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Authors: Dr. Ben Bellows – Chief Business Officer, Nivi Inc. | **Dr. Moazzam Ali** – Medical Officer Reproductive Health and Research, World Health Organization (WHO), Geneva | **Dr. Ali M. Mir** – Senior Director Programs & Research, Population Council

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Best Bets for Accelerating Family Planning in Pakistan

Vouchers for Rights-based, Voluntary Family Planning

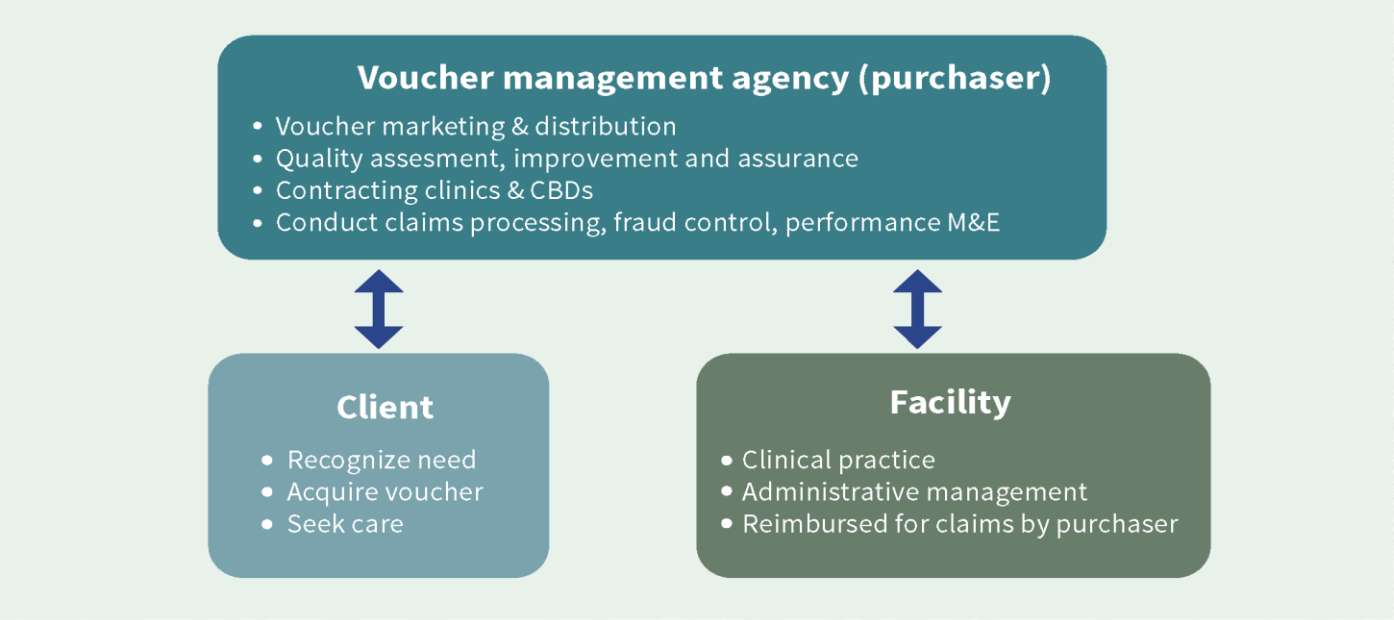
Family planning is unique among health interventions in the breadth of its potential benefits, which include reduced burden of unintended pregnancies, lower maternal and child mortality, empowerment of women, poverty reduction, and enhanced environmental sustainability through stabilization of trends in population growth.[1] However, socioeconomic, demographic, and geographic disparities in contraceptive use and access remain wide between and within countries, with significant implications in terms of unequal attainment of sexual and reproductive health rights.[2,3,4] Inequitable access, skewed method mix, and unmet need are persistent and pervasive challenges in family planning (FP) services in many low- and middle-income countries (LMICs), particularly in sub-Saharan Africa. [2,5,6]

To combat inequities in access to health services, vouchers have emerged as a strategy for both demand- and supply-side financing as part of sexual and reproductive health interventions, including family planning.[7] Since the 1960s, more than 20 family planning programs in LMICs have used vouchers to serve disadvantaged populations and improve access to contraception, particularly long-acting methods.[8-32]

The basic premise of a voucher is that it acts as a token that can be exchanged for goods and services; a health voucher is exchanged for a health good or service, such as contraception or sexually transmitted infection testing.[33] A key feature of voucher programs is that they directly link the demand-side voucher subsidy to the intended beneficiary and the anticipated supply-side output.[34] Although specific modalities vary, certain broad principles are common across voucher programs. Beneficiaries from disadvantaged or marginalized groups are given vouchers that they can redeem at contracted public or private health facilities for services.[35] The facilities then submit claims for reimbursement to the voucher management agency. Voucher programs thus improve financial and non-financial access to care.

As Figure 1 illustrates, voucher programs are designed with three key parties in mind: a management agency, a defined beneficiary population, and contracted service providers.[36] The voucher management agency may be a government agency or parastatal commercial or non-profit entity. Its primary responsibilities are to identify and engage beneficiaries, distribute defined-benefit vouchers, contract providers, and administer claims reimbursement. Healthcare providers included in the program may belong to the public or private sector; they should have the capacity to manage finances as they are often reimbursed according to the number of voucher clients who are treated (output-based) or a clearly defined performance achievement (quality-adjusted output payments). Most programs define beneficiaries by economic status, but other characteristics, such as being an adolescent or a sex worker, may also be applied. In some recent family planning voucher programs, community-based distributors (CBDs) have used a poverty-grading tool based on household assets and amenities to identify beneficiaries.

Figure 1: Key actors and their responsibilities in family planning voucher programs



Evidence of Public Health Impact

Evidence from more than 20 studies of family planning voucher programs in Asia, Africa, and Latin America confirms that such programs can improve equitable access to health services. There is a general alignment in the results of these studies, including increased uptake of contraceptive methods among intended beneficiaries (e.g., the poor, youth, sex workers), reduced fertility, and lower likelihood of contraceptive discontinuation.[7,37,38]

The early literature on family planning vouchers (or "coupons" as they were commonly referred to in the 1960s and 1970s) contains important operational lessons that future research could expand. Vouchers were originally used to track the number of households contacted, acceptors reached, and contraceptives distributed, and to monitor subsidies claimed for contraceptive services.

A 1969 paper noted three advantages of using coupons: administrative verification of intrauterine device (IUD) insertion; educational or motivational aid to the IUD acceptor, who was reminded of the subsidy and opportunity to complete the referral; and ability to monitor and evaluate performance of referral agents and family planning service providers.39

Increased Contraceptive Use

A recent review of studies of voucher programs observes that most have focused on metrics for contraceptive use, and not surprisingly, nearly all of them report changes and a significant increase in contraceptive use.[40] With respect to use outcomes, the voucher is a valuable means to tally contraceptive service visits. However, the review notes that metrics on other dimensions of performance are missing in the literature and synthesis of insights from program operations is lacking. In particular, contraceptive discontinuation in voucher programs has not been well studied. For example, two studies from Pakistan have reported that IUD continuation did not differ statistically between voucher and non-voucher cohorts at 24 months.[26,27] Even though one of these studies does find a consistently higher probability of continuation in the voucher cohort compared to the non-voucher cohort,[27] the statistically small difference in actual continuation merits further examination, particularly of the underlying program modalities that may be responsible.

Enhanced Equity and Increased Choice

Voucher programs can be effective in subsidizing contraceptive products and services, and targeting subsidies to beneficiaries who, in their absence, would have a lower probability of service access and use.[7] Multiple studies find an observed association between being identified as a voucher beneficiary and increased contraceptive uptake.

Studies also show that vouchers are an effective means for governments to flexibly engage private sector capacity. Such programs can expand client choice by reducing financial barriers to contraceptive services and make private providers an option for disadvantaged clients previously restricted by cost.[7] A study of a voucher program in Pakistan found that it substantially expanded contraceptive choice for the underserved population at which it was aimed, improving equity and access, and also enhancing the quality of services available, thereby contributing to universal health coverage targets.[39]

Alignment with Rights-based Programming

The strategic purchasing of sexual and reproductive health services through vouchers can be intentionally aligned within a rights-based approach.[41] A rights-based approach to family planning applies human rights standards and principles to guide programs to enable individuals and couples to decide freely and responsibly the number and spacing of their children, to have the information and services to do so, and to be treated equitably and without discrimination.[41] Many states have committed, under international human rights agreements and national constitutions and laws, to ensure timely and affordable access to quality family planning information, services, and contraceptive commodities for all.[42]

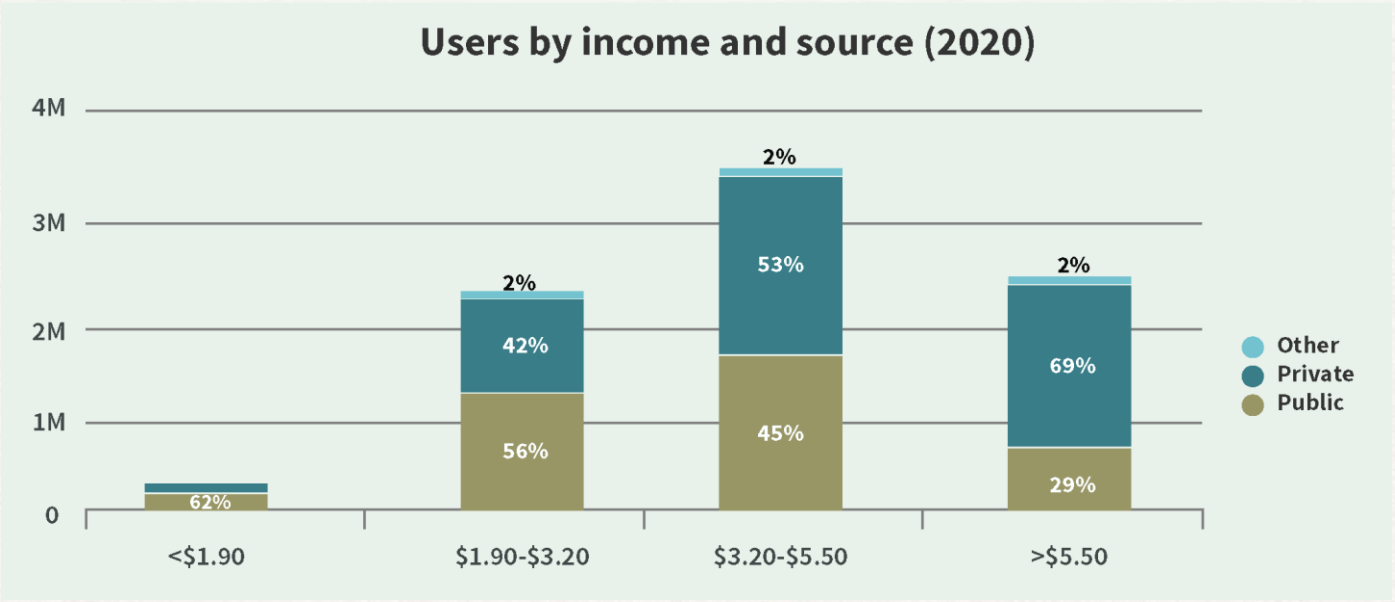
As the above evidence suggests, the public health goals of universal access to FP services can be well-supported by voucher programs, which are specifically targeted at the marginalized or underserved populations whose right to family planning services is most compromised by financial or other constraints.[43, 44, 45] Table 1 provides an overview of sexual and reproductive health rights implications for family planning programs, and how voucher programs can operationalize these rights.

The Case for Using Vouchers in Family Planning Programming in Pakistan

Pakistan has a high total fertility rate (3.6 among married women), combined with a high unmet need for contraception (17%). Women's empowerment remains low, and levels of maternal mortality stubbornly high compared to other countries at similar income levels.[46,47,48]

The modern contraceptive prevalence rate is persistently low and has remained under 20% among all women over the past ten years. The contraceptive method mix is limited and skewed, with sterilization and short-term methods, particularly condoms, dominating contraceptive use.[46,47] There are also significant differences in modern contraceptive use between the richest and poorest wealth quintiles (Figure 2). Pakistan is a lower middle-income country with 37% of the population living on less than $3.20 a day.[49] Although female sterilization is common across income groups, use of other contraceptives varies by poverty status. The poorest third of the population has the lowest contraceptive prevalence but despite economic constraints, more than 40% of poor FP users still procure contraceptives from private sources.[46]

Figure 2: Number of users of any modern family planning method, by average daily income and source



Source: Family Planning Market Analyzer, http://fpmarketanalyzer.org.

Weak protection of sexual and reproductive health rights—notably the lack of practical awareness of local FP services and protection from out-of-pocket costs of these services—prevent a significant portion of poor women in the country from accessing family planning services.[50,51] Women generally have limited agency in realizing their fertility intentions due to constrained decision-making, poor knowledge of available services, or significant financial constraints. Potential users are less likely to take up and continue use of an appropriate preferred method.

Pakistan's unique combination of high socio-economic inequality, skewing of contraceptive use along that

socio-economic gradient, and significant private sector role in provision of FP methods to the poor underscore the value of an FP voucher strategy to drive progress toward universality in voluntary, informed uptake and continued use of contraceptives. Thus far, small-scale voucher programs have been implemented in the country to reach underserved segments of the population with unmet contraceptive needs. Unlike other countries, these voucher initiatives were incorporated in pre-existing social marketing initiatives looking to improve financial access to private sector family planning services. The two principal FP voucher initiatives in the country were initiated by Population Services International (PSI), under the Greenstar brand, and by the Marie Stopes Society.

Greenstar Social Marketing (GSM), a private non-profit organization affiliated with PSI, was launched in 1995 to build awareness and improve availability of and access to reproductive health services via private sector models across Pakistan, including in Karachi, Sukkur, Bahawalpur, Multan, Faisalabad, Lahore, Gujranwala, Islamabad, and Peshawar. By 2020, GSM was responsible for distributing more than 50% of contraceptives in Pakistan's private sector.[52]

GSM operates a network of over 7,000 clinics to provide high-quality, affordable reproductive, maternal, and child health services to low-income women. It has trained female physicians and paramedics in its network. Vouchers were incorporated into GSM's operations to subsidize access and generate demand for its services.[53]

GSM's multiple voucher model in Punjab was conducted as a quasi-experimental study with pre- and post-phases. It was implemented in one intervention district (Faisalabad) and one control district (Toba Tek Singh). The study detected a 20% increase in the modern contraceptive prevalence rate compared to baseline in the intervention district and noted that the intervention positively impacted equity. The model's integrated approach, combining contraception with child immunization, also led to an increase in immunization coverage. The study noted, however, that it will be important for public policy decision-makers to assess the usefulness of this approach, as long-term provision of free contraceptive services may lead to dependency in targeted communities.[53]

In 2008, the Marie Stopes Society (MSS), a local non-governmental organization, introduced a fractional social franchising model under the brand name ***Suraj***, meaning 'sun' in English. By 2015, MSS had enrolled 663 facilities in the initiative, which aimed to provide accessible, affordable, and high-quality family planning services. To strengthen the quality and improve the volume of services, Suraj managers leveraged a mix of supply and demand side improvements, including in-service training and marketing, branding, and a voucher scheme for prospective clients.

Providers were trained and accredited to offer condoms, emergency contraceptives, injectables, and oral contraceptives, and to insert and remove IUDs.[54]

Community-based field workers were trained to mobilize their community catchment by conducting door-to-door visits, providing FP counseling and referrals, and issuing IUD vouchers to eligible women. Eligibility for vouchers was assessed using a poverty grading tool that asked women about the number of meals consumed in their household per day; the construction of their house; cooking fuel; the family's monthly income; earning and dependent family members; water source; sanitation; and access to reproductive health services. Vouchers were redeemed against free IUD insertion, follow-up visits, and removal services.[55]

Through social franchised services enhanced by the voucher program, MSS reached out to underserved women in selected areas in Punjab province to increase access to modern contraceptive methods, with a special focus on long-acting reversible contraceptives (LARCs). This initiative had a quasi-interventional study design with pre and post phases and was implemented in one intervention district (Chakwal) and one control arm, Bhakkar, from August 2012 to January 2015). The results showed that, compared to the baseline, awareness of contraceptives increased by 30 percentage points in the population in the intervention area. Vouchers also resulted in a net increase of 16 percentage points in current contraceptive use and 26 percentage points in modern methods use. In fact, the underserved population demonstrated better knowledge and higher utilization of modern methods than its affluent counterparts. The concentration index indicated that voucher use was more common among the poor and vouchers seemed to reduce inequality in access to modern methods across wealth quintiles.[39]

Recommendations – The Way Forward

Building on the experience of GSM and MSS in implementing voucher programs in Pakistan, it would be necessary to expand the scope of voucher programs to also enhance access and contraceptive choice, especially with the addition of private sector provider's access by the poor.

Going forward, the option of embedding voucher schemes within existing social welfare support initiatives could be explored. One example of such

embedding is a voucher scheme being implemented by the Population Council in cooperation with the Benazir Income Support Program (BISP). The initiative seeks to increase access to FP services among low-income women with FP need. The voucher is offered to BISP beneficiaries and covers both transportation costs and provider fees.

In terms of research needs, there is a paucity of rights-based metrics for strategic purchasing initiatives like the BISP voucher program. There is a need to both validate metrics for specific rights and run high-quality studies with rights-based metrics as study endpoints.

Finally, it is critical to take into account the ongoing COVID-19 pandemic in the planning of voucher programs. COVID-19 is new to humans and only limited scientific evidence is available to identify its impact on sexual and reproductive health.[56] Home isolation and fears of contracting the virus appear to have led to decreased uptake of sexual and reproductive health services, increased intimate partner violence, and in some settings, reduced access to contraception and safe abortion care.[57,58] The Guttmacher Institute estimates that the pandemic will lead to a 10 percent proportional decline in use of short- and long-acting reversible contraceptive methods in LMICs due to reduced access. This will result in an additional 49 million women with unmet need for modern contraceptives and an additional 15 million unintended pregnancies over the course of a year.[59] While creative measures are needed to reverse these trends, safety concerns must also be prioritized. Therefore, to the extent possible, voucher programs should incorporate mobile solutions for beneficiary identification, pre-counseling (priming), referral (e-pharmacy), and post-service accountability.

Conclusion

- To meet the FP2030 and Sustainable Development Goals (SDGs), significant investments are required by countries and donors in priority areas, including sustainable financing, reaching all adolescents, expanding availability of services to the poorest and hard-to-reach populations, and improving the quality and increasing the range of methods available.[59]

- Studies have shown that vouchers can substantially contribute to the SDGs by expanding contraceptive access and choice among the underserved populations. Vouchers can be a good financing tool to enhance equity, increase access, and improve the quality of FP services available to underserved populations within the country.

Table 1: Operationalizing sexual and reproductive health rights in family planning programs

SRHR	Implications for FP programs	How vouchers act to improve SRHR
Accessibility	Geographic, physical, financial, and policy access (i.e., absence of nonmedical eligibility criteria); information is understood; continuous contraceptive security; suitable operational schedule; service integration to avoid missed opportunities.	• Financial access improved via the voucher subsidy. • Geographic access improved via community-based distribution of vouchers and transport subsidy, if part of the package. • Information access improved via CBD/ LHW interpersonal communication.
Acceptability	Culturally appropriate facilities, methods, and services; community/family support for women's ability to choose, switch, or stop method of contraception; tolerance of side effects; privacy and confidentiality respected; client satisfaction with services. Ensuring client privacy and confidentiality.	• Client satisfaction is solicited and factored into provider reimbursement or contract renewal. • Voucher benefits package includes LARC removal • Contracted providers meet standards for confidentiality.
Accountability	Mechanisms exist for community members and family planning clients to provide input and feedback about services, and for health system to investigate and remedy allegations of or confirmed violations of rights; members of the community are involved in planning and monitoring family planning services; good governance and effective implementation, providing an environment that facilitates the discharge of all responsibilities; and the ability to readily access meaningful information, including de-identified data.	• Client experience is solicited and factored into provider reimbursement or contract renewal. • Management agency has means to investigate and remedy allegations of or confirmed violations of rights • Voucher distribution is done by trusted community members. • Routine data is used to monitor service delivery and adherence to standards.
Agency (voluntarism)	Knowledge that one has the right to make decisions about health care; ability to make one's own decisions independent of system, husband, family, or community pressures; informed, voluntary decision making supported; meaningful participation of clients in program design and monitoring; client-controlled methods offered; supportive community gender norms; women, men, and young people know they can ask for services based on their needs, within their rights.	• Community-based voucher distribution supports notion that client controls process and communities accept that CBDs can perform their duties.
Availability	Broad choice of methods offered; sufficient and needs-based distribution at functioning service delivery points	• Broad choice of methods offered in voucher benefits package. • Providers contracted to ensure sufficient contraceptive supplies.
Informed choice	Women and youth and all clients make own decisions about whether and what method of family planning to use, without pressure from anyone, with free access to accurate information they can understand and a range of options to choose from.	• Choice optimized if client perceived quality (MII+) is linked to provider reimbursement • Voucher benefits package optimizes on number of methods • Providers incentivized to deliver a broad method mix
Nondiscrimination	Everyone, no matter what group they identify with, their age, or any other circumstance, has the same access to quality information and services; everyone is treated fairly and equitably.	• Community-based distribution of vouchers to disadvantaged populations addresses this point.
Quality	Service providers are well trained and provide safe services, treat clients with respect, provide good counseling, and protect client privacy and confidentiality (ensuring client information cannot be observed by anyone else without client's consent; ensuring client records are not disclosed); stock a regular supply of contraceptives and all necessary equipment to provide the services clients want.	• Provider accreditation in the voucher program is predicated on meeting standards. • Voucher clients are solicited for feedback on the quality of their experience.

CBD= community based distributor, FP=family planning, LARC=long-acting reversible contraceptive, LHW=Lady Health Worker, SRHR=sexual and reproductive health and rights

SOURCE: Cole et al. 2019.

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