REVIEW OF VOUCHER SCHEME UNDER HOMELESS COMPONENT OF MSI'S EC BLOCK GRANT PROJECT

Conducted for:
Marie Stopes (MS) clinic society
6/2 Block F, Lalmatia
Dhaka 1207

Conducted by:

CAPACITY BUILDING SERVICE GROUP (CBSG)
6/1 Block-B (Ground floor)
Lalmatia, Dhaka 1207
Phone: 8155672, 9131027
Email: cbsg@bdonline.com

March 2008

Abbreviation, Acronyms and Definitions

ANC	Antenatal Care
BCC	Behavioral Change Communication
BDT	Bangladesh Taka (Currency)
CBSG	Capacity Building Service Group
C/S	Cesarean Section
EC	European Commission
FGD	Focus Group Discussion
FP	Family Planning
HO	Head Office
MIS	Management Information System
MSCS	Marie Stopes Clinic Society
MSI	Marie Stopes International
MSV	Marie Stopes Volunteer
MR	Menumstration Regularization
N/A	Not Applicable
NGO	Non Government Organization
NSV	No Scalpel Vasectomy
OT	Operations Theatre
PNC	Postnatal Care
RC	Referral Clinic
RH	Reproductive Health
SDP	Service Delivery Points
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
ToR	Terms of Reference

Acknowledgement

Capacity Building Service Group (CBSG) has conducted the review of Voucher Scheme subcomponent of the EC block grant project of Marie Stopes in March 2008. This report is the result of a co-operative and mutually supportive exercise between CBSG and MSCS staff of all level.

CBSG has the pleasure of thanking all the staff of EC Block grant project of MSCS, but in particular to thank Mr. Shahid Hossain, GM Advocacy and Capacity Building, Dr. Mabarak Hossain, GM, Services, Ms. Lutfa Begum, Coordinator, Dr. Masud Ahmed, Program Manager and Dr. Farzana Amin, Programme Officer for their genuine support and commitment to the work.

Special thanks are also given to Dr. Yasmin H. Ahmed, Managing Director, MSCS and Dr. Reena Yasmin, Director, Services, for extending their full support and providing constructive input during inception meeting, field work and subsequent consultations. We would like to take this opportunity to recognize the contribution of all referral center based staff who have been very instrumental in the whole review. It was refreshing to meet each one of them personally and professionally extremely satisfying as they share the unique view of serving the poor people in our country.

Finally, while acknowledging the valuable inputs of all the above, CBSG stands by the data, analysis and conclusions reached from the review and believes them to be a sound response to the information available. However, CBSG recognizes that the findings, analysis, and conclusion including any errors and omissions contained within this report are of its own.

Table of contents

Executive Summary……..5
1 Introduction 7
1.1 Scope and Objectives of the review: 8
1.2 Methodology 8
1.3 Report Structure 9
2 Voucher Scheme as a demand-side financing mechanism: the concepts and conceptual framework 10
3 Findings and Analysis 11
3.1 Method of implementation of the scheme 11
3.2 Coverage 11
3.3 Effects on awareness and attitude of the target population 12
3.4 Effect on use of services 12
3.5 Quality of services 12
3.6 Client satisfaction 12
3.7 Effect on willingness to pay for healthcare 13
3.8 Voucher Scheme and Key features of MS 13
4 Constraints/ limitations of MS voucher scheme and some recommendations 15
4.1 Cost effectiveness 15
4.2 Lack of consumers' choice for providers: 15
4.3 Increased moral hazard of consumers: 16

Annex-1: ToR of the Review

EXECUTIVE SUMMARY

Voucher Scheme is one the sub components (under homeless component) of the project "Improving the health and SRH status of the poor, most vulnerable and under-served populations in selected urban areas of Bangladesh" funded by European Commission (EC) under EC Block Grant. MSCS has developed the 'Voucher Scheme' to ensure a range of services that are not possible to render from mobile satellite clinic, in particular the delivery care. The objective of the scheme is to create sufficient incentive for the floating population in the urban area to receive appropriate care for the pregnant women.

The project has been in operation for two years. The EC intends to review and assess the progress of the project in terms of quantity and quality vis-à-vis the challenges encountered and the measures taken to address the challenges. This review has tried to identify strategies as to how best the project can focus the remaining time and resources to optimize the results and capture any lessons learned in the process.

The review team found that a large number of homeless patients visit Marie Stopes mobile service facilities for healthcares. The incentives provided under the scheme have induced a reasonably high proportion of pregnant women of the homeless group to receive safe delivery care. At the national level, only (18% of the pregnant women receive delivery care from a medically trained provider.) 8% pregnant women receive delivery care. On the contrary, in the mobile clinic catchment areas, this figure seemed to be much higher as revealed in discussions with the clients. A statistical proof, however, (is not possible under the scope of this review.) could not be made during the review. MSCS's mobilization and quality of care have made an impact for creating high demand for maternal care. Nonetheless, the voucher scheme provided a very good incentive to the most vulnerable women to access critical care, which otherwise could not be possible for them.

The government has been trying with the voucher scheme in a number of rural areas to improve maternal care but the results have not been good. In comparison to that, the achievement of this scheme is much better. The success of the MS scheme can be attributed to two factors: implementation method and selection of a very appropriate group.

The main features of the implementation mechanism adopted by MS are as follows:

- MS is not only providing delivery care free of cost but also reimbursing transport cost under the scheme.
- MS has used an effective mechanism to organize and induce the target people to (utilize?) the clinics. It has involved a large number of volunteers and coordinators who organize the floating population, conduct BCC campaign among them, and accompany them to the clinics.
- MS has employed a group of skilled and committed providers to deliver care under the scheme.
- MS has ensured high accessibility of the floating population to its clinics. Its makeshift clinics and the fixed clinics are located within the acceptable distance from the places of stay of the target people.
- The use of a beautiful van as the clinic has also created some attraction to it for services.
- Finally, the reputation and credibility of MS among the city population has also contributed to successful implementation of the scheme.

Observation under this evaluation study clearly showed that the maternal health cares, as well as other basic health cares, provided by MS in general and under the scheme in particular are of high quality. All the clients interviewed emphatically claimed that they are highly satisfied with the services they received under the scheme. All of them maintained that the scheme provides free care as well as reimburses transport cost, without which it would have been difficult for them to receive delivery care. They are happy with all aspects of services under the scheme. Almost all of them said that they would not receive this care if the benefits are withdrawn. Only a few said that they would continue to receive delivery cares from the MS clinics even if the financial benefits are withdrawn.

As far as the service coverage is concerned, Marie Stopes provides SRH services to roughly 15% of the flouting population in Dhaka city. However, in each spot where it is working, it is reaching a high number of people who live there. This indicates a huge opportunity to expand services to other areas.

The homeless population in the cities frequently moves from one place to another in search of work and shelter. This creates a serious challenge for the Marie Stopes to organize them and deliver services. To overcome this, the existing community support group can be assigned with the task of regularly listing the floating people living in the areas. They will inform MS about the homeless person coming in its area, and thereafter MS will take its measures for delivering cares, as usual.

The major limitation of the MS voucher scheme seems that the target beneficiaries have very limited choice to choose service providers. In Dhaka, the clients have some choice but in other two cities, the clients have no choice of providers. Despite the efforts of MSI to engage other providers in the project, it has been difficult to involve private providers and public sector facilities. The reason is that the frame condition is not quite conducive to open up adequate choice for the beneficiaries as private sector service price is far above the allowable cost under the voucher scheme. Therefore, the private sector providers do not have the motivation to provide service under the voucher scheme. On the other hand, public sector service facilities do not accept the voucher, and the doctors are not allowed to take any form of benefit from clients. Thus the public sector providers have institutional as well as motivational constraints to render services under the MS voucher schemes.

MS arranged MoU with some NGO run facilities, which are supported by public finances through an ADB loan facility. NGO clinics thus have the provision to underwrite the subsidies that are resulted from servicing voucher clients. Thus MoU between MS and NGO run clinics results into a win-win situation, which was not the case for private and government facilities.

The quality and range of services provided by MS are different from business. It reaches equilibrium when average revenue is equal to average cost. The MS clinics are reputed service centers; they provide quality care. MS is also increasing providers' accountability to clients. Given these, the consumers are receiving better care there than at other private or public facilities. The public facilities deliver poor care to them, as mentioned earlier. If the clients were allowed to choose private providers under this scheme, it is very likely that they will not receive as good care as available at MS facilities because the private providers will maximize profit by reducing (service fees?) amount and quality of care (and also because there is asymmetry of information). Therefore, the lack of choice for providers on the part of the clients under the scheme is doing " more good than harm."

Despite this, MS should gradually allow the consumers to choose providers from among the accredited providers. In the absence of any accreditation system in the country, MS can accredit the providers using the service of experts and experienced managers. MS will then enter into contract with the accredited providers regarding reimbursement mechanism if the clients under the scheme ever visit them. Therefore, MS can do this only after coverage increases considerably.

1 INTRODUCTION

Voucher Scheme is one the sub components (under homeless component) of the project "Improving the health and SRH status of the poor, most vulnerable and under-served populations in selected urban areas of Bangladesh" funded by European Commission (EC) under Block Grant. It is designed in line with the EC's Country Strategy Paper (CSP), related National indicative plan (NIP), and Health, Nutrition and Population Sector Programme (HNPSP) of Bangladesh as it seeks to contribute towards the MDGs through the objective of improving the SRH status of the poor, most vulnerable and underserved women, men and young people of Bangladesh. This project is expected to reach some of the most disadvantaged, needy and the poorest segments of the population living in urban areas in Bangladesh.

Under this project, Marie Stopes Clinic Society in Bangladesh is implementing one of its existing outreach activities for the homeless population. Over the years, rapid urbanization has largely contributed to the increasing numbers of urban poor with a relative increase in the hard core poor (e.g. homeless street dwellers), particularly in Dhaka, Chittagong and Khulna. MSCS' prior intervention for this group has shown that these people suffer from a host of health problems, which only increase their vulnerability, and it was not possible within the context of earlier intervention to address some of these much-needed services. So, under this new intervention, MSCS developed a 'Voucher Scheme' to ensure services that are not possible to render from the current mobile satellite sessions.

Under this scheme, a token is given to homeless people (for some much needed services including Normal Delivery, Caesarean Section, STI Lab Diagnosis, MR, D&C, and other services like FP, Dots, severe dehydration and sever malnutrition), which is equivalent to all expenses for delivery of any of these services in any private or NGO clinic or hospital. Against this voucher scheme, the holder (of voucher card) is given opportunity to avail all the facilities required for treatment of the health concern in any clinic/hospital affiliated to the scheme and the service delivery point is receiving their dues from Marie Stopes Clinic Society by submitting the voucher.

Marie Stopes, a large national NGO of Bangladesh, has been implementing for long a number of health service delivery programme in both rural and urban areas of the country. The NGO, compared to other NGOs conducting similar activities, has some distinguishing features that include:

- Its efforts are devoted to achieving the ultimate objective of health service delivery, e.g. increased use of healthcare, and not engaged in carrying out merely the campaign for educating and motivating the people. It efficiently operates a large number of service delivery points, in addition to organizing and motivating the people to use appropriate healthcare.
- Its cost recovery is quite high, creating a unique example for the entire NGO sub-sector. Third, in its approach it attaches high emphasis on ensuring quality of care, encouraging citizen voice and client participation, and enhancing providers' accountability to the clients. Besides, it regularly devises and launches innovative methods and schemes so as to effectively deliver healthcare to the most hand-to-reach people. The voucher scheme of Marie Stopes Clinic Society (MSCS) is one such innovative scheme.

MS has been delivering healthcare services to the homeless floating population of the cities since 1996. In Bangladesh, every year thousands of people move from the rural areas to the large cities in expectation of job and livelihood. These people have already lost land and shelter in the rural areas and failed to find work for them to maintain their households, and have come to the cities for jobs. A segment of the rural-urban migrants found some low-grade jobs in the course of time, and settled in the urban slums. But a large number of them, especially those who have come to the cities in the recent years, are yet to find any stable livelihood strategy and arrange any home even in the slums. They have to continuously move from one place to another in the city for work opportunity and temporarily live on the streets or in the vacant spaces here and there. The floating population (squatter) of the cities constitutes the most disadvantaged population of the society, in that they do not have permanent home, regular income, and access to basic amenities of life. They have high need for healthcare, but, paradoxically, they have least access to healthcare – it is extremely difficult for the conventional health

programme to reach them with healthcare services. Marie Stopes has undertaken the bold efforts to reach this difficult segment of the people and has already achieved discernible success in providing basic healthcare to a large number of them.

Of late, MSCS has added another component to its existing activity of providing basic healthcares to the floating population of cities: a voucher scheme for maternal health care of the same population. The scheme has been launched in 2006, thanks to the financial assistance of EC. The CBSG, a research and capacity building organisation has been assigned with the task of reviewing the performances of the scheme and identifying the measures needed for further improvement of its activities. This report presents findings of the review.

1.1 Scope and Objectives of the review:

The project has been in operation for two years. The EC intends to review and assess the progress of the project in terms of quantity and quality vis-à-vis the challenges encountered and the measures taken to address the challenges. The review would identify strategies as to how best the project can focus in the remaining time and resources to optimize the results, and capture any lessons learned in the process. The scope of the review is to assess the progress of voucher scheme in relation to the overall and immediate objectives stated in the original project document in terms of indicators mentioned in the documents, inputs given as per project documents, the adequacy of the management arrangements and the extent to which the activities for the remaining period are effectively responding to the now available information. Based on this assessment, the mission is to advise Marie Stopes, whether and to what extent the scheme can be successfully implemented according to the current plan and to suggest alternative to the current work-plan if need be, and to support MSCS in re-planning the activities, if and to the extent that is required.

The specific objectives of the review are:

- Review current reproductive health needs of the floating population
- Review to what extend voucher scheme is satisfying their reproductive health needs
- Suggest ways and means to incorporate other reproductive health needs, not currently addressed under the voucher scheme
- Identify any lesson learnt during implementing this scheme
- Identify ways to further improve the utilization of the scheme and /or maximize the use of inputs

1.2 Methodology

CBSG has adopted participatory and interactive methods throughout the process while adhering to the methodology as specified in the ToR. This was further fine-tuned in consultation with the senior management of Marie Stopes. Finally, the following methodologies were adopted to conduct the voucher scheme review.

Document Review: This included review of voucher scheme strategy, project documents, work plan, progress reports, and documentation of various events done so far. This helped us understand the project, and prepare questions for the review exercise, and share and finalize them in the inception meeting with the relevant staff of Marie Stopes.

Inception Meeting: A half-day inception meeting was organized with the management of the project to fine-tune the methodology and to agree on the scope of the review based on the understanding of document review. The draft review questions were developed and shared with the MSCS project team.

Voucher Scheme Review Meeting: It was organized with the main functionaries of the project to review the performance of the scheme. This meeting helped the review team to capture the progress of the project in terms of quantity and quality vis-à-vis the challenges encountered and the measures taken to address the challenges.

Field visits and reality check: The review team physically visited two spots out of eight spots of Dhaka and Chittagong. During the visit, the team met with project support group members, MS staff and Volunteers, project beneficiaries both individually (in-depth interview) as well as in groups (FGDs) to gather information based on the review questions. A total of 12 FGDs were conducted in two spots. The FGDs were conducted with female and male clients, project support committee members and with service providers including MSVs. In addition, 16 exit interviews were conducted with a cross section of service recipients to gauge their perception about the quality of services they received from MS health facilities.

Debriefing session: The mission shared the preliminary findings of the review with the MSCS management and invited their inputs as well as comments on the review findings including suggestions.

The matrix below presents component-wise visit schedule along with tasks accomplished by the MTR team:

Sl.	Program/Event	Place and Date	▪ Task accomplished
1	Inception meeting with MSCS management	MSCS Head Office at Lalmatia (25/3/08)	▪ Meet with MD and other key project staff ▪ Agreed on the methodology of the MTR ▪ Perspective beyond ToR
2	Homeless Program	Sholosahar under Chittagong I (25/3/08) High Court Spot under Dhaka I (30/3/08)	▪ Observe service delivery ▪ FGDs with client ▪ FGDs with PSC members ▪ Exit interviews ▪ Case studies
3	Debriefing with MSCS management and key staff	MSCS Head Office (3/4/08)	▪ Shared preliminary findings ▪ Understand additional information needs

1.3 Report Structure

The report is presented in four sections. Section one includes introduction and methodology adopted for the review. Section two describes the 'Voucher Scheme' as a demand-side financing mechanism - the concepts and conceptual framework; section three presents the findings and analysis, and section four includes the constraints/ limitations of Voucher Scheme and subsequent recommendations.

2 VOUCHER SCHEME AS A DEMAND-SIDE FINANCING MECHANISM: THE CONCEPTS AND CONCEPTUAL FRAMEWORK

The main purpose of launching the voucher scheme for healthcare is to create incentives for the consumers to use care in the situations where the supply-side services (which are also officially free) are not available or where the consumers do not have the required access to the supply side services. Distance of public facilities from the houses of consumers, lack of transport facilities, misbehaviour of providers there, observation of too many formalities, long waiting time, and unofficial fees, etc. can seriously reduce access to the supply side facilities. In such situations, vouchers enable the consumers to choose providers from among the accredited providers (either public or private), empower the poor in the eyes of the providers, and enhance providers' accountability to them. Thus, although both the supply side interventions and the voucher scheme provide free care, voucher yields some additional benefits to the consumers.

A conceptual framework, developed based on theory and preliminary observations, can be utilized to explain the apparent puzzle.

- The healthcares in Bangladesh have some features, which distinguish them from the commodities and services considered in neoclassical economics.
- First, in Health Economics both demand and need of the consumers have to be addressed. A consumer may not have purchasing power but may have need for healthcare.
- Second, neoclassical economics considered merely the charged price of a commodity as the main determinant of demand for it. It ignored the associated costs such as travel cost incurred for buying a commodity, in particular healthcare.
- Fourthly, maternal healthcare in Bangladesh is greatly social, rather than private; it depends on the will of the husband, parents-in-law, relatives as well as neighbours.

A demand function for maternal healthcare can be derived using the utility maximizing model and considering the above characteristics of the care[1]. According to the function, demand for maternal health care depends on charged price, associated costs of care, place of care, gender of provider, accessibility, women's role in the household, and socio -cultural norms. If we consider only the charged price as determinant, the intercept of the function is very small and price elasticity is also low. If the voucher scheme covers only the charged price, i e, price becomes zero, demand increases only marginally. If the scheme covers all the costs (charged price, travel cost, travel time, etc.) demand will substantially increase. Despite this, however, total need for maternal healthcare will not be met; in fact, a considerable amount of unmet need will still exist which can be fulfilled through motivational campaign, increasing accessibility, and empowering women in the society.

The major hypotheses emerging from the literature and the framework of analysis are as follows:

- *Voucher scheme is successful in increasing use of care if it is targeted to the poor with a particular service package and the consumer is given right to choose providers. (However, evidence suggests that the scheme is not successful in improving quality of care).*
- *In a traditional society like Bangladesh, the scheme will be substantially successful in increasing use of maternal healthcare if the women are provided care free of cost and compensated for other costs, accessibility is high, women's role increases, and traditional values are weakened.*

[1] The derivation is not shown here. See Howlader (2007)

3 FINDINGS AND ANALYSIS

3.1 Method of implementation of the scheme

Before starting implementation of the scheme, MSCS conducted an intensive survey to assess the socio-economic characteristics of the urban floating people, their health status and the health care seeking behavior, and the health cares they need. Based on the survey findings, MSCS has identified the target groups as well as the service delivery locations, and developed a basic healthcare service package (including maternal care) that is delivered from a mobile van. Health service delivery has been complemented by periodic awareness campaign and motivational activities.

The spots are selected at or near the places where many homeless people stay, so that the clients of this group do not have to move a long way to reach the service spot. The satellite clinics are held in the evening hours, the time when these people return to their places of stay after work. The service team consists of a doctor, a nurse, one field coordinator and three volunteers. The volunteers motivate the people to receive healthcares. They are selected from within the same (homeless) group, imparted training, and amply motivated to do the activities. The coordinators oversee and monitor the activities of volunteers. A fully equipped mobile van carries the instruments, logistics as well as the service providers to the clinic spots on the selected days. In addition, a makeshift tent established beside the van is used as waiting room for the clients.
The voucher scheme is operated under this general framework of service provision except that it is reserved only for maternal health care, the delivery care is provided at the fixed clinics of MSCS, and the recipients of delivery care not only get free services, but also get reimbursement of the transport cost. The objective of the scheme is to create sufficient incentive for the floating population to receive appropriate care for their pregnant women.

3.2 Coverage

The 1997 census counted "floating population" at 14,999 in Dhaka city and another 17,082 in other metropolitan areas. Islam *el al*[2] estimated the number of street dwellers in 105 locations of Dhaka city at 11,500. There has been no recent data of the "floating population" in major urban centres like Dhaka, Chittagong and Khulna. As the urban centres are experiencing tremendous growth (at about 6% per annum), so is the growth of the "floating population". We find by extrapolation from the above data that on average about 215 floating population dwellers in each spot.

Marie Stopes's mobile services render health services for the homeless in 6 locations in Dhaka city (4 locations under EC block grant) and four spots in Chittagong and Khulna. Marie Stopes renders services in location of high concentration of homeless people (estimate is about 600-1500 in each spot)[3], nonetheless a large number of homeless people still remain outside the reach of these health services. Except for Marie Stopes, health service provision for the homeless people is almost non-existent. Currently MS' health services could reach around 10-15% of the floating population of the three cities through its mobile van. Therefore, there is a need for Marie Stopes to replicate its model and extend health services to the other settlement areas of homeless people. Service coverage within the existing catchments areas found to be very high particularly for ANC and PNC. A recent ICDDR,B study found that only 28% pregnant women sought ANC services and 82% of them received ANC from Marie Stopes mobile health services. These figures indicate that, Marie Stopes coverage for ANC and PNC is very significant within the catchments area. Over last two years, Marie Stopes have rendered about 35,000 services (not necessarily 35,000 person) among the homeless, and it has distributed 1204 vouchers mostly for delivery care including ANC. In other words only 3.5% cases, a voucher was provided. Marie Stopes' penetration for other health services (general health, child health and male

[2] Islam et al (1997). Addressing the urban Poverty Agenda in Bangladesh: Critical Issues and 1995 Survey Finding. Dhaka: Asian Development Bank

[3] Marie Stopes' uses the term 'homeless" not as strictly as census. A good number of the clients comes to service centre who are not completely homeless, but live in squatters that are far worse than any recognized slums.

health) among the homeless people is also quite significant within its existing catchments area. Marie Stopes is receiving a huge number of repeat clients from among the existing clients which manifests in high level of service dispensation.

3.3 Effects on awareness and attitude of the target population

It appears from the interview of the volunteers and the clients that both the groups have increased their knowledge about health, healthcare needs, and availability of MSCS services. The volunteers clearly know what they have to motivate the people, and accompany them to the satellite and the fixed centers when needed. They categorically mentioned that they were happy with MSCS's activities. MS also has good rapport with the clientele population - the clients know them, like them, and comply with their advice.

The clients mentioned that they themselves as well as their neighbouring households like to receive health care from the MS clinics, but they are mostly used to get the care from the traditional providers and pharmacies. They said that MS project has caused this shift in attitude in them..

3.4 Effect on use of services

Even a surprise visit to a satellite service center of MS showed that a considerably large number of patients visit each spot for basic healthcares. There is rush of patients on each clinic day at each spot. A detailed discussion with the volunteers and clients strongly indicated that most of the pregnant women under the scheme coverage now receive delivery care from the MS centers. At the end of 2nd year of the project, the total number of individual services delivered through this scheme is 397. In the first year, only 48 services were provided under the scheme (multiple service provision for one person) while in the 2nd year, it has increased to 1204. The review team found that a large number of homeless patients visit Marie Stopes mobile service facilities for healthcares. The incentives provided under the scheme have induced a reasonably high proportion of pregnant women of the homeless group to receive safe delivery care. MSCS's mobilization and quality care have an impact for creating high demand for maternal care. Nonetheless, voucher scheme provided a very good incentive to the most vulnerable women to access critical care, which otherwise could not be possible for them.

3.5 Quality of services

Some authors have empirically found that in many societies voucher scheme increases use of health care but it does not improve quality of care (Ensor, 2003). But observations under this evaluation study clearly showed that the maternal health care, as well as other basic healthcares, provided by MS in general and under the scheme in particular are of high quality. The providers at both the satellite and the fixed centers (MS clinics) are sufficiently educated, trained and skilled. The mobile vans contain all the necessary equipments and logistics for providing basic health cares, including antenatal care. The MS clinics (fixed) have sufficient inputs to provide quality delivery care. The providers at both the types of centers follow the standard guidelines of delivering care, including counseling, informed choice, listening to patients, proper diagnosis, effective prescription, and follow-up. In fact, MS clinics have earned great reputation and credibility in the cities for high efficacy of their cares (as well as for high cost recovery). The clients under the voucher scheme receive cares from these standard facilities, and they receive cares of the same quality as the others do.

A voucher scheme beneficiary, Afia Khatun, expressed that she had been receiving ANC including Ultra sound examinations from MS under voucher support. She has also been provided with a voucher for delivery at the Nari Maitree health centre. Afia said with confidence," MSV Khala keeps regular contact with me and she will take me to the clinic in time. I feel relaxed even at this critical time"

3.6 Client satisfaction

All the clients interviewed emphatically claimed that they are highly satisfied with the services they receive under the scheme. They cited the reasons for saying so. All of them maintained that the

scheme provides free care as well as reimburses transport cost, without which it would have been difficult for them to receive delivery care. All of them said, moreover, that they had to visit the public facilities on various occasions earlier to receive healthcare but had bitter experiences there. Although care from them is apparently free, they had to wait for long before care was delivered, doctors and staff did not behave properly, the providers did not want to listen to what they wanted to say, they did not get needed level of attention of providers, minimum necessary medicines were not available there, too much formality exists there, and sometimes they had to pay unofficial fees. These problems do not at all exist at the clinics under the scheme. They are happy with all aspects of services under the scheme.

3.7 Effect on willingness to pay for healthcare

Almost all of the homeless said that they would not receive care if the benefits are withdrawn, let alone pay for cares. They do not have the ability to pay and, hence, cannot pay even if they want to pay. Only a few said that they would continue to receive delivery care from the MS clinics even if financial benefits are withdrawn. However, it could not be assessed in this study whether they really meant what they had said.

3.8 Voucher Scheme and Key features of MS

Thus, considered in terms of the level of awareness created and change in attitude brought about in the target group, extent of use of maternal care by the group, and level of client satisfaction from the services, the voucher scheme of MS has been performing very well. The achievement of the scheme is remarkable if we compare it with that of the scheme, which is implemented by the government in a number of rural areas. The success of the MS scheme can be attributed to the two broad factors: method of implementation of the scheme by MS and selection of a very appropriate group of people as the target population.

The main features of the implementation mechanism adopted by MS are as follows:

- MS is providing vouchers not only for providing delivery care but also for transport cost under the scheme.
- MS has used an effective mechanism to organise and induce the target people to use vouchers. It has involved a large number of volunteers and coordinators who organise the floating population, conduct BCC campaign among them, and sometimes accompany them to the clinics.
- MS has ensured high accessibility of the floating population to its clinics. Its makeshift clinics and fixed clinics are located within the acceptable distance from the places of stay of the target people.

Besides these, the NGO has selected an appropriate group of population for the scheme. The target people are homeless and most disadvantaged. They were hitherto almost fully deprived of any modern healthcare. They had high need for care, but the need was latent or uncared.

- Firstly, MS could relatively easily convert the latent need into active need through the services of volunteers and demonstration of quality services.
- Second, voucher scheme has been designed for the most deserving people for a specific type of healthcare - maternal care.
- Third, the target people being homeless have no demand for delivery care to be provided at home, as many households in the rural areas have.
- Fourth, the target people have migrated to the cities from the villages under economic compulsion and, thus, they have also become de-touched from the relatives and peers in their rural areas, who could negatively influence them about receiving delivery care at the facilities, and these people have also broken away from the long-standing customs and traditional values.

- Finally, the women in this group have relatively high liberty in the households, under desperate circumstances though. They have high exposure and mobility, and most of them work outside of home and thus have role in household ‘s decision-making.

It, thus, follows that the voucher scheme of MS has complied with most of the hypotheses as postulated in section-2 based on literature and previous evidence, and that the hypotheses are by and large true in the real world.

During FGD with the Homeless Clients, one beneficiary indicating her new born baby told the MTR team, “‘I would not have given live birth to this child unless MS had arranged a cesarean delivery at Bashbari clinic. To save mothers and children, more organizations should come forward with the voucher support. Fee treatment is no good if services are not of quality.”

4 CONSTRAINTS/ LIMITATIONS OF MS VOUCHER SCHEME AND SOME RECOMMENDATIONS

This section depicts the constraints and the limitations of the MS voucher scheme and put forward recommendations for overcoming them.

4.1 Cost effectiveness

Voucher is a subcomponent of Homeless components of EC block grant project. Therefore, the study did not estimate cost of service provision under the scheme. The marginal cost of a voucher is prefixed and constant. However, if this scheme is considered independent of homeless component, the average cost is quite high, even if we disregard the cost of staff working on the project , cost of providing free care and reimbursement of transport cost to the clients, etc. are entailing huge cost for MS and lowering economic efficiency of the scheme.

4.1.1 Recommendation:

One argument in favor of the MS scheme on the cost issue is that the NGO has targeted the most disadvantaged group in the society and it is very difficult to deliver service to them. Moreover, this type of activity, in particular, targeting the homeless and floating population in urban areas, is carried out for the first time in the country and in the initial phase cost of any activity is high. For any investment project, in the initial periods increased output is the main issue, cost becomes an issue little bit later. The argument has high merit. Notwithstanding this, the NGO should gradually try to devise strategies to reduce cost per person. The cost per person can be reduced either by reducing total cost or by increasing output keeping the fixed cost constant, or by both. It is difficult to find any measure, which can reduce total cost. The only way is to increase output by way of increasing coverage of the homeless population.

The coverage can also be increased by way of including the disadvantaged population living in the temporary shelters of slums - they are also equally deserving of maternal health cares (to be discussed again later).

4.2 Lack of consumers' choice for providers:

The most important limitation of MS voucher scheme seems that the target beneficiaries have very limited choice to choose service providers. In Dhaka, MS have been able to arrange MoU with a few service providers from whom clients can access services with the vouchers. Otherwise, clients are to receive service from Marie Stopes's clinics. In Chittagong and Khulna- the other two cities where the voucher scheme is running, beneficiaries have no choice but to receive services from the Marie Stopes clinics. Literature suggests that giving financial incentive and giving power to choose providers to the target group are the main desirable features of a voucher scheme (standing. 2004; Ensor 2003; Bhatia et al., 2006). While MS scheme gives sufficient financial incentive to the clients, it does not allow them sufficient options to choose facilities. Under the MS voucher scheme, the clients have to receive maternal care generally from its own clinics because, quality and range of services provided by MS is not usually available in urban areas other than Dhaka.

The framework is not quite conducive to open up adequate choice for the beneficiaries as private sector service price remains far above the allowable cost under the voucher scheme. Therefore, private sector providers do not have the motivation to provide service under the voucher scheme. On the other hand, public sector service facilities do not accept the voucher and the doctors are not allowed to take any form of benefits from clients. Thus the public sector providers have institutional as well as motivational constraints to render services under the MS voucher schemes.

MS has arranged MoU with some NGO run facilities, which are supported by public finances through ADB loan facilities. NGO clinics thus have the provision to underwrite the subsidies that are resulted

from servicing voucher clients. Thus MoU between MS and NGO run clinics results into a win-win situation, which was not the case for private and government facilities.

4.2.1 Recommendation:

MS has a strong argument to defend its service mechanism on this point.

The MS clinics are reputed service centers; they provide quality care. MS is also increasing providers' accountability to clients. Given these, the consumers are receiving better care there than at other private or public facilities. The public facilities deliver poor care to them, as mentioned earlier. If the clients were allowed to choose private providers under this scheme, it is very likely that they will not receive care as good as MS facilities because the private providers will tend to maximize profit. Therefore, at present lack of choice for providers on the part of the clients under the scheme is doing " more good than harm".

Despite this, MS should gradually allow the consumers to choose providers, from among the accredited providers of course. In the absence of any accreditation system in the country, MS can accredit the providers using the service of experts and experienced managers. MS will then enter into contract with the accredited providers regarding reimbursement mechanism if the clients under the scheme ever visit them. Anyway, MS can do this only after the coverage increases considerably.

4.3 Increased moral hazard of consumers:

Since the care is free and, in addition, transport cost is reimbursed to the clients, the target population may have the tendency to increase demand for care, even unnecessarily. This can create undue pressure on the limited resources of the organization. Some women can visit the facilities to seek care for minor complication or fictitious/ pretended complications. Some women can even be tempted to give birth to increased number of children. Sometimes they can bring their relatives from the villages or urban slums to avail of the scheme facilities.

4.3.1 Recommendation:

The providers and volunteers have to be careful in choosing the clients under the scheme for delivering care and rigorously verify the complaints of the patients. Furthermore, delivering maternal care must be coupled with strong family planning campaign among the target population of the scheme.

Annex-1

Terms of Reference for Mid-term Review of Voucher Scheme

1. INTRODUCTION:

With financial assistance from European Commission, Marie Stopes Clinic Society in Bangladesh is implementing one of its existing outreach activities for the homeless population. Over the years, rapid urbanisation has largely contributed to the increasing numbers of urban poor with a relative increase of the hard core poor (e.g. homeless street dwellers), particularly in Dhaka, Chittagong and Khulna. MSCS' prior intervention for this group has shown that these people suffer from a host of which only increases their vulnerability and it was not possible within the context of earlier intervention to address some of these much needed services. So, under this new intervention, MSCS developed a 'Voucher Scheme' to ensure services that are not possible to render from the current mobile satellite sessions.

1.1 Voucher Scheme:

Under this scheme, a token is given to homeless people (for some much needed services including Normal Delivery, Caesarean Section, STI Lab Diagnosis, MR, D&C, and other services like FP, Dots, severe dehydration and sever malnutrition) which is equivalent to all expenses for delivery of any of these services in any private or NGO clinic or hospital. Against this voucher scheme the holder (of voucher card) is given opportunity to avail all the facilities required for treatment of the health concern in any clinic/hospital affiliated to the scheme and the service delivery point is receiving receive their dues from Marie Stopes Clinic Society by submitting the voucher.

1.2 Objective of the Voucher Scheme:

- To widen the service delivery for the homeless people
- To enable the under privileged homeless people so that they can avail service facilities that are not provided from the mobile satellite sessions
- To ensure management of health problems like delivery, MR, D&C, FP method, etc by experienced personnel from Govt. /NGO or private institutions, which will prevent complications during service delivery which in turn will play a major role in reducing Maternal Mortality Rate in Bangladesh.

2. DESCRIPTION OF THE ASSIGNEMENT:

Assess the progress of voucher scheme in relation to the overall and immediate objectives stated in the original project document in terms of indicators mentioned in the documents, inputs given as per project documents, the adequacy of the management arrangements and the extent to which the activities for the remaining period are effectively responding to the now available information. Based on this assessment, the mission is to advise Marie Stopes, whether and to what extent the scheme can be successfully implemented according to the current plan and to suggest alternative to the current work-plan if need be, and to support the beneficiary in re-planning the activities, if and to the extent that is required.

Specific Objective(s)

- Conduct a mapping exercise to identify size, distribution and demographics of the floating population in Dhaka, Chittagong & Khulna
- Review current reproductive health needs of the floating population
- Review to what extend voucher scheme is satisfying their reproductive health needs
- Suggest ways and means to incorporate other reproductive health needs, not currently addressed under the voucher scheme

- Identify any lesson learnt during implementing this scheme
- Identify ways to further improve the utilization of the scheme and /or maximize the use of inputs

3. SCOPE OF WORK WILL:

- Review EC Block Grant project related documents
- Discuss/meet Senior management team and MS staff responsible for implementing EC Block Grant project to get an understanding EC Block grant project
- Field visit
- Report writing
- Arrange a workshop with the beneficiary for presenting and discussing the results.

4. SUGGESTED METHODOLOGY

For mid-term review, suggested methodology will be:

- Document review including project documents.
- Focus Group Discussions with field staff and beneficiaries;
- In-depth interviews
- Exit Interviews
- Mapping

5. MAJOR DELIVERABLES

- Review team will conduct a debriefing session after the mid-term review
- Based on the out come of debriefing discussion, a draft report will be submitted to Marie Stopes
- The Review Report will include findings, assessments and recommendations to be represented for MS so as to contribute to decision-making regarding the future development of the project.
- The final report is to be submitted in hard and electronic copies