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Program Profile

PROGRAM PROFILE

SHOPS
Strengthening Health Outcomes
through the Private Sector

Summary: The SHOPS project worked with Marie Stopes Madagascar to implement a year-long program (October 2010 to September 2011) in Madagascar that aimed to (1) expand access to voluntary family planning through provision of long-acting and permanent methods via mobile outreach teams working across underserved regions and (2) increase the demand for quality reproductive health services by removing financial barriers through vouchers. This program profile presents the program context, goals, components, results, and the following lessons learned:

- Public-private partnership was key to increasing the use of LA/PMs through outreach
- Implants were the preferred method in outreach and voucher programs
- Strong demand creation was crucial to the success of the outreach and voucher programs
- Vouchers, when properly targeted, do not displace non-voucher clients
- For voucher programs, it is imperative to put robust monitoring and fraud controls in place to limit and avoid collusion and overcharging to clients

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Keywords: behavior change communication, family planning, long-acting and permanent methods, Madagascar, mobile outreach, reproductive health, vouchers

Recommended Citation: Kemplay, Miles, Meira Neggaz, and Nithya Mani. 2013. *Madagascar Program Profile*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Cooperative Agreement: No. GPO-A-00-09-00007-00

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March 2013

Madagascar Program Profile

PROGRAM CONTEXT

The Republic of Madagascar is an island nation of more than 20 million people located in the Indian Ocean off the coast of southeastern Africa. Ranking 151 out of 187 countries on the United Nations Development Program (UNDP) Human Development Index, Madagascar's citizens contend with high levels of poverty, low education, and poor health. The island's gross national income per capita falls far below that of other sub–Saharan countries. Roughly 70 percent of the population lives in rural areas and 69 percent of Malagasies live below the national poverty line (UNDP, 2011). While infant mortality is lower in Madagascar than in other sub-Saharan countries at 41 per 1,000 live births, 37 percent of Malagasy children under the age of five years are malnourished (World Bank, 2011).

In 2009, Madagascar suffered a political crisis when a series of anti-government demonstrations culminated in military involvement. The crisis left more than 130 demonstrators dead and led to what some have called a *coup d'etat* and the ascension of a new leader, Andry Rajoelina. Political uncertainty continues to the present day.

Madagascar's maternal mortality ratio continues to be high at 440 deaths per 1,000 live births. And, while 86 percent of Malagasy women have at least one antenatal visit, just 44 percent give birth attended by skilled health personnel. Madagascar's total fertility rate remains high at 4.5 births per woman (UNDP, 2011).

Despite an increasing contraceptive prevalence rate, Madagascar is marked by a great inequality in both access to family planning and demand for these services, with poor and rural women particularly disadvantaged (MDHS, 2008–2009). Since the political crisis of 2009, public sector health services have sharply deteriorated with many health facilities becoming understaffed and increasing reports of drug stockouts, including contraceptives. While 40 percent of married women aged 15 to 49 use some form of contraception (UNDP, 2011), almost 20 percent of women of reproductive age continue to have unmet need for family planning. Unmet need is highest among the poorest women and adolescents (aged 15 to 19 years) (MDHS, 2008–2009). While 50 percent of existing users and 45 percent of women with an unmet need want to stop having more children, fewer than 10 percent of family planning users opt for long-acting or permanent methods (LA/PMs), despite their effectiveness and affordability (MDHS, 2008–2009).

In October 2010, with a view toward meeting the needs of the poorest women and those living in rural communities where access to family planning services was weakest, USAID/Madagascar invited the SHOPS project to implement a year-long program through Marie Stopes Madagascar (MSM), aimed at delivering a sustained and positive

increase in the contraceptive prevalence rate. Unable to work through the government of Madagascar following the political crisis of 2009, USAID's support to the SHOPS project focused on working through the non-state health networks created and managed by MSM.

PROGRAM GOALS

1. Expand access to comprehensive voluntary family planning through provision of long-acting and permanent methods via six mobile outreach teams working across underserved regions. By the end of the program, it was expected that 9,000 women of reproductive age and men in hard-to-reach communities would gain access to high-quality LA/PMs as part of a full method mix. This increase would be achieved as a result of exposure to health messages and the availability of free reproductive health services closer to their homes.
2. Increase the demand for reproductive health services through targeted information, education, and communication activities; greater private sector service supply; and the use of vouchers to increase access by breaking down financial barriers. By the end of the program, it was expected that 10,000 vouchers would be sold for a token cost by trained community health workers (CHWs) and that 8,000 of the vouchers would be redeemed at the 50 accredited private sector providers.

Timeline

October 2010: Launch program.

December 2010: Train outreach teams.

February 2011: Begin outreach service delivery, train private service providers, and launch voucher program.

April 2011: Launch mass media campaign for vouchers.

July 2011: Introduce community health educator (CHE) component to improve demand generation for outreach activities.

August 2011: Improve CHE training.

September 2011: Transition program to Support for International Family Planning Organizations mechanism. Launch improved outreach model (mixed model).

PROGRAM COMPONENTS

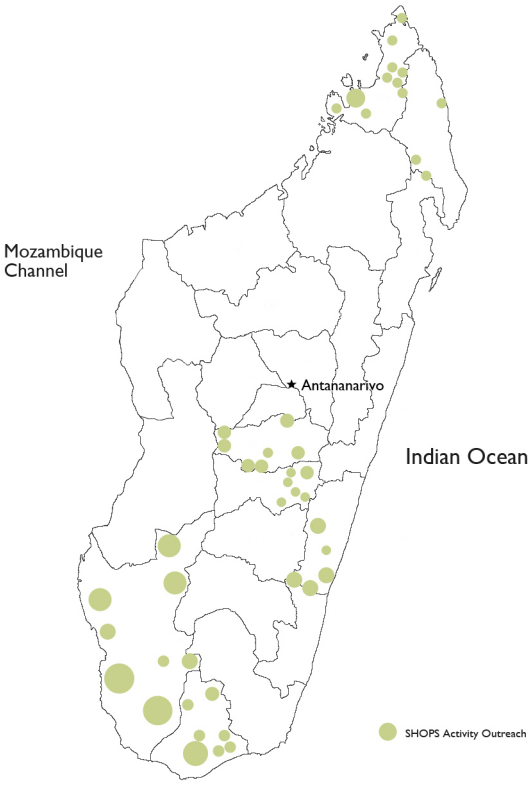
Outreach

Marie Stopes Madagascar has provided mobile outreach services since 2007 through six teams using funding from other donors. The SHOPS program expanded on this effort. In many outreach areas, government partners or social marketing programs only offered short-term methods, such as oral contraceptives or condoms. The outreach program complemented this by focusing on all methods, especially long-acting and permanent methods.

The four-person outreach teams, comprising a coordinator, doctor, nurse, and driver, went to selected communities with limited access to family planning services and offered services free-of-charge. Outreach teams worked for three consecutive weeks, with one week per month based at a local MSM office for reporting, planning, training, and rest. The majority of outreach services prior to the SHOPS program were provided in isolated health center facilities under a public-private partnership framework. By working through these facilities, MSM received subsidized contraceptive implants, access to target communities, and a suitable environment for the provision of voluntary surgical contraception. In addition, public health providers worked alongside CHWs to sensitize and inform clients about family planning and the services provided by MSM. MSM then provided family planning services and additional counseling before service provision to ensure informed choice. While MSM services focused mainly on LA/PMs, outreach teams carried short-term methods in case of stockouts. This partnership provided an opportunity to sensitize health center providers on best practices and to coordinate follow-up support for clients served.

A Marie Stopes Madagascar jeep used for family planning outreach.

Figure 1. Outreach Team Coverage Area



Madagascar's Administrative Structure

Madagascar is made up of regions, which are made up of districts. A number of communes form a district, and a commune typically has up to eight fokontany. A fokontany is Madagascar's smallest administrative unit and is similar to a village.

The SHOPS outreach program built on this existing operational capacity by training outreach teams to meet the family planning needs of the most hard-to-reach populations, outside of public health facilities. This approach aimed to provide high-quality family planning services at the level of a fokontany (see sidebar). Working outside the formal health infrastructure created some new challenges, which were partly addressed through additional training, the purchase of equipment, the allocation of an office to each team, and increased intensity in scheduling of outreach.

Initially, six outreach teams completed a SHOPS orientation; eight additional teams completed orientation toward the end of the program.[1] Much of the orientation was held in communes (administrative subdivisions) where MSM had established local partnerships with public facilities. This facilitated regulatory approval by local health authorities and maximized opportunities for referrals to public facilities for follow-up support in case it was required. In new regions where MSM didn't have existing relationships, the organization recruited local coordinators and selected fokontany according to the size of the population and community support for outreach activities. To adequately equip outreach teams to work in hard-to-reach geographic areas, MSM purchased five new vehicles. Because outreach teams provided services outside of public health facilities, often in areas with no adequate facilities in which to offer services, four tents were specially designed and manufactured in Madagascar to house services while alternative inflatable tents were designed and manufactured in the United Kingdom. Additional equipment purchased included tables for registration and examination, medical instruments, chairs, and recuperation recliners suited to non-formal settings.

The project gave each team an office with information technology equipment needed for reporting, adequate storage for contraceptive commodities (sourced from United Nations Population Fund recipients until USAID commodities were available), and consumables.

Under the SHOPS program, MSM piloted an approach of visiting fewer outreach sites more frequently. Previously, MSM outreach teams had visited outreach sites once every four to six months. Under SHOPS, outreach teams visited sites once every three months. These more regular visits were expected to help attain a critical mass of acceptance of family planning more quickly and break down initial reluctance to the delivery of surgical services in non-formal settings, such as tents. In addition, referral systems and follow-up support were less robust in settings beyond formal facilities, so more frequent visits helped monitor complications and ensure easier access to method removal or method switching, if needed.

The Mixed Model

The initial orientation and deployment of six outreach teams to provide services beyond the formal health infrastructure demonstrated that by reducing the geographical barrier, more isolated communities were able to access family planning services. However, the program required continued collaboration with health centers to ensure follow-up care and maximize referral opportunities, notably in the rare case of complication or for IUD and implant removal.

Based on this experience, MSM developed a "mixed model" intervention using all 14 outreach teams operated by MSM halfway into the project (see text box), which became operational toward the end of the project. The model allowed outreach teams to systematically work at the fokontany

[1] The orientation of the additional eight teams took place at the end of the project before the transition to USAID's Support for International Family Planning Organizations project. This program profile focuses on the original six outreach teams.

level while also incorporating service delivery and coordination through public health centers using completely separate financial resources.

The Mixed Model

In this program profile, the mixed model refers to cofinancing the work of outreach teams to effectively deliver family planning services within the communities and at public health facilities. The United Nations Population Fund financed outreach team efforts in providing services at public health facilities or coordinating with the facilities. The SHOPS project financed outreach team efforts in working outside public health facilities at the fokontany level.

Cofinancing was based on level of effort and proportional costing, which was adapted to donor requirements. Using this model, MSM was able to provide family planning services to women referred to or attending health centers without working with the public sector, which was not possible due to the country's political crisis (see section 1: Program Context). It also improved the quality of follow-up care for clients served outside of public facilities and was a more efficient use of outreach teams' time.

A revised outreach management information system was developed to plan activities and collect financial and activity data to ensure compliance with the mixed model and generate monthly reports on service statistics at the fokontany level. All outreach teams received a computer and internet connection to provide regular reporting and were trained on how to use this equipment.

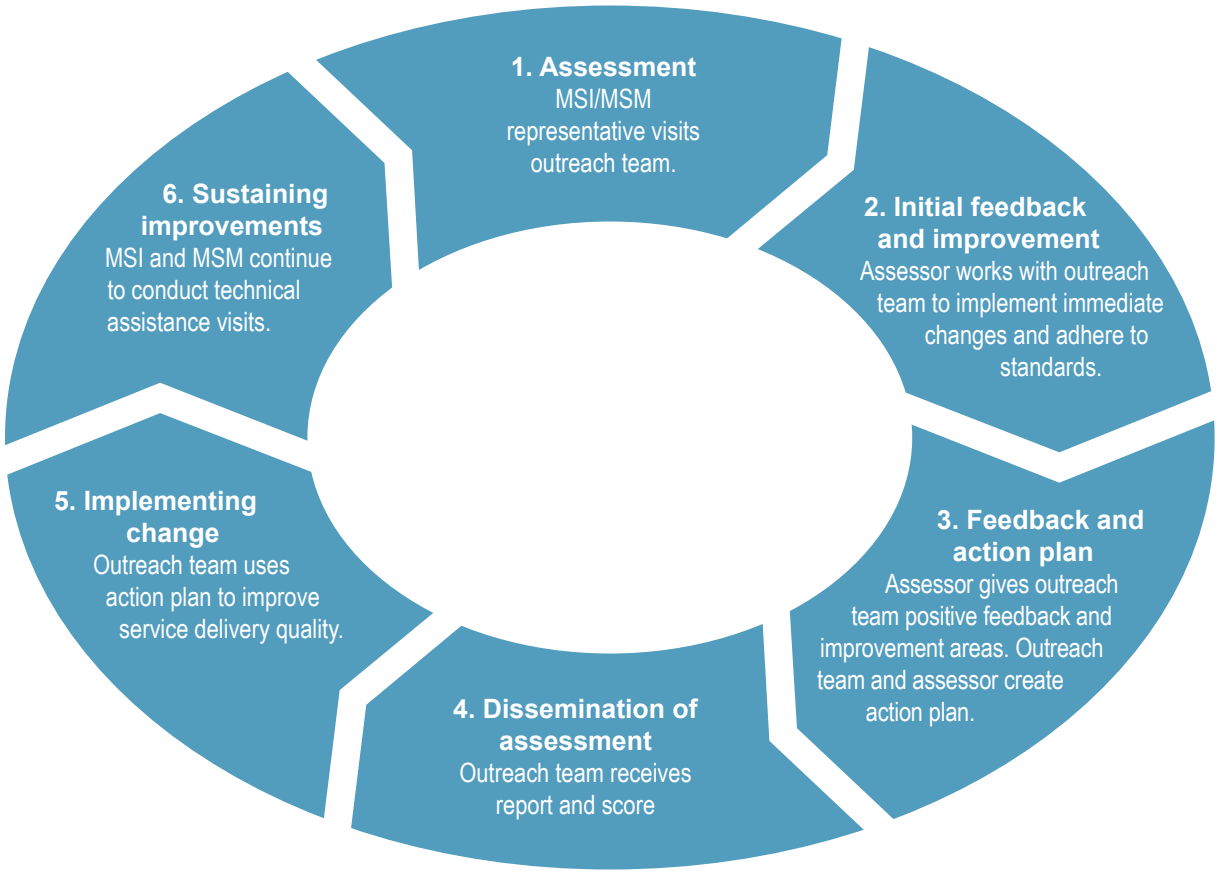
Quality Assurance

The primary mechanism for measuring service delivery quality of Marie Stopes International and Marie Stopes Madagascar were quality technical assistance (QTA) visits to the outreach teams. The goals of the visits were to audit service delivery quality and provide supportive technical assistance to address any weaknesses (see Figure 2). The London-based MSI medical development team conducted an annual quality technical assistance visit, while MSM conducted more frequent quality technical assistance visits.

Quality technical assistance visits lasted approximately five days, during which a medical adviser visited a selection of outreach sites. Key areas reviewed through the visit included clinical governance, infection prevention, supplies and procurement, family planning service delivery, client focus, and emergency preparedness. The findings from these visits resulted in the development of an action plan aimed at improving the quality of the program where standards fell below the 90 percent target.

All of MSM's outreach teams underwent at least one MSM-led QTA visit during the SHOPS program period, and three were assessed by London-based MSI.

Figure 2. Technical Assistance in Quality



Demand Generation for Family Planning Services

In addition to meeting the unmet family planning needs of clients who lacked access to services, MSM also aimed to meet the needs of clients who lacked access to information to help them make an informed decision about which family planning method was best for them and to act on that decision if they chose to seek services. To ensure that people living in the areas served by the outreach teams knew where and when to seek information and services, MSM undertook a number of demand-generation activities under the SHOPS project, including mass media campaigns through 1,373 radio spots on 15 stations, four radio shows on two stations, and community events.

Complementing mass media and community events, MSM developed a community health education model (see Figure 3). Prior to the SHOPS program when outreach teams worked in public facilities, MSM outreach coordinators were responsible for all demand-generating activities and coordination with local communities. Under the SHOPS program, demand generation became more time consuming due to the remote location and lack of regular intermediaries—typically, CHWs supported by other programs—to inform the community and refer clients. Following a review

Community health educators served to enhance, not duplicate, existing community health worker models and helped to integrate the SHOPS program with community health worker infrastructure and local health committees.

four months into the program, MSM decided to reinforce each outreach team with two community health educators (CHEs). In total, 28 CHEs were equipped, supported, and trained on interpersonal communication, family planning methods, United States government family planning compliance, informed choice, and MSM services.

The CHEs were consultants to MSM who served as a link between the services provided by the mobile clinics and the local CHWs. CHEs worked to increase CHW knowledge of family planning, provided tips on discussing family planning, and optimized referral systems. CHEs visited a broader geographic catchment area than the CHWs did, and they relied on CHWs for maintaining contact with client populations. In this way, CHEs served to enhance, not duplicate, existing CHW models and helped to integrate the program with CHW infrastructure and local health committees. The CHE activities took place approximately one week ahead of the arrival of the outreach team.

Figure 3. Community Health Education Model

Marie Stopes Madagascar	• Mobile outreach teams • BlueStar providers • Marie Stopes centers
Community Health Educators	• Sensitization • Mobilization • Information, education, and communication • Referral • Follow-up
Community	• Community health workers • Health care consumers • Local health committees • Community health providers • Nongovernmental organizations

Vouchers

To remove barriers in accessing family planning services for the poorest women and those most at risk for unintended pregnancies, SHOPS suported a social franchise and voucher program. The program leveraged

MSM's existing social franchise network, the BlueStar network, which has been in operation since 2010. This unique model is grounded in MSI's expertise in clinical service delivery. Private providers were selected through a mapping process that evaluated service provision, client volume, training, equipment, and willingness to provide services to the poor.

Providers that met the selection criteria participated in competency-based training on family planning with an emphasis on client focus and infection prevention. They were supplied with necessary equipment and consumables upon becoming accredited as social franchisees. BlueStar franchisees enjoyed regular technical updates, network meetings, and supportive demand generation activities. Clinical quality standards were high, with annual QTA visits to encourage excellence and ongoing quality improvement. Social franchise QTA visits were conducted at the same time as outreach service QTA visits. Annual exit interviews were also conducted to gauge client satisfaction.

As private providers, social franchisees charge a fee for services. Though the fees are low by private provider standards, poor women can find the costs prohibitive. The SHOPS project supported the accreditation of providers in the program area (see Figure 1) and added a voucher program that would remove the cost barrier for women unable to pay full price. The program allowed women to purchase vouchers for a nominal fee and redeem them at any participating private provider. The vouchers gave beneficiaries more control over their choice of health service and health provider. Vouchers can also help strengthen the health system by encouraging service providers to improve their quality of care to attract voucher users. Combined with supply-side interventions that improve access and quality (such as social franchising), and demand-side interventions that address the disequilibrium of information between health providers and beneficiaries (through information, education, and behavior change communication), vouchers can empower beneficiaries, improving their access to reproductive health services.

Providing Reproductive Health Services through Vouchers

The initial roll-out of vouchers under SHOPS used existing BlueStar providers, who were recruited in 2010, and 35 new recruits, for a total of 133 providers. Eighteen of the new BlueStar providers were recruited from expansion districts in Analamanga, Vakinankaratra, and Sofia, with the remainder joining from existing districts. For each region, a standardized baseline survey of private health providers was completed. The survey covered existing competency in reproductive health and family planning and evaluated motivation to join the network.

During the project period, 137 individuals working within BlueStar health centers received training. Each BlueStar member was required to attend at least one training per year. Of the 137 participants, 39 participants represented new BlueStar members who were completing the initial training to join the network. This multi-day training included modules on voucher

system and procedure; USAID family planning policy and legislation (voluntary basis and informed choice); techniques of communication and demand generation; client-focused emergency preparedness and basic life support; infection prevention; quality assurance; supply chain; family planning counseling, service delivery, and follow-up and referral system.

Ensuring that providers offer quality services is a tenet of social franchising. MSM generally conducts a QTA visit six months after a provider joins the franchise and then annually. Each year, a sample of BlueStar members is included in a QTA visit managed by MSI headquarters in London. Prior to being accredited to receive voucher clients, BlueStar members were required to complete an MSM QTA visit. After each QTA visit, an action plan is agreed upon by the assessor and the BlueStar member to address any quality issues.

Voucher distribution targeted areas where women had little access to service and great unmet need.

SHOPS vouchers were distributed by a network of CHEs in communes where BlueStar franchisees were accredited to offer comprehensive family planning counseling and services. CHEs would target areas where women overwhelmingly had little access to services and a great unmet need, ensuring that the clients purchasing vouchers were poorer women unable to access services without vouchers. MSM regularly trained and supported CHEs, and paid the CHEs a standard monthly stipend for their work. The CHE sensitization activities primarily involved face-to-face counseling within target communities, providing information using standardized promotional materials on all family planning methods and where clients could go to receive services. Counseling was followed by interpersonal communication with individuals before voucher distribution. If a woman counseled by the CHE wanted short-term methods, she would be referred to a public facility or social marketing outlet. If a client was interested in accessing a long-acting (IUD or implant) or permanent family planning method, the CHE sold the voucher, redeemable at any BlueStar provider, at a token price. As standard procedure, the CHE would complete a poverty assessment questionnaire with all clients purchasing vouchers to allow MSM to monitor target population reach.

Once in possession of a voucher, women could redeem it at any accredited BlueStar franchise. Informational materials provided by the CHE were available at each BlueStar site to ensure continued counseling and choice of method. The BlueStar providers would review with the client their initial choice of a family planning method, giving them the option to change their minds and opt for a different method. After the second counseling session, the service chosen by the client was provided for free with a flat reimbursement rate to the provider. While the majority of services provided were long-acting methods, sometimes short-term methods or just family planning counseling were provided to beneficiaries. If a permanent method was desired, BlueStar franchisees provided referrals to nearby MSM clinics or outreach services with specialized providers.

The processing of claims was done through mobile phone text messaging. Providers would submit monthly statistics by SMS from a phone number already validated as a BlueStar member. This SMS was received by a standalone database on the MSM intranet. The data was automatically tabulated to identify the provider, the CHE responsible for distributing the voucher, and the service provided by the provider. After each SMS claim was reviewed, a fixed reimbursement value was sent using mobile money to the same phone. The provider could then claim the payment at mobile phone shops. Every claim and payment was later vetted against the physical submission of the voucher and through fraud-control surveillance.

Voucher Demand Generation

To increase awareness of the availability of BlueStar services, MSM used a combination of branding and community sensitization using the CHEs and information, education, and communication materials. As described above, the foundation of the demand generation program was the network of CHEs who sensitized communities, including existing networks of CHWs, about comprehensive family planning options. They also distributed vouchers to help clients access services via accredited BlueStar franchises. In addition, all accredited BlueStar providers received signs approved by local authorities and basic branding materials to help identify them as a provider that would receive clients with vouchers. Complementary information, education, and communication activities to generate demand used mass media channels, including 419 radio spots, 655 radio show trailers, 240 TV clips on two stations, and participation in 161 radio shows on nine stations.

To improve the quality and completeness of counseling, MSM strengthened its marketing and communications team through development of an overall behavior change communication (BCC) strategy. This strategy led to improvements to CHE induction and training, CHE terms of reference, training of trainers for CHE supervision, and revision of BCC tools. A major component of the revised approach was a newly-designed BCC training program. The 76 CHEs supported through SHOPS outreach and voucher programs completed this training near the end of the project to strengthen follow-on activities. To support and implement the improved BCC strategy, MSM developed the following:

BCC Strategy: a 40-page document that describes the communication approach including:

- Messaging based on behavior level
- Techniques of communication (motivational interviewing, active listening)
- Supportive programs such as advocacy and BCC training for BlueStar providers

CHE Operational Manual: a 31-page practical guide for CHEs, which defines their role, the organizational structure, animation techniques, and family planning counseling guidance.

PROGRAM RESULTS

Outreach

MSM planned to reach at least 9,000 women of reproductive age and men in hard-to-reach and underserved communities. By the program's end, MSM's SHOPS-supported outreach teams had provided nearly 10,500 LA/PM services in 662 fokontany, generating nearly 58,000 couple years of protection in total, far exceeding their initial target (see Table 1). Contraceptive implants were the most popular family planning option with IUDs as the second most common choice.

Table 1. Outreach Services by Family Planning Method

Family Planning Method Provided	Total
Implant	5,558
IUD	3,251
Tubal Ligation	1,592
Vasectomy	58
Total number of services	**10,459**
Total couple years of protection	**57,959**

Client Satisfaction with Outreach Services

Exit interviews were conducted with a random sample of 160 outreach service clients to gather input on their satisfaction (see Table 2). In general, results demonstrate a high level of satisfaction with outreach services. Problem areas included waiting times and cleanliness of some sites. Outreach teams used this information to improve service provision and increase levels of client satisfaction in subsequent visits.

Table 2. Outreach Client Satisfaction, July 2011

Question	Yes
Would you recommend the MSI facility to a friend?	93.8%
Would you return for another service in the future?	99.4%
Were you satisfied or very satisfied with your overall experience at an MSI facility?	95.6%
Did the experience meet or exceed your expectations?	98.1%

Reducing Unmet Need and Increasing Choice

The SHOPS-supported outreach teams were able to successfully reach clients with unmet need for family planning services. Twenty-two percent of all outreach clients were new family planning adopters. In other words, they did not use a modern family planning method three months prior to receiving the MSI service. The program met the LA/PM needs of clients who previously had little access. Almost all outreach clients requested and were provided LA/PM services. Based on exit interviews, 68.3 percent of outreach clients were short-term family planning users who chose to switch to LA/PMs. The outreach services complemented existing public and community-based distribution of short-term methods, giving hard-to-reach women and men the full continuum of comprehensive voluntary family planning options.

Quality Service Provision

The services provided by the outreach teams were of high quality as evidenced by their QTA visit results (see Table 3). Overall results exceeded 90 percent across all of the following components examined.

- **Client focus** is evaluated against a standard set of ambiance and behavioral indicators established by MSI to determine to what extent the client is treated with respect and dignity and that client comfort is maximized by, for example, a comfortable waiting area, a private procedure room, and whether vocal local is practiced (see text box).
- **Infection prevention** is measured using a set of indicators related to the cleanliness of the procedure room, sanitation facilities, sharps disposal, waste management, and compliance with MSI global norms and standards.
- **Emergency preparedness** is determined by whether the necessary medications, equipment, and job aids are available for efficient management of complications.
- **Family planning availability** is evaluated by doing a visual assessment of the LA/PM services undertaken (IUD, implant, tubal ligation, and vasectomy) to assess to what extent the provider is following MSI norms and standards.

Vocal Local: Managing Pain

Vocal local is an innovative pain management approach pioneered by MSI. As surgical procedures are conducted with local anesthetic, a trained team member provides positive verbal distraction to clients undergoing their procedure. This distraction has proven effective at reducing the perception of pain and reduces client apprehension through constant verbal engagement and regular eye contact.

Table 3. QTA Scores for SHOPS-Funded Outreach Teams*

Outreach Team	Total Score (MSM QTA)**
Vatovavy Fitovinany	91%
	96%
Amoron'I Mania	92%
Androy	93%
Vakinanankaratra	92%
	96%
Diana/Sava	88%
	98%
Tulear	81%
	97%
Average across all teams	**92%**

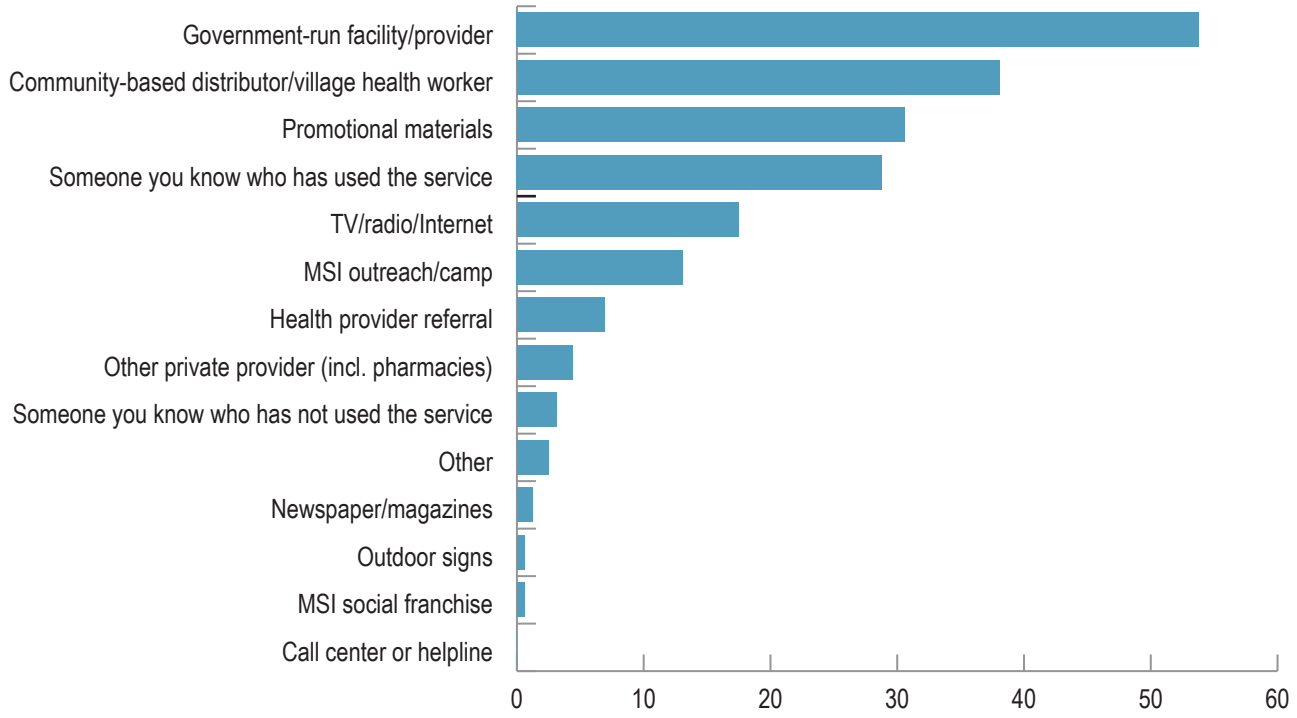
**This table includes the original six outreach teams under SHOPS. The remaining eight teams that went through orientation toward the end of the project are not included, although they did undergo QTA visits.*

***Some outreach teams only had one QTA visit from MSM due to inaccessibility challenges.*

Source of Information

During the exit interviews with outreach clients, interviewers asked how the clients heard about the services offered. The most common source of information was a government-run public facility or provider, cited by more than 50 percent of outreach clients. A CHE and/or CHW was cited as a source of information by 39 percent of outreach clients. Promotional materials were cited as a source by 30.6 percent of clients and promotional information, education, and communication were cited by 17.5 percent (see Figure 4). Separately, clients were asked to rate sources of information by importance and influence. Public health facilities, CHEs and/or CHWs, and word-of-mouth from someone who had used the services were the most important and influential sources.

Figure 4. Common Sources of Information about Outreach Services (%)



Vouchers

The SHOPS voucher program expected to distribute 10,000 vouchers. By program's end, more than 7,800 vouchers had been distributed, of which 3,500 were used by clients and redeemed by the providers (see Table 4).

Table 4. Voucher Distribution, Use, and Reimbursement, 2011

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Vouchers distributed to CHEs	X	500	530	470	1,630	510	2,500	4,260	1,300	**11,700**
Vouchers sold to clients	X	X	500	840	460	792	919	2,563	1,742	**7,816**
Vouchers used by clients and redeemed by provider	X	X	128	296	345	356	612	773	975	**3,485**

**Figures in September 2011 are the result of vouchers being reimbursed for services delivered over prior months. Delays in reimbursement occurred and were due to BlueStar providers retaining the vouchers for long periods before submitting to bundle their claims. During the final quarter, follow-up calls and on-site supervision worked to clear this backlog of vouchers that had been used, but not reimbursed. The 975 services reimbursed in September include a portion from earlier months.*

There are a few reasons for the limited redemption rate by clients. First, the voucher management system was designed to maximize efficiency by using SMS-based technology to report vouchers redeemed and then reimburse using mobile money. Though this approach worked effectively, the slow response rate by BlueStar members who provided services hampered trend analysis. Overall redemption rates were also below initial expectations (44.6 percent against 80 percent projection). The reasons for this were studied through the voucher tracing survey (see page 17). Many clients planned to use the voucher at a much later date, some vouchers were distributed too far from a BlueStar provider, and some were distributed without adequate sensitization of the client. Second, voucher sales were 78 percent of target (10,000) by the end of the project (September 2011). This was a yearly target and due to start-up planning, voucher sales only commenced in March 2011, with services increasing significantly each quarter.

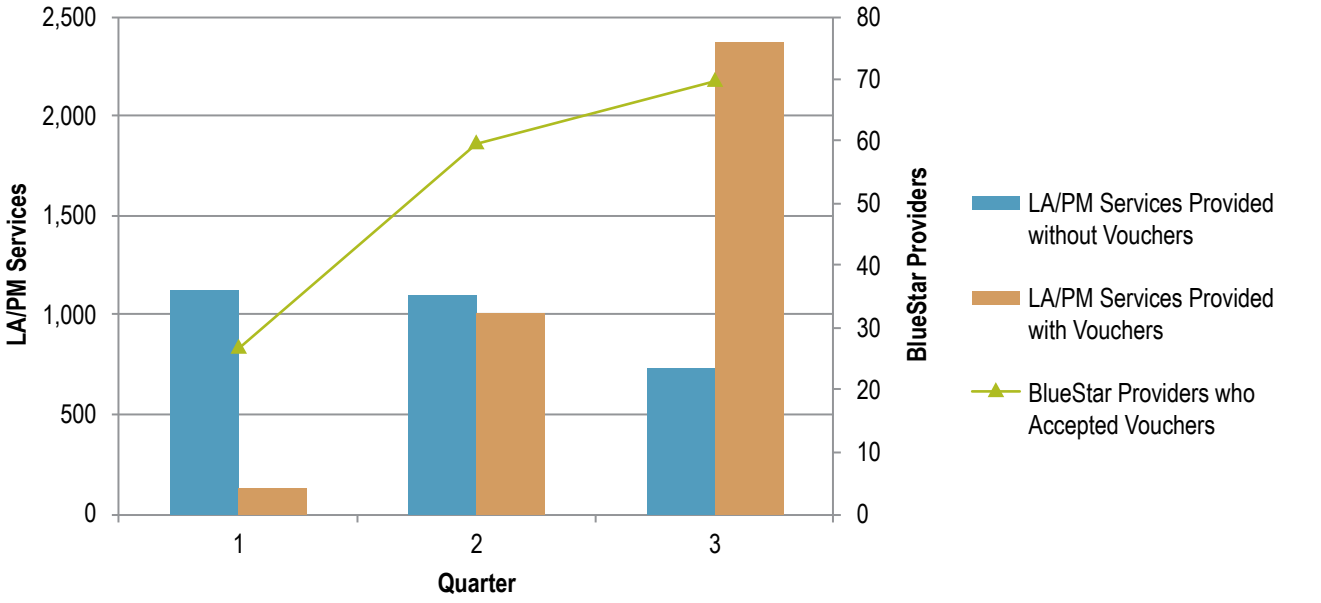
A wide range of contraceptive methods were provided through the BlueStar network, for both voucher and non-voucher clients, during the program period with more than 47,000 services provided (see Table 5). Long-term methods accounted for nearly 6,400 of these services. Just under half of all IUDs and a little more than half of all implants provided by the BlueStar providers went to clients redeeming vouchers. A total of 54 percent of long-term methods were provided to clients through a voucher.

Table 5. Total BlueStar Services and Voucher Services (Vouchers Redeemed), January–September 2011

Service	Total Services	Services with Voucher
Condoms	2,997	
Emergency Contraception	624	
Oral Contraceptives	7,197	
Contraceptive Injections	29,937	
Total Short-Term Methods	**40,755**	**3**
Implants	5,458	3,001
IUDs	939	466
Total Long-Term Methods	**6,397**	**3,467**
Referrals for Permanent Methods		15
Total Services	**47,152**	**3,485**

The goal of introducing a voucher for the use of high-quality BlueStar services was to allow clients who could not typically afford services to obtain them from quality private providers in their geographic location. One potential concern with introducing vouchers to existing clients who might be able to pay was that they would take advantage of the system. MSM examined BlueStar services and found that the introduction of the voucher did not significantly displace non-voucher clients. As voucher clients increased, non-voucher clients only slightly decreased, but remained fairly stable throughout the project period (see Figure 5).

Figure 5. LA/PM Services Provided to Voucher and Non-Voucher BlueStar Clients



Fraud Control

A voucher tracing survey conducted in July 2011 tracked a random sample of 2 percent of the vouchers that were distributed between April and June 2011. A total of 67 vouchers were selected, including 39 that were redeemed for services and 28 that were distributed but not redeemed (see Figure 5). Results of this survey include:

- 100 percent of vouchers were distributed at the correct price or less. Of the vouchers used, there were two cases where the beneficiary reported that the provider asked for payment despite the service being free.
- Among the 67 sample vouchers, 65 vouchers came from an accredited CHE, but there were two cases where the beneficiary was given the voucher by a BlueStar provider.

- All vouchers were reimbursed for services that were actually provided. In other words, the service indicated on the SMS claim corresponded with the service the beneficiary received. The interviewers for the tracing survey were medically qualified and were satisfied that responses were valid.

Voucher Operational Audit

An independent audit of the voucher system in September 2011 provided analysis on the proportion of vouchers that were incompletely filled-out (i.e., address or client profile information was missing), the timeliness of the voucher system, and the supervisory systems of the CHEs. The audit verified that all of the necessary systems for the voucher program were in place. To further strengthen systems, summary recommendations included the implementation of a compliance reporting format to improve tracking of:

- Rates of missing information on vouchers or the poverty grading tool
- Voucher processing delays
- CHE monitoring

The audit also highlighted the need for further investment in information systems, specifically the need to integrate databases that track CHEs, provider SMS reporting, and voucher SMS reporting and reimbursement. Based on this feedback, additional oversight and monitoring were implemented.

Client Satisfaction

Exit interviews were conducted with a random sample of 192 BlueStar clients to gather input about client satisfaction. Results demonstrate a high level of satisfaction with clients overwhelmingly willing to recommend services to a friend and to come back themselves (see Table 6). At BlueStar sites, clients were least satisfied with costs (for those non-voucher users) and waiting times. Among the 192 clients interviewed at BlueStar sites, 18.5 percent were voucher users.

Beneficiary feedback through the previously mentioned voucher tracing survey reported that 93.8 percent of clients who received a voucher were satisfied with the counseling offered by the CHEs and 94.9 percent of clients who used the vouchers expressed satisfaction with how the system functioned.

Table 6. Client Satisfaction with BlueStar Providers, July 2011

Question	Client Satisfaction
Would you recommend the MSI facility to a friend?	98.4%
Would you return for another service in the future?	99.5%
Were you satisfied or very satisfied with your overall experience at an MSI facility?	93.8%
Did the experience meet or exceed your expectations?	99.0%

Reaching the Poorest Clients

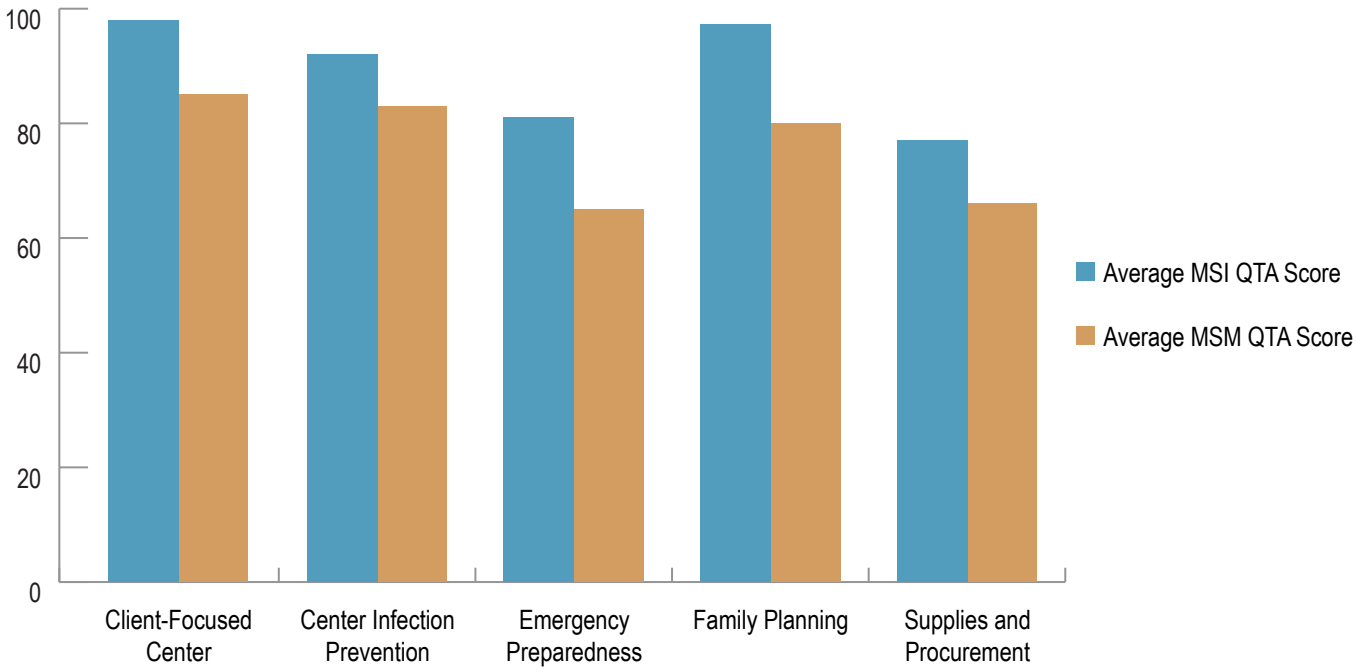
Vouchers are supposed to reach those people who would not normally be able to afford reproductive health services. To track and assess the targeting, the CHEs completed a poverty assessment of each client receiving the voucher. This poverty grading tool uses a validated multi-dimensional poverty index (MPI) of ten indicators to measure the average intensity of poverty.

Between March and September 2011, 5,771 poverty grading tools were completed from five regions. Analysis shows that a greater proportion of voucher clients are poor compared to the national average, with significant regional variation. However, the *intensity* of poverty is slightly less than the national rate, most likely because BlueStar services are not located in the most impoverished districts of Madagascar, which tend to be rural and remote. Importantly, the MPI derived from the exit interviews of some BlueStar clients demonstrates that voucher clients are much more likely to be poor than the average user of BlueStar services. Overall, 75.8 percent of voucher beneficiaries were below the MPI poverty line, and a further 12.7 percent were borderline.

Quality Service Provision

With SHOPS support, 52 BlueStar members accredited to accept vouchers had an MSM QTA visit during the project period. The average results were 80 percent or more for client focus, infection prevention, and family planning services (incorporating short-term and long-acting methods). Lower results for emergency preparedness were linked to the availability of a standardized list of medications; these were subsequently addressed through a new model kit that was distributed to all BlueStar providers in August 2011 with new job aids. In September 2011, the MSI QTA visit took place and included six BlueStar members (see Figure 6). The MSI average results are higher than MSM due to improvements as a consequence of the earlier QTAs. Overall, the sample of BlueStar providers assessed by MSI achieved an average score of 90 percent.

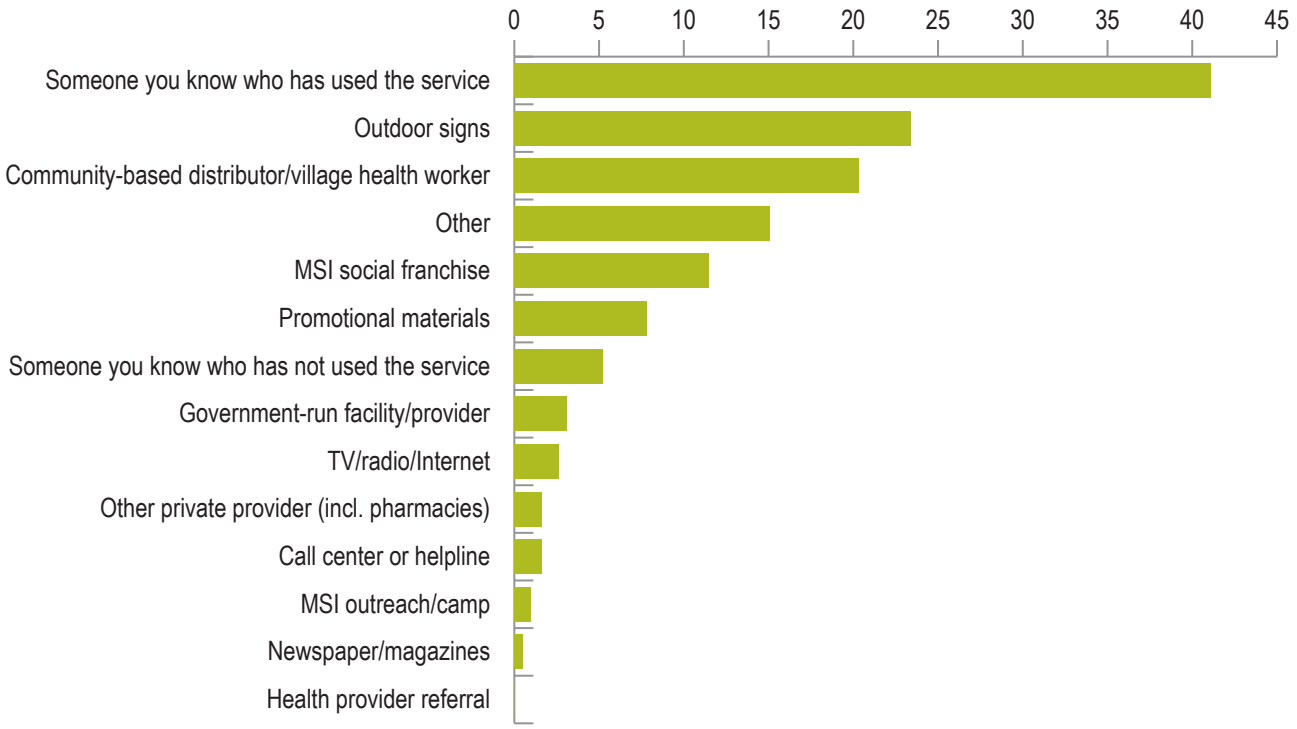
Figure 6. BlueStar Member Quality Technical Assistance Scores



Demand Generation

The exit interviews show that the most common sources of information about BlueStar services were recommendations from someone who had already used the service (41.1 percent), directional signs outdoors (23.4 percent), and a community health agent (20.3 percent) (see Figure 7). Promotional materials were also cited as an influential source of information about BlueStar services (7.8 percent). By far the most influential and important source was a recommendation from someone who had already used the service.

Figure 7. Common Sources of Information about BlueStar Services (%)



CONCLUSION AND LESSONS LEARNED

With USAID support through the SHOPS project, MSM was able to expand multiple innovative service delivery channels that effectively reached the poorest and least accessible women of reproductive age with quality comprehensive family planning services. These innovations also strengthened the health system by providing support and training to private providers who formed part of the BlueStar network. Outreach service delivery using the mixed model was scalable by the project's end and strengthened with an improved management information system and BCC approaches. The combination of social franchising with vouchers provided the most significant growth in service delivery with BlueStar members tripling LA/PM provision during the SHOPS program. This intervention provided a strong foundation to promote awareness about the role the private health sector in Madagascar can play toward achieving Millennium Development Goal 5 (improving maternal health).

The combination of social franchising with vouchers provided the most significant growth in service delivery, with BlueStar members tripling LA/PM provision during the SHOPS program.

Public-private partnership was key to increasing the use of LA/PMs through outreach.
While the program aimed to extend service beyond the facilities of the public sector, the relationship with the ministry of health was instrumental in obtaining increased service delivery. When outreach clients were asked in exit interviews how they heard about the services offered, the most common source cited was a public facility or provider. More than half of the referrals to the mobile outreach teams came from the public sector. This underscores the value of a strong public-private partnership.

Implants were the preferred method in outreach and voucher programs.
In both the outreach and voucher programs, implants were clearly the most popular long-term method. When given a range of family planning options, the majority of clients selected implants over alternatives at both the mobile and static clinics. Though empirical evidence is lacking, outreach teams reported some reluctance among beneficiaries to have surgical procedures in non-formal settings. The social franchises also reported a similarly large proportion of implants among the long-term methods provided. This experience with implants, which can be provided in a variety of settings, has program implications in particular for task shifting.

Strong demand creation was crucial to the success of the outreach and voucher programs.
To ensure that people living in the areas served by the outreach team knew where and when to seek information and services, MSM undertook demand-generation activities using radio and community events. Recognizing that demand creation was more time consuming in the outreach program due to the remote locations and lack of intermediaries, MSM supplemented communication efforts with CHEs. This change in approach was integrated with the CHW infrastructure and local health committees. In exit interviews, clients cited CHEs, CHWs, and promotional materials as important sources of information. The voucher program used branded materials, community sensitization through the CHEs, and broadcast media. To improve the quality and completeness of counseling, MSM modified its approach with improved behavior change communication training materials. This flexibility and the use of multiple channels yielded results. According to the exit interviews, the most common source of information about BlueStar services was a recommendation from someone who had used the service. This was followed by branded signs, community health agents, and promotional materials.

Vouchers, when properly targeted, do not displace non-voucher clients.
The goal of introducing vouchers for high-quality family planning services was to reduce financial barriers, thereby permitting clients who could not afford the services to obtain them. One concern was that the clients using vouchers would displace the clients who were able to pay. To ensure that the clients purchasing vouchers were poorer women unable to access services without vouchers, CHEs targeted geographic areas where women had little access to services. The CHE completed a poverty assessment

questionnaire with all clients who purchased a voucher. Throughout the project period, as voucher clients increased, non-voucher clients remained fairly stable, so overall the market was expanded.

For voucher programs, it is imperative to put robust monitoring and fraud controls in place to limit and avoid collusion and overcharging of clients.

The voucher tracing survey indicated that having robust fraud control mechanisms is essential. Though sampling demonstrated that all services reimbursed were actually provided, there were a small number of cases of non-compliance with payment policies (i.e., the beneficiary paid for a service that should have been free) and with voucher distribution protocols (i.e., cases of vouchers being provided by a BlueStar member).

A BlueStar provider (far right) and his family.

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Acknowledgments
The authors thank the staff at USAID/Madagascar and USAID Washington for their support throughout the implementation of the program. The authors also acknowledge the MSM team in Madagascar, the MSI support team in London and Washington D.C., Natasha Hsi of Abt Associates, and the entire SHOPS team for their contributions to the management, implementation, and evaluation of this program.

For more information about the SHOPS project, visit: www.shopsproject.org

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