PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC1077

Project Name	UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (P144102)
Region	AFRICA
Country	Uganda
Sector(s)	Health (100%)
Theme(s)	Population and reproductive health (70%), Health system performance (20%), HIV/AIDS (10%)
Lending Instrument	Investment Project Financing
Project ID	P144102
Borrower(s)	Ministry of Finance, Planning and Economic Development
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/ Updated	11-Jun-2013
Date PID Approved/ Disclosed	26-Jun-2013
Estimated Date of Appraisal Completion	25-Jun-2013
Estimated Date of Board Approval	31-Jul-2013
Concept Review Decision	
Other Decision (as needed)	The Project Paper has been submitted to the GPOBA for review by the Panel of Experts

I. Introduction and Context

Country Context

Uganda over the past 20 years, from 1990 to 2000 experienced sustained economic growth averaging 7 percent . However, in recent years, the rate of growth has slowed down and is characterized by increased volatility. The growth rate dropped to 3.4% in 2012 and is projected to remain around 4.5% in 2013. Uganda is among the least developed countries in the world with GDP per capita of US$320. Poverty levels remain quite high with half of the population subsisting on less than US$1.25 per day. The high population growth rate (3.2%) and dependency ratio (1.12), which are among the highest in the world are partly responsible for Uganda not fully realizing the benefits of the robust economic growth of the last two decades.

Uganda's progress towards the Millennium Development Goals (MDG) is mixed. Uganda is on track to achieve the MDG targets of halving poverty and improving gender equality and empowerment of women, and has made significant progress in improving access to HIV/AIDS treatment and access to safe water. On the other hand, progress has been slow for other MDGs, especially those related to child and maternal mortality, access to reproductive health services, and control of malaria and other communicable diseases. Maternal mortality remains a major problem in Uganda. Although the 2011 Demographic and Health Survey (DHS) findings reported improvements in skilled delivery attendance and contraceptive prevalence rate (CPR) from 42% to 59% and 24% to 30% between 2006 and 2011 respectively, these did not result in reduced maternal mortality and need to be sustained for Uganda to realize better reproductive health outcomes.

Sectoral and Institutional Context

Peri-natal and maternal morbidity and mortality are major causes of the high disease burden in Uganda, accounting for 20.4 percent of the burden, and reversing poor maternal health outcomes is a key priority for Uganda. Currently several initiatives are being rolled out including expanding use of existing contraceptive methods as well as introducing family planning implants; strengthening management of abortion through the use of manual vacuum aspiration; and strengthening capacity of health facilities to resuscitate newborn babies and to conduct maternal and peri-natal death audits. In order to improve the supply of reproductive health communities, a separate supply chain management system to distribute reproductive health commodities to the private providers has been set up. In addition, efforts are underway to improve patient referrals and streamline management and operations of ambulance services countrywide.

Uganda successfully piloted an Output Based Aid (OBA) scheme to improve safe delivery services through the use of vouchers. The Uganda Reproductive Health Vouchers Program was able to deliver a cumulative total of 65,590 mothers (130 percent of target) and (ii) treat 31,658 STD episodes (90 percent of target). The previous program was able to target poor households, as a significantly higher proportion of women from the two poorest quintiles used the vouchers compared to those from the other quintiles. The program contributed to significant reductions in home-based births and in the likelihood of out-of-pocket payments for deliveries in private health facilities among communities with the voucher program. In terms of lessons, the program revealed the need to consider (a) the inclusion of public providers and PMTCT of HIV/AIDS in any future scheme; (b) simplifying the targeting mechanism to reach poorer women; (c) better management and motivation of staff who have to work harder because of increased service utilization; and (d) establishing a transparent process for setting the unit costs for the different voucher service packages. These lessons will inform the development of the new project.

Relationship to CAS

The proposed project is consistent with the Uganda CAS strategic objective of strengthening human capital development through strengthening health care delivery . The project focuses on achieving results and is consistent with the World Bank's Health Nutrition and Population Strategy and Uganda’s NDP and HSSIP. The project not only addresses MDG 5 on reducing maternal mortality, but also MDG 4 on improving child health through reducing peri-natal deaths, both major health problems of national importance in Uganda, and is expected to contribute to reduction of maternal and child morbidity and mortality. The subsidies reduce the financial barriers to care and support provision of services that reduce risks associated with pregnancy and child birth for poor women. In view of the severity of maternal mortality in Uganda, the national and global commitments to reducing maternal mortality in the MDG framework, the positive externalities associated with

treating STDs in pregnant women, and widespread poverty among the target population, public financing will be required for these services for the foreseeable future. The project among others will contribute to empowerment of women, increase demand and uptake of antenatal care and safe delivery services and institutional capacity for reproductive health service delivery. In the wider policy context of health service development, the output based aid mechanism is seen as an important tool for operationalizing, through public private partnership, results-based and/or demand-side financing models in the public sector.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

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

Key Results (From PCN)

The achievement of the PDO will be assessed through the following indicators:

a) Number and percent of deliveries attended under the voucher scheme;
b) Number and percent of pregnant women who attend 4 ante natal care visits;
c) Number and percent of pregnant women with HIV receiving PMTCT; and
d) Number and percent of mothers who attend postnatal care services.

Over the five-year duration, the project will achieve the following key results:

a) Support 264,000 pregnant women to deliver under skilled attendance;
b) Support 50 percent of pregnant women enrolled under the scheme to attend 4 ante natal care visits;
c) Support 100 percent of pregnant women with HIV enrolled under the scheme to receive PMTCT; and
d) Support 30 percent of mothers enrolled under the scheme to attend postnatal care services.

III. Preliminary Description

Concept Description

The proposed operation would be funded by a US$ 13.3 million grant from SIDA channeled through GPOBA.

(a) Component One - Safe Delivery (USD 9.4 million). The objective of the component is to provide subsidized vouchers to vulnerable and poor pregnant women, enabling their access to a package of safe delivery services from contracted service providers. The women will purchase vouchers at a subsidized fee of Ug. Shs. 4,000 (US$1.60) for safe delivery services. With the voucher the client is entitled to a package of services consisting of four antenatal visits, safe delivery and one postnatal visit as well as to treatment and management of selected pregnancy related medical conditions and the management of complicated deliveries from contracted service providers, including emergency transport and cesarean section. The package will also include services for PMTCT as part of antenatal care. The providers will obtain PMTCT drugs from the National AIDS Control Program in line with current government policy and strategy. The detailed package of services based on the MoH guidelines will be elaborated in the project operational manual.

(b) Component Two - Capacity Building and Project Management (USD 4.175 million). The objective of this component is to support project management functions and build national capacity to mainstream and scale up implementation of the safe delivery voucher scheme in the health sector. Under the component the project will finance (a) specific project management activities/functions including: voucher management agency, independent verification agent, quality assurance and audit, and monitoring and evaluation; and (b) capacity building activities to harmonize, mainstream and scale up voucher implementation in the sector including: promotion of voucher schemes in the sector; streamlining and harmonizing implementation processes – selection of providers, pricing of vouchers, costing of the service packages, verification process, claims processing etc; and provision of technical assistance to national institutions in the implementation of the vouchers program. Under this component, the project will partner with Population Council to conduct an impact evaluation of the scheme.

The safe delivery voucher scheme will operate as a separate voucher scheme from the one on family planning funded by DFID and USAID. The two schemes however are to be implemented in close collaboration and under one ICC established by the MoH to coordinate and harmonize voucher implementation arrangements in the sector. A large number of faith based providers object to providing family planning services and are not willing to integrate the two schemes at the moment. In the interim period efforts will be directed to promoting the use of common implementation arrangements between the two schemes in order to pave the way to amalgamate the schemes in future. Common implementation arrangements will also make it easier for other interested partners in future to join the scheme.

The weighted average cost for a delivery is capped at US$70 . The weighted average cost was estimated on the basis of reimbursement information of the previous project. Tentatively, the average weighted cost for a normal safe delivery is estimated at U$ 60 and for a complicated delivery inclusive of emergency transportation where necessary at US$ 130 . A consultant is currently finalizing reviewing provider reimbursable costs, and upon completing the exercise, the costs will be revised accordingly. Service provider reimbursement will be subject to periodic reviews by the IVEA and the financial auditors. The VMA will be responsible for controlling the cost per voucher in order to reach average weighted cost targets as specified. In the event that the average cost of service delivery exceeds the specified weighted average costs consistently for period of not less than six months, the VMA will duly present the reasons for this development and propose measures to address the issues.

Project Implementation Arrangements

The MoH will be responsible for overseeing and coordinating the program through the ICC. It will constitute the ICC to provide overall guidance to the implementation of the voucher scheme. The MoH will procure the VMA and the IVEA and take lead to support public service providers joining the scheme for the first time. The necessary management protocols as well as the detailed service packages for maternal health services are in already place.

An ICC established by the MoH will oversee and coordinate the program. The committee will provide strategic guidance and oversight, and act as an important advisor to key stakeholders, including the MoH, cooperating development partners, VMA and service providers. In particular, the ICC will be responsible for overseeing the development of operational guidance to govern the

running of the program. It will also be called upon from time to time to approve and comment on annual work plans and budgets, and review program performance on a regular basis. Membership will be drawn from government, cooperating development partners, service providers and VMA.

The VMA will have overall responsibility for the implementation of the safe delivery voucher scheme. The VMA will be selected competitively by the MoH in collaboration with the cooperating development partners who will finance the VMA costs under the overall guidance of the ICC. The VMA will have the following main roles: (a) selection and contracting service providers; (b); designing the voucher and ensuring its security (i.e., fraud control); (c) reviewing and negotiating reimbursement costs with service providers and obtaining endorsement by the ICC and cooperating development partners; (d) claims processing and contract management; (e) marketing the scheme and distribution of vouchers; (f) training service providers and voucher distributors; and (g) quality assurance and monitoring and evaluation.

The project will use existing service providers both public and private to deliver services. Service providers shall be invited through public notices to express interest in providing the services. Before they are certified to participate in the scheme the capacity of service providers will be evaluated. Selection of service providers will take into account both the managerial and clinical capacity required for effective participation in the scheme and will involve an initial site visit and clinical audit. The selection process will specifically seek providers working in rural areas with high levels of poverty as this allows pregnant women living in these areas to buy vouchers without the need for individual poverty assessments (geographical targeting) which improves access, decreases the cost of targeting and reduces stigma among potential clients.

The IVEA will be responsible to verify project outputs and integrity of the processes and systems. The main functions for the IVEA are the following: (1) verify that agreed outputs are achieved; (2) verify that participating service providers perform in accordance with agreed standards; (3) validate performance of the claims processing system; and (4) make recommendations on disbursement of the OBA subsidy.

The contracts with service providers will be negotiated based on uniform provider reimbursement rates according to facility level and category of provider.

The project will be guided by following contractual arrangements described below:

a) Grant Agreement. A Grant Agreement will be signed between IDA, as the administrator of GPOBA, and the Government of Uganda represented by the Ministry of Finance, Planning and Economic Development. The Agreement will specify the amount and purpose of the financial contribution, the disbursement procedures, and the conditions under which a suspension of disbursement and repayment are deemed to enter into force as well as the contractual statements and power of representation.

b) Contract between Cooperating Development Partners and VMA. In this contract the quantitative and qualitative framework under which the project shall operate is to be stipulated. Further Specifications like remuneration/ reimbursement of cos ts and reporting obligations (in accordance with the Operational Manual) will be specified.

c) MoU between the Main Parties. GPOBA and the Cooperating Development Partners will sign a

MoU with the MoH of Uganda reflecting the understandings of the GPOBA, Cooperating Development Partners and MOH regarding the project. The MoU will act as the coordinating framework between GPOBA and VMA for the im plementation of the project to ensure compliance with the requirements of the Grant Agreement and the procedures set out in the Project Operational Manual.

d) Contractual Arrangements between the VMA and Service Providers. The VMA will sign agreements with the service providers, addressing the description of the services, obligations of the service providers, compliance with the rules of the system (adherence to standards and protocols, the Health Care Waste Management Plan as well as national registration and legal requirements, quality assurance as well as training programs, collaboration with the VMA), amount of reimbursement paid for the different services, circumstances which lead to termination of the contract, adherence to inspection visits by VMA, MoH, Cooperating Partners and, external evaluators and quality assurance inspectors. The VMA will draft the contract and obtain approval for it from the Steering Committee.

e) Contractual Arrangements between the VMA and Voucher Distributors. A distribution agreement will be concluded between the VMA and the local distributors. The following contents will form the basis for the contract with selected distributors: description of distribution approach to be used, obligation to attend training, maximum sales prices and commission, adherence to project requirements for proper record keeping to include documentation and keeping the distribution list and invoices, duration of contract, immediate contract cancellation in case of any irregularities or fraud, terms of payment for vouchers and adherence to inspection visits by VMA, MoH, Cooperating Development Partners and external evaluators.

f) IVEA Contract. The MoH on behalf of the ICC will select and contract an IVEA that will provide on-going project support as well as Output Verification Reports.

IV. Safeguard Policies that might apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
Environmental Assessment OP/BP 4.01	×		
Natural Habitats OP/BP 4.04		×	
Forests OP/BP 4.36		×	
Pest Management OP 4.09		×	
Physical Cultural Resources OP/BP 4.11		×	
Indigenous Peoples OP/BP 4.10		×	
Involuntary Resettlement OP/BP 4.12		×	
Safety of Dams OP/BP 4.37		×	
Projects on International Waterways OP/BP 7.50		×	
Projects in Disputed Areas OP/BP 7.60		×	

V. Financing (in USD Million)

Total Project Cost:	13.30	Total Bank Financing:	0.00
Total Cofinancing:		Financing Gap:	0.00

Financing Source	Amount
Borrower	0.00
Global Partnership on Output-based Aid	13.30
Total	13.30

VI. Contact point

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