data collection to improve the quality of data
- pilot the household and individual indicators to address any ambiguities or flaws early on
- use GPS to locate households more accurately
- use text messaging to contact women directly.

USING NATIONAL ID CARDS TO VALIDATE VOUCHERS

In Sierra Leone, checking identity cards (ID cards) is one way for the programme to counteract the potential of falsified claims as they can check that the woman actually does live in the targeted community:

“ID cards in Sierra Leone are very common, especially amongst the younger generations, so this seemed to act as an effective tool against fraud.”
Gillian Eva, Africa Regional Research Manager, MSI

As the voucher scheme develops, Marie Stopes Sierra Leone is finding that some women have been turned away because they don’t carry ID cards. They are currently developing alternative approaches in addition to ID cards, such as a local tax card or a reminder card with a recent passport picture.

“Women are only given a voucher if they present their ID card and they have to have their ID card with them to redeem the voucher. A number of women have been turned away from clinic for not having their ID cards. This might be because: they forgot it; they lost it; they sold/gave the voucher to someone else.”
Abu Kargbo, Voucher Distributor, Marie Stopes Sierra Leone

The client must present her ID when purchasing and submitting the voucher. The client’s individual ID number will be written on the voucher and the receipt. Once clinics have sent vouchers back to Marie Stopes for reimbursement, the vouchers will then be processed against the information and ID numbers will be collated by the distributor.
4.2 The cost and sustainability of voucher programmes

The three voucher programmes highlight that strong partnership with the local Ministry of Health is crucial to the long-term sustainability and scaling up of any voucher programme. In Uganda, several individuals at the Ministry of Health were involved with KFW (the donor) from the early design phase. The Ministry saw the programme as an important mechanism for improving choice and for improving the quality standards amongst mostly unregulated private providers. One of the key lessons learnt from the Uganda programme was the importance of having champions within government and to ensure that the programme is aligned with government priorities and service provision.

One of the main criticisms levelled at voucher programmes is that they are expensive to run mainly due to higher administrative costs.2,7 As this report has shown, there is a natural trade-off between setting up robust systems to ensure quality and reduce fraudulent behaviour, and the consequent reduction in cost-effectiveness. As the Pakistan programme demonstrates, it is possible to set up systems of internal validation, but they are highly resource dependent.

MSI is currently working with the Futures Institute to undertake a cost-effectiveness study in Pakistan and Uganda. The results are expected in early 2011. As an interim measure, we undertook a simple analysis of cost-per-client in Uganda in 2010 and compared the result with the finding by Bellows in 2009. In 2009, Ben Bellows undertook a simple analysis of the May 2006 to May 2008 data on the STI voucher programme in Uganda.27 This analysis showed the average cost per client to be US$53 per patient.27 One year on and an initial analysis of the 2009 data shows the cost per client has reduced to $21 per client visit.xii As hoped for, the cost per client served has reduced as the programme increased in scale.

In Pakistan, the estimated cost per IUD insertion was US $7.21 based on 2009 figures. The project is expected to expand in 2011 from 100 to 170 providers, so it will be important to see the impact on cost per service.

INNOVATION: SMS FOR A MORE EFFICIENT SERVICE

In Uganda, the voucher programme is being delivered in highly remote areas, which creates a number of challenges in terms of claims processing. First, service providers are often late in submitting their claims, as they wait until they travel to the main town where the project team is based. This makes it difficult to plan and respond to claims as there will suddenly be a large number to process. Project staff try to overcome this problem by travelling to the service providers to collect the claims, but this is not cost-efficient – especially if the project is scaled up.

Mobile phone ownership in Uganda dramatically increased after 2000, when it matched and then overtook fixed line subscribers. This is in part due to the cost of mobile phones greatly reducing and shared ownership increasing. In addition mobile phone costs are increasingly regarded as an alternative to transport costs in rural areas.28 Consequently there are currently over 8.5 million mobile phone owners in Uganda.29

A PhD student at Berkeley University in California is currently evaluating a pilot project using mobile phone-based claims submission software with 19 service providers, in which approximately 100 claims were submitted to a secure web-based database from mobile phones.30 Although only at an initial pilot stage, m-health technology offers a huge potential for more efficient claims processing.

In addition, Marie Stopes Uganda is using mobile phones to improve communication with the service providers. The project team has set up a web-based SMS system that allows one person to send text messages via a computer to all the service providers. Outgoing messages include reminders on quality issues and notices on when claims are ready to be picked up. Service providers can then respond with their own queries whereby messages are charged at a local network fee.

xii This estimate is based on dividing the total project expenditure for the 2009 STI programme (estimated at 30% of total voucher programme, including safe motherhood), subtracting voucher income and dividing by the number of clients. This is comparable to the approach taken by Bellow et al.31
Conclusions and recommendations

Access to affordable and safe reproductive and sexual healthcare saves lives and empowers women the world over. Public health systems in developing countries face huge problems in meeting the health needs of their populations. Most countries have developed comprehensive national health strategies and plans with corresponding goals, and have also signed up to ambitious international targets, such as the Millennium Development Goals. However, few countries are meeting these targets through their current health systems, which are based largely on supply-side subsidies, delivered through a network of publicly-owned and operated health facilities.
Voucher schemes have increased the power and ability to provide access to health services to the hardest-to-reach groups. Vouchers are more targeted than traditional approaches to health service delivery. They respond to the fact that the hardest-to-reach are often the poorest people who cannot afford services. Vouchers also work with the private sector, which is the main provider of health services to the poor in many developing countries.

This report has emphasised the innovative and effective ways in which MSI has been experimenting with voucher programmes in order to meet the unmet need of the poorest of the poor. In Sierra Leone, Uganda and Pakistan, MSI voucher programmes are having a real impact on the lives of tens of thousands of women and men. In Uganda, where the programme is most mature, more than 61,000 men and women have been reached through the voucher programme.\(^\text{xiii}\) and as the programme evolves, the cost per service provided has reduced from US $53 to $21.\(^\text{27}\)

The three programmes vary across countries – both through the range of services offered and the way each model tackles common challenges such as assuring quality or targeting the poorest of the poor. Cutting across all three programmes however, there are some clear lessons. For example, all three programmes have successfully developed poverty targeting strategies that are both evidence-based and avoid being too resource-heavy as there is an intrinsic pay-off between a more robust system to check eligibility and prohibitive costs of undertaking a rigorous assessment. These prohibitive costs escalate once a programme starts operating at scale. Ultimately, there is no one approach to poverty targeting that works everywhere. The approach will need to be adapted depending on whether the context is urban or rural.

The role of a community or field based marketing agent is pivotal. These local community members do much more than simply distribute the vouchers. They also help to raise awareness about reproductive health issues, thus breaking down myths and misconceptions. In Pakistan, they also play a role in ensuring a continuum of care, visiting each woman after she has used the voucher to check that she is well and to encourage her to return for the follow-up visit.

Through learning and change, the MSI voucher programmes have developed systems of quality assurance. The main ways in which the voucher management agency can assure quality is by providing training and accreditation, undertaking continual quality audits and checks (internal and external) and setting up and ensuring follow-up and referral networks. All three programmes go further than just assuring quality by also playing a role in improving quality standards.

There are a number of ways to check that quality is maintained at participating service providers. Actual random spot checks at the facility will always play a central role. In addition, client satisfaction surveys, mystery client surveys and analysing claims data for correct diagnostics are all useful tools.

Although internal quality assurance systems need to be in place, it is always important to include external evaluations too.

It is clear that the programme managers recognise that there is always potential for corruption and fraud. Their role is to work out systems to minimise this. Fraud can occur at any stage of the process but can be reduced by setting up clear systems of voucher validation and strong delineated systems for claims processing. Sanctions are an important part of contracts and are applied when quality standards and specifications are not met over a defined period of time. These may take the form of simple warnings, and may proceed to compulsory training, additional monitoring of quality improvements, and eventually exclusion from the programme.

Ultimately, administering a voucher programme is more complex and resource intensive than simply providing free services indiscriminately. However, the common challenges can be overcome, which means that services can be successfully targeted. MSI is still developing its model into best practice. Over the next year, we will be undertaking more in-depth evaluations of each of the three models documented in this report. Although only an initial first stepping stone, we hope that this report has been useful in highlighting some of the successes and innovations of voucher programmes and that it will inspire other partners to realise the potential of vouchers to reach those who were previously unreachable.

**Recommendations for programme managers:**

- develop a strong evidence-based approach to targeting vouchers at poor individuals or communities
- ensure that checks and balances are in place to ensure that vouchers are really being used by poor people
- invest in M&E systems in order to track clients, impact and service provision
- involve local community members in marketing and distributing the vouchers
- set up robust yet simple systems of quality assurance. Define realistic accreditation standards to ensure sufficient providers

\(^{xiii}\) Based on total number of vouchers redeemed as of August 2010.
CONCLUSIONS

- Select the best providers, drop the worst performers and admit new providers.
- Define detailed quality specifications, so providers know exactly what is expected.
- Develop clear performance indicators for monitoring.
- Use the accreditation and training process to ensure that all providers reach a minimum standard of quality.
- Quality specifications must be included in the contract that governs the partnership and are specific to the services to be provided.
- Undertake a range of M&E activities to check that quality is maintained.
- Work with service providers that meet standards.
- Ensure that fraud detection, and the corresponding fraud detection instruments, are incorporated into the monitoring and evaluation (M&E) framework: both for routine M&E, and for ad hoc or specific monitoring activities.
- Ensure that all individuals and groups caught acting dishonestly are punished appropriately (by being sacked or excluded from the system) and that these measures are public and made known to all stakeholders in the scheme.
- Set up robust internal control systems to combat fraud.
- Involve a number of independent players in the management and monitoring of the scheme.
References


30. Ho M. Communications and Computing in Health Facilities of South West Uganda: School of Information, University of California, Berkeley 2010.