

# Family Planning Vouchers

### What is the program enhancement that can intensify the impact of high impact practices in family planning?

Provide vouchers to clients to facilitate equitable access to and choice of voluntary contraceptive services.

### Background

Health care vouchers are paper or electronic referral coupons that clients can take to an accredited health care provider in exchange for health care services. They are used as a financing mechanism and programmatic tool to improve equitable access and increase the use of key health products and services.<sup>1</sup> Vouchers are a form of results-based financing, a type of health system reform which includes payment or non-monetary transfers after services have been attained and verified.<sup>2,3</sup> Clients can choose when and where to seek care, but payment to providers and voucher management systems are only issued when the provider has delivered the care, in accordance with the voucher program standards and guidelines.

In settings where potential clients must pay for contraceptive services and/or methods, individuals may face financial barriers that restrict their ability to access and use some methods. Vouchers can reduce these financial barriers and facilitate client access to more contraceptive options.<sup>4</sup> In addition to reducing financial barriers, vouchers that focus on specific population groups help ensure subsidies reach individuals who may be less likely to have access to and ability to use family planning services and products. Voucher programs can be designed to improve client knowledge of various contraceptive method options and inform potential clients where and when they can access services. Vouchers can also support providers to improve the quality of their services through accreditation and to expand the range of contraceptive methods available.

**Figure 1. How Voucher Programs Work**

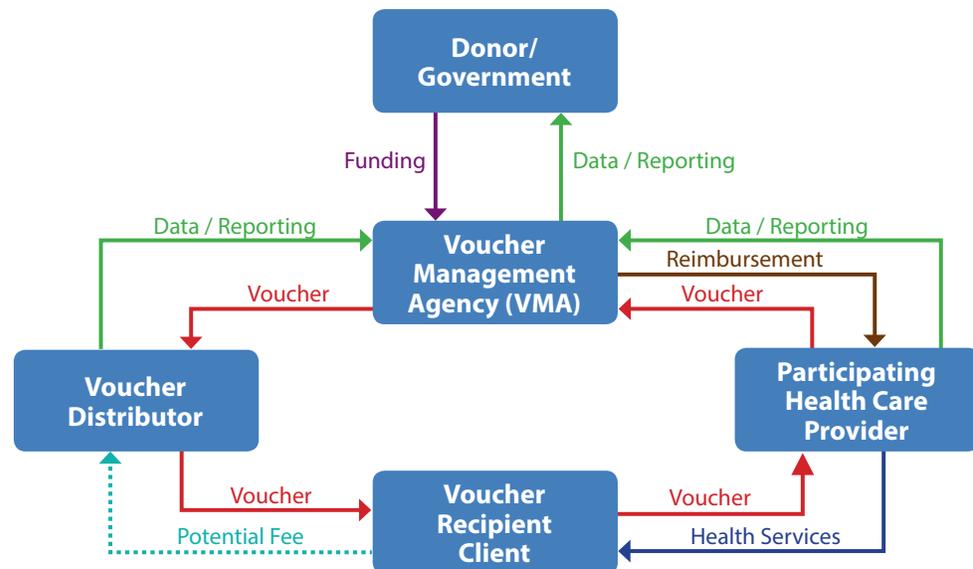


Figure 1 depicts an illustrative example of how contraceptive voucher programs work. Voucher programs typically include a funding body (an implementing body called a voucher management agency), and an independent monitoring and oversight body (e.g., third-party verification agents or a governance board).<sup>5,6,7</sup> Voucher programs typically contract with private and/or public providers who have met quality standards, and they engage community organizations to promote the program and distribute or sell vouchers to eligible, interested clients.<sup>6,8</sup>

This brief describes how vouchers can be used to enhance high impact practices in family planning (HIPs) by addressing specific barriers to accessing and using contraception. It also discusses the potential contributions of vouchers to enhancing the quality and voluntary use of contraceptive services, outlines key issues for planning and implementation, and identifies knowledge gaps.

Vouchers have been identified as a HIP enhancement by the HIP technical advisory group. A HIP enhancement is a tool or approach that is not a standalone practice, but it is often used in conjunction with HIPs to maximize the impact of HIP implementation or increase the reach and access for specific audiences. The intended purpose and impact of enhancements are focused, and therefore the evidence-base and impact of a HIP enhancement is subjected to different standards than a HIP. While there is some evidence and programmatic experience implementing voucher programs, more research and documentation is needed to better understand the potential and limitations of this approach. For more information about HIPs, see <https://www.fphighimpactpractices.org/overview>.

## How can vouchers enhance HIPs?

Vouchers can support implementation of a number of HIPs (Table 1). In general, they can help family planning programs remove financial or other barriers and expand client access to more contraceptive options including those that may be too expensive or otherwise difficult for them to access; improve key population groups' access to contraception; expanding a client's choice of accredited health care providers, including those in the private sector; and create a mechanism to improve provider accountability and quality.

**Vouchers facilitate client access to more contraceptive options.** Even when family planning services are presumed to be free, financial barriers may exist. For example, a survey of seven countries in Latin America and the Caribbean, where family planning is largely mandated free of charge to clients in public-sector facilities, found that client out-of-pocket expenditure was a significant source of family planning financing.<sup>25</sup> Furthermore, stock-outs and rationing presented substantial barriers for clients in low- or middle-income countries to accessing their preferred method or required them to pay out of pocket for their preferred method.

A systematic review concluded that “vouchers can expand client choice by reducing financial barriers to contraceptive services and making private providers an option for disadvantaged clients previously restricted by cost.”<sup>10</sup> Evidence from voucher programs consistently shows that when a voucher program reduces or removes the client's cost for provider-dependent methods, through a voucher that covers either specific or all contraceptive methods, use of provider-dependent methods increases while use of other methods either remains the same or increases.<sup>12,15,18</sup> Vouchers covering specific methods can promote method choice and reduce method-specific barriers, such as shortages of competent providers, lack of commodities or equipment, and/or limited client demand for IUDs. In Pakistan, programs offered free vouchers for voluntary IUD insertion and removal by private social franchise clinics and independent, community nurse-midwives to interested married women who met the criteria for poverty to offset the cost of obtaining an IUD. Voluntary IUD uptake increased in communities served by these voucher programs while use for all other modern methods remained the same or increased.<sup>12,17</sup>

**Table 1. How Vouchers Support HIP Implementation**

HIPs	Vouchers enhance the practice by...	Country Examples
<ul style="list-style-type: none"> <li>• Immediate postpartum family planning</li> <li>• Postabortion family planning</li> <li>• Family planning and immunization integration</li> </ul>	Supporting <b>integrated services</b> by targeting single or multiple related health care services in addition to voluntary family planning services.	A voucher program in <b>Yemen</b> covered both maternity and family planning services <sup>11,19</sup> while in <b>India</b> , it included antenatal care, delivery, postnatal care, and family planning services. <sup>20</sup>
<ul style="list-style-type: none"> <li>• Social franchising</li> <li>• Community health workers</li> <li>• Mobile outreach</li> <li>• Drug shops/pharmacies</li> </ul>	Supporting <b>client-centered access</b> to contraceptive products and services through preferred and convenient service delivery points.	In <b>Kenya</b> , voucher holders could seek services at their choice of participating private, public, and/or nonprofit clinics. <sup>21,22</sup>
<ul style="list-style-type: none"> <li>• Social franchising</li> <li>• Mobile outreach</li> <li>• Drug shops/pharmacies</li> </ul>	Building or expanding capacity and client base in the <b>private sector</b> , thereby potentially strengthening linkages between the private and public sectors.	In <b>Madagascar</b> , a voucher program invested in building capacity of private franchised facilities to offer services for sexually transmitted infections and family planning and to serve youth. <sup>23</sup>
<ul style="list-style-type: none"> <li>• Community health workers</li> <li>• Mass media</li> </ul>	<b>Disseminating key information</b> about contraceptives, services, and how to access them, as well as addressing other nonfinancial barriers.	In <b>Pakistan</b> , a voucher program relied on community outreach workers to raise awareness and counsel about family planning to potential clients. <sup>14</sup>
<ul style="list-style-type: none"> <li>• Domestic public financing</li> </ul>	Improving efficiency of the use of domestic resources by <b>targeting public funding</b> of family planning to beneficiaries facing barriers to access.	Experience with the Vouchers for Health Programme (Kenya) is helping national policy makers prepare for a national social health insurance program. <sup>5</sup> World Bank funds to countries have supported implementation of voucher programs in countries like <b>Bangladesh, India, and Zimbabwe</b> .

**Box 1. What is the evidence that vouchers contribute to population-level impact?**

Reviews of maternal and child health, family planning, and reproductive health voucher programs document program improvements across low- and middle- income countries in Africa, Asia, Europe, and Latin America.<sup>6,9,10,11</sup> By definition, vouchers are intended to address the needs of a selected proportion of the population—interested individuals who meet the eligibility criteria and choose to participate. Therefore, the potential impact of voucher programs at the population level is determined by the size of the target population group, distribution coverage of the program, and client uptake of vouchers. There are few studies that demonstrate a community-level impact on the modern contraceptive prevalence rate (mCPR) of voucher programs. Studies in Jordan and Pakistan have documented significant community-level effects of voucher programs on mCPR,<sup>12,13,14</sup> but other studies in Cambodia, Kenya, and Pakistan have found no statistically significant change in contraceptive prevalence in intervention communities.<sup>15,16,17,24</sup>

Modeling also provides insight on the potential impact of voucher programs. In Uganda vouchers were used to support a social franchising network whose objective was to increase access to implants, intrauterine devices (IUDs), tubal ligation, and vasectomy. A study estimated that 15% of Uganda’s 1.4 percentage-point increase in modern method use among married women between 2011 and 2016 is attributed to this voluntary voucher program.<sup>18</sup>

**Vouchers improve access to contraceptives for key population groups.** A review of 24 NGO-supported voucher programs across 11 countries in Africa and Asia between 2005 and 2015 found that most programs were successful in reaching subgroups, such as the poor and young consumers (under 25 years), although this outcome depended on the targeting approach and how beneficiaries were identified.<sup>11</sup>

In rural India, a voucher program contributed to an increase in mCPR among women living below the poverty line, from 33% to 43%.<sup>20</sup> Similar results were noted from studies in Pakistan.<sup>17</sup> From 2013 to 2014 in Madagascar, a social franchising network offered vouchers for family planning and sexually transmitted infection (STI) services, in which 96% of clients were 20 years old or younger.<sup>23</sup> In Nicaragua, adolescents who obtained vouchers were three times more likely to use participating health centers, twice as likely to use modern contraception, and 2.5 times more likely to report condom use at last sex compared with adolescents who did not obtain vouchers.<sup>26</sup> Vouchers can also reach other disadvantaged groups, such as those with little or no education. For example, in Uganda, where only 23% of women with no education and 34% of women with a primary education use a modern method,<sup>27</sup> a voucher program facilitated family planning access for 330,826 women, 79% of whom had no education or only primary education.<sup>18</sup>

**Vouchers facilitate access to private providers.** Vouchers can serve as an effective means for governments to engage the private sector.<sup>6,9,10,28</sup> Some groups, like unmarried youth, may prefer accessing contraceptive services through private providers due to convenience, a perception of higher quality and greater confidentiality than in the public sector, or other factors.<sup>29</sup> Vouchers can expand access to the private sector for groups who may face access challenges due to prohibitive user fees, such as low-income individuals or adolescents.<sup>30</sup> In addition, vouchers can enable access to health services in private facilities when public facilities are unable to provide services, including in fragile states.<sup>12,17,19,31</sup> Engaging the private sector can also expand geographic coverage and/or access to a wider choice of contraceptive methods.<sup>32</sup>

**Vouchers can drive service quality improvements.** Two systematic reviews concluded that voucher programs can improve the quality of service provision.<sup>9,33</sup> A voucher accreditation process establishes standards of care and assists in developing the capacity of the voucher program to measure and monitor the quality of health services. Voucher payments offer providers a steady flow of income that can be reinvested in improving services. For example, in Kenya 67% to 89% of providers used revenue from voucher payments to improve infrastructure, buy equipment or drugs and supplies, hire new or pay existing staff, or create patient amenities.<sup>34</sup> Voucher program health care providers in Nicaragua had better clinical knowledge, improved provider practices, and, to a lesser extent, improved provider attitudes toward adolescent use of family planning and STI services compared with providers not involved in the voucher program.<sup>26,35,36</sup> Client satisfaction was significantly higher among adolescents using vouchers than among those without vouchers.<sup>35</sup> A study in Pakistan also noted improvement in quality standards in the provision of family planning information, services, and commodities, including the quality of counseling services, the method mix from which clients could choose, respect for clients' privacy, and client satisfaction.<sup>37</sup>

## Box 2. What Do Voucher Programs Cost?

Careful attention should be given to estimating the cost of managing and implementing a voucher program, including costs for training, accreditation, supervision, administration, and other key inputs. These costs are highly variable depending on design, size, content, and context of the program. As one example, between October 2013 and June 2016 in rural Pakistan a total of 168,206 married women of reproductive age received vouchers for private-sector social franchised clinics, costing approximately US\$3.3 million.<sup>38</sup> Kenya's safe motherhood and family planning voucher programs were budgeted at 6.5 million Euros for the implemented between 2006 and 2008.<sup>5</sup>

## How to do it: Tips from implementation experience

### Reaching Intended Beneficiaries

- **Invest in voucher distribution.** Voucher distribution involves identifying members of the client population in a way that is cost-effective, respectful of beneficiary confidentiality and needs, and timely for the beneficiary. Consider working with existing community structures, such as **community health workers**, particularly when trying to reach youth who may face social barriers to accessing services and adopting contraception. Remuneration should not incentivize promotion of particular contraceptives over others. Distributors need to be adequately trained using a client-centered approach that supports voluntary choice. While it can be challenging to implement, regular supportive supervision of community-level distribution is essential. **Digital technologies**, where appropriate such as facilitating provider payments, client identification, client or provider support or follow up, may help.
- **Develop clear, feasible eligibility criteria.** Poverty assessment tools are typically in the form of questionnaires and are used to assess eligibility for vouchers based on wealth assets.<sup>39,40,41</sup> Some countries, like India, use an established standard, such as the “below poverty line” or poverty card. Other programs demark geographic areas as poor or vulnerable communities, called geographic targeting. Debate is ongoing about the relative benefits of means testing, which can be expensive, time-consuming, and intrusive, and geographic targeting, which is less accurate but simpler and entails much lower costs.<sup>42,43</sup> Voucher programs are increasingly opting for geographic targeting alongside training of voucher distributors on how to identify eligible clients.
- **Vouchers should be designed and promoted using **social and behavior change principles and best practices**.** In addition to addressing financial barriers, vouchers constitute a key component of comprehensive demand generation efforts that help improve knowledge among disadvantaged beneficiaries of how to access high-quality contraceptive methods and method choice, as well as overcome other non-cost barriers. In Kenya, for example, voucher distributors escorted adolescents to facilities to help overcome their anxieties over visiting a clinic, and the program’s paper voucher discreetly communicated the purpose of the adolescent’s visit without the need for a verbal explanation.<sup>44</sup> Promotion of the voucher program should be integrated into broader family planning campaign channels and messages to maximize reach, such as local launch events, radio call-in shows, posters, and pamphlets.<sup>45</sup> A randomized controlled experiment tested whether vouchers for free contraception, provided with and without behavioral “nudges,” could increase modern contraceptive use during the postpartum period. At six months postpartum, the voucher combined with an SMS reminder increased reported use of a modern contraceptive method by 25 percentage points compared with the comparison group. Estimated impacts of the voucher alone were not statistically significantly different from the comparison group.<sup>46</sup>
- **Consider whether to use paper vouchers or e-vouchers.** As rates of mobile phone use increase, interest in electronic vouchers grows. However, recent experiences suggest caution should be taken in relying on e-vouchers because mobile phones may be owned by a household rather than an individual; both distributors and clients require reliable network coverage; and if contraceptive use is clandestine, messages relating to family planning may place beneficiaries in danger, make them uncomfortable, or not reach the intended beneficiary. In Madagascar, program managers quickly discovered that adolescents either lacked access to a mobile phone or were concerned about confidentiality when vouchers were sent by phone. After adding a paper voucher option, voucher distribution increased rapidly.<sup>23</sup>

## Provider Selection and Management

- **Choose participating health care providers carefully, using a clear accreditation process.** Prior to launching a voucher program, managers should map and assess potential health care providers to ensure the program is geographically accessible to intended beneficiaries and will be able to meet quality and managerial requirements. In addition to meeting standards for quality service delivery and expectations for providing nonjudgmental care to clients, providers must be able to collect, organize, and manage the vouchers they receive to ensure that the voucher management agency can verify services rendered and accurately pay the facility/provider. Providers will need to consider their own cost and revenue estimates to decide whether to participate in the voucher program. Program managers must conduct regular monitoring to ensure requirements and standards of the voucher program are upheld. When providers do not comply with the terms of their voucher agreement, managers typically sanction non-compliant providers early and publicly to encourage other providers to comply. Partnering with [social franchising](#) networks, in which health care providers are typically accredited and operating under clear service requirements, can facilitate the identification and enrollment of qualified providers.
- **Determine how voucher reimbursements will be used when working with public-sector providers.** Public facilities may not be able to receive direct payments from the voucher management agency for voucher services rendered or decide how to use the revenue for improvements at the facility level; governments must determine how voucher revenue will be used. Public-sector providers may also lack full autonomy to provide services according to the requirements of the voucher program, including the ability to hire additional medical staff or direct resources to facility-level repairs, supply needs, or other improvements.<sup>6</sup> In Cambodia, the voucher program was able to negotiate with the government to make payments, or a portion of payments, directly to facilities. In Kenya, some voucher providers in the public sector have been able to invest a growing proportion of their voucher income into improving service quality.<sup>6</sup>

## Voucher Service Package

- **Offer a service package that is responsive to client demand.** Including a range of health services in the voucher program, typically maternity care or STI diagnosis and treatment services,<sup>6</sup> in addition to family planning can facilitate confidentiality and better meet the health needs of beneficiaries. This may be particularly important for adolescents and unmarried women. Counseling, any desired follow-up, and voluntary removals for long-acting reversible contraceptives should also be covered in contraceptive voucher services, to ensure client-centered care and avoid prohibitive costs to clients.
- **Include safeguards to ensure voluntary, contraceptive choice.** As any program involving financial mechanisms or performance-based incentives, monitoring should be in place so that voucher programs do not inadvertently incentivize inappropriate provider behaviors, such as inflating client numbers or promoting provision of one contraceptive method over another.<sup>3</sup> If provider reimbursements are differentiated by service or contraceptive method, ensure that rates reflect the time, commodities, and skill level required for that service in order to avoid unintended incentives.<sup>3</sup> If a voucher program aims to increase access to specific methods, such as provider-dependent methods, confirm that other methods are also readily available and that providers support voluntary, client-centered family planning service provision. Programs should make sure the cost of a voucher to a potential client is roughly the same as the cost of obtaining another contraceptive method and that voucher distribution agents provide other contraceptive methods or refer clients to the closest service point that offers the method of choice.

## Voucher System Management

- **Design programs to promote accountability.** Voucher management agencies or other voucher governing bodies are charged with putting in place mechanisms to prevent, detect, and manage fraud, should it occur in the program. The physical record of service provision, in most cases a uniquely numbered paper voucher, simplifies auditing, giving these programs a strong accountability mechanism. Separation of the voucher management agency function from participating health care providers can increase transparency, allow for independent verification of service delivery, and help curb informal payments. Results verification and routine voucher data analysis, including tracking trends in vouchers distributed and claims made and use of spot checks, are used to counteract fraud.

## Priority Research Questions

These research questions, reviewed by the HIP technical advisory group, reflect the prioritized gaps in the evidence base specific to the topics reviewed in this brief and focus on the HIP criteria.

1. What happens to clients and services once voucher programs are discontinued?
2. What is the cost of implementing a contraceptive voucher program (management time and financial cost) per client served?
3. Do voucher programs create equitable access to family planning services?

### Voucher programs work best where:

- Financial and other access barriers restrict access to contraceptives among a specific underserved client group.
- Eligible clients can be accurately identified and effectively reached.
- Adequate resources exist to implement vouchers at sufficient scale and over a long enough time to justify a fully functional voucher management system.
- There is at least one, but optimally more, providers with the potential capacity to provide contraceptive services, including voluntary long-acting reversible contraceptives and permanent methods.
- Robust supply-side mechanisms are in place to build and assure service quality, including sanctions for providers who do not meet quality standards.
- There is an absence of other dominant financing mechanisms or financing mechanisms are nascent and there is an opportunity to demonstrate proof of concept, using vouchers as a stepping stone for broader financing mechanisms that include the private sector and reaching the poor.

### Factors contributing to failure of voucher programs:

- Poor management of voucher distributors.
- Provider reimbursement is not set appropriately to make up for the costs of delivering services.
- Providers are not reimbursed in a timely manner for voucher services rendered.
- Definition of what is included in the voucher service package is not clear to the provider and/or the client.
- Ability to verify voucher service delivery is limited.

## Tools and Resources

**A Guide to Competitive Vouchers in Health:** Identifies the advantages of competitive voucher schemes in delivering subsidies; describes the circumstances under which they are superior to other subsidy mechanisms; and explains how to design, implement, monitor, and evaluate a voucher scheme. <http://documents.worldbank.org/curated/en/179801468324054125/A-guide-to-competitive-vouchers-in-health>

**Using Mobile Finance to Reimburse Sexual and Reproductive Health Vouchers in Madagascar:** Describes the mobile money implementation process in Marie Stopes Madagascar and presents lessons learned to help program managers replicate mobile money in sexual and reproductive health programs. <https://mariestopes.org/media/2121/using-mobile-finance-in-madagascar.pdf>

**Reproductive Health Vouchers: From Promise to Practice:** Presents key implementation lessons drawn from Marie Stopes International's experience in setting and managing reproductive health voucher programs in various settings. [https://healthmarketinnovations.org/sites/default/files/Reproductive%20Health%20Vouchers%20from%20promise%20to%20practice\\_0.pdf](https://healthmarketinnovations.org/sites/default/files/Reproductive%20Health%20Vouchers%20from%20promise%20to%20practice_0.pdf)

**Vouchers for Health: A Focus on Reproductive Health and Family Planning Services:** Discusses key aspects of voucher programs, elements for assessing the feasibility of a prospective program, and steps for designing and implementing a program where feasible. [https://pdf.usaid.gov/pdf\\_docs/PNADI574.pdf](https://pdf.usaid.gov/pdf_docs/PNADI574.pdf)

For more information about HIPs, please contact the HIP team at [fhip@k4health.org](mailto:fhip@k4health.org).

## References

A complete list of references used in the preparation of this brief can be found at: <https://www.fphighimpactpractices.org/briefs/family-planning-vouchers>

---

### Suggested citation:

High Impact Practices in Family Planning (HIP). Family planning vouchers: a tool to boost contraceptive method access and choice. Washington, DC: USAID; 2019 June. Available from: <https://www.fphighimpactpractices.org/briefs/family-planning-vouchers>

**Acknowledgments:** This brief was written by Elaine Menotti, Anna Mackay, Benjamin Bellows, and Shawn Malarcher. It was updated from a previous draft authored by Ben Bellows, Elaine Menotti, and Shawn Malarcher. Critical review and helpful comments were provided Michal Avni, Luke Boddam-Whetham, Margaret D'Adamo, Molly Fitzgerald, Anna Gorter, Karen Hardee, Brendan Michael Hayes, Jeanna Holtz, Roy Jacobstein, Beverly Johnston, Jesse Joseph, Baker Maggwa, Erastus Maina, Emily Mangone, Ados May, Alice Payne Merritt, Erin Mielke, Ali Moazzam, Gael O'Sullivan, May Post, John Stanback, Sara Stratton, Nandita Thatte, Caitlin Thistle, and Matthew Wilson.

**This HIP brief is endorsed by:** Abt Associates, Bill & Melinda Gates Foundation, CARE, Chemonics International, EngenderHealth, FHI360, FP2020, International Planned Parenthood Federation, IntraHealth International, Jhpiego, John Snow, Inc., Johns Hopkins Center for Communication Programs, Management Sciences for Health, Palladium, PATH, Pathfinder International, Population Council, Population Reference Bureau, Population Services International, Promundo US, Public Health Institute, Save the Children, United Nations Population Fund, U.S. Agency for International Development, and the University Research Co., LLC.

The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: [http://www.who.int/topics/family\\_planning/en/](http://www.who.int/topics/family_planning/en/).

