

MAY 2021

UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT

RBF CASE STUDIES: A GPRBA RETROSPECTIVE



@2021 The Global Partnership for Results-Based Approaches (GPRBA)
The World Bank
1818 H Street, NW
Washington,
DC 20433
USA

Website: <http://www.gprba.org>

Contact us at: rbfinfo@gprba.org

All rights reserved

This work is a product of the World Bank's Global Partnership for Results-Based Approaches (GPRBA). GPRBA provides innovative financing solutions that link funding to achieved results. GPRBA's results-based financing (RBF) approaches provide access to basic services like water and sanitation, energy, health and education for low-income families and communities that might otherwise go unserved. By bringing together public and private sector funders to maximize resources and designing effective incentives for service providers to reach underserved low-income communities, GPRBA gives people the chance for a better life.

The findings, interpretations, and conclusions expressed in this work do not necessarily reflect the views of The World Bank, its Board of Executive Directors, or the governments they represent. The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgement on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries. Nothing herein shall constitute or be a limitation upon or waiver of the privileges and immunities of The World Bank, all of which are specifically reserved.

Photo Credits:

The World Bank

Rights and Permissions:

This work is licensed under the Creative Commons Attribution-Non-Commercial No Derivatives 4.0 International License. To view a copy of this license, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to:



Share – copy and redistribute the material in any medium or format. The licensor cannot revoke these freedoms as long as you follow the license terms.

Under the following terms:

Attribution – You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

NonCommercial – You may not use the material for commercial purposes.

NoDerivatives – If you remix, transform, or build upon the material, you may not distribute the modified material.

No additional restrictions – You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.

All non-Creative Commons images in this publication require permission for reuse. All queries on rights and licenses should be addressed to GPRBA, The World Bank, 1818 H Street NW, Washington, DC 20433, USA; e-mail: rbfinfo@gprba.org.

MAY 2021

UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT

RBF CASE STUDIES: A GPRBA RETROSPECTIVE



Table of Contents

Overview and Acknowledgments	2
Acronyms	5
Sector Context and Challenges	6
Uganda Reproductive Health Voucher Project	8
INTRODUCTION	8
STAKEHOLDERS	9
PROJECT DESIGN	10
Voucher Reimbursement	10
Identifying Districts	11
Selecting Service Providers	12
Capacity Building and Quality Improvement	12
Behavioral Change Communication (BCC) and Voucher Distribution Strategy	13
PROJECT FINANCING	14
TARGETING MECHANISM	14
PROJECT IMPLEMENTATION	14
PROJECT PERFORMANCE	16
Challenges/Limitations	17
Conclusion	18

Overview and Acknowledgments

This case study is part of a series prepared by the World Bank's Global Partnership for Results-Based Approaches (GPRBA). The objective is to highlight project components that have enabled GPRBA to successfully deploy results-based finance (RBF) approaches for the provision of basic services to low-income communities, with efficiency, transparency and accountability. The present analysis is focused on the Reproductive Health Voucher Program (RHVP) in Uganda. The objective of the project was to increase access to skilled and safe maternal health care during pregnancy, delivery and postnatal stages among poor women living in rural and disadvantaged areas. The vouchers distributed through the project supported 178,413 supervised deliveries through 201 health facilities across 25 districts in Uganda.

The data for this study was collected through a desk review of project documents along with semi-structured interviews and focus group discussions with key stakeholders, namely representatives of the Ministry of Health, Marie Stopes Uganda - the Voucher Management Agency (VMA), district health officials in Mbarara district, staff at both public and private health facilities and project beneficiaries. The findings from these discussions were triangulated by analyzing data collected and submitted by BDO - the independent verification and evaluation agent. Additionally, research papers and reports published by external institutions were taken into consideration. The team acknowledges Jessica Lopez Taylor and Ibrahim Ali Khan for their leadership in the production of this report, Bernard Olayo, Chiho Suzuki, and Rogers Ayiko for their valuable input, and Amsale Bumbaugh for her support during the production process.





Acronyms

ANC	antenatal care
BCC	Behavioral Change Communication
BEMONC	basic emergency obstetric and newborn care
CBD	Community-Based Distributor
CEMONC	comprehensive emergency obstetric and newborn care
CME	Continuous Medical Education
EMTCT	elimination of mother-to-child transmission
FP	family planning
GPOBA	Global Partnership on Output-Based Aid
GPRBA	Global Partnership for Results-Based Approaches
ICC	Inter-Agency Coordination Committee
IUD	intrauterine device
IVEA	independent verification and evaluation agent
KFW	Kreditanstalt FÜR Wiederaufbau
MDG	Millennium Development Goals
MMR	maternal mortality rate
MoH	Ministry of Health
MSU	Marie Stopes Uganda
NGO	non-governmental organization
OBA	output-based aid
PNC	postnatal care
PNFP	private not-for-profit
PPFP	postpartum family planning
RBF	results-based financing
RHVP	Reproductive Health Voucher Project
SD	safe delivery
SP	service provider
STI	sexually transmitted infection
TBA	traditional birth attendants
UBOS	Uganda Bureau of Statistics
UHSSP	Uganda Health Systems Strengthening Project
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHT	Village Health Team
VMA	Voucher Management Agency



Sector Context and Challenges

INSTITUTIONAL CONTEXT AND PRIOR SECTOR SITUATION

Between 1990 and 2015, Uganda reduced the maternal mortality rate (MMR) in the country by about 50 percent, from 687 in 1990 to 343 in 2015.¹ However, despite this significant progress, the country's MMR remained higher than the 2015 target set by the United Nations Millennium Development Goals (MDGs), i.e., fewer than 131 maternal deaths per 100,000 live births.

Most maternal deaths are preventable by accessing quality antenatal care (ANC), skilled care during pregnancy and post-natal care (PNC) services.² Early and frequent ANC attendance during pregnancy is important to identify and mitigate risk factors in pregnancy and to encourage women to have a skilled attendant at childbirth. PNC improves the health of both the newborn and the mother.³ Studies have shown that they remain underutilized due to access barriers such as high

service fees, low coverage of healthcare facilities, insufficient supplies of drugs and/or equipment, and understaffed and low-skilled healthcare workers.⁴ Maternal health care provision is also impeded by the persistently high fertility rate (5.68 children per women) in Uganda.⁵ It strains not only individuals and families but also public resources and health care infrastructure.

These factors force a significant number of women to deliver in the community with the assistance of unskilled birth attendants, such as traditional birth attendants (TBA) or relatives, or without any support at all. Correspondingly, according to the Demographic and Health Survey 2011, only 58 percent of women in Uganda delivered at health facilities.⁶ Even public facilities, which are meant to provide services free of cost, often require that patients buy essential commodities used for procedures due to recurrent shortages of drugs and supplies. Apart from putting a financial burden on the family, informal solutions such as asking mothers to purchase their own supplies have variable implications on the quality of care. While several of them are useful in addressing bottlenecks in the health system, they sometimes place additional burdens and personal costs on health workers, creating mistrust, inequity in care, and negative experiences among mothers who cannot afford the extra costs.⁷

Over the years, many developing countries like Uganda have focused on supply-side interventions as a means to address these challenges.⁸ These include training midwives in safe motherhood and lifesaving skills, training comprehensive nurses who can offer midwifery and nursing services, and constructing health facilities that offer emergency obstetric care.⁹ Unfortunately, these input-based supply interventions have a poor track record in meeting the reproductive health needs of low-income and underserved segments of national populations. They provide little encouragement to patients, especially those from vulnerable communities, to utilize facility-based services. They also do not give service providers (SPs) an

¹ WHO, 2015.
² UNICEF, 2008
³ Rutaremwa, G., Wandera, S.O., Jhamba, T. et al., 2015
⁴ Ekirapa-Kiracho E, Waiswa P, Rahman MH, et al., 2011

⁵ World Bank 2015
⁶ UBOS. Uganda Demographic and Health Survey 2011.
⁷ Munabi-Babigumira, Susan, Claire Glenton, Merlin Willcox, and Harriet Nabudere, 2019
⁸ Ekirapa-Kiracho E, Waiswa P, Rahman MH, et al. 2011,
⁹ Makerere University School of Public Health (MUSPH), 2009

incentive to provide better services beyond the basic essentials.¹⁰ Alternatively, evidence suggests that a multipronged strategy aimed at both the supply and the demand side deficiencies of a health system has a greater probability of improving the utilization and quality of care services.¹¹

WORLD BANK INTERVENTIONS

To address the demand and supply-side barriers and increase equity in the use of reproductive health services, in 2008, the World Bank's Global Partnership for Results-Based Approaches (GPRBA), formerly the Global Partnership on Output-Based Aid, and Kreditanstalt für Wiederaufbau (KfW, German Development Bank), implemented a project that utilized an output-based aid (OBA) approach. This approach utilized vouchers to incentivize women and couples to access reproductive health care services at qualified facilities, as well as to incentivize private health facilities to provide quality services to previously underserved populations in Uganda. KfW had previously piloted the OBA approach through the Sexually Transmitted Infections OBA Voucher Project between 2006 and 2007.

The program, named the Reproductive Health Voucher Program (RHVP), was financed by a \$4.3 million GPRBA grant.¹² It covered sexually transmitted infections (STI) treatment and safe delivery (SD) services in 20 districts across southwestern Uganda. Beneficiaries were able to redeem these vouchers at selected health facilities for a package of services. The voucher program was implemented by Marie Stopes Uganda (MSU), which acted as the voucher management agency on behalf of the Ministry of Health (MoH), Uganda. The project successfully supported 65,590 safe deliveries and treated 31,658 cases of STIs.

Through the project, it was established that vouchers create incentives to improve the efficiency of health service delivery and increase access to important health services for new users. They

Output-Based Aid (OBA) is a form of results-based financing (RBF) in which subsidies are paid to SPs based on verification of pre-agreed project targets (outputs) defined during project design, thereby offering a strong incentive for the delivery of results.

stimulate demand for underutilized services and give the poor the purchasing power to seek care from the full range of available SPs. They also have the potential to improve health care and health outcomes at the facility level and among the general population.¹³ The evaluation of the program noted that it successfully:

- a) Provided reproductive health services to women from the poorest quintiles;
- b) Increased deliveries in health facilities; and
- c) Led to significant reductions in the likelihood of out-of-pocket payment for deliveries among women in communities served by the program.

In 2011, based on the success of the RHVP, a similar voucher program was implemented by USAID, through a project called Strengthening Health Outcomes Through the Private Sector. They even deployed the same systems and processes set up for the RHVP.

Similarly, consistent with GPRBA's strategy of scaling-up successful projects, a continuation of the Safe Delivery component¹⁴ was planned and implemented by the World Bank in 2015. Since strengthening the collaboration and partnership between the public and private sectors in health was an essential guiding principle of the National Health Policy, the scale-up included both private and public healthcare facilities as potential SPs. Engaging the public sector was a way to address inequities in coverage and improve its long-term sustainability. It also increased the likelihood that the government was more involved in the program at both national and district levels.¹⁵

¹⁰ Bua, J., Paina, L. & Kiracho, E.E, 2015

¹¹ Center for Global Development, 2009

¹² Funds contributed by the International Finance Corporation (IFC)

¹³ Obare, Okwero, Villegas, Mills and Bellows, 2016

¹⁴ The STI voucher scheme was not continued because verification of STI treatment proved difficult in the first phase.

¹⁵ Okal, Kanya, Obare, Njuki, Abuya, Bange, Warren, Askew, and Bellows, 2013



Uganda Reproductive Health Voucher Project

INTRODUCTION

In 2015, GPRBA provided a grant of \$13.3 million¹⁶ to the MoH for the implementation of the second phase of the Uganda Reproductive Health Voucher Project (URHVP) over four years. The project, a scale-up of the safe delivery component of the first URHVP, had the objective of increasing access to skilled and safe maternal health care during pregnancy, delivery, and postnatal stages among poor women living in rural and disadvantaged areas. Similar to the first project, it subsidized safe maternal health care by providing a voucher to poor and vulnerable pregnant women within selected districts in southwestern and eastern Uganda. Public facilities not previously utilized were also integrated into the scale-up. Their inclusion improved the pool of potential providers and provided an opportunity to strengthen their performance and introduce an accountability mechanism within the public health sector.

The project aimed to provide 156,400¹⁷ poor pregnant women with access to a defined package of safe delivery services from contracted private and public providers. The package of services covered under the voucher consisted of four antenatal visits, 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 elimination of mother-to-child transmission (EMTCT) of HIV as part of antenatal care. A year into implementation, postpartum family planning (PPFP) was also added to the services package. The costs associated with PPFP were paid for by MSU through their own funds.

The second component of the project focused on building national capacity to implement similar programs. The government was expected to draw lessons from the project to target services to the poor and institutionalize RBF mechanisms in the health sector, by re-orienting disbursement of public subsidies on an output basis.

¹⁶ All dollar amounts listed in this report are USD.

¹⁷ The target was revised from 132,400 due to additional funds received from the Government of Uganda and the United Nations Population Fund, in addition to depreciation of the Ugandan Shilling in comparison to the US dollar

STAKEHOLDERS

Ministry of Health – As the recipient of the grant, the MoH had the responsibility of overseeing and coordinating the implementation of the project. Additionally, to address the risk of duplication of other related schemes, MoH also had to set up an Inter-Agency Coordination Committee (ICC), which would be responsible for coordinating and harmonizing voucher implementation processes in the country. The committee also had to provide strategic guidance and oversight to the project and other voucher schemes in the sector.

Voucher Management Agency – The MoH contracted MSU as the Voucher Management Agency (VMA) to serve as the project implementation agency. In discharging its duties, the VMA had to work under the guidance of the MoH and collaborate closely with district-level officials. The main roles of the VMA were as follows:

- Selecting and contracting SPs
- Designing the voucher and ensuring its security
- Negotiating reimbursement costs with SPs
- Managing claims processing systems
- Marketing the scheme and distributing vouchers through community-based distributors
- Training SPs and voucher distributors
- Conducting quality assurance and monitoring and evaluation activities

MSU had previously managed the pilot program and had already built the necessary infrastructure and systems to implement the second phase successfully and efficiently.

Service Providers – SPs contracted by MSU were responsible for delivering services covered under the voucher scheme. The SPs were selected from a pool of private and public health facilities. Private facilities included both private for-profit and private not-for-profit (PNFP) health care providers. They were invited through public notices to express an interest in providing services, and upon meeting the selection criteria, were approved to participate in the scheme. The selection of SPs 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
- d) Capacity to provide the defined package of services

Preference was given to health facilities from poor and rural communities/areas where access to safe delivery services was low. SPs, both public and private, were mapped to create functional referral networks between health facilities providing basic emergency obstetric and newborn care (BEMONC) services, and those providing comprehensive emergency obstetric and newborn care (CEMONC) services. This ensured that women were provided with safe and adequate maternity care, including emergency services.

To remain in the scheme, participating SPs underwent annual clinical audits to assess the quality of care and their adherence to the service guidelines and protocols. The 85 active SPs contracted under the first phase also underwent an assessment and were not automatically deemed eligible to participate in the project.

BEMONC facilities have capabilities to perform the following functions:

- Administering antibiotics, uterotonic drugs (oxytocin) and anticonvulsants (magnesium sulphate)
- Manual removal of the placenta
- Removal of retained products following miscarriage or abortion
- Assisted vaginal delivery, preferably with vacuum extractor
- Basic neonatal resuscitation care

CEMONC facilities can perform all the basic functions listed above, with additional capabilities for the following:

- Performing caesarean sections
- Safe blood transfusion
- Provision of care to sick and low-birth weight newborns, including resuscitation¹⁸

¹⁸ UNFPA, 2014

Community-Based Distributors – The Community-Based Distributors (CBD) contracted by MSU were responsible for selling the vouchers to eligible mothers within their specified catchment area. Two CBDs were assigned to each SP and were selected from the Village Health Teams (VHT). VHTs are made up of volunteers that promote community participation in healthcare and act as a link between communities and the formal health service delivery system.¹⁹ Their responsibilities include “recording demographic and health data, educating on health and hygiene topics, mobilizing families to engage in health programs such as vaccination campaigns, monitoring for illness, making referrals, and providing post-discharge follow up.”²⁰

All CBDs received training in effective marketing approaches and communications skills to promote voucher sales and ensure their effective use by clients.

The following selection criteria was adopted to select CBDs from the VHTs:

- Ability to read and write in English
- Prior experience with social programs in the health, education, sanitation and/or agriculture sector
- Possesses a basic mobile phone
- Reputed member of the community (established through recommendation from the local council)
- Lives within a radius of not more than 5 kilometers from the approved SP

The CBD also played a key role in ensuring the scheme benefited poor women. Before selling the voucher, they had to administer a poverty-grading tool²¹ to establish the interested woman’s eligibility. The tool was to be administered only in areas where at least 60 percent of the population was deemed to be poor.

Independent Verification and Evaluation Agent –

To verify project outputs, the integrity of the processes established by the VMA, and the quality of service provided by the SPs, the MoH recruited BDO²² as the Independent Verification and

Evaluation Agent (IVEA). They carried out on-site physical verifications of a number of randomly selected SPs. The purpose was to ascertain the SPs’ existence and their activities. For each SP visited, the IVEA physically certified its functioning according to the required standards in terms of staffing, skills, facilities, equipment, and care protocols, and verified the associated records kept at the offices of the SP. They also carried out exit and focus group interviews with patients attending the health facilities, to gain information about their experiences with the voucher. These surveys were conducted at random intervals and reports were made available as part of the bi-annual reports submitted to the World Bank and MoH.

PROJECT DESIGN

The project design ensured accountability for results and empowered beneficiaries to choose their providers. It was similar to the first phase whereby pregnant mothers purchased the vouchers at US\$4,000 (\$ 1.60), inclusive of a markup for the CBD as an incentive. Since the voucher scheme targeted the poorest and most vulnerable women, the voucher cost was set at a rate affordable to the targeted users. The user contribution was vital as it made getting a voucher an active exercise, rendering the voucher valuable and not simply a ‘giveaway.’ It also provided a mechanism to pay distributors (CBDs), who took a percentage of the money received as a form of an output-based payment.

Enhanced security features were incorporated into the design of the voucher. They were numbered, barcoded, and included clear instructions in English and local languages. This made it difficult for the voucher to be misused or forged and enabled MSU to identify cases of fraud.

Voucher Reimbursement

Upon purchasing the voucher from the CBDs, pregnant women were entitled to access any contracted SP for the services covered by the voucher. The SPs were reimbursed on a fee-for-service basis,

¹⁹ Ministry of Health, Uganda, Village health teams, Strategy and operations guidelines, 2010

²⁰ Mays, D.C., O’Neil, E.J., Mworosi, E.A. et al, 2017

²¹ Modified version of a Grameen foundation poverty assessment tool

²² BDO is an international network of firms providing accounting, audit, tax and business consulting services

Figure 1. URHVP Voucher

following negotiated contracts signed with MSU. After the introduction of PPFP services, rates for family planning (FP) services also had to be negotiated with the SPs and a coupon was included in the voucher.²³ In situations where complicated deliveries required care originally unanticipated when negotiating the contracts, SPs were required to first contact MSU to determine the appropriate course of action. A ceiling of \$350 was set for the management of unexpected emergency deliveries.

There were, however, different reimbursement rates for public facilities. They took into account the funding already being provided by the government to public providers. The funds reimbursed to public providers were regarded as extra budgetary support and were used at the facility in the following proportions:

1. Remuneration of health workers (additional stipend) – 40 percent
2. Drugs and supplies – 50 percent
3. Minor repair for the health facility building, plus compound cleaning and supervisory support to the District Health Office – 10 percent

Whenever a voucher holder utilized a service through a contracted SP, a coupon related to the visit had to be retained by the SP. They then submitted a claims form to MSU for vetting, processing, and payment. The vetting process involved verifying the woman's details, the appropriateness of the service made and the claimed amount against the negotiated service contract.

Identifying Districts

The findings of the first phase fed into the expansion of the RHVP to 25 Districts in both eastern and southwestern Uganda. Prioritization of intervention districts was based on national data on the percentage of institutional deliveries per district, with districts below the national average being selected for the project. From the data, the following 12 districts in southwestern Uganda were included in the intervention:

- | | |
|-------------|--------------|
| 1. Buhweju | 7. Kiruhura |
| 2. Ibanda | 8. Mitooma |
| 3. Isingiro | 9. Ntungamo |
| 4. Kabale | 10. Rubirizi |
| 5. Kanungu | 11. Sheema |
| 6. Bushenyi | 12. Mbarara |

Despite having a higher-than-average rate of institutional delivery, Mbarara district was included in the project because of its high capacity to support CEMONC services within the region. The district housed the regional referral hospital and a number of private hospitals, enabling it to support other relatively weaker districts.

A slightly different mechanism had to be deployed to identify districts in the eastern part of the country. Data showed that they were amongst the worst performing with regard to institutional deliveries, with most below the national average. Therefore, to make implementation easier, districts located next to each other were prioritized. The 13 districts in the eastern region were:

- | | |
|--------------|--------------|
| 1. Bugiri | 8. Namutumba |
| 2. Buyende | 9. Kibuku |
| 3. Kaliro | 10. Jinja |
| 4. Kamuli | 11. Iganga |
| 5. Luuka | 12. Tororo |
| 6. Mayuge | 13. Busia |
| 7. Namayingo | |

The Jinja and Iganga districts were included because of their capacity to support CEMONC for the region.

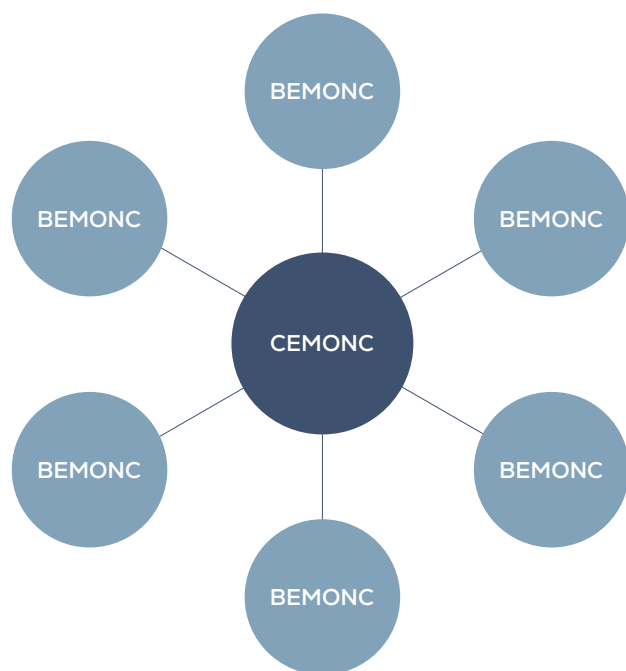
²³ As mentioned previously, the cost associated for these services were funded by MSU directly and not through the World Bank project

Selecting Service Providers

Phase two of the project required MSU to identify health facilities in the selected districts that could provide BEMONC and CEMONC services.

Clusters of these facilities were formed, with each cluster having between four to six BEMONC and at least one CEMONC. The CEMONC served as a referral facility for cases that the BEMONC facility was not equipped to handle. These included caesarean sections and other pregnancy-related complications. As a result of the mapping exercise, the program was based around the SPs and did not necessarily cover the whole population of a district.

Figure 2. Illustration of a Cluster



Participating health facilities were chosen after an assessment to ensure they satisfied a minimum standard of quality for safe maternity services. However, in hard-to-reach locations, facilities that were found to be slightly below the standard of quality were given an opportunity to improve their facilities before joining the project.

Capacity Building and Quality Improvement

MSU, in concurrence with the MoH, developed a training curriculum covering the core areas of BEMONC and CEMONC. MSU used the curriculum to organize staff trainings at the SPs. Some of the skills the trainings imparted included:

- Use of a partograph for proper monitoring of labor
- Management of postpartum hemorrhage
- Neonatal care/newborn resuscitation
- Management of obstetric emergencies

To further strengthen the provision of services, MSU required every referral CEMONC facility in the cluster to organize at least two Continuing Medical Education (CME) sessions, led by a suitable specialist, every year. These CME sessions would cover major causes of maternal and perinatal incidences including deaths, as well as any other key medical gaps. All lower facilities within the cluster were required to attend.

Once PPFP services were incorporated into the project, MSU developed an additional module covering essential Family Planning (FP) skills. The training covered both theory and practicum in the following areas:

- Screening clients for eligibility to use the various FP methods
- Managing clients for contraceptive services at initial and routine follow-up visits
- Managing clients with contraceptive-related side effects and complications
- Provision of long-acting reversible contraceptives (interval IUD, PPIUD and implants)

Lastly, MSU conducted spot checks and routine support supervisory visits in health facilities to ensure satisfactory quality of service provision, the safe handling and disposal of medical waste, and proper infection prevention practices. MSU was empowered to suspend facilities that were unable to meet service requirements, using substandard infection prevention and medical waste handling and disposal practices. Facilities were rated on

a scale of 1 to 5 based on MoH clinical quality standards. In 2016, 88 percent of facilities received a score between 1 and 3; by 2019, 81 percent of facilities had achieved a 4 or 5, showing significant improvement in quality achieved over the project's life.

Behavioral Change Communication (BCC) and Voucher Distribution Strategy

MSU had a dedicated BCC staff that recruited, trained, and supervised CBDs; they also carried out community sensitizations and mass media campaigns, including radio talk shows. The communication and marketing strategy focused on the key population groups, emphasized behavior change messages, promoted voucher sales, and leveraged relationships with existing community groups and institutions. The mass media campaign, "ndi HERO," was designed to motivate pregnant women and persuade family and community members to support them in accessing services from a health facility; the following slogan was used: "every pregnant mother's dream is a healthy baby."

CBDs formed the most crucial pillar of the marketing and distribution campaign. The CBDs underwent a weeklong training covering the protocols on the correct methods of selling the vouchers. These communication strategies promoted the best way to use vouchers, as well as the appropriate method for screening potential clients to establish their eligibility. In addition, clients were encouraged to report any deviation from the expected services, including the price of the voucher, to a toll-free line. This enabled the MSU to identify CBDs that were charging clients above the agreed voucher price and identify non-compliant SPs.

The vouchers, priced at US\$4,000 for the beneficiaries, were provided to the CBDs for US\$2,700. The difference was meant to incentivize the CBDs to sell more vouchers and cover marketing and distribution costs. To increase their credibility amongst the community, the CBDs were also provided with uniforms, badges, backpacks and raincoats.



PROJECT FINANCING

The primary source of financing for the project came from a \$13.3 million grant provided by GPRBA. Co-financing was provided by the MoH from the Uganda Health Systems Strengthening Project (UHSSP) and the United Nations Population Fund (UNFPA).

Table 1: Funding breakdown for URHVP

Funding Source	Amount
GPRBA	\$13,300,000
MoH/UHSSP	\$3,058,950
UNFPA	\$954,436
Total	\$17,313,386

TARGETING MECHANISM

The project targeted poor and vulnerable pregnant women residing within the catchment areas of the contracted health facilities. They were expected to be able to reach the facilities in less than two hours. In the absence of a nationally agreed targeting framework, the project utilized a combination of geographical targeting and a poverty-grading tool to select eligible beneficiaries.

The following criteria was used to determine eligibility under the project:

- Pregnant women residing in sub-counties where over 60 percent of households deemed poor were eligible to join the scheme without undergoing household assessment. Such sub-counties were identified using poverty maps provided by the Uganda Bureau of Statistics (UBOS). Only women living in four districts, namely Buhweju, Buyende, Luuka and Rubirizi, qualified under the geographical targeting mechanism.
- Pregnant women residing in sub-counties where poverty was not deemed widespread underwent a poverty assessment using the poverty-grading tool. The process involved CBDs visiting and interviewing women in their households to determine their poverty status. Those with a score of 12 or less were eligible to join the scheme.²⁴

PROJECT IMPLEMENTATION

Project activities by MSU started in September 2015; voucher distribution started in the southwest region in March 2016 and in the eastern region in May 2016. MSU initially selected 122 health facilities in southwestern Uganda and 70 health facilities in eastern Uganda after assessing 450 health facilities (250 from western and 200 from eastern regions). In preparation for the competitive selection process, a number of SPs had already made significant investments at their facilities.

At project inception, differences in preparedness between the eastern and western regions were apparent. For instance, despite the standards laid down by MSU, some facilities in the eastern region required women to bring at least one additional item with them at the time of delivery, most commonly soap, a basin and a plastic sheet. On the other hand, most SPs in the western region were, due to prior experience with the first phase, well-versed with and prepared to meet the project's stringent quality and service requirements. The distribution of vouchers in the eastern region was also a challenge. Lack of exposure to a similar scheme and "rumors" in some areas, such as that the voucher program was a scam, made it difficult for the CBDs to sell the voucher. However, supported by a sustained mass media campaign, once word of mouth about the services' reliability and quality spread, the number of vouchers sold increased.

Moreover, motivating expectant mothers to utilize ANC and PNC services was initially a challenge across both regions. Often, the vouchers were used only for deliveries at certified facilities rather than for the full package of services. In some cases, the vouchers were purchased only as insurance in case of complications during delivery. To address this issue, MSU had shifted its marketing strategy from focusing on sales to improving service utilization. By September 2017, CBDs were encouraged to conduct follow-up visits to all voucher clients, promote complete utilization of voucher services and increase awareness about the benefits of maternity services. As the project transitioned away from sales and focused on the redemption of vouchers already in circulation, a new reimbursement strategy for the CBDs was adopted. It provided a monetary incentive to CBDs based on the ANC and PNC uptake of their clients, in addition to maintaining a

²⁴ The maximum score under the tool is 21



good track record in sales (i.e., no record of fraud, timely submission of monthly reports). As a result of this heavy mobilization and CBD follow-ups, there was a 54 percentage point increase in mothers attending ANC from year one to year four of the project, and a 20 percentage point increase in PNC attendance. PPFP, which was introduced to the project at the end of year one, increased from 10 percent uptake in year two to 48 percent by project close. The integration of PPFP with other services, including child immunization days and ART clinics, also improved the redemption rates.

However, HIV tests and EMTCT targets continued to lag because of challenges in accessing HIV test kits, especially for the private sector. This was exacerbated by a lack of accreditation by the national AIDS control program for several contracted health facilities to provide EMTCT services. Furthermore, CBDs could not be utilized to follow up with HIV-positive mothers for EMTCT services because of concerns around confidentiality.

Additionally, timely reimbursement of SP claims continued to be an issue throughout project's

duration. This forced some SPs to seek financial assistance from external sources or in some cases, even suspend services for voucher clients. The delays were caused due to the inability of many SPs to submit proper claims and delays in the release of funds by the MoH. The IVEA noted that facilities were improving their management of the claims process throughout the duration of the project and were preparing claim forms in accordance with the amounts set by the system. This resulted in fewer claims being disallowed, and the amounts payable more closely reflected the amounts claimed. By the end of the project, fewer claim forms were being rejected or quarantined, but delays in payments persisted.

Nonetheless, as a result of participating in the project, SPs, both public and private, were utilizing the increased revenue to procure equipment, hire more staff, and expand or improve infrastructure. The clustering model created an effective communication and feedback mechanism, strengthening the referral systems. The referring SPs were able to call the referral facility to discuss the case beforehand, so that the latter was prepared to receive and treat the patient promptly. In other instances, referring SPs could address complications themselves after the referral facility provided guidance on how to properly manage the case.

The design also successfully addressed concerns regarding public facilities' ability to provide services in accordance with high-quality standards. By allowing for voucher reimbursements to be utilized at source and granting the facilities certain discretion to use voucher funds, public facilities were able to provide services on par with private facilities. The extra-budgetary support enabled public facilities to improve services for all women seeking maternity care, not just for voucher mothers. Even the staff at the public facilities, due to the improved working conditions, additional income, and availability of drugs and supplies, was motivated to compete with private facilities to attract voucher mothers. District referral facilities, though not part of the program, also benefitted. There was a visible decongestion at those higher-level facilities within the project areas, which was mainly attributed to public and private facilities' ability to handle a large number of pregnancy-related complications.



PROJECT PERFORMANCE

The project surpassed its target of supporting the number of deliveries attended by skilled health personnel. 231,002 vouchers were sold, of which 178,413²⁵ were utilized for deliveries and 196,668 used for at least one ANC visit. The low number of women referred is also considered a successful indicator, as the capacity-building activities enabled the BEMONC facilities to handle cases that they previously would have referred. Illustrating improved quality of care, facilities improved their average clinical quality score²⁶ from 70 percent in 2016 to 88 percent in 2019. Maternal mortality incidence

also remained low during the project period. There were a total of 44 maternal deaths (5 at BEMONC and 39 at CEMONC). Additionally, considering the challenges with following up with HIV-positive women, it was commendable that of the 4,107 women who tested positive for HIV, 96 percent received EMTCT services.

Women also appreciated the expanded choice of facilities, and barriers such as distance and cost continued to decline due to the increasing number of SPs throughout the project. By the end of the project, there were 201 facilities covered under the project - 102 in the southwest region (64 BEMONC

²⁵ Project target was 156,400

²⁶ Using MoH Quality of Care standards

Table 2. Project targets and results achieved

Indicators	Project Targets	Results
Number of deliveries attended by skilled health personnel	156,400	178,413
Number and percentage of vouchers distributed and redeemed for deliveries under the project	70%	77% (178,413)
Number and percentage of women attending at least one ANC visits under the project	90%	86% (196,668)
Number and percentage of vouchers redeemed for PNC	35%	41% (84,572)
Percentage of pregnant women tested for HIV	90%	80% (157,247)
Number of mothers referred	19,900	12,612

and 38 CEMONC) and 99 in the 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 CBDs (224 in the southwest region and 232 in the eastern region). Cumulatively, 23 health facilities, of which 82 percent, or 19, were public health facilities, were upgraded to active CEMONC status by functionalizing their operating theatres. All in all, the additional funds, training and supervision brought an increased number of CEMONC facilities closer to disadvantaged communities.

Furthermore, the staff at the SPs valued the opportunity to learn new clinical skills. These included goal-oriented ANC, management of post-partum hemorrhage, infection prevention, neonatal resuscitation, delivery of breech births, managing obstructed labor, using partographs, and proper waste management.

Another outcome of the project was the mobilization of private health facilities in the Western region to form an association called the Private-led Health Providers Association of Uganda Ltd. The association, with 125 members, seeks to amplify the private sector's ability to advocate for increased support by the government. It also is working towards maintaining the standards established during the project and plans to continue building internal capacity through trainings and CME for its members.

Challenges/Limitations

Transportation to referral facilities remained a challenge. Though the voucher reimbursed the facility to transport women to a referral facility, there was no provision of reimbursement for return trips. Therefore, women either completely avoided the trip or were left stranded post treatment at the CEMONC facility. There were also variations between the performance of the eastern and western region. Despite the difference in capacity and experience between the two regions, there were no measures placed within the design to avert the imbalance. The work plans should have ideally considered the varying needs of the two regions and allocated resources accordingly.

Lastly, the MoH did not formally appoint members to form/constitute the ICC and therefore it was not operationalized. This resulted in a perceived lack of strategic guidance and oversight of the project by the national government. However, the health officials at the district level were highly engaged in the implementation of the project and complemented MSU in ensuring the service quality at both the private and public facilities was up to the required standards.

Conclusion

The project demonstrated that paying subsidies through a voucher scheme using an OBA approach resulted in improved outcomes in terms of utilization of safe delivery services and the quality of care. It also provided a framework for granting greater autonomy to public health facilities. Additionally, tying payment to results enhanced service delivery at all levels i.e., SPs, the VMA and the government. All in all, the RBF mechanism brought greater accountability and transparency to the healthcare system. Furthermore, by creating competition between health facilities, the project empowered pregnant women by enabling them to exercise their right to demand quality healthcare. Having a voucher made private facilities accessible and created incentives for public facilities to ensure women felt respected. Lastly, through its cost-effective engagement of private health facilities, the project illustrated the benefits of strategically procuring services from the private sector.

Drawing on lessons from the RHVPs, the MoH is currently implementing another voucher scheme through USAID funding. It is expected to support approximately 250,000 safe, facility-based deliveries by 2021. This continuous consolidation and scale-up of voucher projects has contributed to capacity building, institutional strengthening, and reinforcement of accountability mechanisms within the health sector. Further building on the project's technical aspects, the World Bank is also implementing an RBF program focusing primarily on supply side interventions. This project, called the Uganda Reproductive, Maternal and Child Health Services Improvement Project, utilizes the platform built through voucher projects by deploying an RBF approach to support public and PNFP facilities to scale-up essential reproductive maternal neonatal child and adolescent health services.

However, while the project helped to significantly improve the capacity and financial position of rural healthcare facilities in the country, the project's financial sustainability remains a challenge. This

is primarily because the interventions supported under the voucher scheme require ongoing subsidies to address the needs of new cohorts of women requiring the services. While public and PNFP facilities are continuing to receive financial support through the ongoing World Bank²⁷ RBF program, the opportunities and incentives for private for-profit health facilities to continue to serve poor households are limited. As expressed by some of the private facilities interviewed for the case study, there is a probability that many will face difficulties in sustaining the capacity built during the project.

Nonetheless, the progressive implementation of voucher projects across Uganda has led to RBF being recognized as an innovative way of improving service delivery and health outcomes, thereby contributing to broader health care reforms. In accordance with the decentralization policy of health services in Uganda, a national RBF framework has been developed to customize RBF functions to national and district levels. Many functions previously undertaken by international and local NGOs (non-governmental organizations) have recently been integrated within MoH and District Health Management Teams.²⁸ The mechanism promoted by the project is also a step towards establishing an equitable healthcare financing system that insures against catastrophic health expenditures.

A growing body of national, regional, and international research suggests that vouchers can act as a starting point for developing systems and expanding social health insurance. Many of the voucher scheme activities, including accreditation and contracting of SPs, defining benefits packages, claims processing, quality assurance and fraud control, are needed in any insurance-based scheme. The claims processing system is of particular importance to health insurance. The Uganda Reproductive Health Voucher Program is therefore seen as a major experiment that will inform the introduction of social health insurance, a policy which is currently being debated by the parliament in Uganda.

²⁷ Uganda Reproductive, Maternal and Child Health Services Improvement Project.

²⁸ Witter, Bertone, Namakula, Chandiwan, Chirwa, Ssenyonjo, and Ssengooba, 2019





www.gprba.org



SUPPORTED BY
WORLD BANK GROUP

www.worldbank.org