



Report Number: ICRR0022325

1. Project Data

| Project ID P144102 | Project Name UG-Reproductive Health Voucher Project | | | | | | | | | | | | | |
|--|---|--|--|-----------------------|---------------------|---------------------|---------------|---------------|--------------------|---------------|---------------|--------|---------------|---------------|
| Country Uganda | Practice Area(Lead) Health, Nutrition & Population | | | | | | | | | | | | | |
| L/C/TF Number(s) TF-15995 | Closing Date (Original) 29-Dec-2017 | Total Project Cost (USD) 13,299,216.00 | | | | | | | | | | | | |
| Bank Approval Date 03-Oct-2014 | Closing Date (Actual) 15-Dec-2019 | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th></th><th>IBRD/IDA (USD)</th><th>Grants (USD)</th></tr> </thead> <tbody> <tr> <td>Original Commitment</td><td>13,300,000.00</td><td>13,300,000.00</td></tr> <tr> <td>Revised Commitment</td><td>13,299,216.00</td><td>13,299,216.00</td></tr> <tr> <td>Actual</td><td>13,299,216.00</td><td>13,299,216.00</td></tr> </tbody> </table> | | | | IBRD/IDA (USD) | Grants (USD) | Original Commitment | 13,300,000.00 | 13,300,000.00 | Revised Commitment | 13,299,216.00 | 13,299,216.00 | Actual | 13,299,216.00 | 13,299,216.00 |
| | IBRD/IDA (USD) | Grants (USD) | | | | | | | | | | | | |
| Original Commitment | 13,300,000.00 | 13,300,000.00 | | | | | | | | | | | | |
| Revised Commitment | 13,299,216.00 | 13,299,216.00 | | | | | | | | | | | | |
| Actual | 13,299,216.00 | 13,299,216.00 | | | | | | | | | | | | |

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2. Project Objectives and Components

a. Objectives

As stated in Schedule 1 (p. 6) of the Global Partnership on Output-Based AID Grant Agreement, “The objective of the Project is to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.” The Project Appraisal Document (PAD) (pages iii and 4) states the same objective. The statement of project objectives remained unchanged at restructuring in 2017, but one outcome target (total deliveries assisted under the project) was increased to reflect parallel financing received from an ongoing Bank project and UNFPA, and other outcome indicators were modified to



make them more measurable. Given that both the original and increased targets for deliveries were exceeded, this review does not apply a split rating.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

17-Oct-2017

c. Will a split evaluation be undertaken?

No

d. Components

1. Package of Safe Delivery Services to Poor Pregnant Women (original estimate: \$9.5 million; actual cost: \$8.7 million). This component aimed to provide 132,400 pregnant women with access to a package of safe delivery services from contracted private and public providers, including: 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. Elimination of mother-to-child transmission of HIV (EMTCT) services were included as part of antenatal care. Under a voucher scheme administered by a Voucher Management Agency (VMA), already piloted in Uganda, pregnant women were to purchase vouchers at UShs 4,000 (US\$1.60), entitling them to access this package of safe delivery services from contracted providers. These providers were expected to deliver the specified services and submit claims, together with appropriate voucher coupons, for settlement on the basis of the fees negotiated in their signed contracts. The recommended Weighted Average Costs for safe delivery package (\$60) and for a package including caesarean (\$130) provided a framework for the VMA to negotiate reimbursement rates with providers. Costs were net of EMTCT drugs, provided by the National HIV/AIDS Control Program. Eligible beneficiaries were to be selected based on a combination of geographical targeting (based on poverty mapping) and a customized poverty grading tool (PAD p. 6).

2. Capacity Building and Project Management (original estimate: \$3.8 million; actual cost: \$4.6 million). This component aimed to support project management and build capacity to mainstream and scale up implementation of the safe delivery voucher scheme. Day-to-day management of the scheme was delegated to the VMA under the oversight of the Ministry of Health (MoH), which was the implementing agency. The project was to finance specific project management activities, including: MoH oversight, VMA administration and management, the work of Independent Verification and Evaluation Agents (IVEA), service provider selection, audit, and monitoring and evaluation (M&E). It also supported capacity building activities (training, quality assurance). Contracted health facilities were to be selected from two regions, which were the focus of project support: Eastern Region and South Western Region.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates



The total project cost was \$13.3 million, exactly as estimated, but the distribution across components changed. The actual cost of Component 1 was 92 percent of the estimate, while the cost of Component 2 exceeded the original estimate by 20 percent, due to higher than anticipated administrative costs (see Section 5 on Efficiency).

The project was financed by a \$13.3 million grant from the Global Partnership on Output-Based Aid (GPOBA), which was fully disbursed. No Government financing was planned or delivered. The project also received parallel financing in the amounts of \$3.1 million from an ongoing Bank (Uganda Health Systems Strengthening Project) and \$0.95 million from UNFPA, boosting support to \$17.3 million. This parallel financing was drawn in during the time project approval was substantially delayed (from February 28, 2017 to December 18, 2014) due to concerns regarding the anti-homosexuality act. The ICR's estimates of actual cost do not include the parallel financing, but its economic analysis takes all three sources of financing into account.

The closing date was extended by two years (from December 29, 2017 to December 15, 2019) as a part of project restructuring, undertaken in October 2017, following the April 2017 mid-term review. This extension was granted to: compensate for the 12-month delay of project approval and effectiveness, combined; account for the additional parallel financing which triggered an increase in a PDO target (see Section 2.c); and enable the implementation by the VMA of mid-term review recommendations for improved program performance.

3. Relevance of Objectives

Rationale

The PDO is substantially relevant to the current (2016-2021) Uganda Country Partnership Framework (CPF) (Report No. 101173-UG). It is highly responsive to the country situation described in the CPF, particularly: high levels of poverty, with one-third of the population living below the international poverty line (less than \$1.90 per day); significant inequalities across regions and between rural and urban areas in terms of poverty, vulnerability and access to social services; and large discrepancies in the use of reproductive health services (e.g., share of all births delivered at public health facilities ranges from 4 to 94 percent). The CPF is designed to support Uganda's Second National Development Plan (2015/16 – 2019/20). Two of the four primary development objectives of Uganda's NDP II are fully in sync with the PDO: enhancing human capital development; and strengthening mechanisms for quality, effective, and efficient service delivery. The CPF's support to NDP II emphasizes ending extreme poverty and promoting prosperity in a sustainable manner and accords special attention to the Northern and Eastern Regions, where 84 percent of Uganda's poor people reside (CPF, p. 8). Its Strategic Focus A (governance, accountability, service delivery) includes an objective of improving service delivery, with health-specific focus on: strengthening maternal and child health services, addressing high fertility, reducing regional gaps in health services, and providing incentives for health providers. Strategic Focus B (raising incomes in rural areas) and Strategic Focus C (inclusive growth in urban areas) seek to address poverty and equity issues through social protection of poor and vulnerable populations and enhanced, more equitable opportunities. The PDO is explicit in its focus on poor women living in rural and disadvantaged areas.



Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.

Rationale

The project supported inputs and activities to improve the supply of and increase the use of a well-defined set of safe pregnancy and delivery services in selected districts. Primary beneficiaries were poor and vulnerable pregnant women residing within the catchment areas (mothers were expected to be able to reach the contracted health facilities within two hours) (ICR, p. 7-8). Supply-side support included: the selection and training of qualified service providers, both public and private (for-profit and not-for-profit); the establishment and clustering of functional referral networks linking Basic Emergency Obstetric and Newborn Care (BEmONC) sites and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) sites; the conduct of clinical audits and other activities to track and ensure service quality. To stimulate the use of these services, the project supported: demand creation activities in the communities; and the sale of vouchers covering a package of safe pregnancy and delivery services. Together, these inputs and activities were expected to lead poor women to purchase vouchers and redeem them, thus culminating in increases in the number of women attending at least one ANC visit and in the number of deliveries assisted by skilled birth attendants. The project-financed Voucher Management Agency would reimburse providers for services rendered, as validated by an Independent Verification and Evaluation Agency. The project's impact was articulated around expected reductions in maternal morbidity and mortality.

The project focused on two geographic regions: the Eastern region, Uganda's poorest region, which is also a priority of the CPF; and the better-off South Western Region, where the voucher system was piloted under a previous project. The ICR (p. 8) cited several considerations informing the choice of these two regions, including poverty status, percentage of births attended by skilled personnel; and infant mortality rates. It also cited Uganda National Household Survey 2016/17 data on the differences in poverty levels (percentage of the population estimated to live in households spending less than what is needed to meet their caloric requirements, affording them a markup for non-food needs): 24.7 percent in the Eastern Region; 7.6 percent in the South Western Region (ICR p. 7, footnote 9).

Under the project's targeting methodology, pregnant women would be deemed eligible to purchase vouchers if they fell into one of two categories: (1) those residing in sub-counties where over 60 percent of households are assessed to be poor on the basis of (Uganda Bureau of Statistics) poverty maps, without undergoing additional household-level assessment; or (2) those residing in sub-counties where poverty is not deemed to be widespread, and whose households undergo a poverty assessment, using a poverty grading tool, and receive a grade of 12 or less (ICR p. 9, footnote 11).



The Bank's project team (by email 1-26-21) noted that "with regard to the affordability of the vouchers, a willingness to pay study was conducted earlier and provided the basis for the SHs 4,000 (\$1.2) price of the voucher." The voucher price equivalent was given as \$1.6 at project completion (ICR, p. 8).

Outputs and intermediate results:

- A total of 201 health providers were selected, trained and contracted under the project to provide a package of safe delivery services, composed of: four prenatal visits, safe delivery, one postnatal visit, treatment and management of selected pregnancy-related medical conditions and complications, including caesarian sections, emergency transport, and elimination of mother-to-child transmission (EMTCT) as part of prenatal care. Of these 201 providers, 102 operated in 12 districts in the South Western Region and 99 operated in 13 districts in the Eastern Region. These providers accounted for about 30 percent of all health facilities in each region. Although the ICR does not provide details on provider types (public, private, etc.), the Bank's project team (email 1-26-21) stated that "of the 201 providers, 77 were public, 39 were private-not-for-profit, and 85 were private-for-profit."
- The project organized these providers into clusters of Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) to strengthen the referral system for emergency obstetric care, composed of 64 BEmONC and 38 CEmONC in the South Western Region, and 87 BEmONC and 12 CEmONC in the Eastern Region. A cluster training approach supported improved management of obstetric emergencies.
- Quality assurance was addressed through annual clinical audits to assess providers' quality of care and adherence to service guidelines and protocols issued by the Ministry of Health.
- The project engaged a total of 456 community-based distributors (CBDs)/village health teams (VHTs) responsible for promoting and selling vouchers, of which 224 operated in the South Western Region and 232 in the Eastern Region.
- The project supported activities to incentivize CBDs to sensitize and follow-up with women who purchased vouchers to promote the benefits and uptake of services in the safe delivery package, notably: antenatal care (early first visit; four visits), postnatal care, postpartum family planning
- A total of 231,002 safe delivery vouchers were sold during the project period. The ICR does not provide a breakdown of these sales, by region or district. The Bank's team also noted (by email 1-26-21) that the independent verification reports did not disaggregate the voucher clients on the basis of the targeting methodology used.
- Sixty percent of all claims administered by the Voucher Administration Agency were reimbursed within 20 days of submission, falling short of the 80 percent target. Two factors hindered better performance: limited liquidity caused by the initial withdrawal ceiling of US\$800,000 imposed by the World Bank; and, initially, a very slow and laborious claims verification process.
- The Independent Verification and Evaluation Agency fully achieved its target of submitting all eight of its semi-annual reports. The ICR notes that project records show no evidence of issues with the timeliness of these submissions, which were due within 50 days after the end of each reporting period.

Outcomes:

Project data reveal that a total of 158,322 people received essential health, nutrition and family planning services, slightly exceeding the target of 156,400; and beneficiaries were satisfied with the care they received. The ICR (p. 16) states that by the project's end, 90 percent of sampled respondents in the IVEA's last biannual verification survey assessed the services they received to be satisfactory at least, fully achieving



the 90 percent target. This survey also documented beneficiaries' greatest appreciations: their access to safe delivery services provided by the voucher (99 percent of respondents); and the quality and competence of providers (98 percent of respondents). On the other hand, beneficiaries considered the time spent waiting to receive services and general hygiene at facilities to be moderately satisfactory (87 percent).

Below, the description of project outcomes is organized around the three categories of safe delivery services -- antenatal care, deliveries, and postnatal care -- and the category coverage of poor women. As indicated below, findings reported in the ICR suggest that access to safe delivery services did improve among women who purchased vouchers. (Targets and outcomes in the results framework are quantified in terms of numbers of women who used safe delivery services, and as a share of all women who purchased vouchers.)

Antenatal Care

- A total of 196,668 women (86 percent of pregnant women enrolled under the voucher scheme) attended at least one antenatal visit, almost achieving the 90 percent target. As expected, redemption of vouchers for the first visit was highest, declining gradually to 34 percent (77,590) of enrolled women attending the fourth visit (Government contribution to ICR, Annex 5, page 46).
- Of the 196,668 women who attended at least one antenatal visit, 157,247 (or 80 percent) were tested for HIV, falling short of the 90 percent target. This lower-than-expected result is due in part to a change in the HIV testing algorithm and the stock outs of the new test (Bioline), which affected testing volume.
- Of the 4,017 pregnant women who tested positive for HIV, 3,874 (or 96 percent) received elimination of maternal to child transmission of HIV treatment, falling far short of the 7,100 target. The 4 percent of HIV-positive pregnant women were lost to tracking because of long-distance referrals between the voucher facilities (not set up to provide antiretroviral therapy) and facilities providing antiretroviral therapy. This happened mostly between the private for-profit non-antiretroviral therapy facilities and the public or private not-for-profit antiretroviral facilities.

Assisted Deliveries

- In total 178,413 deliveries, covered under the voucher scheme, were attended by skilled health personnel, surpassing both the original target of 132,400 and the revised target of 156,400. Of the total assisted deliveries, 29,509 (16.5 percent) were caesarian sections, and 148,904 (83.5 percent) were normal deliveries.
- The total number of deliveries translates into a voucher redemption rate of 77 percent, exceeding the original target of 70 percent. 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. The ICR (p. 13, footnote 20) states that anecdotal evidence indicated that some women purchased vouchers for a sense of insurance and some purchased vouchers but did not deliver at facilities accredited by the project (in other words the voucher was purchased, but not used).
- A total of 12,612 mothers, who delivered under the voucher scheme, were referred from the basic (BEmONC) to a comprehensive emergency obstetric (CEmONC) facility, with transport costs covered by the scheme. This amounts to 9.5 percent of the initial target of 132,400 deliveries, falling short of the target of referring 14 percent of all deliveries. When shown as a share of the actual number of deliveries achieved under the project (178,413), this rate falls to seven percent, or half of the 14 percent target. The ICR notes that referral data only include women whose transport costs were covered by the voucher scheme and there may be others who were advised to seek care at a



higher-level facility based on potential risks identified during antenatal visits. It also notes that improved quality of care as a result of project investments in lower level facilities (average clinical quality score rising from 70 percent to 88 percent during 2016-19) may have reduced the need for referrals. Moreover, maternal mortality incidence remained low during the project period (44 deaths out of 178,413 live births), of which only five at the basic facilities and 39 at the referral facilities.

- Fresh stillbirths were used as a quality measure of safe pregnancy services, as many associated risks can be identified and addressed through antenatal visits. The project set a target of 330 stillbirths, or 0.25 percent of its original estimate of 132,400 deliveries. A total of 458 stillbirths actually occurred among women delivering under the voucher scheme, achieving the same low 0.25 percent share of the actual (178,413) voucher scheme deliveries.

Postnatal Care

- A total of 84,572 vouchers were redeemed for post-natal care or 47 percent of the 178,413 deliveries assisted under the project, exceeding the project target of 35 percent.
- The share of mothers benefiting from assisted deliveries under the project, who received postpartum family planning services, increased over the life of the project from an initial 4 percent to 42 percent by mid-2019.

Coverage of Poor Women

- Although the PDO specifies “poor women living in rural and disadvantaged areas,” the ICR does not provide sufficient evidence to discern the extent to which poor women were in fact able to capture the project benefits. Project indicators tracked the number of women who bought vouchers and, within this group, the number of women who used the vouchers to access safe delivery services, but these numbers were not disaggregated by wealth quintile or other indicators of poverty. The ICR (footnote 11) stated that “the project used a combination of geographical targeting (based on poverty mapping) and a customized poverty grading tool to select eligible beneficiaries” and further defined the criteria for eligibility in the same footnote. However, one of the PAD’s “lessons learned and reflected in the project design,” which mentioned this geographical targeting and the poverty grading tool, went on to say “In the absence of a nationally agreed targeting framework, accurate and cost-effective targeting remains a challenge and the methods used will be monitored and refined over the program’s lifetime” (PAD, p. 8). This statement in the PAD suggests that these targeting methods were understood to be rudimentary and sets up an expectation that the implementation of geographical targeting and the poverty grading tool would be monitored and assessed during project implementation to determine their effectiveness in enabling the project to reach the intended poor women. The ICR, however did not provide sufficient information on whether or how the targeting methods were monitored and refined over the project’s lifetime.
- The ICR (p. 21) states that “the IVEA’s biannual surveys ascertained that targeting was effective, that is, the project beneficiaries were predominantly poor (96.5 percent)” but without specifying the numerator and denominator in this percentage. In response to IEG queries, the Bank’s project team clarified (by email, 1-26-2021) that the sample for the IVEA biannual surveys was drawn from women who had purchased and used vouchers within the last 12 months, and that 96.5 percent was actually the share of respondents who had been selected for the program through the project’s targeting methodology.. The Bank’s project team’s clarification (email, 1-26-2021) stated that, “pregnant mothers recruited under the targeting scheme were deemed to be poor since they were expected to have met the poverty targeting methodology.” However, the true percentage of project beneficiaries



who were poor remained unknown. There was no breakdown of the IVEA survey respondents (or of all beneficiaries) by type of targeting methodology. Project subcounties were identified through geographic targeting, where over 60 percent of households were assessed to be poor on the basis of poverty maps. However, residents of these subcounties did not have to undergo additional household-level assessment. Reliance on this geographic targeting meant that, in these subcounties, all women--poor and non-poor--were eligible to purchase vouchers. Without a better understanding of the numerator and denominator of the IVEA's 96.5% citation, the regions/subcounties covered, the targeting methodologies used, and the points in time when data were collected, the information provided is insufficient to determine the true extent to which poor women benefited, and this gap is understood as a moderate shortcoming in achievement of the related outcomes.

- No systematic assessment of the affordability of the vouchers to the poor was undertaken during or at the close of the project. The ICR (page 53) provided anecdotal evidence of the unaffordability of vouchers to some of the poorest women. The Bank's project team noted (email 1-26-21) that, "during implementation, the mothers never complained about the cost of the voucher; if anything most mothers doubted if one could [access] services at the cost. Furthermore, the ICR mission team's interviews with VHT/CBDs who were in contact with beneficiaries also provided us with indications that the price was deemed affordable by the targeted beneficiaries." The Government in its contribution to the ICR stated the need to conduct further studies on the extent to which poor people can afford to pay for their health services (ICR p. 48).

Attribution. Evidence provided in the ICR suggests that the project contributed to improved access to a package of quality safe delivery services in the project subdistricts, as indicated by increases in: antenatal care visits, births attended by skilled health personnel, and postnatal visits. These achievements can be plausibly linked to elements of the project results chain, built around: supply-side improvements to service quality and availability; demand stimulation activities, especially the promotion and sale of vouchers to women, providing them access to that package of services; and the strengthening of results-based management systems and capacities. Results achieved in the project area are attributable to the project, with acknowledgement of UNFPA's financial contribution of US\$0.95 million, which helped expand the number of deliveries originally anticipated. USAID financed a similar safe delivery voucher scheme, but was operating in completely different subdistricts in the Northern and Eastern regions.

Counterfactual. In the absence of this project, it seems reasonable to conclude that the strengthening, and uptake, of safe delivery services would probably not have been achieved. It is also reasonable to conclude that, in the absence of this project, the health sector would have acquired considerably less experience and capacity in results-based management and financing and would, as a result, have been more challenged in implementing GoU's 2016 decision (ICR p. 19) to move toward a results-based financing approach and the establishment of a National Health Insurance Fund.

Rating
Substantial

OVERALL EFFICACY



Rationale

The project increased the availability and quality of a package of safe delivery services in selected facilities and supported the sale of vouchers to women so that they could access these services. There was an uptake in critical services by women who purchased vouchers, including antenatal care, births attended by skilled personnel, and postnatal visits. Although the ICR described the targeting methodology, including the application of a poverty grading tool, it did not provide sufficient information on whether or how the targeting methods were monitored and refined over the project's lifetime or on the wealth/poverty status of beneficiaries who actually bought and used vouchers.

Overall Efficacy Rating

Substantial

5. Efficiency

At the time of appraisal, and as documented in the PAD, an economic analysis of project interventions was carried out, based on the previously implemented Bank-financed Reproductive Health Vouchers in Western Uganda. This analysis estimated the incremental cost-effective ratio (ICER) at \$156 per disability-adjusted life year (DALY) averted. The project was considered to be highly cost-effective since the ICER per DALY averted was less than half the annual GDP per capita in Uganda (\$490 at that time). The ICR notes an important caveat, however. 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, the ICR pointed out that this criterion is widely criticized.

The economic analysis undertaken at closing used the assumptions from the original economic analysis. The main outcome assessed was the reduction in maternal deaths among women 15-49 years of age. Increasing coverage and quality of antenatal care and facility-based deliveries supported under the project was assumed to culminate in a reduction in maternal deaths. Based on WHO data for low-income countries, it was assumed that every maternal death averted would account for 85 DALYs. Benefits and costs were discounted at 3 percent. Results of a sensitivity analysis reveal that the \$16.1 million in discounted spending under the project, yielded \$120 million in discounted benefits and a benefit-cost ratio of 7.5:1. The cost-effectiveness ratio was estimated at \$98 per DALY averted. The conclusion that the project was highly cost-effective was based on three different thresholds or assessment criteria. Specifically, the cost-effectiveness ratio of US\$98 per DALY averted was lower than (a) the ICER of \$156 per DALY averted under the previous Bank-financed Reproductive Health Vouchers Output-Based AID scheme; (b) the US\$116 opportunity cost based cost-effectiveness threshold for low-income countries; and (c) the US\$732 GDP per capita for Uganda in 2019.

Implementation Efficiency. The ICR's economic analysis, detailed in Annex 4 of the ICR, assessed that 25 percent of the total project costs were administrative, and that these costs, as a share of total project costs, were lower than the 29 percent estimated in the PAD (p. 7, Table 1), and also lower than the 28 percent achieved under the previous Bank-financed reproductive health voucher scheme. However, as shown in the ICR final cost table (Annex 3), the actual administrative costs under the project (\$4.6 million) reflect a substantial increase over the original estimate of \$3.8 million. This amounts to a share of over one third (35 percent) of the total, fully disbursed GPOBA Grant of \$13.3 million vs. the PAD's 29 percent estimate. However, the 25 percent achievement reported in the ICR reflects these administrative costs as a share of the total project costs,



including, the additional \$4 million in parallel financing provided by another Bank project and UNICEF (see Section 2e). The ICR also shows a fluctuating trend in annual administrative costs as a share of total costs during the life of the project, suggesting some efficiency issues: 13 percent in 2016/17; 30 percent in 2017/18; 18 percent in 2018/19; and 57 percent in 2019/20. It is important to note that the \$4.0 million in parallel financing was disbursed during the first two years of the project's four-year life. It was these high administrative costs that were behind GoU's decision not to continue the voucher program after the project's end, as they were deemed financially unsustainable. The ICR (p. 29) notes that the Government stopped the voucher scheme at project closure because of its primary concern with "...the cost of sustaining vouchers and their associated activities and systems, as well as the overall administrative cost."

The economic analysis did not assess the efficiency of the targeting. The economic analysis also did not assess the relative efficiencies of the different categories of health facilities contracted under the project: (public, private not-for-profit, faith-based, and private for-profit), which was an important and innovative feature of project design (ICR pp. 20, 31). The Bank project team noted (email, 1-26-21) that "the project's approach of including private service providers and improving their service quality contributed to concerted and coordinated efforts to expand choices and capacity of lower-level facilities, leading to decongestion at higher-level public facilities, and consequently to overall improvement in choices and service quality to beneficiaries."

The GPOBA Grant was fully disbursed. The two-year extension was justified in that it allowed the full use of this Grant plus the additional \$4 million in parallel financing and the achievement/surpassing of the PDO targets set at the mid-term review.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

| Rate Available? | Point value (%) | *Coverage/Scope (%) |
|-----------------|-----------------|--|
| Appraisal | 0 | 0 <input type="checkbox"/> Not Applicable |
| ICR Estimate | 0 | 0 <input type="checkbox"/> Not Applicable |

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives: The relevance of the project development objective is rated high. It is highly responsive to the low levels and inequities in health status and in access to health services endured by the poorest and most vulnerable segments of Uganda's population. It is also fully in sync with the current (2016-2021) Country Partnership Framework's support to Uganda's Second National Development Plan (2015/6 –



2019/20), which seeks to enhance human capital development and strengthen service delivery, including maternal and child health services.

Efficacy: Supply- and demand-side investments culminated in the purchase of safe delivery vouchers and the uptake of key services by women residing in the project areas who purchased vouchers. Project efficacy is rated substantial, given the notable outcomes documented for these women. However, the extent to which the target group (poor women) was reached is not adequately evidenced. This weakness in evidence about the extent to which poor women benefited from the project is assessed as a moderate shortcoming in achievement of some of the objectives/outcomes used in the assessment of overall Efficacy, and this moderate shortcoming is factored into the Outcome rating.

Efficiency: Investments in reproductive health are highly cost-effective. The strengthening of services at lower-level facilities and the clustering of these into referral systems provided more quality and choice to beneficiaries and a more efficient use of referral facilities. Administrative costs of the voucher program, however, led the Government to decide against sustaining the program after project closing (see Section 7).

a. **Outcome Rating**

Moderately Satisfactory

7. Risk to Development Outcome

At the time of project closing, the Government noted that, due to its limited resources, it would be unable to sustain the full scope of the program. The primary concerns were the cost of sustaining vouchers and their associated activities and systems, as well as the overall administrative cost. The voucher scheme was thus stopped at project closure. The Government did, nevertheless, decide to incorporate some supply-side elements of the project into the ongoing Bank-financed Reproductive, Maternal and Child Health Services Improvement project, specifically activities and support to public and private not-for-profit service providers that met the results-based financing readiness thresholds. On the other hand, it is uncertain whether or to what extent private for-profit service providers, not included in the transition to the ongoing project, would be able to retain improvements in service quality, staffing and motivation, post-project. The ICR also notes that after project closing district health officers' ability to supervise these for-profit providers and oversee their adherence to MoH quality assurance guidelines may be limited. The ICR does not assess the social and beneficiary ownership dimensions of risk to development outcome. It would have been interesting to obtain any beneficiary feedback, or local NGO perspectives, on the benefits and buy-in of the poorest women and on other alternatives for improving their access to care at low or free cost. Government has a policy of providing free primary health care, but their ability to implement that policy is not assessed in the ICR.

8. Assessment of Bank Performance

a. **Quality-at-Entry**

The PDO was well aligned with Government of Uganda's health sector priorities, which emphasized reproductive health services and the importance of equity in access to quality services and in health



outcomes. The project design combined geographical targeting (based on poverty mapping) with the application of a customized poverty grading tool in its effort to reach the intended target population. The PAD (p. 8) also stated that "In the absence of a nationally agreed targeting framework, accurate and cost-effective targeting remains a challenge and the methods used will be monitored and refined over the project's lifetime." The IVEA was slated to monitor project implementation, including implementation of the targeting methodology, but there was no specific responsibility for assessing the accuracy and cost-effectiveness of the targeting methodology in terms of its success in reaching the poor target group. The project's technical design factored learning from previous projects on the strengths and weaknesses of Uganda's service delivery systems and claims processing systems. Learning from previous operations also informed implementation arrangements. The rationale for choosing a range of public and private facilities was to exploit more fully the use of these facilities for delivering services. The ICR (p. 22) notes that the design addressed the risk of fraudulent voucher sales by ensuring that the voucher be made more secure, durable, and difficult to reproduce fraudulently. However, the design does not seem to have adequately addressed (through proper supervision and monitoring) the risk that village health teams and service providers could experience incentives to sell vouchers to anyone at any price to cover their costs and maximize their profits. While the PDO's focus on the poorest women in the targeted areas was appropriate and explicit, one of the two regions (the South West Region) had a relatively low poverty rate. This Region was chosen, since it was where the voucher was piloted in a previous operation; and, within this region, poorer subdistricts were slated for targeting. The design involved charging the poorest women a fee for vouchers, in order to increase access to safe delivery care and offer more choices for women. The M&E design included good indicators to track the uptake of relevant services, but it did not provide for monitoring, data collection or studies to assess the extent to which the beneficiaries were poor. Also, M&E design did not incorporate provisions to monitor and refine the targeting methods during implementation in terms of their accuracy and cost-effectiveness, as indicated in the PAD (p. 8, cited above). The M&E design did not provide for an assessment of actual affordability –that is, among poor women who were eligible but did not purchase vouchers. Instead, provisions were made to count and assess only those who did purchase vouchers.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

The quality of supervision benefitted from the Bank's longstanding collaborative relationship with the Government and the Voucher Management Agency, built through previous projects. This was further strengthened by continuity in the task team. The project was led, over an extended period, by the TTL who led the previous project, and was ultimately transitioned to another TTL, who was intimately involved with the project. Moreover, the in-country presence of the task team allowed for close engagement with Government and implementers and timely support and guidance. All of this created a collaboration marked by trust, stability and constancy. The team was especially proactive in: ensuring that HIV+ women received antiretroviral treatment; improving infection prevention control measures and waste management; and reducing payment delays to the Voucher Management Agency and Independent Verification and Evaluation Agency.



The Bank's focus on development impact during supervision was undermined by weaknesses in M&E design (cited above in Section 8a and in Section 9), which did not define indicators to assess the extent to which poor women (the target population specified in the PDO) were the ones actually purchasing the vouchers and benefiting from the safe delivery services. This omission was not addressed during implementation, despite the fact that the PAD (p. 8) articulated the intention to monitor and refine targeting methods during implementation in light of their unfolding accuracy and cost-effectiveness in reaching the poor. Supervision of fiduciary and safeguard aspects were carried out well, through regular supervision, which appropriately identified and corrected shortcomings on these fronts throughout implementation.

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

M&E design included a number of strong features. First, PDO indicators tracked the use of relevant reproductive health services by women who purchased vouchers, specifically number of deliveries attended by skilled health personnel and number and percentage of women attending at least one antenatal visit. Indicators also tracked elements of antenatal care quality and content (HIV testing and EMTCT) and referrals. Second, M&E arrangements, plans, and roles and responsibilities were well defined in the project Operations Manual. Third, the design built on already existing capacity (using the same Voucher Management Agency as for previous projects), expanded that capacity through training of service providers and the district health officers, and ensured links and coherence with the national health information system. Fourth, the Independent Verification and Evaluation Agency was responsible for: (1) providing external semi-annual monitoring of the project; (2) verifying services rendered, service quality, voucher distribution and behavior change communication and training activities; (3) assessing the claims processing, payment and fraud control systems of the Voucher Management Agency; and (4) quarterly reporting to MoH, Interagency Coordinating Committee (ICC) and development partners on project implementation.

There were also shortcomings. First and most critical, there were no indicators to track the extent to which the poorest women were reached and benefited, which would be expected given that the PDO specified "poor women living in rural and disadvantaged areas." Aggregate numbers of vouchers purchased, deliveries assisted, and ANC visits undertaken did not provide sufficient breakdown of which women benefited (by region/district, by type of targeting, by poor/non-poor). Second, the M&E system focused primarily on monitoring and accountability. The ICR notes that an evaluation that would have allowed comparison of outcomes between project beneficiaries and a control group may have provided further evidence of the efficacy of the voucher scheme. Beneficiary surveys of poor eligible women who did not purchase vouchers would have shed light on affordability issues and the project's coverage of the target population. Evaluation of the governance structure, its sustainability, against alternative approaches, and analysis of benefits and beneficiaries by wealth quintile would also have provided considerable value



added. More information on the implementation of the targeting methodology at the community level by village health teams and community distributors, had this been incorporated into the M&E design, would have shed more light on women reached/not reached.

b. M&E Implementation

Responsible for M&E implementation and quality assurance, the Voucher Management Agency prepared quarterly results reports, based on data reported by service providers. The Independent Verification and Evaluation Agency verified results, along with processes and systems. Its work involved: (a) verification that agreed outputs were indeed achieved; (b) verification that participating service providers adhered to agreed standards; (c) validation of the claims processing system performance; (d) recommendations regarding disbursement of output-based aid; (e) assessment of behavior change communication and training carried out by the VMA; and (f) preparation of semi-annual reports to inform stakeholders of project implementation and performance.

c. M&E Utilization

The ICR reports that the project encouraged a culture of data use, enabling both the monitoring of results and decision-making. This was attributed to key features of the operation, especially the results-based financing (RBF) and its focus on outputs; the voucher distribution and claims processing systems; and the data review sessions at the district level, which, according to a district health officer, facilitated the review of data, identification of problems and the search for solutions. District-level supervisions were also helped by their increased focus on facilities' adherence to quality standards, and standard operating procedures for quality control. The project also supported monthly performance review meetings at the district level, attended by technical staff, political leaders and village health teams.

Project data also informed the mid-term review, which involved a broad range of actors and stakeholders and included field visits. The review culminated in the restructuring of the project, which involved adjustments to the results framework and targets, based on key findings. There was a missed opportunity during the ICR phase to check and assess geographic breakdowns of beneficiaries against the Updated Poverty Maps of Uganda, undertaken by Uganda Bureau of Statistics with World Bank and UNICEF, which provides poverty rates at the sub-county level.

In short, based on the above assessment of M&E design, implementation and utilization, quality of M&E is rated barely substantial, in light of two moderate shortcomings: (1) the quality of the evidence to document the extent to which the target group benefited from the project is not fully established; and (2) the M&E design and implementation did not include a systematic assessment of the implementation and effectiveness of the project's targeting methods, as envisaged in the PAD.

M&E Quality Rating

Substantial

10. Other Issues



a. Safeguards

The ICR indicated satisfactory compliance with the Bank's safeguard policies. 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. It did not involve any civil works/construction or any land acquisition. Project contracting of already existing health facilities was expected to generate minimal localized medical waste impacts in those facilities. The ICR (p. 27) stated that because environmental and social impacts were considered to be very minimal, project activities were not envisaged to require Environmental Assessment during implementation. Uganda's National Health Care Waste Management Plan, also used in the previous health systems strengthening project, was adopted to guide management and handling of medical waste under the project. The Voucher Management Agency, working under the oversight of MoH's Environmental Health Division, was responsible for ensuring that contracted service providers properly disposed of medical waste in accordance with guidelines outlined in the Project Operations Manual.

Management of health care waste was monitored closely through supportive supervision visits. Contracted health facilities followed most of the guidelines (segregation/separation of waste, display of protocols and guidance on the walls, and handling the waste from the maternity). But some cases of incomplete combustion of the wastes were found during the early implementation period. The Voucher Management Agency and MoH strengthened their efforts and carried out spot checks to ensure compliance with the required standards for infection prevention procedures and medical waste handling and disposal, which ultimately improved on both fronts. By the last year of implementation, environmental safeguard performance had improved and earned a satisfactory rating.

b. Fiduciary Compliance

While not stated explicitly, the ICR indicated that procurement and financial management were carried out in accordance with World Bank Guidelines (ICR pages 27-28). IEG's request (11-27-20 email) for confirmation of compliance with the Bank's Guidelines received no response from the TTL and ICR author.

Procurement fell under the responsibility of an experienced Project Implementation Support Unit established within MoH under the Health Systems Strengthening project. The main procurements included the selection and recruitment of the Voucher Management Agency, the Independent Verification and Evaluation Agency and a project officer to support implementation. Procurement risks were substantially mitigated thanks to the established capacity and experience within MoH, and the OBA design of the project.

Financial Management responsibility was assigned to a unit within the Accounts Department/MoH, headed by the assistant commissioner, to support IDA project implementation. Direct disbursements to the Voucher Management Agency were made from a Designated Account in the Bank of Uganda for this purpose. The appraisal established a number of risk mitigation measures within this set-up, including the recruitment of a project accountant and an accounts assistant, all with a view to improving management of financial records, advances to staff, quality of interim financial reports, timely preparation of financial statements, submission of external audit reports, among others. During implementation, financial management arrangements were observed to be satisfactory. Quarterly interim financial reports with verification letters were submitted on time and of acceptable quality. Early implementation delays in



payments to the Independent Verification and Evaluation Agency and Voucher Management Agency were resolved through Bank discussions with the assistant commissioner on modalities to expedite payment processing while not increasing financial risks. At project completion, the overall fiduciary risk was assessed to be substantial, the same rating assessed at the time of appraisal. The ICR does not indicate whether any of the external audit reports were qualified or whether audit recommendations were sufficiently addressed. The TTL and ICR author have not responded to IEG's request (11-27-20) for this information.

c. Unintended impacts (Positive or Negative)

None noted.

d. Other

11. Ratings

| Ratings | ICR | IEG | Reason for Disagreements/Comment |
|------------------|--------------|-------------------------|--|
| Outcome | Satisfactory | Moderately Satisfactory | Insufficient evidence, in particular about the extent to which the project reached the target population specified in the PDO (poor women living in rural and disadvantaged areas). |
| Bank Performance | Satisfactory | Moderately Satisfactory | Moderate shortcomings in M&E design and implementation included (1) lack of indicators or monitoring to assess adequately the extent to which poor women benefited from the program and (2) lack of a systematic assessment of the accuracy and cost-effectiveness of the project's targeting methods (despite being envisioned in the PAD). |
| Quality of M&E | Substantial | Substantial | |
| Quality of ICR | --- | Substantial | |

12. Lessons



Some of these lessons are drawn from the ICR, while others are drawn from IEG's review of the ICR.

Lesson from IEG's review of ICR:

Shortcomings in the selection of outcome indicators -- combined with lack of follow-up to address those shortcomings by improving the M&E framework during implementation -- hinder the ability to show achievement of a project's development objective. This project's development objective specified a particular target group. However, the ICR (and the M&E results framework it relied upon) did not sufficiently document the extent to which the intended target group – poor women living in project areas – was effectively reached. An M&E system, which would have tracked and assessed the breakdown of actual beneficiaries by poor/non-poor, region, and targeting methodology, would have provided a fuller assessment of PDO achievement. The project's stated intention (PAD p. 8) to undertake systematic monitoring and assessment of the project's targeting methods, in terms of its accuracy and cost-effectiveness in reaching the poor, was not reported on in the ICR. Future projects of this nature may benefit from the review and triangulation of project data with other available and relevant data sources to assess the poor/non-poor breakdown of beneficiaries (e.g., data from the Office of Auditor General's Audit of the project, and Uganda's Bureau of Statistics sub-district poverty maps, 2018, among others).

Lessons from ICR:

Enhanced ownership, coordination and stewardship of the MoH are critical to sustain and build on the innovations and achievements made under any project, especially those piloting innovations. A similar project would benefit from a Steering Committee led by a senior MoH official, along with a MoH focal point who would work directly with and monitor the voucher program and foster more regular discussions and field visits at the ministry level.

Efforts to increase demand need to be matched with efforts to increase service delivery capacity to meet that demand. Supply-side challenges in Uganda constrained the delivery system to respond effectively to the demand generated. Among these constraints were: some essential medical equipment and supplies; and staffing constraints at the referral level.

Referral system strengthening is key and requires longer-term investments in the health sector and other sectors, particularly the transport sector and investments in rural road infrastructure.

13. Assessment Recommended?

Yes

Please Explain

Further assessment of this project would shed light on the extent to which the project benefits accrued to the "poor women living in rural and disadvantaged areas," as defined in the PDO. There is an opportunity to explore and update the findings of the ICR with any additional studies on this project that may have been undertaken in the meantime, along with complementary fieldwork that would incorporate the views of both



project beneficiaries and non-beneficiaries. Further analysis could provide clearer guidance and lessons on the most cost-effective and sustainable ways to achieve improved access of the poorest women to reproductive health services. Now that Government has decided not to continue with the voucher scheme, it would be interesting to assess how the lessons and support of this project have been incorporated into ongoing efforts by Government to refine its sector strategies and approaches (health insurance, health financing, results-based financing, and fee policies).

14. Comments on Quality of ICR

Quality of Evidence and Results Orientation. The ICR was systematic in presenting evidence on each of the outcome and intermediate outcome indicators established under the project's M&E arrangements. It was also fairly systematic in citing sources, virtually all of them project-based. While this evidence suggests that outcome targets related to health services were likely met or exceeded, the ICR did not provide a breakdown of how many of these beneficiaries actually belonged to the target group specified in the PDO (poor women living in rural and disadvantaged areas).

Quality of Analysis. The ICR was candid and insightful on many aspects of its analysis, especially in linking and organizing the various indicators into an informative narrative constructed around the results chain and in its assessment of implementation arrangements and challenges, and sustainability. The ICR's analysis could have been strengthened had it addressed additional salient topics. The project theory of change summarized in the ICR (p. 7) did not provide enough information to explain how and why poor women living in rural and disadvantaged areas would be able to afford the vouchers or how the project would mitigate the risk of women in higher wealth quintiles coopting the benefits, nor did it analyze the accuracy and cost-effectiveness of the targeting methodology. The ICR did not provide a breakdown of the 201 providers contracted under the project by type (public, private, faith-based), which would have facilitated an analysis of any lessons and outcomes across these various facility types. This breakdown was subsequently provided by the Bank's team (email 2-16-21).

Quality of Lessons. For the most part, the ICR's lessons were well grounded in its evidence and analysis. They were well articulated, specific to the project's experience, yet also useful and relevant for other countries. Shortcomings in evidence and analysis cited above undermined the articulation of potential lessons related to targeting the poor and to the strengths and weaknesses of different types of providers, together and separately.

Internal Consistency. The ICR was internally consistent, with a couple of caveats. The ICR's estimates of actual cost (Annex 3) did not include the parallel financing from two additional sources, while the economic analysis (Annex 4) took all three sources of funding into account. The Government's contribution to the ICR (Annex 5) highlighted the need to strengthen/further act upon: the identification and mapping out of poor beneficiaries and the systematic reporting and follow-up of this group; the building of strong community-led demand generation structures to promote and support poor women's access to safe delivery services; and the conduct of further studies on the extent to which poor people can afford to pay for their health services. These salient issues were not addressed in the main body of the ICR.

a. Quality of ICR Rating



Substantial