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IMPLEMENTATION COMPLETION AND RESULTS REPORT

TF015995

ON A

GPOBA GRANT

IN THE AMOUNT OF US$13.3 MILLION

TO THE

MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT
THE REPUBLIC OF UGANDA

FOR THE

UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (P144102)

August 28, 2020

[This ICCR replaces the version cleared for Board distribution on September 11, 2020. The excerpt from the client's End of Project Report in Annex 5 has been updated to align with their revised report (pages 46-49).]

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2020)

Currency Unit =	Ugandan Shillings (UGX)
UGX 3,690 =	US$1
US$1.41 =	SDR 1

FISCAL YEAR
July 1–June 30

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Camille Anne Nuamah
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Practice Manager:	Francisca Ayodeji Akala
Task Team Leader(s):	Bernard O. Olayo
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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
CAO	Chief Administrative Officer
CAS	Country Assistance Strategy
CBD	Community Based Distributor
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CME	Continuous Medical Education
DALY	Disability-Adjusted Life Year
DHO	District Health Officer
DHS	Demographic and Health Survey
DHT	District Health Team
EMTCT	Elimination of Mother-to-Child Transmission
FM	Financial Management
GDP	Gross Domestic Product
GoU	Government of Uganda
GPOBA	Global Partnership on Output-Based Aid
HC	Health Center
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICC	Interagency Coordination Committee
ICER	Incremental Cost Effectiveness Ratio
ICR	Implementation Completion and Results Report
IFR	Interim Financial Report
IVEA	Independent Verification and Evaluation Agency
JMS	Joint Medical Stores
KfW	German Development Bank (*Kreditanstalt für Wiederaufbau*)
LCV	Local Council V
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSU	Marie Stopes Uganda
MTR	Midterm Review
NHIF	National Health Insurance Fund
NMS	National Medical Stores
OBA	Output-based Aid
PAD	Project Appraisal Document
PDO	Program Development Objective
PNFP	Private-Not-for-Profit
PFP	Private-for-Profit
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PY	Project Year
QoC	Quality of Care

RBF	Results-based Financing
SD	Safe Delivery
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
TTL	Task Team Leader
UBOS	Uganda Bureau of Statistics
UHC	Universal Health Coverage
UHSSP	Uganda Health Systems Strengthening Project
UNFPA	United Nations Population Fund
URHVP	Uganda Reproductive Health Voucher Project
URMCHSIP	Uganda Reproductive, Maternal and Child Health Services Improvement Project
USAID	United States Agency for International Development
VHT	Village Health Team
VMA	Voucher Management Agency
WHO	World Health Organization

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DATA SHEET

BASIC INFORMATION

Product Information

Project ID	Project Name
P144102	Uganda Reproductive Health Voucher Project
Country	**Financing Instrument**
Uganda	Investment Project Financing
Original EA Category	**Revised EA Category**
Partial Assessment (B)	Partial Assessment (B)

Organizations

Borrower	Implementing Agency
Ministry of Finance, Planning and Economic Development	Ministry of Health (Uganda)

Project Development Objective (PDO)

Original PDO

The project development objective is to increase access to skilled care among poor women living in rural and disadvantaged areasduring pregnancy and delivery.

FINANCING

	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Financing			
TF-15995	13,300,000	13,299,216	13,299,216
Total	**13,300,000**	**13,299,216**	**13,299,216**
Non-World Bank Financing			
Borrower/Recipient	0	0	0
Total	**0**	**0**	**0**
Total Project Cost	**13,300,000**	**13,299,216**	**13,299,216**

KEY DATES

Approval	Effectiveness	MTR Review	Original Closing	Actual Closing
03-Oct-2014	02-Sep-2015	19-Apr-2017	29-Dec-2017	15-Dec-2019

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Amount Disbursed (US$M)	Key Revisions
03-Oct-2017	3.75	Change in Results Framework Change in Loan Closing Date(s) Change in Implementation Schedule

KEY RATINGS

Outcome	Bank Performance	M&E Quality
Satisfactory	Satisfactory	Substantial

RATINGS OF PROJECT PERFORMANCE IN ISRs

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	16-Mar-2015	Satisfactory	Satisfactory	0

02	18-Nov-2015	Satisfactory	Satisfactory	0
03	25-May-2016	Satisfactory	Moderately Satisfactory	.50
04	13-Dec-2016	Moderately Satisfactory	Moderately Satisfactory	1.21
05	26-Jun-2017	Moderately Satisfactory	Moderately Satisfactory	3.40
06	20-Dec-2017	Satisfactory	Satisfactory	3.75
07	29-Jun-2018	Satisfactory	Satisfactory	6.91
08	20-Dec-2018	Satisfactory	Satisfactory	10.64
09	28-Jun-2019	Satisfactory	Satisfactory	13.04
10	19-Dec-2019	Satisfactory	Satisfactory	13.30

SECTORS AND THEMES

Sectors

Major Sector/Sector	(%)
Health	**100**
Public Administration - Health	29
Health	71

Themes

Major Theme/ Theme (Level 2)/ Theme (Level 3)	(%)
Private Sector Development	**10**
Public Private Partnerships	10
Human Development and Gender	**100**
Disease Control	10
HIV/AIDS	10
Health Systems and Policies	90
Reproductive and Maternal Health	90

ADM STAFF		
Role	**At Approval**	**At ICR**
Regional Vice President:	Makhtar Diop	Hafez M. H. Ghanem
Country Director:	Philippe Dongier	Camille Anne Nuamah
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I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Context

1. **The Uganda Reproductive Health Voucher Project (URHVP) was developed when the country was undergoing economic challenges combined with high population growth rate and high poverty levels.** It had experienced a decline in economic growth compounded by increased volatility (3.4 percent in 2012 and 5.8 percent in 2013). Uganda's gross domestic product (GDP) per capita was US$490, and poverty levels were high with half of the population subsisting on less than US$1.25 per day. Its population growth rate of 3.2 percent and dependency ratio of 1.12 were among the highest in the world. While child and infant mortality saw a substantial drop between 2006 and 2011, reduction in the maternal mortality ratio had been slow (438 maternal deaths per 100,000 live births), despite improvements in skilled delivery attendance and contraceptive prevalence rate in the preceding years. Perinatal and maternal morbidity and mortality were major causes[1] of the high disease burden in Uganda, accounting for 24.4 percent of the burden. Low coverage of skilled delivery services, especially comprehensive emergency obstetric care, was a major problem.[2] Adolescent reproductive health services were generally limited, and while contraceptive use had increased,[3] coverage remained low and the unmet need for contraceptives remained high. Induced abortions were quite common with about 297,000 induced abortions estimated annually. Total fertility rate of 6.2 births per woman in the reproductive age group was among the highest in the world. Moreover, coverage of elimination of mother-to-child transmission (EMTCT) of human immunodeficiency virus (HIV) infection was estimated to be only 52 percent.[4]

2. **Improving maternal health outcomes has been a key priority for Uganda** and a key focus in the country's strategies as outlined in the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2006–2015) and the Reproductive Health Commodity Security Strategic Plan (2010/11–2014/15). These strategies included (a) expanding maternal and newborn care services, (b) improving management and staff motivation, and (c) strengthening supply chain management for reproductive health commodities. The country had been expanding the use of existing contraceptive methods, introducing implants, strengthening services for post-abortion care and resuscitation of newborn babies, and expanding maternal and perinatal death audits. In 2012, Uganda adopted the policy to enroll all HIV-positive pregnant women in the EMTCT program and give them lifelong treatment. In addition, a separate supply chain management system for reproductive health commodities had been set up to serve private providers, and the Government was in the process of streamlining the management and operations of ambulance services countrywide.

[1] Hemorrhage, abortion, sepsis, obstructed labor, pregnancy-induced hypertension, and malaria are the major causes of maternal deaths and stillbirths.
[2] According to the 2011 Demographic and Health Survey (DHS), over 90 percent of mothers attended at least one antenatal care (ANC) visit; 47 percent attended at least 4 ANC visits; 59 percent delivered under skilled care; and contraceptive prevalence rate was estimated at 30 percent.
[3] According to the 2011 DHS, contraceptive use increased from 18 percent in 2001 to nearly 30 percent in 2011.
[4] HIV prevalence was estimated at about 7.3 percent among pregnant women and vertical transmission of HIV to children by mothers contributed over 15 percent of HIV new infections annually.

3. **Uganda operates a two-tiered health system involving public and private providers.** At the national level are one national referral hospital and regional referral hospitals, the national medical stores (NMS), the national public health laboratories, and the National Health Research Organization; these institutions report to the Central Government. At the district level, the system consists of multiple categories that report to the local governments: (a) village health teams (VHTs)/volunteers that provide promotive, preventive, and basic curative services in the communities, (b) health centers (HCs) (Types II–IV), and (c) general hospitals. The public providers are complemented by private-not-for-profit (PNFP) and private-for-profit (PFP) service providers[5] as well as traditional and complementary practitioners. The facilities deliver essential health care services including safe delivery services and are expected to be licensed by the appropriate Professional Medical Council. According to the government policy, services rendered by public providers carry no user fees apart from private wings in public hospitals that are allowed to levy user fees.

4. **It was in this context that the URHVP was developed to further the country's efforts in improving maternal health outcomes.** It was a follow-on to the World Bank-supported Reproductive Health Vouchers in Western Uganda Project (2007–2012) with a safe delivery (SD) component, which Uganda had successfully executed.[6]

Theory of Change (Results Chain)

5. **The operation's results chain was designed based on the global evidence and the lessons from the previous project, which was rated Satisfactory (Reproductive Health Vouchers in Western Uganda).** A key assumption was that combined investments in (a) the demand side (to remove financial barriers to service utilization among poor pregnant women residing in rural areas through provision of highly subsidized vouchers[7]), (b) the supply side (to improve access to and quality of obstetric services), and (c) the health system's capacity (to strengthen project management and implementation capacity) would lead to reduction in risks associated with pregnancy and childbirth.

6. **A key aspect of this new project was the implementation of the output-based aid (OBA) financing.** This financing model had been used in the two projects that preceded this new project: Sexually Transmitted Infections (STIs) OBA Voucher Project (financed by German Development Bank [*Kreditanstalt für Wiederaufbau* (KfW]) and Reproductive Health Vouchers in Western Uganda (financed by KfW). This model held service providers accountable for results by only disbursing payment upon verification of the achievement of the pre-agreed results listed below. The Global Partnership on Output-Based Aid (GPOBA)

[5] The PNFPs are predominantly faith based. The PFP providers predominantly comprise clinics but also include drug shops and vendors operating informally.
[6] Implementation Completion and Results Report (ICR) on *Reproductive Health Vouchers in Western Uganda*, December 31, 2012.
[7] The 2011 Uganda DHS indicated that financial barrier was a critical factor that hinders poor women in rural areas to access maternal care services. According to the survey, 49 percent of women reported that getting money to seek health care services was a problem (53 percent among women in the rural areas; 60–70 percent among women in the bottom 40 percent of the households).

was the contributor of the US$13.3 million grant, with funds from the Swedish International Development Cooperation Agency (SIDA).[8]

7. **The project at appraisal did not have a Theory of Change (as this was not a requirement at the time).** The results chain presented in Table 1 was prepared based on the information in the Results Framework. The results chain also guided the economic efficiency analysis (presented in section II.C and annex 4). As key inputs (activities), the project set up a voucher management agency (VMA) and an independent verification and evaluation agency (IVEA), selected and trained service providers, created demand in communities, distributed vouchers to receive a package of SD services, carried out clinical audits and quality assurance of service providers, and also set up clusters of functional referral networks between Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC). These inputs were to lead to (a) improved quantity and quality of ANC, delivery, and postpartum services and (b) increased coverage and utilization of antenatal and delivery care services. The long-term impact would be reduced maternal morbidity and mortality.

Table 1. Theory of Change (Results Chain)

Inputs (Activities)	Outputs	Outcomes (PDO)	Impact
• VMA and IVEA in place • Service providers selected and trained to provide quality services • Demand creation in communities • Vouchers distributed and redeemed by mothers to receive a package of safe delivery services • Clinical audits and quality assurance of service providers • Cluster of functional referral networks between BEmONC and CEmONC sites formed	• Number of deliveries assisted by skilled birth attendants • Number of vouchers distributed and redeemed for deliveries • Number of women attending at least one ANC visit	• To increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery • Improved quantity and quality of antenatal, delivery, and postpartum services • Increased coverage and utilization of antenatal and delivery care services	• Reduced maternal mortality • Reduced maternal morbidity

Project Development Objectives (PDOs)

8. **The PDO was to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.** The primary beneficiaries were the poor and vulnerable pregnant women residing within the catchment areas of contracted health facilities in two regions of Uganda: South Western Region and Eastern Region. Several considerations including poverty status, percentage of skilled delivery, and infant mortality rate at the time of design guided the selection of the two regions.[9] The South Western region was also where a voucher project had been implemented

[8] GPOBA is a multi-donor trust fund administered by the World Bank which specialized in results-based financing (RBF) to improve access to basic services for the poor and other vulnerable populations. In 2019, the name was changed to the Global Partnership for Results-Based Approaches (GPRBA).

[9] Uganda National Household Survey 2016/2017 Report (https://www.ubos.org/wp-content/uploads/publications/03_20182016_UNHS_FINAL_REPORT.pdf). The 2012/2013 poverty estimate for the Eastern Region was 24.7 (that is, 24.7 percent of the population in the region were estimated to live in households that spend less than

(under the previous project), which the URHVP built on. The mothers were expected to be able to reach the facilities in less than 2 hours; this was the principle that guided the distribution of the vouchers to mothers who are able to reach the facilities. The contracted service providers and surrounding communities were the secondary beneficiaries.

Key Expected Outcomes and Outcome Indicators

9. The following PDO-level indicators were to assess the project's achievements. These are organized in two parts.

PDO Part 1 - Increased access to skilled care during pregnancy:

- Number and percentage of women attending at least one ANC visit under the project
  - Achieve 90 percent of pregnant women enrolled under the scheme attend at least one ANC visit.

PDO Part 2 - Increased access to skilled care during delivery:

- Number and percentage of deliveries assisted under the project
  - Achieve 156,400 pregnant women to deliver under skilled attendance.[10]
- Number and percentage of vouchers distributed and redeemed for deliveries under the project
  - Achieve a voucher redemption rate of 70 percent for deliveries.

Components

10. The operation had two components: (a) Package of safe delivery services to poor pregnant women and (b) Capacity building and project management.

11. **Component 1: Package of safe delivery services to poor pregnant women (US$9.5 million).** The objective of this component was to provide 156,400 pregnant women access to a defined package of safe delivery services from contracted private and public providers. The package of services consisted of four ANC visits (according to global standards), safe delivery, one postnatal visit, treatment and management of selected pregnancy-related medical conditions and complications (including caesarian sections), and emergency transport. The package also included services for EMTCT as part of ANC and postpartum family planning (PPFP) (from 2017; following midterm review [MTR] and restructuring). Access to these services involved purchasing of vouchers at UGX 4,000 (US$1.60) by eligible pregnant women through the scheme administered by a VMA. Women were assessed and selected for the scheme using a combination of

what is necessary to meet their caloric requirements and to afford them a markup for non-food needs); for the South Western Region, the estimate was 7.6.

[10] The original target for total deliveries assisted under the project was 132,400. Given the parallel financing that the project obtained from the Uganda Health Systems Strengthening Project (UHSSP) and the United Nations Population Fund (UNFPA), the target was increased from 132,400 to 156,400.

geographical targeting (based on poverty mapping), vulnerability assessment, and a customized poverty grading tool (defined in the Operations Manual; tool in Appendix 6).[11]

12. **The project covered 25 districts (12 in the South Western Region and 13 in Eastern Region) of the country.** There were 201 participating service providers (public, PNFP, and PFP) by the end of the project period (102 in the South Western region [64 BEmONC and 38 CEmONC] and 99 in Eastern region [87 BEmONC and 12 CEmONC]—accounting for about 30 percent of all health facilities in each region—along with a total of 456 community-based distributors (CBDs)/VHTs (224 in the South Western region and 232 in the Eastern region). Service providers were selected based on a set of criteria (defined in the Operations Manual)**12** and were subject to annual clinical audits to assess quality of care (QoC) and adherence to service guidelines and protocols issued by the Ministry of Health (MoH). Service providers were then mapped to create functional referral networks (clusters) between health facilities providing BEmONC services and those providing CEmONC services. They were expected to provide the specified services and submit claims together with the appropriate voucher coupons to the VMA for settlement on the basis of the negotiated fees. The IVEA verified project outputs as well as the integrity of the claims processing system and reported to the MoH every six months.

13. **Component 2: Capacity Building and Project Management (US$3.8 million).** This component's objective was to support project management functions and build national capacity to implement SD voucher scheme in the health sector. Under this component, the project financed (a) specific project management activities including oversight functions by the MoH, project administration and management by the VMA, verification activities by the IVEA, service provider selection, audit, and monitoring and evaluation (M&E) and (b) capacity-building activities including training and quality assurance activities to streamline and harmonize implementation processes for scaled-up implementation of the voucher scheme in the sector.

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION (IF APPLICABLE)

14. **The project (with a total financing of US$13,300,000) was approved on December 18, 2014, instead of February 28, 2014, as originally planned due to concerns regarding the anti-homosexuality act.** The delay allowed the project to draw in more resources, that is, parallel financing of US$3,058,950 from the UHSSP and US$954,436 from the UNFPA. These were added to the original financing of US$13,300,000 from the GPOBA, and enhanced the project's overall resource envelope (totaling US$17.31

[11] The project used a combination of geographical targeting (based on poverty mapping) and a customized poverty-grading tool to select eligible beneficiaries. Eligibility for geographical targeting was determined through the use of poverty maps prepared by the Uganda Bureau of Statistics (UBOS) using the 2002 census. The following criteria were used to determine eligibility for subsidies under the project: (a) pregnant women residing in sub-counties where over 60 percent of households are deemed poor on the basis of the poverty maps by UBOS shall be eligible to join the scheme without undergoing household assessment and (b) pregnant women resident in sub-counties where poverty is not deemed widespread will undergo a poverty assessment using the poverty grading tool. Eligible beneficiaries will be selected by scoring individual households on a number of different variables, and those with a score of 12 or less will be eligible to join the scheme.

[12] The selection of service providers was guided by the following principles: (a) location in the areas mapped under the project, (b) expression of interest to provide safe delivery services, (c) licensed to practice by the appropriate medical council, and (d) capacity to provide the defined package of services. Further details are provided in the Operations Manual, April 2015.

million)[13] and its ability to reach a larger number of vulnerable women with safe delivery services.[14] The additional funding from the UNFPA was intended to support an estimated 10,453 safe deliveries in eight project districts of Eastern Uganda over a period of one year; US$736,937 was allocated to voucher service reimbursements and US$217,499 for VMA costs, inclusive of value added tax. The additional resources from the UNFPA and the UHSSP were front-loaded to ensure the project absorbed all available funding before the closing dates of the two co-fundings (UNFPA: December 31, 2016 and UHSSP: June 30, 2017).

15. **Following the MTR mission of April 2017, the project underwent restructuring in October 2017;** it aimed to compensate for the delay with project approval and effectiveness of 12 months and to account for the additional parallel financing obtained. The project closing date was extended from December 29, 2017 to December 15, 2019. The Results Framework was adjusted during this restructuring, including change in a PDO indicator (see details in the next section). In addition, the restructuring aimed to assist the VMA to implement recommendations of the MTR, including (a) strengthening the referral system, (b) encouraging mothers to seek ANC early and to attend subsequent antenatal visits as well as postnatal care (PNC), (c) promoting PPFP, (d) conducting continuous quality assessment and providing mentoring to service providers, and (e) incentivizing CBDs to follow up with mothers and to carry out interpersonal communication beyond voucher sales.

Revised PDOs and Outcome Targets

16. **During the 2017 restructuring, the target of a PDO indicator was revised to accommodate the parallel financing obtained from the UHSSP and the UNFPA described earlier.** The target for total deliveries assisted under the project was increased from 132,400 to 156,400.

17. **Project indicators were revised in line with the MTR recommendations.** The changes included (a) dropping the PDO indicator ‘direct project beneficiaries’, as this was no longer a World Bank core sector indicator; (b) replacing the indicator ‘number and percentage of deliveries under the project’ with a World Bank corporate results indicator, ‘number of deliveries attended by skilled health personnel’; and (c) adding the indicator on citizen engagement: ‘percentage of voucher mothers satisfied with the services’.

II. OUTCOME

A. RELEVANCE OF PDOs

Assessment of Relevance of PDOs and Rating

Rating: High

18. **The project’s key expected outcomes were aligned to the World Bank Group’s Country Assistance Strategy (CAS) (2011–2015) Report No. 54187-UG, which was in place at the time of appraisal, in particular, its strategic objective three - promote human capital development, and**

[13] The data sheet does not contain the parallel financing from the UHSSP and the UNFPA. It only indicates the financing through the URHVP of US$13.3 million. However, all calculations on costs and effectiveness consider the full resource envelope of US$17.31 million.

[14] The UNFPA resource was to support an estimated 10,453 safe deliveries in eight project districts of Eastern Uganda over a period of one year.

specifically Outcome 3.2: Strengthened health care delivery. The CAS intended to address the needs and constraints of women (and men) to benefit from health care and other social services and opportunities. The project was and remains relevant and aligned to the current Country Partnership Framework 2016–2021, which continues its focus on 'strengthening health systems and improving incentives for health providers, as well as maternal and child health', and 'increasing the results focus of the government health programs'.[15] Furthermore, the project objective's specific focus on 'poor women living in rural and disadvantaged areas' was aligned to the equity and inclusion agenda of the World Bank Group's corporate goals, to improve well-being of the poorer segments of the society.

19. **Furthermore, the project objective was highly relevant to and consistent with the country's current development priorities to tackle the high level of maternal mortality.**[16] The project was designed and aligned to the vision articulated in the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007–2015).[17] It aimed to contribute to accelerating progress toward achievement of the Millennium Development Goals and was informed by its predecessor, Reproductive Health Vouchers in Western Uganda (2007–2012), which used the OBA model and provided subsidized reproductive health services and treatment of STIs to vulnerable clients.

20. **In summary, the project objective was consistent with the World Bank's country and sectoral assistance strategies as well as the institution's equity and inclusion agenda (that is, improving access to skilled delivery services for poor and marginalized women in rural areas).** It was also consistent with the country's strategy on improving maternal health outcomes and its focus on evidence-based cost-effective package of services (from pre-pregnancy/ANC, through delivery, to postpartum care including family planning). Thus, the relevance of PDO is assessed as High.

B. ACHIEVEMENT OF PDOs (EFFICACY)

Assessment of Achievement of Each Objective/Outcome

Rating: Substantial

21. **The PDO was to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.** The achievement is assessed for each of the two aspects of the PDO: increased access to skilled care (a) during pregnancy and (b) during delivery.

[15] 2016–2021 Uganda Country Partnership Framework Report No. 101173-UG.

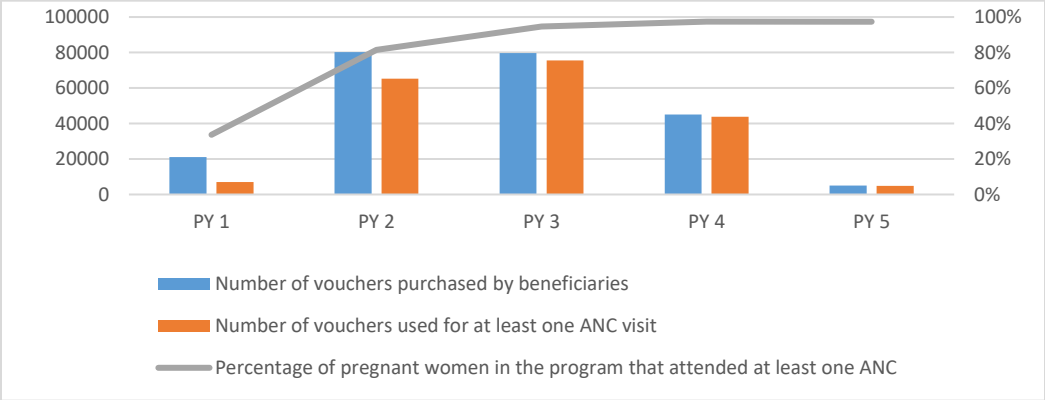
[16] According to the 2016 Uganda DHS, its estimate was 375 deaths per 100,000 lives over the seven-year period preceding the 2016 Uganda DHS and it accounted for 18 percent of all deaths among women ages 15–49 years.

[17] Specifically, the project's objectives were in line with the two main objectives of the road map: (a) to increase the availability, accessibility, utilization, and quality of skilled care during pregnancy, childbirth, and postnatal period at all levels of the health care delivery system and (b) to promote and support appropriate health-seeking behavior among pregnant women, their families, and the community. Inclusion of PPFP in the second half of the project period was in line with the third objective of the road map: to strengthen family planning information and service provision for women/men/couples who want to space or limit their childbearing thus preventing unwanted and/or untimely pregnancies that increase the risk of a maternal death.

PDO Part 1 - Increased access to skilled care during pregnancy
Rating: Substantial

22. **The PDO Part 1 was measured by the achievement of one PDO indicator and two intermediate indicators.** The PDO indicator measuring the achievement of this PDO was the percentage attending at least one ANC visit. The number of women attending at least one ANC visit under the project grew from slightly over 7,000 in year 1 to 40,000–75,000 in years 2 through 4, achieving a cumulative total of almost 200,000 women by the end of the project (196,668), reaching a total of 86 percent against the end target of 90 percent (Figure 1). Thus, the achievement against the target is 95 percent.

Figure 1. Number and Percentage of Pregnant Women Enrolled under the Scheme That Attend at Least One ANC Visit



Source: URHVP End of Project Report September 2015-December 2019, MoH
Note: PY = Project Year.

23. **There were two intermediate indicators that contributed to increased access to skilled care during pregnancy (PDO Part 1): percentage of women who tested for HIV and number and percentage of pregnant women with HIV who received EMTCT.** In terms of HIV testing, 80 percent (157,247 out of 196,668) of pregnant women were tested for HIV—slightly below the end target of 90 percent which is equivalent to 88 percent achievement of the target. While still a significant achievement, this was lower than expected partly because of a change in the algorithm for HIV testing. The new test (Bioline) experienced stock-outs, and thus, health facilities were challenged in accessing the test kits, which in turn affected the testing volume. However, it is commendable that of the 4,017 women who tested positive for HIV, 96 percent of them received EMTCT services.[18] Given the achievements across these three indicators, the rating for PDO Part 1 is Substantial.

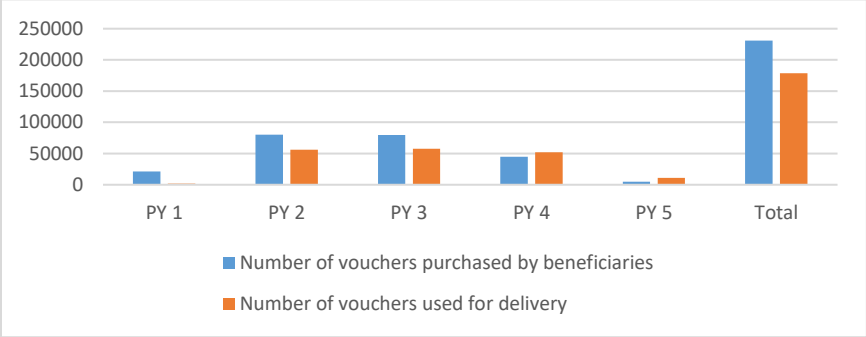
PDO Part 2 - Increased access to skilled care during delivery
Rating: Substantial

24. **The PDO Part 2 was measured by two PDO indicators and three intermediate indicators.** The two PDO indicators that measured the achievement of PDO Part 2 were (a) percentage of vouchers distributed and redeemed for delivery and (b) number of skilled deliveries attended by skilled personnel.

[18] The 4 percent lost to tracking resulted from long-distance referrals from non-antiretroviral therapy (ART) voucher facilities to ART facilities. This happened mostly between the PFP non-ART facilities and the public or PNFP ART facilities.

With respect to the first PDO indicator, the project surpassed the end target of the voucher redemption rate[19] of 70 percent for deliveries. A cumulative total of 178,413 target beneficiaries redeemed the voucher for deliveries (from a total of 231,002 vouchers distributed during the project period), reaching 77 percent (well over the end target) (Figure 2).[20] It is worth noting that at least two districts in the Eastern Region (Jinja and Tororo) and four districts in the South Western Region (Bushenyi, Kabale, Mbarara, and Sheema) achieved well over 80 percent coverage. Variability in achievement between districts is likely to be due to the differences in the number of facilities accredited to participate in the project and in the level of district leadership and ownership. It should also be noted in Figure 2 that bars indicate purchase and use in each PY; there is a time lag between when vouchers are purchased and when they are used (that is, some of the vouchers purchased in PY 4 were used in PY 5). In addition, the total number of vouchers was fixed for the project period, and their sale was controlled/regulated in the final years of the project so as to not run out.

Figure 2. Comparison of Vouchers Purchased by Beneficiaries and Vouchers Used for Delivery – by PY



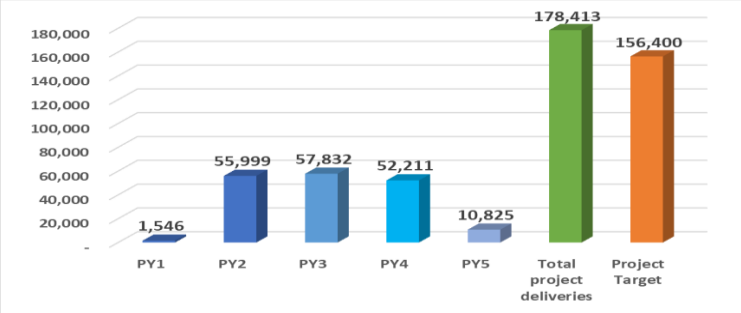
Source: URHVP End of Project Report September 2015-December 2019, MoH

25. **With respect to the second PDO indicator, the project reached a cumulative total of 178,413 deliveries attended by skilled personnel, surpassing the end target of 156,400 (figure 3).** The number of deliveries attended by skilled health personnel increased substantially from little over 1,500 in the first year of operation to well over 50,000 every year in year 2 through year 4 and over 10,000 in year 5 when the project closed. Of the total deliveries, 29,509 (16.5 percent) were caesarian sections, and 148,904 (83.5 percent) were normal deliveries.

[19] Voucher redemption rate measures the proportion of vouchers purchased by clients utilized for safe delivery. It was used to monitor the proportion of vouchers sold that were actually used for safe delivery.

[20] Voucher redemption rate of about 70 percent was expected as evidence from similar voucher programs suggests a range in terms of redemption rate between 44 percent and 92 percent (ref: Eva, et al. 2015. "Vouchers for Family Planning and Sexual Health and Reproductive Health Services: A Review of Voucher Programs Involving Marie Stopes International among 11 Asian and African Countries." *International Journal of Gynecology and Obstetrics* 130 (3): E15–E20). The project took this into account in determining the number of vouchers to be distributed. Discussions during the ICR mission revealed anecdotal evidence that some women purchased vouchers for a sense of insurance and some purchased vouchers but did not deliver at health facilities accredited by the project (and thus the voucher was purchased but not used).

Figure 3. Deliveries Attended by Skilled Personnel



Source: URHVP End of Project Report September 2015-December 2019, MoH

26. **Three intermediate outcome indicators contributed to increased access to skilled care during delivery (PDO Part 2): (a) percentage of vouchers distributed and redeemed for PNC, (b) percentage of mothers referred (to higher-level facilities), and (c) number of fresh stillbirths.** First, the percentage of vouchers distributed and redeemed for PNC increased over the course of the project period and achieved 41 percent (surpassing the project target of 35 percent): 84,572 vouchers redeemed for PNC out of the 178,413 vouchers redeemed for skilled delivery. Percentage of mothers that received PPFP services increased from 4 percent to 42 percent by the end of June 2019. The CBDs/VHTs played an increasingly active role in generating demand in the communities. A performance-based pay for CBDs/VHTs was used as an incentive (a payment of UGX 30,000 per month) to motivate them to not only increase women's access to ANC and skilled delivery services but also to retain them through the continuum of services post delivery, thus contributing to increased uptake of PNC and PPFP.

27. **In terms of referrals, the project tracked the number of pregnant women referred against the total number of women who delivered under the project.** A cumulative total of 12,000 mothers were referred from the lower-level facilities (BEmONC to CEmONC facilities), whose cost of transport was covered by the project. Based on the indicator definition, this represents 9.5 percent against the end target of 14 percent (that is, 12,612 pregnant women referred from among 132,400—which was the initial target number of women with deliveries assisted). This is a significant achievement since pregnant women referred electively (not an emergency) and whose transport was not facilitated by the project were not in the total count. The project tracked referrals by those where the health facilities covered the cost of transport, and women whose potential risks were identified during ANC visits and were guided to seek delivery service at a higher-level facility did not go into the count. Thus, this indicator's ability to assess the total number of referrals the project achieved was limited. Additionally, the original target was estimated by the MoH and the World Bank at the start of the project based on literature available at the time: around 14 percent of women would experience complications that would require referral. Rather than holding the denominator constant at the initial target number of deliveries attended by skilled personnel, a more appropriate approach would have been to review and adjust the target of this indicator at the time of restructuring. For some reason, this was not done.

28. **Significantly, improvement in the QoC as a result of project investments at the lower-level facilities may have suppressed the need for referrals to higher-level facilities (that is, improved QoC using MoH QoC Standards demonstrated by an average clinical quality score of 70 percent in 2016 to 88 percent in 2019 and training of midwives at lower-level health facilities on post-abortion care and**

provision of necessary kits). It is also important to note that the low level of referrals did not seem to affect maternal outcomes. According to the MoH maternal and perinatal death review system (which tracks, reports, and reviews maternal and perinatal death at the facility level), maternal mortality incidence remained low during the project period; there was a total of 44 maternal deaths (out of 178,413 live births)—5 of them at BEmONC facilities and 39 of them at CEmONC facilities. Thus, the lower-than-expected levels of referrals are likely to be partly due to substantial improvements of capacity at lower-level facilities, bringing quality services closer to women.

29. **Number of fresh stillbirths was a proxy measure of safe delivery services.** The cumulative number of stillbirths over the course of the project period reached 458 (against the end target of 330), indicating higher-than-expected poor newborn outcomes.[21] The primary factor for this seems to be that the target for this indicator was not adjusted during restructuring in line with the increase in the target of the number of deliveries (that is, the target number of deliveries increased from 132,400 to 156,400 deliveries, but the target number of fresh stillbirths was not adjusted up).[22] While the intent to measure quality of safe delivery services using this indicator is commendable, a better alignment with the core focus or the investment of the program would have been more appropriate.

30. **Finally, there were two intermediate indicators on project management that contributed to the achievements of both parts of the PDO (Table 2).**

Table 2. Summary of Intermediate Outcome Indicators

Intermediate Outcome Indicators	Baseline	Actuals	Target	Achievement against Target (%)
Percentage of claims reimbursed timely (%)	0	60	80	75
Timely verification reports provided	0	8	8	100
Percentage of voucher mothers satisfied with services (%)	0	90	90	100

31. **The first indicator assessed the timeliness of claims being reimbursed.** Claims were to be redeemed within 20 days of submission. The timely reimbursement of claims to contracted facilities was critical for the operation to effectively provide safe delivery services. Meeting the timeline was initially a challenge. Over the course of the project period, however, the percentage of claims reimbursed timely increased from 50 percent in the initial year to over 60 percent by the end of the project period (against the end target of 80 percent). There were two factors that hindered timely reimbursement at the beginning. First, the initial withdrawal ceiling on the part of the World Bank was capped at US$800,000, which affected liquidity. Second, the process of verifying claims was very slow and laborious in the beginning, and this delayed timely reimbursement. The second indicator related to the timeliness of verification reports provided. The IVEA reports were to be submitted within 50 days after the end of the six-month reporting period. Review of relevant project records did not provide evidence of any challenges with timely submission of verification reports by the IVEA, and the project achieved 100 percent of the target.

[21] Over 75 percent of the 458 stillbirths took place during the first three years of the project period.
[22] The target for the indicator was set initially at 0.25 percent of the total number of deliveries (that is, 330 fresh stillbirths of 132,400 deliveries).

32. **The Results Framework also included a proxy measure of service quality from the beneficiaries' perspective: percentage of voucher mothers satisfied with services.** This measure (which reflects achievement of both parts of the PDO) was assessed during the biannual verification by the IVEA among sampled respondents. By the end of the project period, 90 percent of respondents in the survey found the maternal and safe delivery services that they received to be at least satisfactory (consistent trends across previous surveys) against the target of 90 percent. What the beneficiaries appreciated the most were(a) the services being free (99 percent) and (b) the quality of services and competence of service providers (98 percent). At the same time, the time spent waiting to receive services as well as the general hygiene conditions at facilities were moderately satisfactory (87 percent).[23]

33. **To conclude, the PDO indicators either achieved or surpassed their end targets (Table 3).** As discussed earlier, the level of achievement for intermediate results is slightly more varied, but overall, significant achievements were attained.

Table 3. Achievement of the PDO Indicators

PDO Indicators	Baseline	Midline (2017)	Actuals	Target	Achievement against Target (%)
PDO Part 1					
# and % of women attending at least one ANC visit	0	34%	86%	90%	95
PDO Part 2					
# of skilled deliveries attended by skilled personnel	0	43,042	178,413	156,400	114
# and % of vouchers distributed & redeemed for delivery	0	23%	77%	70%	110

34. **Based on the above assessment, achievements of both parts of the PDOs are Substantial.** Therefore, overall efficacy is rated Substantial.

C. EFFICIENCY

Assessment of Efficiency and Rating

35. **To determine the rate at which the available resources and inputs under the project were converted into results, a benefit-cost analysis and an operational/implementation efficiency review were conducted.** The results show that the benefits or results were achieved at least cost, and the implementation process was largely efficient albeit with some delays. Details are provided below.

36. **An economic analysis of project interventions was undertaken at appraisal and is outlined in the Project Appraisal Document (PAD).** The analysis was based on a previous project—the Reproductive Health Vouchers in Western Uganda[24]—which was implemented just before the URHVP. The results from this analysis were then used to undertake an economic analysis for the URHVP. Specifically, the estimated costs and benefits for the URHVP were compared with the alternative of not using vouchers. Subsequently, the incremental cost-effectiveness ratio (ICER) was estimated at US$156 per disability-

[23] URHVP II IVEA Bi-Annual Report June-November 2019 (submitted December 2019).
[24] This project was financed by KfW and the GPOBA, which is a global partnership administered by the World Bank.

adjusted life year (DALY) averted. Since the ICER per DALY averted was less than half the annual GDP per capita in Uganda (US$490 at that time), the URHVP was considered to be highly cost-effective.[25]

37. **Using the assumptions from the economic analysis that was carried out during the preparation of the URHVP, a new economic analysis was undertaken to calculate the benefits and costs of the URHVP at closure (annex 4).** The main outcome that was assessed was the reduction in maternal deaths for the 15–49 years age group as this is the most active childbearing age group in Uganda. It was assumed that increasing coverage and quality of health care for antenatal and facility-based deliveries through the project would lead to a reduction in maternal deaths. In addition, it was assumed that every maternal death averted accounted for 85 DALYs based on the World Health Organization (WHO) data for low-income countries. The benefits and costs were discounted at 3 percent while a sensitivity analysis was also conducted to gauge the robustness of the results. The results show that the US$16.1 million in discounted spending under the URHVP yielded US$120 million in discounted benefits and a benefit-cost ratio of 7.5: 1. This implies that each US$1 that was invested in the URHVP yielded US$7.5. The cost-effectiveness ratio was estimated at US$98 per DALY averted, and based on three different thresholds or assessment criteria, the conclusion is that the URHVP was highly cost-effective. In particular, the cost-effectiveness ratio of US$98 per DALY averted under the URHVP was lower than (a) the ICER of US$156 per DALY averted under the Uganda Reproductive Health Vouchers Output-Based Aid Scheme—which was implemented just before the URHVP; (b) the US$116 opportunity cost based cost-effectiveness threshold for low-income countries;[26] and (c) the US$732 GDP per capita for Uganda in 2019.

38. **With regard to implementation efficiency, the processing time for the URHVP took much longer than anticipated due to factors beyond the control of the task team and the implementing agency.** Specifically, it took 17.9 months to make the first disbursement after Board approval. The project had to be restructured to recover the time that was lost due to the initial implementation delays. After the initial delays, funds were disbursed efficiently, and by the end of the project, 99.99 percent of the funds were spent. At the time of writing the ICR, the verified unfunded commitment was estimated at US$496,443.30, which was 3 percent above the total funding from all the funding sources. To inherently measure implementation efficiency and use of the vouchers, the project had a PDO indicator on the distribution and actual use of the vouchers for deliveries. By the end of the project, the target for this indicator was fully achieved (as discussed earlier under section II.B).

39. **Various aspects of the project design and implementation arrangements helped reinforce the purchaser-provider split.** These aspects include the use of a private firm (Marie Stopes Uganda [MSU]) as the VMA, BDO East Africa as the IVEA, the MoH for oversight and stewardship, and the communities (VHTs) for demand generation. First, this enhanced the purchasing arrangement and contributed to improved efficiency and value for money, technical sustainability, and provision of quality health care services.[27] Second, through training, clinical mentorship, and support supervision, the project improved

[25] Based on cost-effectiveness thresholds by the WHO's Choosing Interventions that are Cost-Effective (WHO-CHOICE) initiative, an intervention that costs less than once the national annual GDP per capita per DALY averted is highly cost-effective. However, this criterion is widely criticized.

[26] Woods, B., P. Revill, M. Sculpher, and K. Claxton. 2016. "Country-level Cost-effectiveness Thresholds: Initial Estimates and the Need for Further Research." *Value in Health* 19 (8): 929–935.

[27] For example, the project managed to supplement the supply of drugs and medical supplies at the public health facilities by investing part of the income from the vouchers toward the purchase of drugs and medical supplies. This intervention minimized

the capacity of service providers to manage normal and complicated pregnancies, newborn care, and family planning. Third, with support from the project, 23 health facilities (of which 19 were public) were upgraded to CEmONC status. Last, transitioning the URHVP districts to the RBF scheme under the MoH was easier given that health workers and communities in the URHVP districts had considerable experience with vouchers, which is a demand-side RBF mechanism.

40. **Considering that a number of firms and agencies were being used in the URHVP, it is important to review the administrative costs as a share of the total project costs to determine whether cost efficiencies were gained.** While this assessment is already available in the benefit-cost analysis (annex 4), it is often important to highlight the administrative costs of voucher programs as this is often the crux of the debate in contracting-out and/or demand-side performance-based financing. Ultimately, there are three main primary costs associated with voucher programs: (a) the administrative costs of setting up and running the program, (b) the costs of the goods and services provided, and (c) capacity building and demand generation. Results from the URHVP show that 25 percent of the total project costs were administrative. This includes VMA fixed and variable costs such as staff time, rent, utilities and other office running costs; creation of provider networks; voucher distribution; claims processing; and independent verification/audits by the IVEA. At 25 percent, administrative costs as a share of the total project costs under the URHVP are relatively lower than the 29 percent that were planned (see Table 1 in the PAD) and the 28 percent that were achieved under the Uganda Reproductive Health Vouchers Output-Based Aid Scheme, which was implemented between 2006 and 2011, just before the URHVP. In neighboring Kenya, the share of administrative costs is relatively similar to the URHVP. A review of a voucher project for family planning and sexual and reproductive health in Kenya shows that 24 percent of the total project costs covered administration and evaluation.[28]

41. **It is important to note that administrative costs are critical for running the voucher program and also for building a long-term demand-side financing mechanism.** Administrative costs could be high in the initial years but reduce after some years when expertise and best practices for voucher management are acquired. This was observed during the Uganda Reproductive Health Vouchers Output-Based Aid Scheme. However, there was a fluctuating trend during the implementation of the URHVP due to delays in sourcing the VMA and the IVEA and reimbursement of service providers. Consequently, administrative costs as a share of the total project costs under the URHVP were estimated at 13 percent in 2016/17 rising to 30 percent in 2017/18, dropping to 18 percent in 2018/19, and then increasing to 57 percent in 2019/20. These fluctuations reflect the differences in processing monies for the VMA, IVEA, and the service providers over the years. Nonetheless, the overall share of administrative costs from the total project cost was 25 percent. Based on the results from the benefit-cost analysis (annex 4), the ability to deliver subsidies through health vouchers was clearly more efficient and effective and outweighs the additional administrative costs.

42. **In summary, the project was highly cost-effective,** enhanced the purchasing arrangement, and improved efficiency and value for money, and the experience with vouchers enabled the smooth

stock-outs of essential medicines and supplies in public health facilities thereby limiting unnecessary client referrals and incomplete treatments.

[28] Germany's Federal Ministry for Economic Cooperation and Development and Ministry of Public Health and Sanitation, Kenya. 2012. "Vouchers: Making Motherhood Safer for Kenya's Poorest Women." Accessed on August 16, 2020, from http://health.bmz.de/ghpc/case-studies/Vouchers-MDG5/Vouchers_long_EN.pdf.

transition of the URHVP districts to the RBF scheme under the MoH. However, given some delays in implementation, the overall rating for efficiency is Substantial.

D. JUSTIFICATION OF OVERALL OUTCOME RATING

43. **The overall outcome of the operation is assessed as Satisfactory given the ratings for each of the three dimensions of outcome.**

Table 4. Outcome Rating

Outcome Dimensions	Ratings
Relevance	High
Efficacy	Substantial
Efficiency	Substantial
Project Outcome Rating	Satisfactory

E. OTHER OUTCOMES AND IMPACTS (IF ANY)

Gender

44. **The project's primary beneficiaries were pregnant women and mothers; over the course of the project period, 178,413 economically disadvantaged and vulnerable women benefited from skilled delivery (well over the target of 156,400).** Furthermore, the project may have also contributed to addressing the broader social norms that affect women's ability to access health services. During the ICR mission, it was also noted (anecdotally) that the voucher program contributed to relieving the social and financial pressures in the households and consequently relieved family tension as well. The scheme enabled households to bear the cost and allowed women to access safe delivery services.

Institutional Strengthening

45. **The project by design aimed to build national capacity to mainstream and scale up implementation of the safe delivery voucher scheme in the health sector.** The project financed management and administration activities by the MoH and the VMA; this included service provider selection, capacity-building and quality assurance activities, verification activities, audit, and M&E. As a result, the capacity of the MoH and the VMA was enhanced in the use of vouchers for safe delivery (including ensuring voucher security), targeting of beneficiaries, engagement with the private sector service providers (PNFP and PFP providers), service quality improvement and assurance, clinical and financial audits, and use of data to monitor and improve performance. This experience informed the ongoing operation, Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHSIP) (2016 2021) and enabled the national systems to implement the RBF of the URMCHSIP in line with the move of the Government of Uganda (GoU) toward RBF as expressed in its 2016 Health Financing Strategy.[29] On a critical note, the project contributed to the broader health financing agenda and the country's vision toward attainment of universal health coverage (UHC) by (a) building institutional

[29] *Health Financing Strategy 2015/2016–2024/2025: A Health Financing System that Responds to the Dynamic Aspirations of the Health Sector* (February 2016).

capacity and the required systems and (b) informing the dialogue around the National Health Insurance Fund (NHIF), as well as the intergovernmental fiscal transfers.

Mobilizing Private Sector Financing

46. **The deliberate choice of using both public and private service providers licensed to practice by the relevant medical councils contributed to improving service quality on the part of both types of service providers and enhanced choices on the part of the primary beneficiaries.** Mobilizing the private sector was in line with the GoU's recognition of the critical role the private sector plays in service delivery, management of health services, capacity development, financing, and so on[30] and ultimately toward the achievement of the UHC. Private service providers account for 40 percent of services in Uganda, and thus, the inclusion of private service providers was an important consideration. This approach enabled improvement in service quality and uptake on the part of public service providers (with resources from the project beyond their regular resources), while at the same time, it had the following effects on the private service providers:

(a) Improved competence of staff at the participating private service providers (especially PFP providers)

(b) Purchased more equipment, employed more staff including obstetricians and thus enhanced service range, and generally became more profitable

(c) Improved compliance with the MoH guidelines and standards on service quality assurance, safety, and infection control

(d) Improved record keeping

(e) Were brought under and benefited from supportive supervision of the district health teams (DHTs).[31]

47. **The project worked through the DHTs to transform the mind-set of the private service providers to comply with the MoH standards and guidelines and through the team's routine technical supervision to enhance accurate record keeping.** During the ICR mission, the team was made aware that the inclusion of private service providers and improvement in their service quality contributed to expanded choices and capacity of lower- level facilities, leading to decongestion at higher-level public facilities[32] (for example, regional referral hospitals, such as the one in Mbarara) and consequently to overall improvement in choices and service quality provided to beneficiaries.

[30] National Policy on Public Private Partnership in Health (http://library.health.go.ug/sites/default/files/resources/National%20Policy%20on%20Public%20Private%20Partnerships%20in%20Health%20Final%20Print_0.pdf); Private Public Partnership Act, 2015.
[31] Initially, the private service providers that joined the project had a lot of room for improvement in terms of facilities, quality, infection control, and so on. Also, the 'for-profit' nature of the private service providers sometimes led to an overdrive in seeking clients (facilitated by the additional resources expected from the project based on service outputs). Some private service providers were removed from the project for erroneous reporting and fraud.
[32] Examples include regional referral hospitals, such as the one in Mbarara.

Poverty Reduction and Shared Prosperity

48. **The cornerstone of this operation was in its targeting of the most vulnerable women in underserved communities.** As mentioned earlier, poverty status along with key health indicators guided the selection of the regions (paragraph 8). By effectively targeting the most vulnerable women in the selected regions through geographical targeting and the poverty grading tool,[33] the project addressed poverty and its association with poor health outcomes and financial barriers. It removed their financial barriers and enabled them to access hospitals to receive the same set and quality of delivery services as those of the affluent women at subsidized cost. The IVEA's biannual surveys ascertained that targeting was effective, that is, the project beneficiaries were predominantly poor (96.5 percent). Furthermore, the project's positive spillovers permeated to other community members. The project provided opportunities for motivated and committed community members (that is, CBDs/VHTs) to participate and contribute to the project's results as well as to gain financially from it.[34]

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

49. The URHVP benefited significantly from the lessons gained from and foundations laid during the two previous projects mentioned earlier (paragraph 6). Below is a summary of the key factors during the preparation stage or at entry that affected implementation and outcomes.

50. **The learning from the two previous projects informed the design of the project and also made it possible to build on the claims processing and data systems of MSU (the VMA), as well as the verification process.** Also, by the time this operation was being designed, the districts in the Western and South Western regions of the country were already familiar with the 'RBF' approach and principles; payments are linked to the satisfactory results based on verification of the delivery of specified outputs or outcomes. The shift in the mind-set to focus on results had already been started in at least one of the two regions covered by the URHVP. All of these factors provided the foundation for the operation and contributed greatly to the readiness in terms of implementation of the project.

51. **The PDO was focused, realistic and clear, and easy to track.** Building on the lessons of the previous project, the project ensured that 'the PDO focused on only the outputs or outcomes for which the project will be held accountable, and to indicate the change expected in the primary target group'. It was fully aligned to the GoU's strategic document on reducing maternal and neonatal mortality and mobility (as described under section II.A) and with a deliberate focus on 'poor women living in rural and disadvantaged areas' for the project's equity focus. The selection of indicators from the routine health

[33] The tool was jointly developed by MoH and MSU during the pilot project, and with some enhancement based on the previous experiences (described earlier) this was administered in the operation. The tool has since been used by other projects related to poverty in Uganda. It is used by MSU under the DFID-funded RISE project (which has a voucher component for family planning services in the private sector).

[34] During the ICR mission, the team encountered VHTs who had utilized the gains from sales of vouchers to pay for their children's school fees and to purchase livestock to improve their well-being. Also, small rural health facility owners (who are mostly midwives) also experienced increase in earnings/income through the project.

information systems enabled ease of monitoring of results not only by the MoH and the VMA at the central level but also by the district health officer (DHO) at the subnational level.

52. **Cost analysis of the previous project and cost-effectiveness analysis informed the project design.** The objectives of the cost analysis were to (a) review service provider reimbursement rates, (b) review the VMA costs, and (c) assess and recommend implementation arrangements for the expanded voucher scheme. It also considered additional costs related to scaling up the program. The findings informed the budget of the project and the distribution by cost items. Cost-effectiveness analysis was carried out to establish the cost-effectiveness of safe delivery services in terms of costs and consequences between the OBA voucher intervention arm and the nonintervention arm (only existing government and private sources of delivery care operating with status quo funding arrangements). These analyses informed the project design and budget, and the costs of services calculated were used by the VMA as a basis for negotiating reimbursement rates with service providers.

53. **Risks and mitigation measures were adequately assessed.** During preparation, the following key risks were identified: (a) structural challenges likely to confront public providers joining the scheme, (b) compliance with treatment standards and protocols by service providers, (c) targeting of the beneficiaries, (d) possible duplication of the voucher schemes, and (e) fraudulent activities. These agreement on the risks were guided by the understanding of the context as well as the experiences from the previous projects. The overall risk rating was Moderate, which seemed appropriate given the successful implementation of the two previous projects and the capacity within the Government as well as the VMA to manage and implement the URHVP. For each of these risks, several mitigation measures were agreed between the Government and the World Bank and built into the project. First, on points (a) and (b), it was determined that the MoH will not give special preference to public providers and will apply common selection criteria for all categories of service providers. The MoH was to also set up a team to support implementation of the voucher program, issue guidelines to regulate the provision of services and use of resources generated through the scheme by public providers, and ensure compliance through a robust quality assurance system. On point (c), lessons and recommendations from the previous project guided the decision to rely on geographical targeting using detailed poverty maps from UBOS, supplemented by information on pregnancy-related morbidity patterns from the MoH. These points on selection criteria, guidelines, and targeting approaches were elaborated, and steps were clearly defined in the Operations Manual of the project. On point (d), all partners were to sign a memorandum of understanding committing to work in a collaborative manner under the oversight of the MoH/Interagency Coordination Committee (ICC). Finally, on point (e), it was agreed that the design of the voucher be made much more secure, durable, and difficult to reproduce fraudulently, and that the claims processing systems be further refined to improve fraud detection and claims tracking and reporting. This would strengthen overall governance and accountability of the voucher scheme.

B. KEY FACTORS DURING IMPLEMENTATION

54. **There were a number of factors that affected implementation. First, there were factors subject to government/implementing agency control.** Building on the lessons from the previous projects, capacity and systems to manage a voucher program was improved. A robust and effective electronic claims processing system was put in place by the VMA (including a back-up manual system) along with adjustments made to the ceiling of the Designated Account that allowed the VMA to access all the needed funding in a timely manner. Over the course of project implementation, these led to eventual

improvement in the timely review and processing of reimbursement of claims by service providers and decrease in fraudulent claims reported. It also ensured that most of the clients targeted were poor. This hinged on improved record management along with improved understanding of what expenses are valid claims starting at health facilities combined with the VMA's ability to vet and input claims, leading to overall improvement in the percentage of approved claims reaching over 90 percent by the fourth year of project implementation.[35]

55. **Technical assistance by the VMA ensured preparedness of health facilities to provide high-quality safe delivery services.** During project implementation, the VMA placed extensive efforts through training, mentorship, and quality assurance visits to facilities to improve the clinical competence of 440 service providers in the following areas: (a) provision of comprehensive ANC package; (b) use of partograph for proper monitoring of labor; (c) management of postpartum hemorrhage; (d) neonatal care/new born resuscitation through mock drills; (e) medical/obstetrical emergency management through mock drills; and (f) incident management, investigations, reporting and sharing of lessons learned. This was complemented by a continuous medical education (CME) approach that ensured each service provider received on-site mentorship four times a year. Also, 50 doctors and 26 anesthetic officers were trained to improve management of complications. Furthermore, through the 'reimbursement fund', the project supported CEmONC facilities to have functional theaters and equipment.[36] While the efforts may not have reached all 440 service providers with equal level of intensity, the IVEA's observations concluded this effort contributed to improvement in clinical standards particularly in areas of managing postpartum hemorrhage, use of partographs, and neonatal care.

56. **The increase in demand generated by the project affected service delivery due to constraints that were difficult to resolve.** Given the challenge with access to medical equipment and consumables from NMS, the VMA and the MoH established mechanisms to avail drugs and medical equipment starting with the public providers through the Joint Medical Stores (JMS) to ensure facilities have regular supplies needed to meet the demand and to provide high-quality services. However, the limited availability of essential medical equipment (such as resuscitation equipment) and the inadequate supply of blood and blood products remained a challenge. Furthermore, staffing constraints at some of the CEmONC facilities also affected their ability to keep up with the demand that increased due to the operation and to provide the full range of CEmONC services.

57. **The coordination role of the MoH was constrained by other competing tasks.** At the time of the project design, it was assumed that the Maternal and Child Health Department within the MoH would provide the overall oversight. The idea of an ICC was also in the design, which was to coordinate the project and to also look at other voucher programs in the country (to ensure standardization and

[35] These gradual improvements were substantiated by the IVEA's reports that confirmed that (a) the outputs presented by the VMA reflect an accurate picture of the performance of the project, (b) the VMA has good internal control systems in place for the management of the project, (c) the quarterly financial reports by the VMA show a true and fair view of the financial results of the operations of the project, (d) most of the clients targeted were poor, and (e) there were no indications of fraud found during the review of the financial transactions or the voucher management process (indicating that the VMA was adequately identifying fraud cases at the service provider level).

[36] According to the presentation by the VMA during the ICR mission, in total, 23 health facilities supported to have fully functional theatres and conducting caesarean sections (19 public Health Center IVs (HC IV) and 4 private facilities).

uniformity in pricing, and so on). However, during the course of implementation, given other competing responsibilities along with limited resources, the MoH was unable to fully carry out these roles.

58. **Finally, there were factors outside of the Government/implementing agency's control that affected the project implementation.** The delay in the project becoming effective had some negative implications. It affected the MoH's ability to source the VMA and the IVEA (the IVEA recruitment process had to be restarted). Also, when the project became effective, it had lost about 18 months. This delay also substantially shortened the length of implementation during the first year. The actual service delivery started in March 2016 in the South Western Region and July 2016 in the East Region following the selection and training of service providers. At the time, the project was scheduled to close on December 29, 2017. The initial delays contributed to the project requiring two additional years of implementation (with the total deliveries assisted under the project increased to 156,400).

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF MONITORING AND EVALUATION (M&E)

M&E Design

59. **The World Bank team worked together with the MoH to ensure that the M&E design emphasized on intermediate outcomes and focused on accountability for results.** It also indicated change expected in the primary target group. The indicators in the Results Framework were aligned to the theory of change,[37] and the service delivery-related indicators were chosen from those in the national health information system for which the tools were already in place from the participating service providers and CBDs. This enabled ease of tracking of results. M&E arrangement and plan were well defined in the Operations Manual of the project, which spelled out how the results were to be tracked, reported, and verified and at what frequency and the roles and responsibilities. One indicator in the Results Framework may not have been the most appropriate given the investments under the project, namely the indicator on fresh stillbirth as a proxy measure for safe delivery service. Also, the indicator on referrals did not capture the full extent of referrals that the project achieved. Both of these indicators and the end targets could have been reviewed and adjusted during restructuring. These points are discussed earlier in section II.B. However, overall, the Results Framework included relevant indicators to measure the PDO.

60. **The project's M&E capacity benefited from working with the same VMA of the previous projects.** The URHVP further enhanced M&E capacity by including training of the service providers and the District Health Office in the M&E design. This was an important consideration to ensure that the project outputs were captured in the district records by ensuring that all participating service providers

[37] The choice of the indicator 'attendance of at least one ANC visit' rather than 'attendance of ANC of 4 or more visits' was guided by an earlier study that found that pregnant women attend ANC in different health facilities (both voucher and non-voucher facilities), which made tracking of ANC 4 through the voucher scheme unworkable.

send copies of the reports to the District Health Offices. This enabled capturing of progress outputs through the national health information system and tracking of results.[38]

61. **The project focused primarily on 'monitoring' of results.** Since the previous projects included evaluation and generated evidence that guided the design of the project,[39] it was felt that rather than allocating resources to undertake a similar exercise (that is, evaluation), the investments should focus on service delivery and the emphasis should be placed on monitoring of results and enhancing accountability. This consideration is understandable especially taking into account the cost implications as well as the scale of the project; a provision for evaluation that allowed comparison of outcomes between the project beneficiaries and a control group may have provided further evidence on the efficacy of the voucher scheme.

M&E Implementation

62. **The role of M&E implementation and quality assurance rested with the VMA,** which provided quarterly progress on results by drawing on the data reported from service providers that were maintained in the project database. The results were verified (along with the processes and systems) by the IVEA. The verification involved the following: (a) verify that agreed outputs have been achieved, (b) verify that participating service providers performed in accordance with agreed standards, (c) validate performance of the claims processing system, (d) make recommendations on disbursement of the OBA subsidy, and (e) assess behavior change communication and training activities carried out by the VMA. The findings were compiled in reports and shared with the key stakeholders of the project to inform project implementation.

M&E Utilization

63. **The design of the operation enhanced a culture of data use to monitor results and guide decisions.** This was likely to have been due to the key features of the operation, namely, the RBF and its focus on outputs, the voucher distribution and claims processing systems put in place by the VMA, and the data review sessions at the district level.[40] Data were also used as a service audit mechanism to guide the DHT's supervision and support to health facilities to ensure adherence to standards for quality of services as well as Standard Operating Procedures for quality controls/infection controls (for example, data identified unsafe environments that led to sepsis and death among infants, which guided the DHT's support to health facilities and led to the situation being improved). Furthermore, the project enabled district teams to use the project resources for monthly performance review meetings at the district level (project resources supplemented by district resources), which brought together technical staff, political leaders, and VHTs.

[38] Arrangements and roles and responsibilities related to implementation, program M&E, safeguards monitoring and mitigation, financial management (FM), disbursement, and procurement were clearly defined in the Operations Manual.
[39] Obare, et al. 2016. "Increased Coverage of Maternal Health Services among the Poor in Western Uganda in an Output-Based Aid Voucher Scheme." World Bank Group Policy Research Working Paper 7709, World Bank, Washington, DC. https://elibrary.worldbank.org/doi/abs/10.1596/1813-9450-7709.
[40] At a district visited during the ICR mission, a DHO observed that the project enhanced focus on results and quality and the DHT's ability to examine data, identify problems, and look for solutions.

64. **The project data also informed the MTR undertaken jointly by the MoH and the World Bank in April 2017.** Documents and results matrix were used to assess and review (a) implementation progress against original benchmarks and targets, (b) appropriateness/relevance of the project design and implementation arrangements in light of implementation experience, (c) fiduciary and procurement arrangements, (d) environmental and social safeguards, (e) key implementation bottlenecks and appropriate remedial measures, and (f) valuable lessons to inform the OBA practice. Field visits were undertaken, and consultations were held between government (central and local), the VMA, the IVEA and selected health service providers and the World Bank. The review and the findings [41] informed restructuring of the project, where a few adjustments were made to the Results Framework and the targets for the project objective on the total number of deliveries assisted under the project along with those for a number of intermediate results indicators to account for the extension of the project (explained in detail under section II.B). Adjustments to the targets pertaining to (a) number of women testing positive for HIV and (b) number of fresh stillbirths were not made during restructuring; these indicators did not achieve the targets. Adjustments were not made at the time as the achievements seemed to be progressing toward the targets initially set.

Justification of Overall Rating of Quality of M&E

65. Given the achievements described, the capacity and systems that improved data consistencies and reporting, and the enhanced culture of data use during the project implementation period, the overall quality of M&E is rated Substantial.

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

66. **Social.** The project offered safe delivery and family planning services to mothers, including HIV testing, and those who tested positive to benefit from antiretroviral treatment. A few social safeguards considerations were made to account for the potential social risks and impacts. The project was based around approved providers with capacity to provide CEmONC services and associated BEmONC services. The marginalized and vulnerable people in Uganda reside in areas where such facilities are lacking, and therefore, the project did not intervene in these areas. Furthermore, the project did not require acquisition of land, relocation/displacement of land use or/and persons, loss of sources of income or means of livelihood, and restriction of access to legally designated protected areas. Therefore, no social safeguards were triggered at the time of appraisal or during implementation (including at restructuring). The safeguards rating remained Moderate with a satisfactory social performance.

67. **The project, by its design, made deliberate targeting of poor and vulnerable women to ensure that the most vulnerable were not excluded from opportunities to receive quality safe delivery services.**[42] Thus, the project affected first and foremost the vulnerable mothers and their children in the communities (including teenagers/child mothers). During implementation, the project also generated

[41] Key findings were the following: (a) the low number of pregnant women started on antiretrovirals was much lower than the target, partly attributed to the high target estimates which were based on the previous HIV prevalence projections; (b) the need for the VMA to improve its records to capture nonemergency/elective referrals (which seems to have affected the ability to accurately track the number of mothers referred; and (c) the need to improve timely processing and reimbursement of claims (the turnaround time was still greater than the recommended 20 days).

[42] As indicated in paragraph 44: 178,413 economically disadvantaged and vulnerable women benefited from skilled delivery (well over the target of 156,400).

ripple effects of social and economic gains that extended to other actors in the community. These included increased income for private health facility proprietors, expansion of facilities to meet the increasing number of mothers, employment of more staff, and consequently improvement in quality of services offered beyond safe delivery and family planning. The project also contributed to enhanced motivation of health workers at government facilities and also enabled health facilities to use the income from the voucher services to purchase medical supplies/consumables and to buy fuel for the ambulance in case of referrals (which relieved the burden from the mothers).

68. **Environmental.** The project Environmental Assessment Category was B - Partial Assessment. It triggered Environmental Assessment OP/BP 4.01 due to anticipated handling of medical waste products. The project was expected to generate minimal localized medical waste-related impacts (that is, in the contracted health facilities) and its environmental and social impacts were considered very minimal. Therefore, based on the limited scope and nature of project impacts that were anticipated, the project activities were not envisaged to require Environmental Assessment during implementation. Instead Uganda's National Health Care Waste Management Plan, which was also used in the World Bank-funded UHSSP (P115563), was adopted to guide management and handling of medical waste at participating health facilities. Specific guidance on the handling and disposal of the health care waste was included in the project Operations Manual. The VMA, under the oversight of the Environmental Health Division, was to ensure that contracted service providers properly disposed medical waste in accordance with the guidelines outlined in the project Operations Manual.

69. **During implementation, management of health care waste was monitored closely through supportive supervision visits.** While much of the guidelines were observed by the health facilities (segregation/separation of waste, display of protocols and guidance on walls, and handling of the waste from maternity—placenta), incomplete combustion of the wastes were found in some cases during the initial period of implementation. The VMA together with the MoH strengthened efforts and carried out spot checks during their supportive supervision visits to facilities to enforce compliance with the required standards regarding infection prevention procedures and medical waste handling and disposal. Facilities that were found to not comply with the guidelines after receiving additional support were suspended from the project. This contributed to improvement in infection control and waste management practices. By the last year of the project implementation, the environment safeguard performance rating had improved to Satisfactory.

70. **Procurement.** Procurement was conducted by the MoH through the unit established within the ministry under the UHSSP. The main procurements were (a) the VMA, (b) the IVEA, and (c) a project officer to support implementation. The Project Implementation Support Unit in the MoH was established in 2011, which mitigated most of the risks. Also, the OBA nature of the project was also thought to reduce risks to implementation.

71. **Fiduciary.** At the time of the appraisal, based on the experience of the previous project, it was observed that Uganda had adequate FM capacity to manage the project. The responsibility for the overall FM arrangement of the project rested with the MoH and was managed by the unit established within the MoH in the Accounts Department headed by the assistant commissioner to support implementation of IDA projects. A Designated Account in the Bank of Uganda was set up for the project, from which disbursements were done directly to the VMA. The FM assessment during appraisal led to specific risk mitigation measures including recruitment of a new project accountant and an accounts assistant to

overcome challenges in the management of financial records, advances to staff, quality of interim financial reports (IFRs), delay in preparation of financial statements, submission of external audit reports, and so on. The overall residual risk was assessed as Substantial at the time of appraisal.

72. During implementation, in general, the FM arrangements were observed to be satisfactory, and the quarterly IFRs accompanied with the verification letter were submitted in acceptable quality and within the stipulated time. In the initial period of implementation, there were delays in paying the IVEA and the VMA. Discussions took place between the World Bank task team and the assistant commissioner regarding modalities to expedite processing of payments while not compromising on the financial risks. At the completion of the project, the overall fiduciary risk remained Substantial.

C. BANK PERFORMANCE

73. **The World Bank worked collaboratively with the Government, the VMA, the IVEA, and the donor and ensured quality technical support and supervision at entry and during implementation of the project.** The World Bank's project team also ensured that the gains of the URHVP beyond its closing are sustained through the URMCHSIP. This section summarizes the World Bank's effectiveness in addressing key factors that affected preparation, implementation, and outcomes.

Quality at Entry

74. **The World Bank's performance during preparation and appraisal was satisfactory.** The World Bank ensured that the PDO was well aligned to the GoU's health sector priorities as described earlier. The project also had gender and equity focus (targeting poor pregnant women), which was a critical consideration given the known financial barriers this group of population faced in accessing safe delivery services. Its deliberate use of a combination of geographical targeting (based on poverty mapping) and a customized poverty grading tool to select eligible beneficiaries proved to be sufficiently effective in reaching the intended target population. The technical design was well grounded on solid understanding of the cultural context and learning from the previous projects on the strengths and weaknesses of the service delivery systems and claims processing systems. The learning from the previous projects also informed implementation arrangements. The Results Framework was largely well designed, with indicators aligned to the theory of change (discussed under section IV.A). The deliberate selection of indicators from the National Health Management Information System and reliance on its reporting system contributed to enhanced use of data from the existing systems and the eventual and smooth transition to RBF under the URMCHSIP.

75. **The World Bank's approach to risk assessment was thorough, experience based, consultative, and candid.** Risks were identified and mitigation measures agreed in consultation with the Government during appraisal, which were built into the design. In particular, due considerations were given to FM matters; the World Bank used the FM assessment at the time of appraisal to build into the design specific risk mitigation measures to overcome challenges foreseen in FM.

Quality of Supervision

76. **The World Bank's performance in terms of supervision was satisfactory.** First, the World Bank enhanced a collaborative relationship with the Government and the VMA that had been built through the

previous projects. The ICR mission observed that there was a strong sense of trust from both the Government and the VMA that the World Bank task team had gained and the confidence in the technical advice provided by the team. Also, the project was led by the same task team leader (TTL) who led the previous project through much of the duration of the project and transitioned to another TTL who was intimately involved with the project. This contributed to stability and constancy of the supervision support provided and to a solid working relationship as well as seamless transition and continuity. Furthermore, the task team's presence in-country contributed to close engagement with the Government and implementing agencies and allowed timely provision of technical support and guidance during implementation support missions[43] and through regular contacts and dialogue. Beyond the technical supervision and advice provided during the missions, the World Bank team stepped in promptly to moderate discussions between key stakeholders (that is, the Government, the VMA, the IVEA, and the donor) and contributed to amplifying the commitment and enthusiasm of all those involved in implementing the project.[44] Technical support along with the respectful and collegial working relationship between these stakeholders were appreciated by the clients at the central as well as the subnational levels. These aspects contributed to allowing the project to steadily progress toward the set targets.

77. **Moreover, the team actively monitored issues pertaining to social and environmental safeguards and FM through implementation support missions.** Risks identified at approval along with compliance with mitigation measures and progress in addressing these risks were assessed through verification reports and discussed during missions. Key areas that the team addressed included the following: (a) to ensure pregnant women who tested positive for HIV receive antiretroviral treatment and to improve overall monitoring and reporting on social aspects and issues emerging from the project, (b) to improve infection prevention control measures and waste management, and (c) to reduce delays in payments to the VMA and the IVEA by taking up discussions with government counterparts to expedite processing of payments while not compromising on the financial risks.

Justification of Overall Rating of Bank Performance

78. **The overall rating is Satisfactory.** There were no significant shortcomings in quality at entry and quality of supervision.

D. RISK TO DEVELOPMENT OUTCOME

79. **A key risk to development outcome is the issue of sustainability of the gains made by the URHVP.** As the project was drawing to an end, sustainability of the gains beyond project closure was discussed in depth during the implementation support mission of the project's final year. While the Government recognizes the positive achievements of the project, it is constrained by limited resources to sustain the full scope of the program.[45] Thus, the demand-side component of the project (that is, the voucher scheme) was stopped at project closure. The supply-side component of the project was seen to complement the RBF of the URMCHSIP, and thus based on the GoU decision, the activities and support to public and PNFP service providers that met the RBF readiness threshold were incorporated into the

[43] These missions at times included visits to the sister voucher project, the Uganda Voucher Plus Activity (financed by the United States Agency for International Development [USAID]), to share implementation experience.
[44] Noted through observations and interviews with key stakeholders during the ICR mission.
[45] The primary concern was the cost of sustaining vouchers and their associated activities and systems as well as the overall administrative cost.

ongoing URMCHSIP. With the closure of the URHVP, it remains unknown to what extent PFP service providers (that were not included in the transition to URMCHSIP) are able to retain the gains in quality, staffing (increased in response to demand), and motivation. With the resources from the project having come to an end, the DHOs' ability to supervise these PFP service providers and for them to comply with the MoH guidelines on quality assurance may be limited.

V. LESSONS AND RECOMMENDATIONS

80. There are a number of lessons and recommendations that emerged from the URHVP. This section provides the key lessons and discussions to inform the future operations.

81. **First, the project demonstrated that voucher programs that implement the 'money-follows-patient' concept can be an effective, efficient, and pro-poor form of provider payment.** The scheme allowed poor vulnerable women to access skilled care at subsidized cost. It also contributed to relieving the social and financial pressures on the households as well as family tension.

82. **In terms of the overall operation, enhanced ownership, coordination, and stewardship of the MoH are critical to sustain and build on the gains made.** Should a similar project be developed in the future, a Steering Committee led by a senior official of the MoH along with a focal point within the ministry that works directly with the voucher program and monitors its performance on a regular basis may be considered. It would be critical that the information pertaining to project implementation and performance is shared and discussed more regularly at the ministry level. Periodic field visits by the MoH to document lessons learned and to provide support for improved maternal and perinatal death audits would be valuable.

83. **Increase in demand needs to go hand in hand with increased capacity on the service delivery side.** The project was successful in generating and boosting demand for skilled delivery in a relatively short period. However, the supply-side challenges constrained the service delivery system to respond effectively to the demand. The project used innovative approaches to overcome challenges with access to medical equipment and consumables from NMS, but some of the essential medical equipment and supplies that are critical remained a challenge. Also, staffing constraints at some of the CEmONC facilities could not keep up with the increased demand for a full range of CEmONC services. Service delivery-side challenges are more difficult to overcome and require longer-term investments.

84. **CME and on-site mentoring, combined with competency assessment, proved to be more effective and less resource intensive to build capacity of service providers and improve service quality.** This approach combined with the annual assessment of service providers competence against the MoH QoC Standards[46] contributed to relationship building among service providers and improved service quality. At the time of completion, some CEmONC facilities were continuing to organize CME on their own. It would be most valuable to take stock of and document lessons on this model that emerged from this project to inform ongoing and future projects.

[46] MoH QoC Standards: Service provider competency, clinical governance and data management, infection prevention and waste disposal, and emergency medical management including stock management.

85. **Referral system strengthening is key and requires longer-term investments in the health sector and beyond.** Strengthening the referral systems is a critical piece in the design of future operations of this nature. The project demonstrated that investments in lower-level facilities can suppress the need for referrals to higher-level facilities. At the same time, referral system strengthening requires longer-term investments in the health sector as well as working across sectors to coordinate with, for example, the transport sector and its investments in rural road infrastructure.

86. **Second, on the learning around voucher schemes, VHTs/CBDs play a critical role in the communities as a demand creator, voucher distributor, and service utilization enhancer.** They connected effectively with the target beneficiaries and influenced purchasing of vouchers and followed up to ensure they receive a full range of SD services. Furthermore, the continued community dialogue they facilitated together with district leadership (technical and political) provided space for women to demand maternity services and express their concerns and also enhanced maternity service-seeking behavior.

87. **Mobilization of private service providers and formation of networks with public service providers expanded choices to beneficiaries, increased quality of services, improved access, and contributed to beneficiaries' satisfaction.** The approach of targeting of services to the poor and marginalized population, the process of selecting and contracting of service providers, claims processing, quality assurance, and fraud control mechanisms are critical aspects that have been adjusted and adopted by the RBF program. These experiences and lessons will likely inform future operations of similar nature as well as shape the dialogue around the NHIF and the efforts toward the UHC.

88. **Finally, a well-targeted and managed voucher program has the potential to generate a ripple effect on the whole community.** Such a program benefits first and foremost the most vulnerable, giving them opportunity to access hospitals and receive quality services at subsidized cost. It also enables motivated and committed community members to contribute to better maternal outcomes of vulnerable women in their own communities as well as to gain financially from it. The project demonstrated that VHTs as well as small rural health facility owners (who are mostly midwives) also gained earnings/income from the program, thus creating a ripple effect that reached the whole community.

ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

A. RESULTS INDICATORS

A.1 PDO Indicators

Objective/Outcome: Increase access to skilled care among poor women in underserved areas during pregnancy and delivery

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
People who have received essential health, nutrition, and population (HNP) services	Number	0.00 02-Dec-2013	156400.00 02-Sep-2015		158322.00 13-Dec-2019
Number of deliveries attended by skilled health personnel	Number	0.00 02-Dec-2013	132400.00 02-Dec-2013	156400.00 31-Oct-2017	178413.00 13-Dec-2019

Comments (achievements against targets):

Objective/Outcome: Voucher numbers and redemption rate

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number and percentage of	Percentage	0.00	70.00		77.00

vouchers distributed and redeemed for deliveries under the project; (Percentage, Custom Supplement)		02-Dec-2013	02-Dec-2013		13-Dec-2019

Comments (achievements against targets):

Objective/Outcome: Number and percentage of women attending at least one ANC visits under the project. (Percentage, Cus

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number and percentage of women attending at least one ANC visits under the project. (Percentage, Custom Supplement)	Percentage	0.00 02-Dec-2013	90.00 02-Dec-2013		86.00 13-Dec-2019

Comments (achievements against targets):

A.2 Intermediate Results Indicators

Component: Component 1: Package of Safe Devliery Services to Poor Pregnant Women

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion

Number and percentage of vouchers distributed and redeemed for postnatal care.	Percentage	0.00 02-Dec-2013	35.00 02-Dec-2013		41.00 13-Dec-2019
Comments (achievements against targets):					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of mothers referred;	Number	0.00	7.00 30-Sep-2018		14.00
Comments (achievements against targets): Unit of Measure: Percentage (not number)					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of fresh still births	Number	0.00 02-Dec-2013	330.00 02-Dec-2013		458.00 13-Dec-2019
Comments (achievements against targets):					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of pregnant women tested for HIV;	Percentage	0.00	90.00 30-Sep-2018		80.00
Comments (achievements against targets):					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of pregnant women with HIV who receive EMTCT	Number	0.00 02-Dec-2013	7100.00 02-Dec-2013		3874.00 13-Dec-2019
Comments (achievements against targets):					

Component: Component 2: Capacity Building and Project Management

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of voucher mothers satisfied with the services	Percentage	0.00 02-Dec-2013	90.00 02-Dec-2013		90.00 13-Dec-2019
Comments (achievements against targets):					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Timely verification reports provided	Number	0.00 02-Dec-2013	8.00 02-Dec-2013		8.00 13-Dec-2019

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of claims reimbursed timely	Percentage	0.00 02-Dec-2013	80.00 02-Dec-2013		60.00 13-Dec-2019

Comments (achievements against targets):

B. KEY OUTPUTS BY COMPONENT

Objective/Outcome 1: Package of safe delivery services to poor pregnant women (GPOBA US$9.5 million)	
Outcome Indicators	1. Number and percentage of deliveries assisted by skilled health personnel under the project 2. Number and percentage of women attending at least one ANC visits under the project 3. Number of people who have received essential health, nutrition, and population (HNP) services (Corporate Results Indicator)
Intermediate Results Indicators	1. Number and percentage of vouchers distributed and redeemed for postnatal care 2. Percentage of pregnant women tested for HIV 3. Number and percent of mothers referred 4. Number of fresh still births 5. Number of pregnant women with HIV who received EMTCT
Key Outputs by Component (linked to the achievement of the Objective/Outcome 1)	1. Provide pregnant women access to a defined package of safe delivery services from contracted private and public providers (four ANC visits, safe delivery, one postnatal visit, and treatment and management of selected pregnancy-related medical conditions and complications—including caesarian sections), emergency transport, and EMTCT as part of ANC. 2. Strengthen referral system for emergency care and links between BEmONCs and CEmONCs (forming clusters). 3. Promote early ANC visit, subsequent ANC attendance, and PNC. 3. Promote PPFP. 4. Incentivize community-based distributors to follow up with mothers and to carry out interpersonal communication beyond voucher sales (community sensitization and client follow-up).

Objective/Outcome 2: Capacity building and project management (GPOBA USD 3.8 million)	
Outcome Indicators	1. Number and percentage of vouchers distributed and redeemed for deliveries under the project 2. Number of direct project beneficiaries of which are female (percent) 3. Conduct continuous quality assessment and provide mentoring to service providers
Intermediate Results Indicators	1. Percentage of claims reimbursed timely 2. Timely verification reports provided 3. Percentage of voucher mothers satisfied with the services
Key Outputs by Component (linked to the achievement of the Objective/Outcome 2)	1. Administering and management of vouchers by a VMA 2. Verification of project outputs as well as the integrity of the claims processing system by an IVEA 3. Oversight provided by the MoH 4. Capacity building to service providers (CME) at CEmONC sites using 'cluster training approach' (connecting CEmONC and BEmONC sites) to improve management of obstetric emergencies 5. Provision of continuous quality assessment and routine support supervision/mentoring and quality technical assistance to service providers

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Preparation	
Peter Okwero	TTL
Grace Nakuya Musoke Munanura	Procurement Specialist(s)
Edwin Nyamasege Moguche	FM Specialist
Christine Makori	Counsel
Herbert Oule	Social Specialist
Constance Nekessa-Ouma	Social Specialist
Supervision/ICR	
Bernard O. Olayo	TTL
Grace Nakuya Musoke Munanura, Mulugeta Dinka	Procurement Specialist(s)
Edwin Nyamasege Moguche	FM Specialist
Agnes Kaye	Procurement Team
Peter Okwero	Team Member
Harriet E. N. Kiwanuka	Procurement Team
Christine Makori	Counsel
Howard Bariira Centenary	Procurement Team
Clare Busingye	Procurement Team
Janet Christine Atiang	Procurement Team
Jessica Anne Lopez	Team Member
Rogers Parmen Enyaku	Team Member
Constance Nekessa-Ouma	Social Specialist
Sammy Ratemo Kinara	Environmental Specialist

B. STAFF TIME AND COST

Stage of Project Cycle	Staff Time and Cost	
	No. of staff weeks	US$ (including travel and consultant costs)
Preparation		
FY13	13.531	51,189.95
FY14	11.037	39,540.97
FY15	.300	951.72
Total	**24.87**	**91,682.64**
Supervision/ICR		
FY13	2.408	7,208.63
FY16	18.798	88,253.83
FY17	16.740	76,701.98
FY18	23.141	79,858.66
FY19	14.975	74,119.08
FY20	18.300	116,912.18
Total	**94.36**	**443,054.36**

ANNEX 3. PROJECT COST BY COMPONENT

Components	Amount at Approval (US$, millions)	Actual at Project Closing (US$, millions)	Percentage of Approval (%)
Package of safe delivery services to poor pregnant women	9.5	8.7	92
Capacity building and project management	3.8	4.6	120
Total	**13.3**	**13.3**	**100**

ANNEX 4. EFFICIENCY ANALYSIS

1. The main goal of the URHVP was 'to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery'. To achieve this goal, vouchers were provided to poor and vulnerable pregnant women to access antenatal, delivery, and postpartum care at accredited private and public health facilities. The main assumption under the project was that increasing coverage and QoC for antenatal, delivery, and postpartum care would reduce maternal and newborn deaths. This assumption has been validated in a systematic review by Mangham-Jefferies et al. (2014),[47] which suggests that demand- and supply-side strategies to improve maternal and newborn health care can be cost-effective. Further, a literature review by Horton and Levin (2016)[48] shows that safe motherhood initiatives (a package combining antenatal and postpartum care with trained birth attendants, potentially in a health facility) are cost-effective and that the gains are in the range of US$150 to US$1,000 per DALY averted. In addition to the literature, the project design for the URHVP was informed by a previous project—the Uganda Reproductive Health Vouchers Output-Based Aid Scheme—which had been largely successful. An assessment of the reimbursement mechanism, VMA costs, and implementation arrangements from this project was undertaken, and the results from the assessment informed the design of the URHVP.

2. In view of the above, the economic analysis that was undertaken as part of the ICR evaluated the achievement of the PDO and thereof the contribution of the project to reducing maternal deaths in the project areas. The theory of change is depicted in Table 4.1. The key assumption was that increasing coverage and quality of health care for antenatal and facility-based delivery through the URHVP would lead to a reduction in maternal deaths. Therefore, the primary outcome that was assessed was the reduction in maternal deaths for the 15–49 years age group as this is the most fertile or active childbearing age group in Uganda. Effectiveness was measured in DALYs, which is a composite measure that combines years lived with disability and years lost to premature death. It was assumed that every maternal death averted accounted for 85 DALYs based on the WHO's data for low-income countries.[49] The benefits (DALYs averted) were then equated to the GDP per capita income of US$732 in Uganda in 2019.[50] With regard to the costs, all the funding that was disbursed directly or indirectly through the URHVP amounting to US$17.3 million was accounted for. Direct financing for the URHVP was obtained from the World Bank through a grant from SIDA–GPOBA while indirect or parallel financing was obtained from another World Bank project (UHSSP, P115563) and the UNFPA. These funds and disbursements by year are summarized in Table 4.2. A discount rate of 3 percent was used to rebate both the costs and benefits associated with

[47] Mangham-Jefferies, L., C. Pitt, S. Cousens, et al. 2014. "Cost-effectiveness of Strategies to Improve the Utilization and Provision of Maternal and Newborn Health Care in Low-income and Lower-middle-income Countries: A Systematic Review." *BMC Pregnancy Childbirth* 14: 243.

[48] Horton, S., and C. Levin. 2016. "Cost-effectiveness of Interventions for Reproductive, Maternal, Neonatal, and Child Health." In *Reproductive, Maternal, Newborn, and Child Health. Disease Control Priorities*, edited by R. E. Black, R. Laxminarayan, M. Temmerman, and N. Walker, 319–334. Third edition, volume 2. Washington, DC: World Bank.

[49] Data were extracted from the WHO's Global Health Observatory Data (2014). The ratio of DALYs to the total all-cause deaths for the 15–49 years age group was estimated at 85 in 2014.

[50] According to the Disease Control Priorities and the Copenhagen Consensus, benefits can be calculated as either one or three times per capita GDP. Jha, et al. 2015. "Benefits and Costs of the Health Targets for the Post-2015 Development Agenda." http://dcp-3.org/sites/default/files/resources/health_assessment_-_jha_et_al_0.pdf.

the project. Further, a sensitivity analysis was conducted to gauge the robustness of the results with changes in the key parameters and values.

Table 4.1. Theory of Change

PDO	Inputs (Activities)	Outputs	Outcomes	Impact
To increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery	• VMA and IVEA in place • Service providers selected and trained to provide quality services • Demand creation in communities • Vouchers distributed and redeemed by mothers to receive a package of safe delivery services • Clinical audits and quality assurance of service providers • Cluster of functional referral networks between BEmONC and CEmONC sites formed	• Number of deliveries assisted by skilled birth attendants • Number of vouchers distributed and redeemed for deliveries • Number of women attending at least one ANC visit	To increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery Improved quantity and quality of antenatal, delivery, and postpartum services Increased coverage and utilization of antenatal and delivery care services	• Reduced maternal mortality • Reduced maternal morbidity

Table 4.2. Project Disbursement by Year

	2016	2017	2018	2019	TOTAL
Funding through the URHVP					
Expected (US$)	3,600,000	4,400,000	5,300,000	—	**13,300,000**
Actual	1,205,477	2,543,739	6,890,000	2,660,000	**13,299,216**
Cumulative	*1,205,477*	*3,749,216*	*10,639,216*	*13,299,216*	***13,299,216***
Annual Disbursement Rate	*33%*	*58%*	*130%*	—	—
Cumulative Disbursement Rate	*9%*	*28%*	*80%*	*100%*	*100%*
Total	**1,205,477**	**2,543,739**	**6,890,000**	**2,660,000**	**13,299,216**
Parallel financing					
UHSSP	1,434,267	1,624,683	—	—	3,058,950
UNFPA	334,053	620,383	—	—	954,436
Total financing	**2,973,797**	**4,788,805**	**6,890,000**	**2,660,000**	**17,312,602**

3. The results show that the URHVP was highly cost-effective (Table 4.3). The US$16.1 million in discounted direct and indirect funding yielded about US$120 million in discounted benefits. The cost-effectiveness ratio was estimated at US$98 per DALY averted, which is much below the US$732 GDP per capita for Uganda in 2019. Further, the benefit-cost ratio was estimated at 7.5: 1, which implies that each US$1 that was invested in the project yielded US$7.5. Results from the sensitivity analysis (Table 4.4) also show that the performance of the URHVP remained positive even at higher discount rates and if the percentage of maternal deaths averted was 50 percent less than the reported numbers.

4. Notwithstanding the above, the total social and economic benefits may have been underestimated because very conservative assumptions were used to undertake the analysis. For example, potential benefits from additional investments in HIV/AIDS,[51] family planning, postpartum care, and capacity building were not factored into the analysis. Further, while the analysis only focused on maternal health, anecdotal evidence suggests that the URHVP also had a positive effect on child health and nutrition and household-level income. In addition, given the difficulty in accounting for potential benefits from efficiency improvements, these were excluded from the analysis. Therefore, the result of this analysis should be interpreted as an underestimation of the potential benefits from the URHVP.

Table 4.3. Results from the Benefit-Cost Analysis

Year	Maternal Deaths with Program	Maternal Deaths Averted	DALYs Averted (thousands)	Funding (US$, thousands)	Benefits (US$, thousands)
2016	0	0	0	2,974	3
2017	14	700	60	4,789	43,735
2018	14	700	60	6,890	43,735
2019	16	698	60	2,660	43,610
TOTAL	**44**	**2,098**	**179**	**17,313**	**131,083**
3% discount rate		1,921	164	16,070	119,998
		Cost per Life Saved	**Cost-effectiveness**	**Benefit-Cost Ratio**	
			Cost/DALY	*US$732/DALY*	
3% discount rate		US$8,366.42	US$98	US$7.47	

Table 4.4. Sensitivity Analysis

	Cost-effectiveness (US$)	Benefit-Cost Ratio	Net Present Value (US$)
Ideal scenario (3% discount rate)	98	7.47	119,998,000
Sensitivity analysis			
Only 50% of the maternal deaths averted	196	3.73	60,000,000
Discount rate (5%)	99	7.40	113,330,000
Discount rate (10%)	101	7.24	98,792,000

[51] Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome.

ANNEX 5. BORROWER, CO-FINANCIER AND OTHER PARTNER/STAKEHOLDER COMMENTS

Comments from the MoH and from SIDA are presented below.

Immediately below is the End of the Project Report from the MoH. As the document exceeded the allowable page limit of 10 pages, only the Executive Summary, Lessons Learned and Recommendations, and Conclusion sections in their report are included here.

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (URHVP)

MINISTRY OF HEALTH

SEPTEMBER 2015 – DECEMBER 2019

END OF PROJECT REPORT

EXECUTIVE SUMMARY

1. This report highlights the cumulative performance of the URHVP (September 2015-December 2019) against the overall project indicators.

Provision of skilled delivery services

2. During the project period, a total of 178,413 facility-based deliveries were supported by voucher project. This is an achievement of 114% against the project target of 156,400. This output is a result of a voucher redemption rate (for delivery) of 75% compared with the project target of 70%.

Antenatal and Post-natal Attendance

3. Cumulatively, the project distributed 231,002 vouchers out of which 193,658 (86%) were redeemed for at least one ANC visit. As expected, redemption for ANC1 was highest and subsequent visits reduced as follows; 80% (184,846) at ANC1, 67% (154,690) at ANC2, 54% (124,386) at ANC3, 34% (77,590) at ANC4.

4. A total of 73,198 mothers attended postnatal care during the project period translating to 41% redemption (73,198 PNCs compared to 178,413 deliveries). Post-Partum Family Planning (PPFP) registered an upward trend throughout the project from 10% in PY2 when the services were added to the voucher package to 39% in the project extension. *NB; note that PPFP services where authorized by MoH to be part of the reimbursed voucher service package in the second year of the project.

Capacity building

5. The project improved the capacity service providers to manage pregnancy and its complications as well as newborn care and Post-Partum Family Planning. This was done through trainings and mentorships and support supervision. Focus interventions were on 1) Technical competence 2) Clinical governance and infection prevention 3) Stock management. A total of 440 health workers were trained, mentored and their competences were assessed as level one.

6. With support from the project, 23 health facilities, of which 82% (19) are public health facilities were upgraded to active CEmOC facilities by functionalizing their operating theatres.

7. URHVP contributed to strengthening of the supply chain for essential maternal health medicines and supplies in public facilities by complementing the existing National Medical Stores (NMS) supply with an alternative source; the Joint Medical Stores (JMS). This intervention minimized stock outs of essential medicines and supplies in public health facilities thereby limiting unnecessary client referrals, incomplete treatments and compulsion of poor clients buy supplies.

Demand generation for Maternity services

8. URHVP utilised both the mass media and interpersonal communication through the Village Health Team members (VHTs) to disseminate information to the target audience about the benefits of accessing maternity services from health facilities as well as selling and redeeming vouchers. In total, the project

trained 475 VHTs, contracted 11 radio station that broadcasted a total of 146 talk shows, 12,584 Spot adverts and 6,210 DJ mentions by end of the project.

Conclusion

9. As detailed in the log frame below, URHVP was a successful project that met and surpassed its objectives. It undeniably contributed to improvements in health systems and generated learnings that are already informing the scale up of Results Based interventions for more efficient delivery of quality health services.

LESSON LEARNT AND RECOMMENDATIONS:

10. Throughout the implementation of the voucher project there are lessons learnt that are vital in informing any future voucher programming or any results-based financing programme in Uganda. Below are some of the lessons learnt categorized along three major lines:

Scale and impact (reaching out to the underserved poor in rural areas):

11. The voucher project exhibited good practices of identifying the poor people that deserved to benefit from the demand side financing program through using community agents (CBDs) to identify, verify and empower the poor beneficiaries' knowledge wise in the communities. This helped the project to be spot on in reaching out to the underserved people with subsidized maternity services. There is need to strengthen the community systems through improved technological systems to enable easy identification and mapping out the beneficiaries (pregnancy mapping of the targeted poor beneficiaries) for systematic reporting and follow up.

12. Looking at the accreditation process of the voucher facilities where 91% of the facilities contracted on the project were rural and peri-urban based, this gave an opportunity to rural communities have access to voucher services within the reachable distances. This reduced the burden of moving long distances in accessing vouchers services. However, there are many health facilities in hard to reach areas that failed to meet the minimum quality standards to join the project. Going forward, there is need to have flexible assessment processes that can give opportunities to facilities in hard to reach locations to re-prepare and meet the quality standards to join such results-based financing programmes should they fail on their first attempt on the assessment exercise (Giving a window of improvement to join). There is also need to undertake the profiling of health facilities according to level and depth of reach by the wealth quintiles and have stratified considerations in the assessment processes for facilities that serve lower wealth quintiles.

Quality of care as a driver for client attraction for improved health service access

13. Much as there were no specified quality of care indicators in the project log frame, the VMA thought it wise to develop and institute quality indicators for both clinical standards as well as customer management standards. This helped a lot in improving the client experience at the contracted facilities, a situation that improved services uptake and client satisfaction. With high scores on client satisfaction, there is high chances of satisfied user referrals and completion of service packages. Going forward, results-

based financing programs need to develop clear quality indicators that are measurable and incorporated in the reimbursements frameworks of such projects.

Sustaining the gains of URHVP after the project ended.

14. In the implementation of the project, MSU designed some interventions to advance the gains of the project after its lifetime. MSU looked at sustainability at two levels;

(a) In order to build sustainable positive health seeking behaviors amongst the poor rural women and families even after the end of URHVP, there is need to build strong community led demand generation structures that will continue to promote and support poor women and families access quality maternity services from health facilities. MSU groomed and empowered the local council leaders, cultural and religious leaders to be the champions/Heroes of change in supporting the poor communities access maternity services. Even after the end of the project the community structures have continued to educate and refer poor pregnant women to health facilities for service access. The community structures were strengthened with the inclusion of the district leadership (the technical and political leaders) in being continuous change agents for positive health seeking behaviors amongst the poor communities.

"Now that the voucher project is here and it is addressing the financial barrier to accessing services by our poor people, it is our responsibility as leaders at the district to engage our poor people to embrace it and access services. This will help improve the quality of life in homes. I am going to organize my team at the district to ensure we reach all the pockets of Buyende district and sensitize our people" The L.CV Buyende district Mr. Ziribasanga Robert

(b) Strengthening health systems to provide client centered services that attract poor women and men to cost share service expenses. URHVP model demonstrated health systems strengthening in providing quality services to the poor. The fact that poor women were able to contribute UGX 4,000 for exchange of quality maternity services is a steppingstone to confirm that even poor people/communities can financially save to their own health provided they receive the quality of care they deserve. With poor people starting to appreciate and financially contribute to their health (however small the contribution was on URHVP) is proof that cost sharing of health service can be smartly introduced amongst the poor people for sustainability. URHVP on the other hand empowered the poor voucher beneficiaries to demand for quality services. There is need to conduct further studies on the extent to which the poor people can afford to pay for their health services (affordability study) such that the contribution of the poor people in the cost sharing arrangement can be maximized. This will inform the possibility of introducing Community health insurance financing mechanisms to support the poor access health services

(c) Strengthening Management and accountability systems and structures at the district level to sustain the implementation of results-based financing programs and make the districts own the project. One of URHVP's mandate in managing the voucher project was to build

districts capacities to manage results-based financing programs as opposite to the traditional input-based systems. In the course of implementation of URHVP, MSU trained and mentored various stakeholders at the district on how to manage results-based financing projects.

- The VMA trained and mentored all district Maternal focal persons in 25 project districts on management of quality standards with the client centered approach.
- The VMA oriented Chief Administrative Officers (CAOs), DHOs and facility in-charges in all the 25 districts on the claims reimbursement process and how to manage the utilization of reimbursement funds at the facility level as stipulated in the contract. CAOs were mandated to supervise the use of reimbursed funds to the facilities.
- District political leaders including the LCV chairpersons, councilors, Secretary for health, Resident District Commissioners (RDCs) on effective stimulation of demand for maternal health services amongst the poor communities, effective supervision of RBF projects and how to demand for accountability in terms of quality of care, utilization of reimbursement funds to improve service delivery and measuring client satisfaction.

  All the above district engagement strengthened the districts' abilities to understand and manage RBF programs. This increased their interest to own up the Voucher project. Indeed, all the districts with the voucher project have better understanding of RBF programmimg than other non-voucher districts before the introduction of MoH RBF program.

  Transitioning the URHVP districts to MoH RBF program was smoother due to the fact the districts had good exposure to some form of RBF management under URHVP.

- Embracing technologies to maximize efficiencies as well as minimize avoidable project costs leading to reduction in voucher management costs. Throughout the implementation of URHVP, the voucher printing and distribution was dominated by hard copy prints which were expensive to produce and time consuming for the voucher to reach the end beneficiary. Overall, this increased the cost of running the voucher project. Towards the end of the project, an electronic voucher (e-voucher) was successfully piloted and the results showed tremendous financial and time saving for the vouchers to be managed. The e-voucher is easy to manage, and clients can easily be traced as opposed to the print voucher.

CONCLUSION:

15. By the end of the project, URHVP had performed excellently in meeting the main development objective of project of increasing access to safe delivery services for marginalized women living in rural and disadvantaged areas. The URHVP has provided lessons and learnings some of which have been adopted by the MoH Results Based Financing program. In line with MoH health financing strategy, the project has provided lessons on approaches for targeting services to the poor and institutionalizing Results Based Financing mechanisms in the sector. Some of the activities in the voucher scheme including accreditation and contracting of service providers, claims processing, quality assurance and fraud control have been adopted by RBF with likely modifications to suit the program setting. The project worked well

with the various stakeholders more especially at the district level to ensure ownership and accountability are handed over to district leadership.

16. Below are the comments from SIDA. The views presented below were expressed by Adam Kahsai Rudebeck, Programme Manager - Health, Embassy of Sweden, Kampala, during the phone conversation with the ICR main contributor held on August 19, 2020.

(a) From the SIDA side, there is no doubt this has been a successful project, despite significant delays in project start-up. The embassy undertook its own field visits and also participated in monitoring missions led by the GoU and the World Bank.

(b) Dialogue with the Government is critical for project success. Our dialogue with the MoH and MSU has been useful, and we benefited from direct and detailed reporting on the status and achievements of the project from them. The overall relationship and partnership with the World Bank have also been good.

(c) The main issue is related to sustainability. Though there were discussions with the GoU and key stakeholders in advance of the project closure, the voucher scheme was not extended. It does not take away the achievements, but how the gains on the demand side will be sustained remains a challenge. That said, it is encouraging that the supply-side gains will be sustained as targeted districts have been incorporated into the URMCHSIP (which SIDA also supports). For future projects, it may be useful to have a contingency plan to mitigate impact of closure.

ANNEX 6. SUPPORTING DOCUMENTS - POVERTY GRADING TOOL

HEALTHY BABY POVERTY GRADING TOOL/SALES FORM:

Voucher Management Agent, Marie Stopes International - Uganda,
Plot No 16 Mc Alister Road, Mbarara, P.O. Box 548, Mbarara

MBARARA DISTRICT: **S/N.....**

CLIENT NAME		OCCUPATION	
AGE		RELIGION	
EDUCATION		TRIBE	
ADDRESS		MARITAL STATUS	
PARISH		SUB COUNTY	
SUB DISTRICT		COUNTY	
DISTRICT		VILLAGE/TOWN	
POVERTY GRADING			

		Tick appropriate Box
Access health services	a) Visit Municipal H/Cs, Mbarara Referral Hospital 1 mile from their homes	1 ☐
	b) Visit Municipal H/Cs, Private clinics less visited, arrive by boda, or taxi	2 ☐
	c) Visit Private clinics and government facilities accessed by paid transport	3 ☐
Water source	a) Buys water from tap (100-150 jerry can) Or unprotected well water	1 ☐
	b) Has tap in his/her compound and tank, or buys water but can buy plenty	2 ☐
	c) Has both tank and tap uses plenty of water daily	3 ☐
Land	a) No Land	1 ☐
	b) Limited Land 1 – 2 plots	2 ☐
	c) Plenty of land	3 ☐
Housing	a) Unfinished brick house, leaking, temporary doors/windows, old iron sheets	1 ☐
	b) Finished house not varnished or cemented, small (2-3 rooms)	2 ☐
	c) Complete and varnished house, large 3-6 rooms, iron sheets, ventilated	3 ☐
Sanitation	a) Poor drainage system, leaking latrine which is communal, small Compound	1 ☐
	b) Shared latrine, made of bricks	2 ☐
	c) Private, well built latrine/toilet with lid, good ventilation, good drainage system	3 ☐
Live Stock	a) No Animals to a few, Chicken, goats 1-3	1 ☐
	b) has some animals 5-10	2 ☐
	c) Has a large farm with many animals (Cows, goats, sheep) chicken >10	3 ☐
Sources of income	a) hired to graze cattle and goats	1 ☐
	b Sell of goats, hired to graze animals	2 ☐
	c Sell of cattle, milk and goats	3 ☐
Average meals / day	a) Matooke, posho with sauce, 1 meal day evening tea	1 ☐
	b) More than 2 types of foods a day (Matooke, rice, meat, peas, beans)	2 ☐
	c) Balanced diet three meals a day, milk tea with sugar, soda	3 ☐

TOTAL SCORE:		GRADES		
Eligible 0-12		Poor: 0-9	Middle: 10-15	Rich: 16-21
Sold Voucher? YES / NO		VOUCHER NO		
DISTRIBUTOR NAME		DISTRIBUTOR'S SIGN		
VOUCHER STICKER	THUMB PRINT	CLIENT'S SIGN	DATE	

Source: Operations Manual - URHVP, April 2015 (Annex 3).

ANNEX 7. SUPPORTING DOCUMENTS - VIEWS OF THE KEY STAKEHOLDERS

The following are the views of the key stakeholders expressed during the ICR mission (February 2020):

(a) **MoH official.** The GoU appreciated the URHVP. Its objective was to increase uptake of institutional delivery. But it was not just about delivering at facilities; it was an integrated approach that led to better health outcomes for mothers and children. Promoting institutional delivery created opportunities to enhance women's knowledge on nutrition, the importance of ANC and immunization, values of hygiene practices, and so on. As a result, maternal and child outcomes improved in the project regions. Furthermore, the project had social impact on poor households; the voucher project removed financial stress from men (who bear financial responsibilities especially in rural areas) and enabled women to seek ANC and skilled delivery services.

(b) **MoH official.** It was a well-conceived intervention; it enhanced the willingness of mothers to make a contribution toward their own health care. For a country like Uganda that is looking at a national health insurance scheme, this was paramount and one of the biggest hidden unintended benefits (that people are now willing to contribute toward their health care). This project addressed the issue of equity by undertaking a vulnerability assessment. It used a poverty scoring tool to identify those in need; it was not given to everyone, only to those in most need. The MoH and MSU jointly developed this tool during the initial pilot. The tool is MoH owned and can be used for other projects. When support and services go to those in most need, this made us happy.

(c) **MSU staff.** The project enabled MSU to go beyond family planning to broader reproductive health, along the life cycle. We were very excited while implementing this project, there was a lot of enthusiasm among the team.

(d) **District official, South Western Region.** We worked to improve the quality of services, and we saw changes. The project was result oriented and focused more on the quality, the skills of the health facility teams, and so on. The project gave leverage in terms of resource and capacitating the teams to fix the gaps in skills; for example, midwives' ability to resuscitate babies improved through the project. Also, the project brought together public and private sector providers and enhanced access and choices for pregnant women. We want to continue to support private sector providers to deliver services that are of good quality and according to the GoU standards.

(e) **Medical team, Mbarara Community Hospital.** This hospital joined the URHVP in May 2016. Before the project, we received no support; thus, we were only able to provide skilled delivery services to those who were able to pay for services. The project enabled poor women to access hospitals (those who came without slippers/shoes, just walking in) and receive the same services as those of the affluent women. (ICR mission)

(f) **Medical team, Mayanja Memorial Hospital.** The project helped the rural poor access better reproductive, maternal, newborn, and child health services. It gave opportunities to those

who could not afford to deliver in hospitals to do so. Women usually came having heard that "this hospital gives services for poor people." They usually came with fear—is it true, such hospitals exist? You are not going to charge? We counseled and calmed them down. Women came with their voucher, poverty grading tool form (provided by VHTs), and their ID; these were key for registration. During the registration process, we also asked about household income. For us health workers, the project gave us exposure for skill improvement. Also, through the project, this hospital supported lower level facilities with a lot of CME. The project helped start monthly quality improvement meetings at the facility level, looking at performance, quality, and waste management of every department. This has continued beyond December 15 (project closure).

(g) **In-charge, Kinoni Health Center.** The URHVP was a good project because it improved services for poor pregnant mothers in the community. When they came for services, they received quality care and medication that they could not afford. It also helped health facilities improve, and staff in the facility benefited from it. VHTs in the communities also benefited.

(h) **VHT, South Western Region.** The village chairperson was mobilizing and recruiting VHTs. I received training from the MoH (on health matters) and from MSU (on vouchers). This was a way to contribute to my community and their health. Some of the women were so poor, they did not even have UGX 4,000. So, as VHT, I covered the cost of the voucher and sometimes paid for their transport. Some men appreciated the vouchers because with UGX 4,000, their wives were able to receive services. Through the income gained by selling the vouchers, I was able to pay school fees for all five of my children and also bought animals (livestock).

(i) **Voucher mother and her husband, South Western Region.** *Woman:* I heard about the vouchers from a mobilizer. I also received a 'Mama Kit' with mosquito net (USAID-supported program). I used a voucher for delivery of my fourth (no voucher for the last born; raised own resources to deliver at a facility). The fourth child's delivery was prolonged, and I needed to hire a car/taxi to get to a hospital. *Husband:* Having a voucher, we were at peace. It was well covered, and there were no charges at the facility.

(j) **Voucher mother, South Western Region.** A friend told me about the vouchers. I delivered at a health facility for my first and the last child (mother with four children).

ANNEX 8. SUPPORTING DOCUMENTS – DOCUMENTS REVIEWED

Project related documents:

- Project Appraisal Document. October 2014
- Operations Manual. April 2015
- Implementation Support Missions Aide Memoire
- Implementation Status Reports
- Project Restructuring Paper
- Quarterly and Annual Project Progress Reports, MSU
- IVEA Biannual Reports of the Verification and Evaluation of Activities Implemented by MSU
- Presentation by MSU during the ICR Mission, February 2020
- Presentation by IVEA during the ICR Mission, February 2020
- End of Project Report, June 2020. Ministry of Health, Uganda
- Financial Management Report, June 30 2020, Ministry of Health, Uganda

Other documents/materials:

Eva, et al. 2015. "Vouchers for Family Planning and Sexual Health and Reproductive Health Services: A Review of Voucher Programs Involving Marie Stopes International among 11 Asian and African Countries." *International Journal of Gynecology and Obstetrics* 130 (3): E15–E20).

Germany's Federal Ministry for Economic Cooperation and Development and Ministry of Public Health and Sanitation, Kenya. 2012. "Vouchers: Making Motherhood Safer for Kenya's Poorest Women." Accessed on August 16, 2020, from http://health.bmz.de/ghpc/case-studies/Vouchers-MDG5/Vouchers_long_EN.pdf.

Government of Uganda. National Policy on Public Private Partnership in Health (http://library.health.go.ug/sites/default/files/resources/National%20Policy%20on%20Public%20Private%20Partnerships%20in%20Health%20Final%20Print_0.pdf*)*

Government of Uganda. Private Public Partnership Act, 2015.

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