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Vouchers in three parts: Addressing inequities in access to contraceptive services

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PART 1

RATIONALE & BACKGROUND

Inequality in family planning use

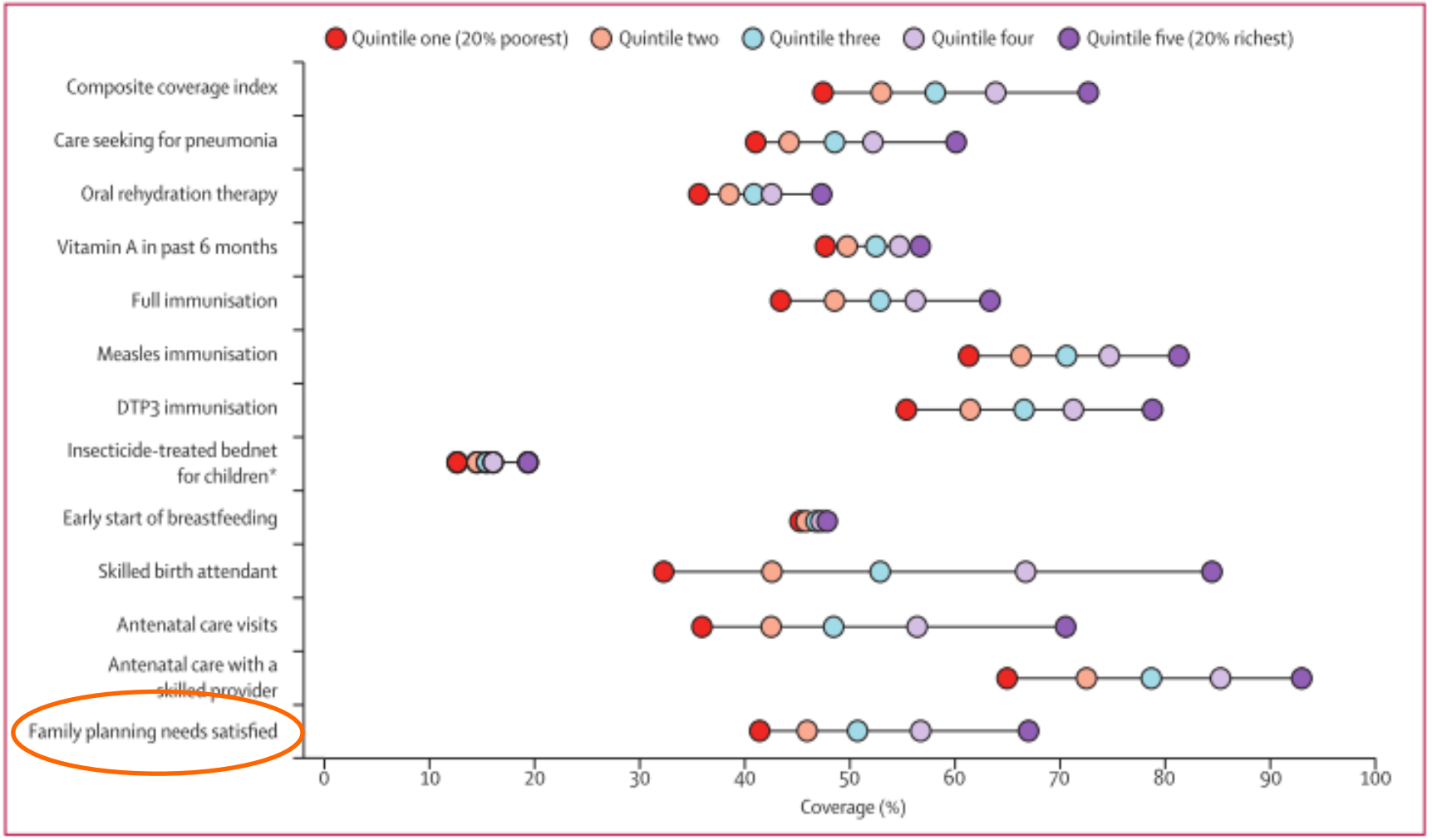
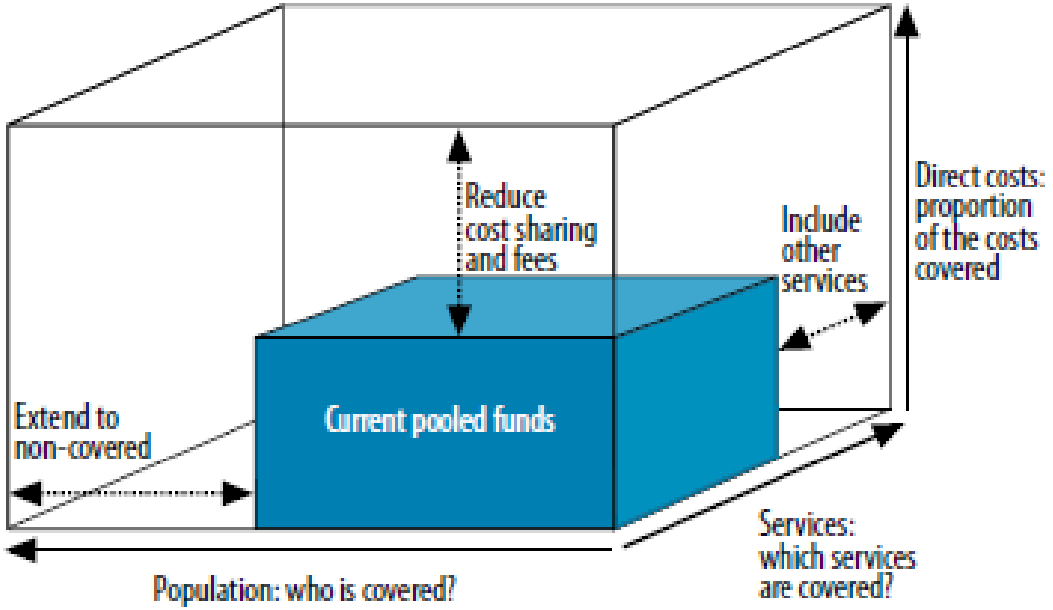


***Figure 1:* Mean coverage in each wealth quintile for the studied interventions in 54 Countdown countries**
Coloured dots show the average coverage in each wealth quintile. Q1 is the 20% poorest wealth quintile; Q5 is the 20% richest. The distance between quintiles 1 and 5 represents absolute inequality. *Appendix p 1 specifies age ranges of children.

*Barros, A. J. D., Ronsmans, C., et al. (2012). "Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries". Lancet, 379(9822), 1225-33.

Additional financing for universal access to family planning

1. Access: extend services to population with unmet need
2. Scope: improve number of methods offered to current population
3. Financial protection: reduce out-of-pocket costs that suppress demand



Vouchers as a form of “progressive universalism”

- Vouchers are intended for beneficiaries who want the service but, in most cases, would not have used the service if the voucher were not available

Voucher program design & functions

Program objectives, funding sources, timeframe, governance structures

Voucher functions (management)

- Voucher management agency – VMA: government-run, contract-out, or franchise
- Quality assurance and improvement (e.g. facility accreditation, CMEs)
- Process claims & conduct fraud control
- Monitor trends in costs, utilization, quality
- Consider supply-side strategies to meet minimum standards (e.g. financial credit to facilities, peer-led learning exchanges)

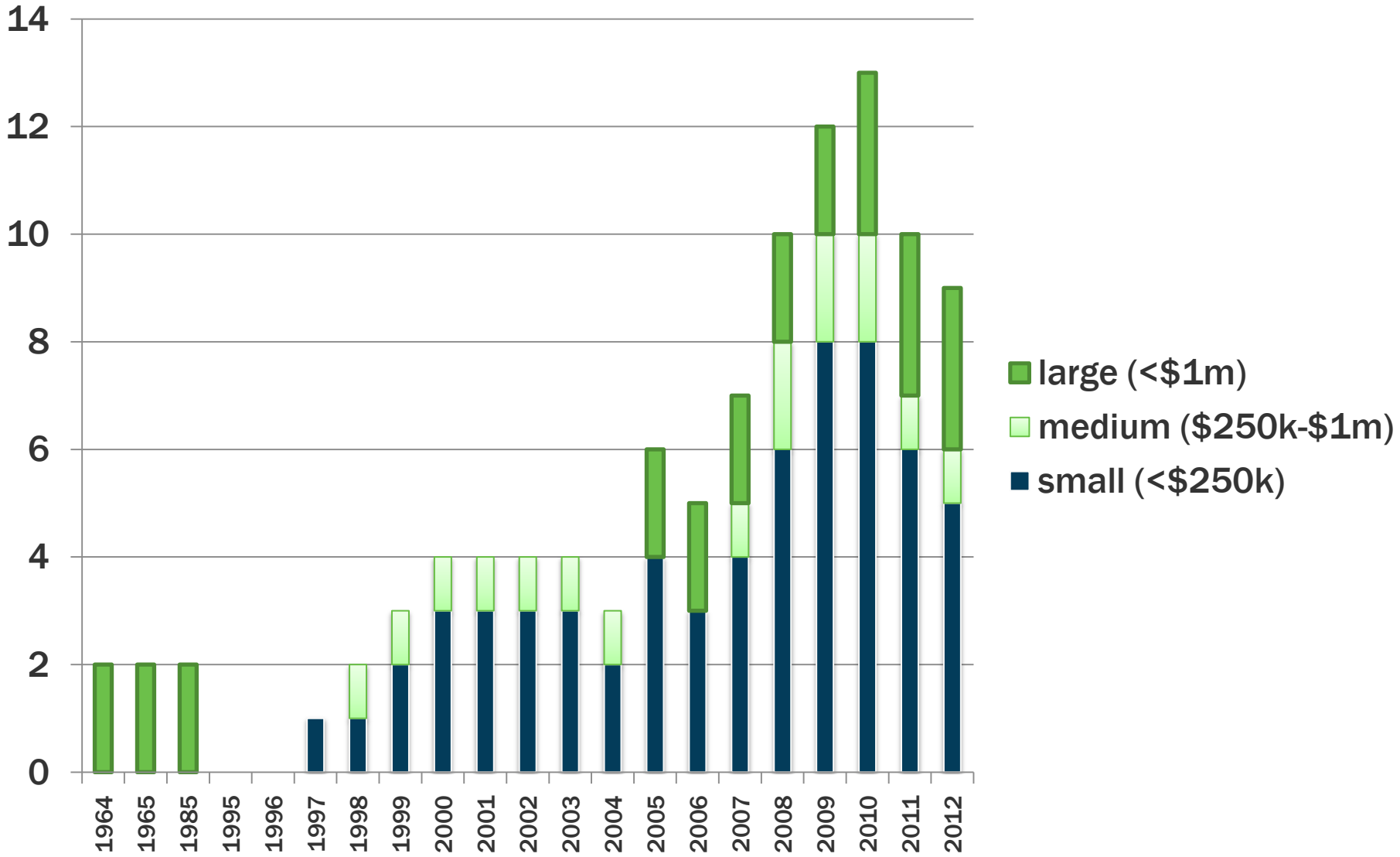
Client

- Poverty status & need?
- Free or paid voucher?
- Which services offered?

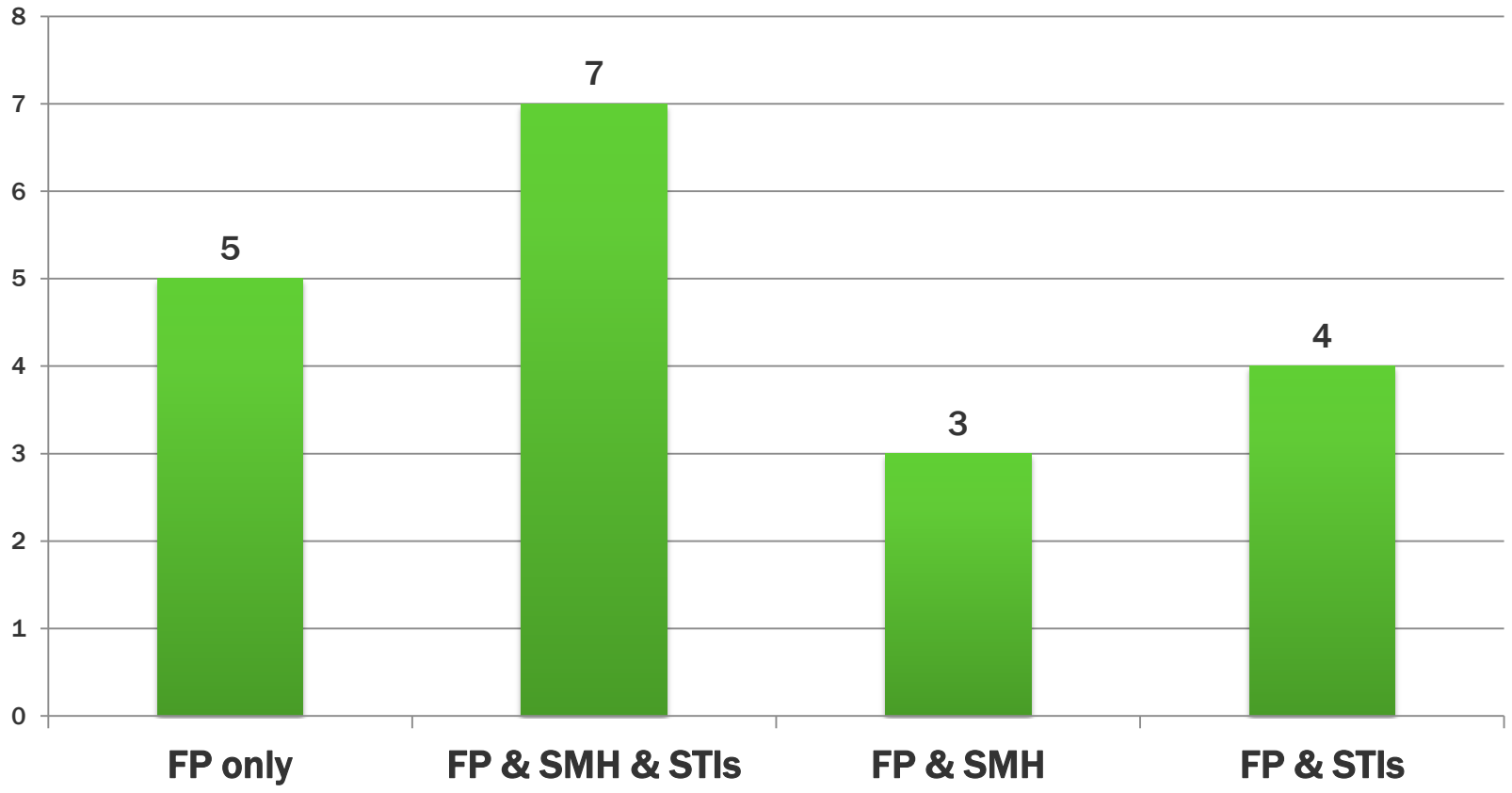
Facility

- Accredited?
- Clinical quality?
- Competition?
- Reimbursement rates?

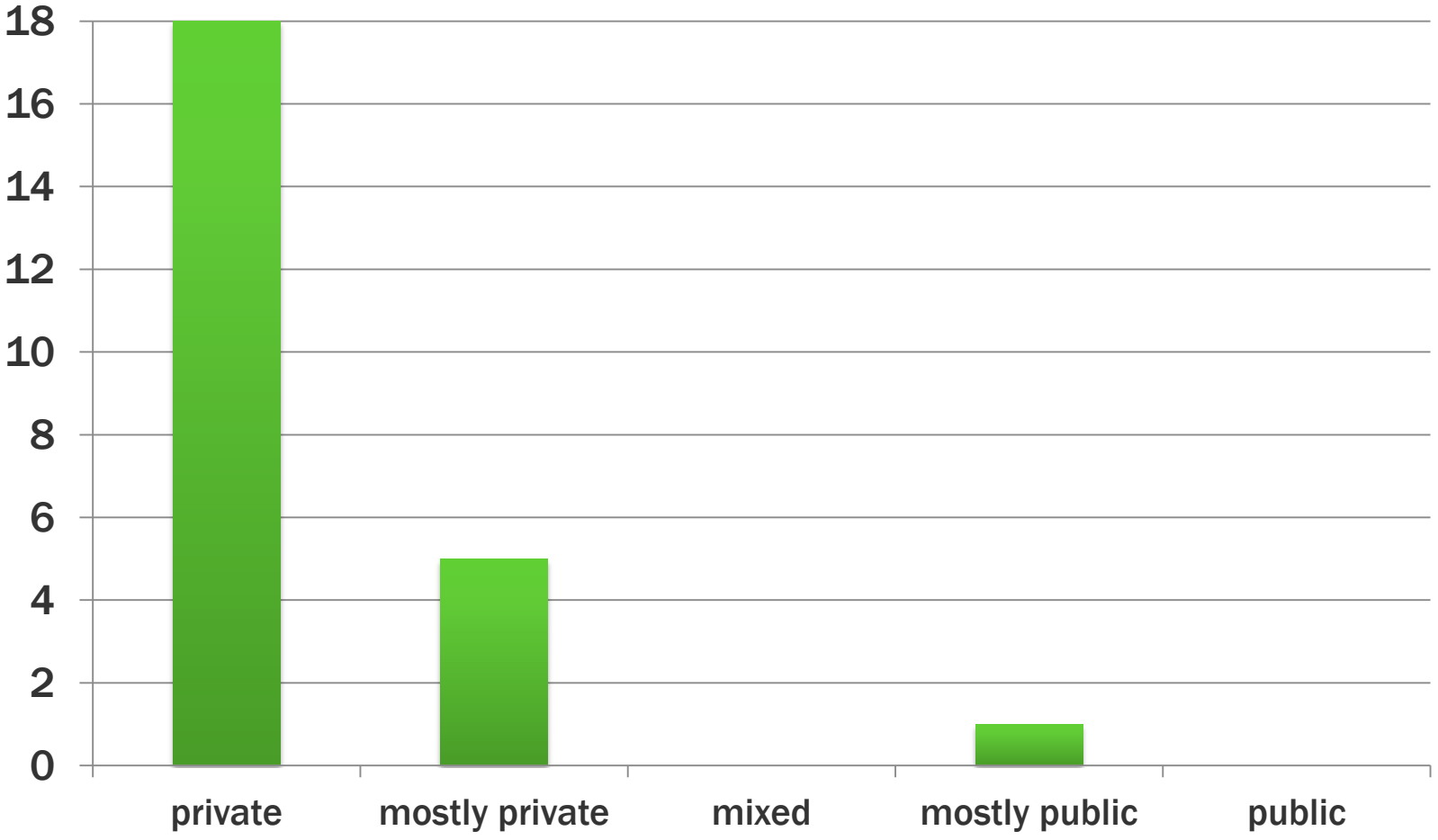
19 FP voucher programs, active 1964-2012



19 FP voucher programs and available services



Provider types in 19 FP voucher programs



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Part 2

PROGRAM IMPACT: The Cambodia Case

Contraceptive Background: Cambodia

Knowledge High but Current Use much Lower

- Virtually all women in Cambodia have knowledge of contraceptives

- **51% of married women currently using contraceptives in most recent DHS:**
  - 35% Modern; 16% Traditional
  - Most widely used is Pill (15%), followed by withdrawal (12%), then injectable (10%)
  - Unmet need for contraception is 17.1%

- **Long Acting Reversible Contraceptive use is very low particularly among younger (20 to 29 year olds)**

Reproductive Health Vouchers in Cambodia

RH Voucher program implemented by NGO on behalf of the Cambodian Ministry of Health, funded by German Development Bank (KFW), in 2011

- Designed to reduce barriers to utilization of RH healthcare services among disadvantaged women (maternal healthcare, family planning, abortion)

Family Planning Voucher:

- LAPMs such as IUD and sterilization offered at public and NGO clinics.
- Short term methods and some longer term methods such as injectables offered at public clinics
- Transportation subsidy also included
- No User Fee

Quasi-experimental Evaluation of Cambodia's RH Voucher program

Sample: **2200 women** of reproductive age (18-49 years)

Sites: Communities in **9 Operational Districts** (ODs) in the 3 voucher provinces. Comparison Sites in **9 propensity score matched control ODs** without vouchers from non voucher provinces.

Study Design: Pre and Post Intervention Study with Controls

- 2011: Baseline study before Vouchers were implemented
- 2013: Endline Study after Vouchers were implemented

Results: LARC Use Comparison between 2011 and 2013

	Intervention		Control	
	Before program	**After program**	**Before program**	**After program**
Use of LARC	**1.4**	**6.7**	**1.9**	**3.5**
Wealth Quintiles				
Poorest(Q1)	1.1	8.8	0.4	3.1
Q2	1.7	7.9	2.3	3.4
Q3	0.9	5.1	2.8	4.3
Q4	0.4	6.5	3.2	2.9
Richest(Q5)	3.0	5.1	1.5	3.9
Education level of women				
No school	1.1	11.8	0.6	4.8
Primary school	0.9	6.0	2.8	2.9
Secondary school	2.2	5.6	0.9	4.5
High school	5.3	5.8	0.0	3.2
N	**961**	**993**	**975**	**993**

Discussion

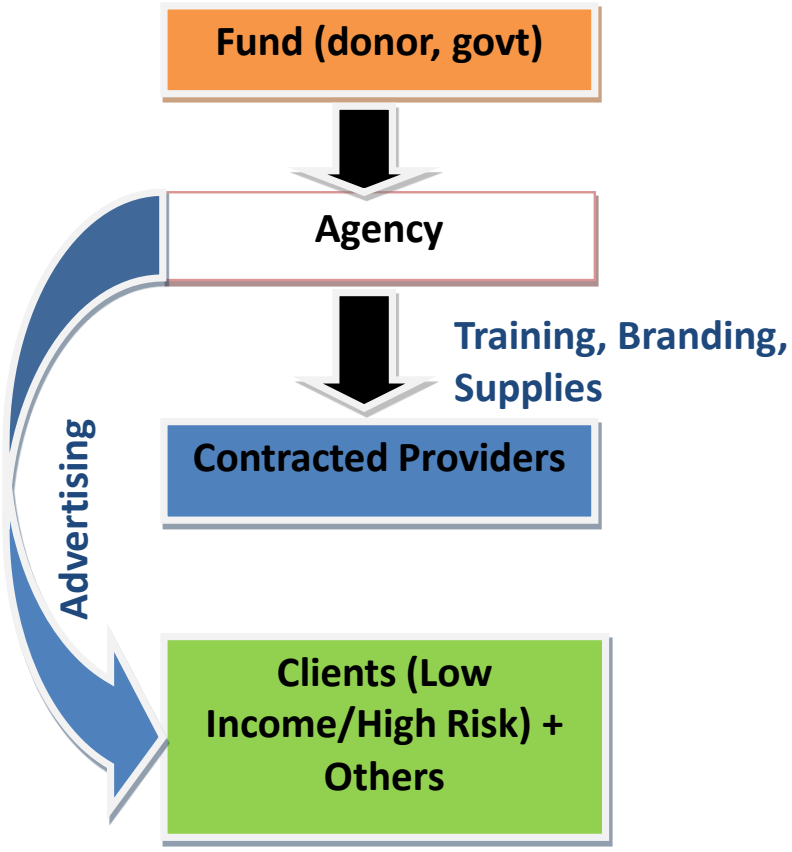
Robust Evidence: Difference-in-Difference results show that voucher program significantly increased the use of LARC over two years among post partum women.

- Increase in Voucher areas 3.7 percentage points higher than increase in Non-Voucher areas
- Across all age, SES and education groups with stronger increases among older age groups, lower SES, and lower education.
- Most pronounced among women with No Schooling

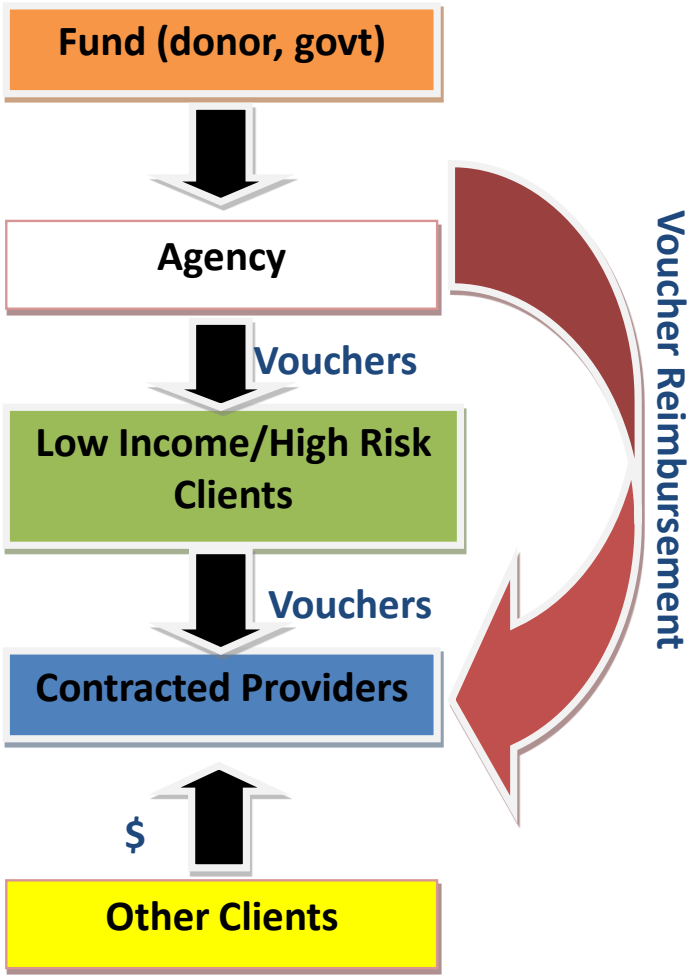
PART 3

IMPLICATIONS FOR TODAY'S CONSULTATION

Supply-Side Special Franchise

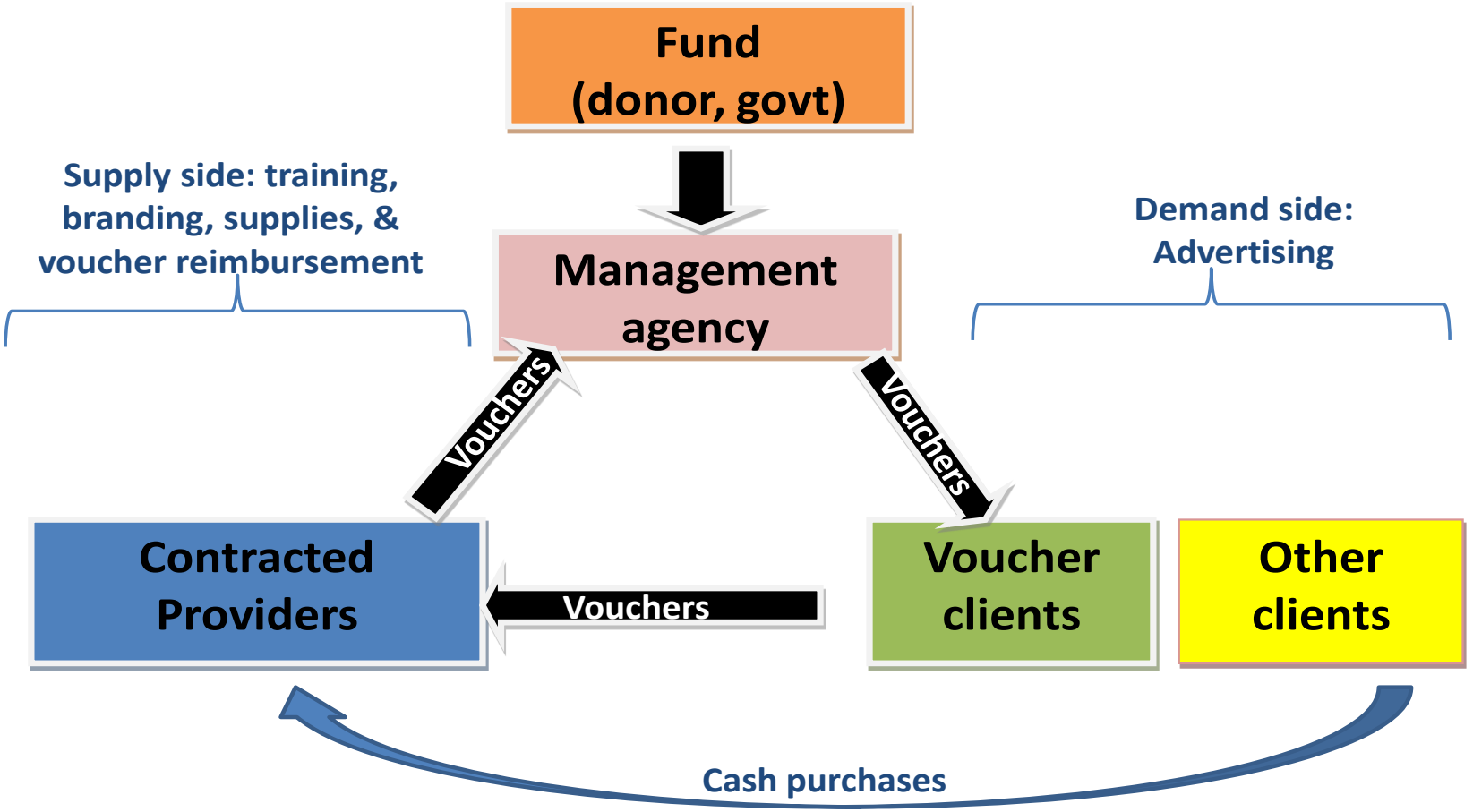


Demand-Side Voucher System



Integrating demand & supply

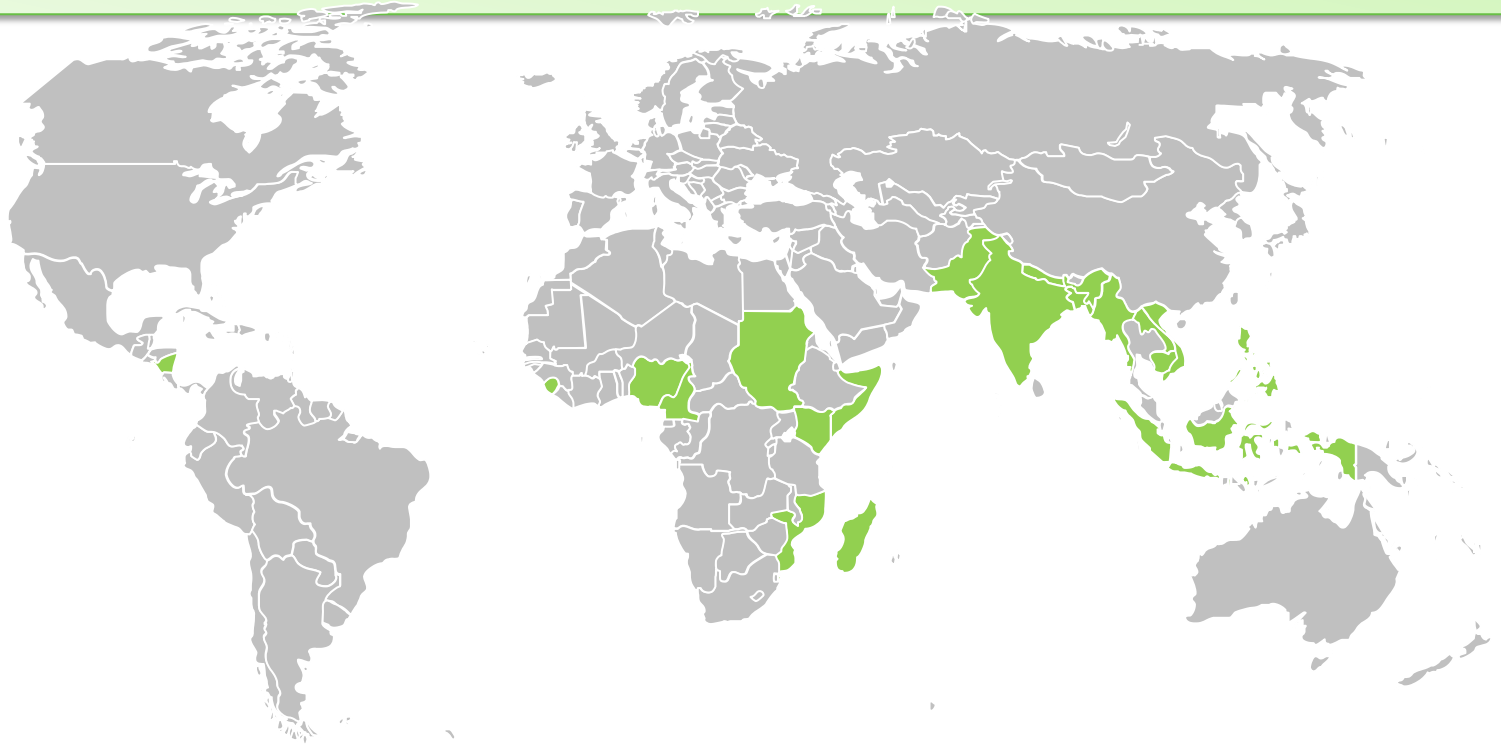
Combined Demand-Side, Franchise System



Where is SF+DSF Happening?

In the 2011 Social Franchise Compendium, 52 SFs were surveyed in 36 countries.

- 25 of the SFs (48%) reported that they were employing some form of DSF in their organization
- 13 SFs reported the use of vouchers
- 8 SFs reported using working with insurance DSF strategies.



Scale, franchising & FP vouchers in Uganda

- 33% of married women (~2.3 million) had an unmet need in 2011 DHS
- Marie Stopes Uganda sells FP vouchers through BlueStar network with community-based distributors
- Since 2012, MSU has served 204,984 voucher users with FP methods of their choice, mostly LAPMs.
- 137,518 were first time initiators (new users)
- *MSU franchising + vouchers met FP needs of 6% of 2.3 million women in Uganda*

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Next Steps

Build stronger systems to monitor performance metrics

- Is the program bringing in new LAPM users, retaining repeat users?
- How do FP programs perform in terms of efficiency, quality, equity, reduced discontinuation rates, DALYs averted, financial protection.
- Ask: what's the scale of FP service uptake?

Demonstrate "price transparency" to Uganda Government and other national funds eager to purchase services on behalf of citizens and make progress toward universal, voluntary FP coverage as part of UHC.

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conducts biomedical, social science, and public health research. We deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world.