Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: 84295-UG

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT FROM THE GLOBAL PARTNERSHIP ON OUTPUT-BASED AID (GPOBA)

IN THE AMOUNT OF US$ 13.3 MILLION

TO THE

REPUBLIC OF UGANDA

FOR A

SCALE UP: UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (RHVP-II)

October 3, 2014

Health Nutrition and Population
East Africa 1 (AFCE1)
Africa Region

CURRENCY EQUIVALENTS

Exchange Rate Effective December 31, 2013

Currency Unit = Uganda Shillings
Uganda Shillings 2529.02 = US$1
SDR0.64935065 = US$1

FISCAL YEAR

July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
CAS	Country Assistance Strategy
CEmOC	Comprehensive Emergency Obstetric Care
DALY	Disability Adjusted Life Year
DFID	Department For International Development (United Kingdom)
DHS	Demographic and Health Survey
EAPHLNP	East Africa Public Health Laboratory Network Project
EHD	Environmental Health Division
FINMAP	Financial Management Accountability Program
EMTCT	Elimination of Mother To Child Transmission of HIV
GDP	Gross Domestic Product
GPOBA	Global Partnership on Output-Based Aid
HCW	Health Care Waste
HCWMP	Health Care Waste Management Plan
HDP	Health Development Partners
HIVAIDS	Human Immunodeficiency Virus
ICC	Inter-Agency Coordinating Committee
IP	Implementing Partner
ICER	Incremental Cost-Effectiveness Ratio
IDA	International Development Association
IVEA	Independent Verification and Evaluation Agent
KfW	German Development Bank
MDA	Ministries Departments and Agencies
MDG	Millennium Development Goal
MOFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MSI-U	Marie Stopes International- Uganda
NHA	National Health Accounts
NGO	Non-Governmental Organization
NDP	National Development Plan
OBA	Output-Based Aid
ORAF	Operational Risk Assessment Framework
PEFA	Public Expenditure Financial Accountability
PFP	Private For Profit

PNFP	Private Not For Profit
RHVP	Reproductive Health Voucher Program
SIDA	Swedish International Development Agency
STD	Sexually Transmitted Diseases
ToR	Terms of Reference
UBOS	Uganda Bureau of Statistics
UHSSP	Uganda Health Systems Strengthening Project
USAID	United States Agency for International Development
VMA	Voucher Management Agency
VSHD	Venture Strategies for Health Development
VSP	Voucher Service Providers
WAC	Weighted Average Cost

Regional Vice President:	Sri Mulyani Indrawati
Country Director:	Philippe Dongier
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Abdo S. Yazbeck
Task Team Leader:	Peter Okwero

UGANDA

Scale Up: Uganda Reproductive Health Voucher Project (RHVP-II, P1441022)

TABLE OF CONTENTS

List of Tables

List of Figures

PAD DATA SHEET

Uganda

UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (P144102)

PROJECT APPRAISAL DOCUMENT

AFRICA

Report No.: 84295-UG

Basic Information		
Project ID P144102	EA Category B - Partial Assessment	Team Leader Peter Okwero
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 3-Oct-2014	Project Implementation End Date 29-Dec-2017	
Expected Effectiveness Date 30-Oct-2014	Expected Closing Date 29-Dec-2017	
Joint IFC No		

Practice Manager	Senior Global Practice Director	Country Director	Regional Vice President
Abdo S. Yazbeck	Timothy Grant Evans	Philippe Dongier	Sri Mulyani Indrawati

Borrower: Ministry of Finance, Planning and Economic Development			
Responsible Agency: Ministry of Health			
Contact:	Dr. Asuman Lukwago	Title:	Permanent Secretary
Telephone No.:	+256 414 340872	Email:	ps@health.go.ug,

Project Financing Data(in USD Million)					
[ ]	Loan	[X]	Grant	[ ]	Guarantee
[ ]	Credit	[ ]	IDA Grant	[ ]	Other

Total Project Cost:	13.30	Total Bank Financing:	13.30

Financing Gap:	0.00

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

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2018
Annual	3.60	4.40	5.30	0.00	0.00
Cumulative	3.60	8.00	13.30	13.30	13.30

Institutional Data

Practice Area /Cross Cutting Solution Area

Health, Nutrition and Population

Cross Cutting Areas

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[ ] Gender
[ ] Jobs
[X] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Population and reproductive health	70
Human development	Health system performance	20
Human development	HIV/AIDS	10

Total	100

Proposed Development Objective(s)
The project development objective is to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.

Components	
Component Name	**Cost (USD Millions)**
Component One - Package of Safe Delivery Services to Poor Pregnant Women.	9.50
Capacity Building and Project Management.	3.80

Systematic Operations Risk – Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Low
9. Others	
Overall	**Moderate**

Compliance		
Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	

Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10		**X**
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Recipient shall appoint an Independent Verification Evaluation Agency		30-Oct-2014	

Description of Covenant

The Independent Verification Evaluation Agency is responsible for verification of outputs achieved under the Project, as elaborated in the Operations Manual.

Name	**Recurrent**	**Due Date**	**Frequency**
The Recipient shall carry out the Project in accordance with the Op. Manual	**X**		Continuous

Description of Covenant

The describes the operational arrangements and processes for the project

Name	**Recurrent**	**Due Date**	**Frequency**
Carry out the project in accordance with HCWMP and Guidance Notes	**X**		Quarterly

Description of Covenant

The Recipient shall, through the Ministry of Health, ensure that the Project is carried out in accordance with the National Health Care Waste Management Plan and in accordance with the Health Care Waste Guidance Note.

Name	**Recurrent**	**Due Date**	**Frequency**
Provide independent verification reports	**X**		Quarterly

Description of Covenant

The Recipient shall, through the Independent Verification Evaluation Agency, and in accordance with terms of reference satisfactory to the Association, conduct independent

verification and certification of outputs under Part 1 of the Project, all in accordance with the provisions of the Operations Manual.

Conditions

Name	Type
The Recipient has appointed the Voucher Management Agency.	Effectiveness

Description of Condition

The Recipient has appointed the Voucher Management Agency in accordance with the provisions of Section I.A.1 of Schedule 2 to the Grant Agreement

Name	Type
Preparation of an Operations Manual (OM), satisfactory to the World Bank.	Effectiveness

Description of Condition

The Recipient has adopted the Operations Manual in accordance with the provisions of Section I.B of Schedule 2 to the Grant Agreement.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Luis M. Schwarz	Senior Finance Officer	Senior Finance Officer	CTRLA
Peter Okwero	Senior Health Specialist	Team Lead	GHNDR
Leslie Villegas	Infrastructure Specialist	Infrastructure Specialist	GSOUA
Harriet E. N. Kiwanuka	Program Assistant	Program Assistant	AFMUG
Christine Makori	Senior Counsel	Senior Counsel	LEGAM
Howard Bariira Centenary	Senior Procurement Specialist	Senior Procurement Specialist	GGODR
Rajesh K. Advani	Infrastructure Specialist	Infrastructure Specialist	GSOUA
Eunan Ugonna Onyenuma	Finance Analyst	Finance Analyst	CTRLN
Edwin Nyamasege Moguche	E T Consultant	E T Consultant	GGODR
Herbert Oule	Environmental Specialist	Environmental Specialist	GENDR

Non-Bank Staff

Name	Title	Office Phone	City

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Uganda	Eastern Region	Eastern Region	**X**	**X**	Contracted Health Facilities are to be selected from the two regions
Uganda	Western Region	Western Region	**X**	**X**	

STRATEGIC CONTEXT

A. COUNTRY CONTEXT

1. **Macroeconomic Overview**. Uganda experienced sustained economic growth between 1990 to 2010 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 percent in 2012 and increased to 5.8 percent in 2013. Uganda is among the least developed countries in the world with GDP per capita of US$490. Poverty levels remain high with half of the population subsisting on less than US$1.25 per day. Uganda's population growth rate of 3.2 percent and dependency ratio of 1.12 are among the highest in the world.

2. **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. Child and infant mortality also recorded a significant drop between 2006 and 2011. Progress, on the other hand, has been slow for MDGs related to maternal mortality, access to reproductive health services, and control of malaria and other communicable diseases. Maternal mortality remains high, and Uganda is unlikely to achieve the MDG on reducing maternal mortality by three-quarters by 2015. Although the 2011 Demographic and Health Survey (DHS) reported improvements in skilled delivery attendance and contraceptive prevalence rate (CPR) from 42 percent to 59 percent and 24 percent to 30 percent between 2006 and 2011, respectively, these did not result in reduced maternal mortality, which has stagnated at 438 deaths per 100,000 live births. While 80 percent of health facilities in Uganda provide Elimination of Mother to Child Transmission of HIV (EMTCT) services, actual coverage is estimated to be only 52 percent.

B. SECTORAL AND INSTITUTIONAL CONTEXT

3. **Peri-natal and maternal morbidity and mortality are major causes[1] of the high disease burden in Uganda, accounting for 20.4 percent of the burden**. Low coverage of skilled delivery services, especially comprehensive emergency obstetric care, is a major problem[2]. According to the 2011/2012 Annual Health Sector Performance Report, only 7 percent of sampled facilities provided comprehensive emergency obstetric care. Adolescent reproductive health services are generally limited. Although contraceptive use has increased, coverage remains low and unmet need for contraceptives remains high. Induced abortions are quite common and it is estimated that about 297,000 induced abortions take place annually. Total fertility rate of 6.2 births per woman in the reproductive age group is among the highest in the world. HIV prevalence is estimated at about 7.3% in pregnant women and vertical transmission of HIV to children by mothers contributes over 15 percent of HIV new infections annually.

4. **Improving maternal health outcomes is a key priority for Uganda**. The main strategies are outlined in the Road Map for Acceleration of Maternal and Neonatal Mortality and Morbidity (2006 – 2015) and the Reproductive Health Commodity Security Strategic Plan

[1] Hemorrhage, abortion, sepsis, obstructed labor, pregnancy induced hypertension and malaria are the major causes of maternal deaths and still births.

[2] According to the 2011 DHS preliminary results, over 90% of mothers attend at least one ANC visit; 47% attend at least 4 ANC visits; 59% deliver under skilled care; and contraceptive prevalence rate is estimated at 30%.

(2010/11 – 2014/15) and include: (a) expanding maternal and newborn care services; (b) improving management and staff motivation; and (c) strengthening supply chain management for reproductive health commodities. Uganda is currently expanding use of existing contraceptive methods; introducing implants; strengthening services for post-abortion care and resuscitation of newborn babies; and expanding maternal and peri-natal death audits. In addition, a separate supply chain management system for reproductive health commodities has been set up to serve private providers and government is in the process of streamlining the management and operations of ambulance services countrywide. In 2012, Uganda also adopted the policy to enroll all HIV positive pregnant women in the EMTCT program and giving them lifelong treatment.

5. **Uganda's health system comprises public, private-not-for-profit (PNFP) and private-for-profit (PFP) providers as well as traditional and complementary practitioners**. National and Regional Referral Hospitals report to the central government; General Hospitals and Health Centers (HC) (Types II–IV) report to the local governments. The districts are further divided into Health Sub-Districts, which are administered at the HC IV level. The PNFPs are predominantly faith based. The PFP providers predominantly comprise clinics, but also include drug shops and vendors operating informally. The facilities deliver essential health care services including safe delivery services and are expected to be licensed by the appropriate Professional Medical Council. According to government policy, services rendered by public providers carry no user fees apart from private wings in public hospitals, which are allowed to levy user fees.

6. **According to the 2012 National Health Accounts (NHA), households through out of pocket payments contribute 70 percent of the total funding towards reproductive health**. The findings are consistent with the generally high levels of out of pocket expenditures on health. A large share of the funding is reported to be spent on commodities and drugs by the clients. The NHA also found that a large share of donor funding is channeled through NGOs as earmarked funding to specific programs like family planning and prevention of mother to child transmission of HIV.

C. HIGHER LEVEL OBJECTIVES TO WHICH THE PROJECT CONTRIBUTES

7. **The project contributes to Uganda's National Development Plan 2011 – 2015 (NDP)**. The plan seeks to transform the economy by: (a) raising income levels; (b); improving human development; and (c) improving Uganda's competitiveness. The proposed project contributes to the NDP objectives of enhancing human capital development and increasing access to quality social services and is consistent with the health sector goals outlined in the National Health Policy (NHP, 2010/11 – 2019/20) and Health Sector Strategic Investment Plan (HSSIP, 2010/11 – 2014/15) of improving the health of Ugandans, reducing health inequalities and enhancing socio-economic development by scaling up access to cost-effective health care interventions.

8. Linkages to the World Bank's Country Assistance Strategy (CAS) for Uganda. The project is consistent with the Uganda CAS (Number 54187-UG dated April 27, 2010). A major strategic objective of the CAS is strengthening human capital development through improved health care delivery. The project is also consistent with the World Bank's Health Nutrition and Population Strategy. The project addresses MDG 5 on reducing maternal mortality and 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. 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 sexually transmitted infections (STIs) in pregnant women, the benefits of EMTCT and continued ARV treatment, and widespread poverty among the target population, public financing will be required for these services for the foreseeable future.

9. **The project is consistent with the Bank's twin goals of ending absolute poverty and boosting shared prosperity and with the objectives of the World Bank's 2011 regional strategy for Africa**. The project is expected to enhance access to quality obstetric care among rural and poor women. The introduction of demand side financing through the output based aid financing will assist in lowering the costs for obstetric care among poor pregnant women. The objectives of the strategy, called "Africa's Future and the World Bank's Support to It", are to increase Africa's competitiveness and employment, reduce vulnerability to climatic change and other shocks, and improve governance and public sector capacity. Through subsidized vouchers, the project will assist in reducing vulnerability of poor pregnant women in accessing safe delivery services. The project will also contribute to empowerment of women, increase demand and uptake of antenatal care and safe delivery services and strengthen institutional capacity to deliver reproductive health services. In the wider policy context of health service development, the output based aid mechanism is seen as an important tool for operationalizing results-based and/or demand-side financing models in the public sector, which will contribute towards improved public sector capacity.

D. RATIONALE FOR WORLD BANK/GPOBA INVOLVEMENT

10. **Poor women in Uganda face several challenges with accessing safe delivery services.** The majority reside in rural areas where safe delivery services in general are inadequate. In addition to geographical barriers, the poor women also face significant financial barriers. Whereas services offered by public facilities are meant to be free, owing to recurrent shortages of drugs and supplies, the patients are usually required to buy the various commodities. The targeting of subsidies will reduce financial barriers to care and promote demand and access to services that reduce risks associated with pregnancy and child birth for poor women. The government in the draft Health Financing Strategy intends to strengthen result orientation of public sector funding, and through GPOBA involvement, the government expects to draw lessons from the project to target services to the poor and institutionalize result based financing mechanisms in the sector by re-orienting disbursement of public subsidies on an output basis.

11. **The project is consistent with GPOBA's strategy of scaling-up successful pilot projects.** The project builds on a successful pilot voucher scheme to provide safe delivery services to poor pregnant women. The Uganda Reproductive Health Vouchers Program (RHVP), launched in September 2008, and financed by the German Development Bank (KfW) and the Global Partnership on Output-Based Aid (GPOBA), provided a grant of US$ 6.3 million in support of a voucher scheme to provide safe delivery and Sexually-Transmitted Infections (STI) services to rural communities in Western Uganda. The project supported 65,590 safe

deliveries and treated 31,658 cases of STIs. The evaluation of the program[3] noted that the scheme successfully (a) provided 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. Over 90 percent of clients expressed satisfaction with the project. Based on the success of the RHVP, the government and development partners have expressed interest in expanding the safe delivery services component of the pilot project. The STI voucher scheme will not be continued because verification of STI treatment proved difficult in the pilot; however, STIs in pregnancy will be treated under the project as part of the package of services. The Swedish development agency, (Sida), has provided GPOBA with additional grant funding for this project.

12. **The voucher scheme approach will be mainstreamed within government systems.** While the pilot project was implemented by Marie Stopes International, a Non-Governmental Organization (NGO) specializing in reproductive health services, the scaled-up project will be implemented by the Ministry of Health (MoH). As a result of the project, the MoH will build capacity to mainstream the use of voucher schemes in the health sector that will benefit from future public funding from the government and other health development partners (HDPs). DFID and USAID are currently running a US$ 30 million Family Planning voucher scheme. In addition, USAID[4] is considering scaling up the safe delivery voucher scheme. All these schemes are to be managed by the MoH using common implementation arrangements.

PROJECT DEVELOPMENT OBJECTIVE

A. PDO

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

B. PROJECT BENEFICIARIES

The primary beneficiaries are the poor and vulnerable pregnant women resident within the catchment areas of the contracted health facilities. The mothers are expected to be able to reach the facilities in less than two hours. The contracted service providers and surrounding communities are the secondary beneficiaries.

C. PDO LEVEL RESULTS INDICATORS

14. **The following are the indicators [5] to assess achievement of the PDO**:

a) Number and percentage of deliveries assisted under the project (%);
b) Number and percentage of vouchers distributed and redeemed for deliveries under the project (%);
c) Number and percentage of women attending at least one Ante-Natal Care (ANC) visit under the project (%).

[3] Population Council; The Reproductive Health Vouchers Program in Uganda: Summary of Findings from Program Evaluation; March 2012
[4] The actual amount has not yet been determined.
[5] The indicators are based on the number of vouchers sold.

d) Direct Project beneficiaries (number) of which female (percent).

15. **The following are the key project results**:

a) Support 132,400 pregnant women to deliver under skilled attendance;
b) Achieve a voucher redemption rate[6] of 70 percent for deliveries;
c) 90 percent of pregnant women enrolled under the scheme attend at least one ante natal care visit.

PROJECT DESCRIPTION

A. PROJECT COMPONENTS

16. **The project comprises two components**. These are: (1) Package of safe delivery services to poor pregnant women, and (2) Capacity Building and Project Management. The proposed activities under each component are presented below.

17. **Component One - Package of Safe Delivery Services to Poor Pregnant Women (GPOBA US$9.5 million).** The objective of the component is to provide 132,400 pregnant women access to a defined package of safe delivery services from contracted private and public providers. The package of services consists 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 includes services for EMTCT as part of antenatal care.

18. **Voucher scheme.** The component will be implemented through a voucher scheme administered by a Voucher Management Agency (VMA). The voucher entitles pregnant women to access a defined package of safe delivery services from contracted service providers. The service providers are expected to provide the specified services and submit claims together with the appropriate voucher coupons to the VMA for settlement on the basis of the negotiated fees. The pregnant mothers will purchase vouchers at UShs 4,000 (US$1.60). The Independent Verification Evaluation Agency will periodically verify project outputs as well as the integrity of the claims processing system and report to the MoH.

19. **Service Provider Selection Criteria**. The scheme will use both public and private service providers licensed to practice by the relevant medical councils[7]. The selection of service providers will be guided by the following principles:

a) Location in the areas mapped under the project;
b) Expression of interest to provide safe delivery services;
c) Licensed to practice by the appropriate medical council; and
d) Capacity to provide the defined package of services.

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

[7] Uganda Medical and Dental Practitioners Council and Allied Health Professional Council

20. **The service providers shall be invited through public notices to express interest to provide services,** and upon meeting the selection criteria, be approved to participate in the scheme. Public service providers, hitherto excluded from the previous scheme, will form part of the new scheme. In order to address the unique challenges faced by public providers, the MoH will issue guidelines to regulate the provision of services and use of resources generated through the scheme by public providers. To remain in the scheme, participating service providers will be subjected to annual clinical audits to assess quality of care and adherence to service guidelines and protocols. Service providers will be mapped to create functional referral networks between health facilities providing basic emergency obstetric care (BEmOC) services and those providing comprehensive emergency obstetric care (CEmOC) services. These functional CEmOC/BEmOC clusters are essential if women are to be provided with safe and adequate maternity care including emergency services, which are the key prerequisites to reducing maternal morbidity and mortality. According to current projections, the project will require approximately 35 clusters of service providers. The clusters will be composed of 35 CEmOCs and 176 BEmOCs selected on the basis of 1 CEmOCs to 4-6 BEmOCs.

21. **The project will use a combination of geographical targeting (based on poverty mapping) and a customized poverty grading tool to select eligible beneficiaries.** Pregnant women residing in sub-counties where over 60 percent of households are deemed poor shall be eligible to join the scheme without undergoing household assessment. Pregnant women resident in sub-counties where poverty is not deemed widespread will undergo a poverty assessment using the poverty grading tool. Eligible beneficiaries will be selected by scoring individual households on a number of different variables, and those with a score of 12 or less will be eligible to join the scheme. The poverty grading tool was developed during the pilot project and will be included in the project operations manual.

22. **Service provider reimbursement.** The recommended Weighted Average Cost (WAC) for safe delivery package is US$ 60 and for a package including Caesarean is US$ 130. These costs were derived from analysis of the costs of the pilot project and the review of market prices for the various services in the package (e.g., ante natal care, safe delivery, post natal care etc.) and take into account inflation, exchange rate fluctuations, and price trends of medical supplies in the country. These costs also cater for complications and transport for emergencies and provide a framework for the VMA to negotiate reimbursement rates with the service providers. The estimates exclude the costs for EMTCT drugs as the providers will obtain the drugs from the National HIV/AIDS Control Program in line with government policy.

23. **The negotiated signed contracts will be the basis for reimbursing service providers.** Service providers will be reimbursed on the basis of fee-for-service. The pilot project revealed that a small number of complicated deliveries may require care originally unanticipated when negotiating the contracts. In such cases service providers are expected to first contact the VMA to agree on the management approach. To guide the VMA, a ceiling/cap of US$350 will be set for management of unexpected emergency deliveries. To avoid the possibility of cost overruns, the VMA will monitor the voucher redemption rates on a quarterly basis, and with the information regulate the distribution/sale of vouchers.

24. **Component Two - Capacity Building and Project Management (USD 3.8 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. The MoH as the implementing agency will oversee project implementation but delegate day-to-day management of the scheme to the VMA. Under the component, the project will finance (a) specific project management activities including: oversight functions by the MoH, project administration and management by the voucher management agency, verification activities by the independent verification evaluation agent, service provider selection, audit, and monitoring and evaluation; and (b) capacity building activities including training and quality assurance activities to streamline and harmonize implementation processes for scaled up implementation of the voucher scheme in the sector. The main reason for harmonizing implementation arrangements is based on the need to avoid fragmentation of the different schemes in the country given the heightened interest on using vouchers.

B. PROJECT FINANCING

25. **The project will be supported through a recipient-executed grant of US$13.3 million.** The project is expected to generate an additional US$290,000 from the sale of vouchers as user contribution. The project costs based on available financing are captured in Table 1. These costs do not represent the full cost of the package of services, as the service providers receive subsidies from other sources including government.

Table 1. Project Cost and Financing

Project Component[8]	**Project Cost**	**Grant Financing**	**% Financing**
Subsidies for Safe Delivery			
1. Safe Deliveries	9,500,000		100%
Sub Total	**9,500,000**	Grant	100%
Capacity Building and Project Management			
1. Program Management Costs*	2,150,000		
2. Service Related Costs	1,250,000		
3. Independent Verification Evaluation Agent (IVEA)	400,000		
Sub Total	**3,800,000**	Grant	100%
Total Project Costs	**13,300,000**	Grant	100%

NB. The total costs exclude US$290,000 from user contribution from the sale of vouchers.
* Includes staff salaries and other fixed Costs including office space and a token of US$100,000 for MoH oversight functions.

C. LESSONS LEARNED AND REFLECTED IN THE PROJECT DESIGN

26. **Uganda successfully implemented a reproductive health voucher scheme and gained the necessary implementation experience**. The following lessons drawn from the pilot project have mainly informed the design of the project:

[8] The costing exercise presented in Annex 3, revealed that the unit costs paid in subsidies to providers are much lower than the actual market prices charged by the providers and that the reimbursement rates do not represent the full costs of service provision.

a) **Monitoring the voucher redemption rate during implementation**. In order to track the use of vouchers in service delivery and regulate their sales, the VMA will monitor the voucher redemption rate. The vouchers will include expiry dates in order for the VMA to periodically compute the redemption rates.
b) **Timely recruitment of the VMA and IVEA**. The pilot project experienced delays at the initial stages, mainly due to the delay with recruiting the VMA. This time round the VMA and IVEA will be recruited early enough in order to avoid the delays experienced with the pilot project.
c) **The project will sign contracts on the basis of uniform provider reimbursement rates according to facility level and category of provider**. In addition, service provider reimbursement rates will undergo periodic reviews to allow costs to be adjusted for inflation and exchange rate variation of the Uganda shilling against the US$, while maintaining the principle of shared risks.
d) **Focus on capacity building and ensuring compliance with treatment and voucher protocols.** Targeted capacity building activities will be conducted to mainstream the scheme in the health sector. A robust quality assurance (QA) system will be established to conduct regular clinical audits, process reviews and financial audits with the aim of maintaining good clinical quality of care and efficient and effective business processes. Regular training on project administration and clinical refresher trainings on safe delivery will be conducted targeting newly contracted service providers and recruited staff.
e) **Simplification of targeting of beneficiaries**. The project will increasingly rely on geographical targeting using the detailed poverty maps provided by the Uganda Bureau of Statistics (UBOS), and where necessary supplemented by the customized poverty grading tool and information on pregnancy related morbidity patterns from the MoH. 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.
f) **Avoid duplication of schemes.** The increased interest around the use of vouchers in the country brings with it the risks of duplication and development of parallel schemes. The Inter Agency Coordination Committee (ICC) established under the MoH will be responsible for coordinating and harmonizing voucher implementation processes in the country. All partners will sign a MoU committing to work in a collaborative manner. The project under the capacity building component will support activities to streamline and harmonize voucher implementation arrangements and promote their common use by all parties.
g) **Ensure voucher security and continually improve the claims processing system**. The voucher design will incorporate sophisticated security, making the vouchers durable and difficult to reproduce fraudulently. The project will also monitor timeliness of claims processing as a key project output and ensure payment to service providers are processed electronically and transferred to their accounts on a regular basis. The system will continually undergo improvements to enhance capacity for fraud detection, claims tracking and reporting and introduction of web-based claims processing where appropriate.

IMPLEMENTATION

A. INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

27. **The project will be administered by the Ministry of Health.** The MoH will have overall responsibility for overseeing and coordinating implementation of the project and will set up an Inter-Agency Coordinating Committed (ICC) with membership drawn from government, cooperating development partners, representatives of the service providers as well as the VMA and IVEA. The committee will provide strategic guidance and oversight to the project and other voucher schemes in the sector. The MoH will contract a VMA through a competitive process to serve as the project implementing agency. The service providers contracted by the VMA will be responsible for providing safe delivery services to clients. To verify project outputs and the quality of service provision, the MoH will recruit an IVEA. The MoH in the interim will rely on the existing management team established in the ministry to support implementation of the IDA projects[9] to oversee the scheme. This will assist the MoH mainstream voucher management functions within its structures. The main roles of the parties involved in the scheme are highlighted in Table 2.

Table 2. Roles and Responsibilities of the Principal Parties

MOH/ICC	VMA	Providers	IVEA[10]
• Policy and overall coordination; • Strategic guidance and oversight, and act as an advisor to key stakeholders, including the MoH, contributing HDPs, VMA & service providers • Oversee the development of operational manual and changes thereto; • Approval of mechanisms to appoint the VMA and IVEA. • Review and endorse annual work plans and budgets, progress reports, financial statements, withdrawal applications, and overall performance	• Implement and manage the Project in line with the Operational Manual and strive to increase the efficiency and effectiveness of its management systems. • Design and produce security-coded vouchers which are difficult to forge. • Distribute vouchers to the target population. • Select, train and contract services providers to give the agreed services. • Implement an efficient and fraud-detection enabled claims processing system.	• Provide the services as described in the Treatment Guidelines and the Operational Manual • Treat clients with respect and dignity and to strive to improve the quality of care. • Allow the VMA and the IVEA full access to the facility, records and staff	• Provide external monitoring of the project at 6 monthly intervals • Verify whether clients received claimed services; assess the quality of service provision, voucher distribution and BCC and training activities. • Assess the claims processing, payment and fraud control systems of VMA. • Report every 3 months to MoH, ICC and Development Partners on the

[9] Uganda Health Systems Strengthening Project and the East African Public Health Networking Project
[10] The IVEA is NOT an auditor and payments to providers do not have to be verified by the IVEA before they can be made.

			project implementation.

28. **The project is designed to be implemented as a partnership between the MoH and cooperating development partners.** In order to ensure adherence to using common implementation arrangements, the partners will sign a MoU setting out the obligations of the main parties and the agreed common implementations arrangements. Common implementation arrangements in terms of (a) service package; (b) voucher management; (c) reimbursement rates; (d) service provider selection etc. will make it easier for other interested partners in future to join the scheme. USAID is running a safe delivery scheme in four districts supported under the pilot project, and has indicated to government their plans to scale up RHVP in collaboration with other partners including the Bank. In addition, DFID and USAID are running a separate nationwide Family Planning Voucher Scheme. The voucher schemes are currently managed by the same VMA. The Family Planning scheme will continue as a separate program from the safe delivery scheme as 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. However, both schemes will be implemented under the coordination of the MoH and the ICC. The detailed implementation arrangements are included in Annex 3.

B. RESULTS MONITORING AND EVALUATION

29. **A results framework has been developed to monitor project implementation progress.** The results framework allows for the monitoring of project implementation and assessment of achievement of its development objectives. It places emphasis on intermediate outcomes and focuses on accountability for results. The selected indicators are consistent with the project objective and attributable to the project, and measure both quality and process elements relevant to the project objectives. The project will collect routine data using existing tools already in place from the participating service providers and community based distributors. Data collection, analysis and reporting are the responsibility of the VMA. In discharging its roles the VMA will work under the guidance of the MoH and collaborate closely with the District Health Offices. In order to ensure that the project outputs are captured in the district records, the participating service providers are expected to send copies of the reports to the District Health Offices. Every quarter, the VMA will provide quarterly progress reports and

quarterly Interim Financial Reports to the MoH for onward submission to the Bank in accordance with the reporting requirements set out in the Operations Manual. The IVEA will prepare quarterly verification reports as defined in the ToRs and the project will undergo the statutory financial audit annually. The complete Results Monitoring Framework is included in Annex 1.

The following reports will be provided on a periodic basis:

a) The VMA will submit quarterly progress reports to the MoH and cooperating partners;
b) MoH will submit semi-annual performance reports to the World Bank and GPOBA in accordance with the reporting requirements set out in the Operations Manual;
c) To satisfy the fiduciary requirements of project fund disbursements, MoH will provide Interim Financial Reports on a quarterly basis to the World Bank; and
d) Annual audited financial statements.

C. SUSTAINABILITY

30. **Nature of health sector subsidies**. The provision of health services to the poor in Uganda is largely subsidized and requires long-term funding commitment by government and development partners. Results from the pilot project noted that financial sustainability of RHVP remains an issue. The interventions supported under the voucher scheme do not entail one-off subsidy but require ongoing subsidies to address the needs of new cohorts of women requiring the services. The pilot 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 provided by service providers targeted under the project. The objective of the scale-up is to replicate the approach by allocating new donor funding to RHVP through a tested OBA mechanism.

31. **The project will support capacity building activities to mainstream implementation of the safe delivery voucher scheme in the health sector**. The project will extend specific capacity building activities to Voucher Service Providers (VSPs), MoH and VMA in order to harmonize, mainstream and institutionalize voucher implementation in the sector in the following areas: costing of the service packages, claims processing, provider selection and certification, and output verification. The institutionalization of these functions at the MoH is expected to contribute to improved sector performance in the long run, as government will continue to use some of these systems in the future in the sector. Some of the partners have expressed willingness to provide technical assistance to the MoH in the implementation of the vouchers program. The International Finance Corporation (IFC) has agreed to provide technical assistance to the MoH to support project activities. Additionally, it is currently providing TA to the MoH in the area of public private partnership for health, and has also agreed to provide TA to mainstream voucher implementation in the MoH.

32. **The project promotes the use of common implementation arrangements and is designed to allow interested partners to join the scheme in the future**. The MoU by the main parties will set out their obligations and define agreed common implementations arrangements including commitment to adherence to using common implementation arrangements. New partners will not incur set up costs, and since management systems (voucher management and verification of program outputs) were developed under the previous scheme, the overall

management costs of the new scheme are expected to be lower.

33. **Activities under the project offer great opportunity to strengthen performance and introduce accountability mechanisms in the public sector**. The accruing benefits are expected to spill over into the sector. The MoH is currently preparing a health financing strategy and is expecting to draw lessons from the project on approaches for targeting services to the poor and institutionalizing result based financing mechanisms in the sector. Uganda is also considering introducing social health insurance and a Bill is under preparation. Many of the activities in the voucher scheme including accreditation and contracting of service providers, defining benefits package, 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. There is a growing body of national, regional and international research that suggests that vouchers can act as a starting point for, and a place to both develop systems and expand social health insurance. The Uganda Reproductive Health voucher Program is therefore seen as a major experiment that will inform the introduction of social health insurance in Uganda.

KEY RISKS AND MITIGATION MEASURES

A. RISK RATINGS SUMMARY TABLE

Risk Category	Rating
Stakeholder Risk	**Low**
Implementing Agency Risk	
- Capacity	**Substantial**
- Governance	**Substantial**
Project Risk	
- Design	**Moderate**
- Social and Environmental	**Moderate**
- Program and Donor	**Low**
- Delivery Monitoring and Sustainability	**Moderate**
Overall Implementation Risk	**Moderate**

B. OVERALL RISK RATING EXPLANATION

34. **During preparation, key risks were identified and mitigation measures agreed with government.** The following are the key risks identified during project preparation: (a) structural challenges likely to confront public providers joining the scheme; (b) ensuring compliance by service providers with treatment standards and protocols; (c) targeting the appropriate beneficiaries; (d) duplication of the voucher schemes; and (e) fraudulent activities. The mitigation measures are summarized below and the details are provided in the Operational Risk Assessment Framework (ORAF).

35. **The MoH has agreed to the application of one common selection criteria for all categories of service providers**. Public providers will not receive special preference. The MoH will establish a dedicated team to support implementation of the voucher scheme in the public

sector and issue guidelines to regulate the provision of services and use of resources generated through the scheme by public providers. In addition, a robust quality assurance system will be established to ensure compliance by service providers with guidelines and protocols covering clinical as well as operational aspects.

36. **The project will rely on geographical targeting using detailed poverty maps from the Uganda Bureau of Statistics (UBOS)**. This will be supplemented where necessary by the poverty grading tool and information on pregnancy related morbidity patterns from the MoH. As an additional measure, the poverty grading tool will undergo periodic reviews to better target vulnerable clients. To minimize the risks of duplication and development of parallel schemes, all partners will sign a MoU committing to work in a collaborative manner under the oversight of the MoH/ICC.

37. **The claims processing arrangements will continually undergo improvements to enhance capacity for fraud detection, claims tracking and reporting**. The design of the voucher will incorporate sophisticated security, making the vouchers durable and difficult to reproduce fraudulently. The project will establish a transparent process for revising reimbursement costs for the service package, while maintaining the principle of shared risks. Furthermore, an appropriate Behavioral Change Communication (BCC) and marketing strategy will be developed and implemented as an ongoing activity during project implementation focusing on the key population groups, emphasize behavior change messages, promote voucher sales, and leverage relationships with existing community groups and institutions.

38. **In light of the above mitigation measures, the overall implementation risk rating is considered moderate**. Uganda has built capacity to successfully implement a reproductive health voucher program. The new project builds on the previous one, and capacity for voucher management already exists in the country. The MoH is expected to provide oversight and coordinate implementation of the scheme and in the process ensure harmony in implementation of the voucher program. In addition, a dedicated team selected by the MoH will support public providers joining the scheme for the first time.

APPRAISAL SUMMARY

A. ECONOMIC AND FINANCIAL ANALYSIS

39. **Economic Analysis.** In many health projects, the avoided productivity loss is considered as one of the economic benefits. A publication by the World Health Organization[11] (WHO) on estimating the costs of maternal-newborn illness and mortality demonstrates the use of the REDUCE Safe Motherhood model to estimate avoided productivity losses, which can be used to estimate an Economic Rate of Return (ERR) using a social discount rate. However, such modeling requires estimates to be made about a project's ability to lower the probability of death and disability when a voucher is used compared to situations where no voucher is used. Sufficient data is not available to justify such estimates, hence no ERR has been estimated. However, research findings to date have generally noted that voucher programs offer a number of potential advantages for scaling up access to delivery care in suitable contexts. Voucher schemes are seen as a vehicle to target subsidies to the poor and voucher programs have been

[11] "The cost of maternal-newborn illnesses and mortality" Islam, Karmul; Gerdtham, Ulf-G: WHO, 2006.

shown to improve investment in health facility capacity. On the other hand, voucher programs require effective administrative arrangements, which come with additional costs. Operating costs have been suggested as the main threat to the viability of vouchers for scaling up access. In this regard, a cost-effectiveness study was carried out for the pilot RHVP.

40. **Findings of the cost-effectiveness study of the pilot RHVP.** The study was conducted in the six districts in Western Uganda under the pilot OBA project on the basis of the provider perspective. The costs and effects of the program were modeled using a decision tree model with data from national and international sources. A hypothetical cohort of 25,000 women of median childbearing age with a projected life expectancy of 37 years was used in the model. Outcomes were measured in disability-adjusted life years (DALYs) averted, discounted at a social discount rate of 3 percent. The resulting incremental cost-effectiveness ratio (ICER) is estimated at US$156 per DALY averted. A higher ceiling advocated by WHO-CHOICE is equal to annual per capita GDP per DALY averted. As nominal GDP per capita in Uganda is US$490, the OBA program is considered to be cost-effective. A summary of the cost effectiveness analysis is presented in Annex 4.

41. **Financial Analysis.** Service providers under the project represent three main categories; namely: private facilities, public facilities, and church run facilities. The cost structure of each category varies depending on the funding arrangements. For example, public facilities largely run on public funding while church run facilities receive government subsidies in the form of supplies. The subsidy amounts will therefore be negotiated depending on the amount of subsidy required for a service provider to deliver the package of services expected under the project, subject to the subsidy cap. As a result, it is not possible to calculate an estimated financial rate of return to the service providers under the project. Instead, a cost analysis of the pilot project was undertaken, which presents findings of actual costs incurred under the pilot. These costs will be used by the VMA as a basis for negotiating reimbursement rates with service providers. The Weighted Average Cost (WAC) of delivering a healthy baby in the pilot project was US$53.5. The recommended WAC for safe delivery under the project is US$60 for a normal delivery and US$130 for a Caesarean section. A summary of the cost analysis is presented in Annex 3.

B. FINANCIAL MANAGEMENT

42. **The World Bank conducted an assessment of the financial management arrangements of the proposed project in April/May 2013**. Further assessment will take place when the VMA is recruited. The findings, based on the experience of the pilot project, indicate Uganda has adequate FM capacity to manage the project.

43. **The MoH will be responsible for overall financial management arrangements of the project**. The financial management arrangements will be managed by the Unit established within the MoH in the Accounts Department headed by the Assistant Commissioner to support implementation of IDA projects: Uganda Health Systems Strengthening Project (UHSSP) and East Africa Public Health Laboratory Network Project (EAPHLNP). Because of the long outstanding lapsed loans that require settlement, the Designated Account advance is temporarily suspended as a disbursement option for new projects. The project in the interim will rely on direct payment and reimbursement modes of disbursement and upon resolution of the matter, the MoH will open a Designated Project Account in the Bank of Uganda through which the grant

proceeds will be processed. The MoH will submit consolidated quarterly IFRs in a form and content acceptable to the Bank within 45 days after the end of the quarter. The Withdrawal Applications will be submitted through E-Signature and E-Disbursement. The MoH will ensure that the audited financial statements together with the management letter are submitted to the Bank six months after the end of the Financial Year. The MoH has experienced challenges in the management of financial records, advances to staff, non-operationalization of Navision accounting software, quality of IFRs, delay in preparation of financial statements, submission of audit reports for FY ended June 30, 2012 and inadequate staffing in accounting. Most of these have been addressed with recruitment of a new project accountant. In addition, the MoH is in an advanced stage to recruit an accounts assistant. Specific risk mitigation measures agreed with the MoH are contained in the detailed FM Assessment included in Annex 5.

44. **The MoH will contract a VMA and ensure that it has the requisite financial management capacity to manage the voucher operations**. The VMA will maintain adequate and acceptable financial management arrangements including having adequate qualified accounting staff to manage the scheme. The VMA will also be expected to have a reliable accounting system that will be used to process project transactions and generate reports. The VMA will ensure that all financial records are adequately maintained. The VMA will open a project account in a commercial bank acceptable to the Bank to which the advance from the Designated Account will be deposited and payments made from. The VMA will also maintain adequate internal controls throughout the implementation process.

45. **According to the results of the assessment, the mitigated risk rating is Substantial which satisfies the Bank's minimum requirements under OP/BP10.00**. The recommended improvements are detailed in the Financial Management Action Plan in Annex 5.

C. PROCUREMENT

46. **Procurement under the Project will be carried out in accordance with the World Bank's Guidelines**: Procurement of Goods, Works and Non Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers dated January 2011; and Selection and Employment of Consultants by World Bank Borrowers dated January 2011.

47. **Procurement under the project will be conducted by the Ministry of Health** through the Unit established within the Ministry under the Uganda Health Systems Strengthening project. The planned major procurements include (i) The Voucher Management Agency; (ii) the Independent Verification Evaluation Agency; and (iii) a Project Officer to support implementation. The VMA will be responsible for hiring of voucher service providers throughout the country and paying them against outputs. In order to ensure open participation and equal opportunity for all, the VMA shall publish an invitation in newspapers of wide national circulation inviting interested service providers to express interest in participating. A Procurement Plan has been prepared and reviewed by the Bank (Annex 6).

48. **The Project Implementation Support Unit in the Ministry of Health was established in 2011** in response to the procurement and project implementation risks identified under the Uganda Health Systems Strengthening Project. Therefore, use of this unit to implement the project already mitigates most of the risks. Further, the OBA nature of the project also reduces

risks to implementation. The overall risk rating for procurement is considered Low.

D. SOCIAL (INCLUDING SAFEGUARDS)

49. **No social safeguards are anticipated to be triggered based on the project design**. The project will be based around approved providers with capacity to provide comprehensive emergency obstetric care (CEmOC) services and associated basic emergency obstetric care (BEmOC) services. The Indigenous People (IP) in Uganda reside in areas where facilities with the capability to provide CEmOC are lacking, therefore the project will not intervene in areas where IP reside. The project will not require acquisition of land, relocation/displacement of land use or/and persons, loss of sources of income or means of livelihood and restriction of access to legally designated protected areas.

E. ENVIRONMENT (INCLUDING SAFEGUARDS)

50. **The project will be implemented through existing health facilities selected on the basis of set and approved criteria and will not involve any civil works/construction, or any land acquisition**. The interventions with environmental and social implications center on component one, which involves the handling of medical products and thus contributing to increased generation of medical waste in the contracted health facilities.

51. **The Ministry of Health has substantial experience in the handling of medical waste in compliance with Uganda's National Environmental requirements**, and experience with World Bank safeguards gained from implementation of UHSSP (P115563). Environmental compliance is the responsibility of the Environmental Health Division (EHD) of the Ministry of Health which is charged with executing the National Health Care Waste Management Plan under the overall policy guidance of the National Environment Management Authority. The National Health Care Waste Management Plan for 2009/2010 – 2011/2012 was completed and disclosed in April 2010 during preparation of the UHSSP and the Integrated Safeguards Data Sheet approved and disclosed on July 7, 2013.

52. **A study**[12] **on Health Care Waste Management in Uganda noted that Health Care Waste (HCW) generated by facilities varies from under 20 kg per day in small health centers to 90 kg per day in big hospitals**. Of this, 30 to 40 percent is considered hazardous. The study further identified challenges affecting HCW management and recommended measures to improve the HCW management practices in Uganda. These shall be taken into consideration when updating the Project Operations Manual. The government is working on a number of measures to improve HCW management: (a) a new strategy for the handling and disposal of pharmaceutical waste is under preparation; (b) the infrastructure standards were revised to take into consideration measures to reduce infection control; (c) installation of incinerators is underway in 40 hospitals in the country; and (d) infection control guidelines including tuberculosis infection control have been developed for use in the hospitals. In addition, private operators have been contracted to handle the disposal of medical waste generated by private practitioners in Kampala.

53. **The project is expected to generate minimal localized medical waste related impacts**.

[12] A USAID (AIDSTAR-One project) Study Report, June 2012

Under the project, the Voucher Management Agency working under the oversight of the Environmental Health Division (EHD) will ensure that contracted service providers properly dispose medical waste in accordance to the guidelines outlined in the Project Operations Manual. The Health Care Waste Guidance Note developed in the previous project - Reproductive Health Vouchers in Western Uganda (P104527) will be updated to reflect the new changes and included in the Project Operation Manual.

Safeguard Policies	Triggere	Explanation (Optional)
Environmental Assessment OP/BP 4.01	**Yes**	The project contributes to generation of medical waste in the contracted health facilities.
Natural Habitats OP/BP 4.04	**No**	N/A
Forests OP/BP 4.36	**No**	N/A
Pest Management OP 4.09	**No**	N/A
Physical Cultural Resources OP/BP 4.11	**No**	N/A
Indigenous Peoples OP/BP 4.10	**No**	Indigenous Peoples in Uganda reside in areas where facilities with the capability to provide comprehensive emergency obstetric care are lacking.
Involuntary Resettlement OP/BP 4.12	**No**	N/A
Safety of Dams OP/BP 4.37	**No**	N/A
Projects on International Waterways OP/BP 7.50	**No**	N/A
Projects in Disputed Areas OP/BP 7.60	**No**	N/A

Annex 1: Results Framework and Monitoring

Country: Uganda

Project Name: UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (P144102)

Project Development Objective: The project development objective is to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery.										
These results are at	Project Level									
Project Development Objective Indicators										
				Cumulative Target Values					Data Source/	Responsibility for
Indicator Name	Core	Unit of Measure	Baseline	YR1	YR2	YR3	YR4 End Target	Frequency	Methodology	Data Collection
Deliveries assisted under the project (%);	☐	Percentage	0.00	19,860 (15%)	52,960 (40%)	92,680 (70%)	132,400 (100%)	half yearly	VMA	
Vouchers distributed and redeemed for deliveries under the project (%);	☐	Percentage Sub-Type Supplemental	0.00	19,600 (10%)	53,000 (30%)	92,000 (50%)	132,400 (70%)	Half yearly	VMA	
Women attending at least one ANC visits under the project (%)	☐	Percentage		28,400 (15%)	66,000 (35%)	123,000 (65%)	170,000 (90%)	Half yearly	VMA	

Direct Project beneficiaries (number) of which female (percent)	☐	Number	0.00	38,000	105,000	186,000	264,000	Half yearly	VMA	
Intermediate Results Indicators										
				Cumulative Target Values					Data Source/	Responsibility for
Indicator Name	Core	Unit of Measure	Baseline	YR1	YR2	YR3	YR4 End Target	Frequency	Methodology	Data Collection
Vouchers distributed and redeemed for postnatal care under the scheme (%)	☐	Percentage	0.00	7,500 (4%)	15,000 (8%)	38,000 (20%)	66,000 (35%)	Half yearly	VMA	
Fresh still births[13]	☐	Numbers	0.00	30	80	270	330	Half yearly	VMA	
Pregnant women tested for HIV (%)	☐	Percentage	0.00	15,800 (12%)	46,000 (35%)	86,000 (65%)	119,000 (90%)	Half yearly	VMA	
Pregnant women with HIV who received EMTCT.	☐	Percentage	0.00	900	2,700	5,000	7,100	Half yearly	VMA	

[13] Fresh still birth is a proxy measure of the quality of safe delivery services. While the cumulative number of fresh still births increases the actual proportion of still births decreases with improved quality of safe delivery services. The projections are based on the data from Ugandan hospitals.

Mothers referred (%)	☐	Percentage	0.00	4,000 (3%)	9,000 (7%)	13,240 (10%)	18,500 (14%)	Half yearly	VMA	
Claims reimbursed timely*(%)	☐	Percentage	0	30%	50%	70%	80%	Half yearly	VMA	
Timely verification reports provided.	☐	Percentage	0	2 100%	4 100%	6 100%	8 100%	Half yearly	IVEA	

Annex 1: Results Framework and Monitoring

Country: Uganda

Project Name: UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT (P144102)

Project Development Objective Indicators	
Indicator Name	Description (indicator definition etc.)
Deliveries assisted under the project (%);	Measure of the deliveries under the project against the number of mothers who bought vouchers
Vouchers distributed and redeemed for deliveries under the project (%);	Measure of vouchers sold redeemed for safe delivery
Women attending at least one ANC visit under the project (%).	Core indicator
Direct Project beneficiaries (number) of which female (percent)	Measures both mothers and babies who received care under the project
Intermediate Results Indicators	
Indicator Name	Description (indicator definition etc.)
Vouchers distributed and redeemed for postnatal care (%).	Measure of vouchers sold redeemed for post natal care
Number of fresh still births;	Measures number of fresh still births against total number of births
Pregnant women tested for HIV (%);	Measure of women accessing HIV testing
Mothers referred (%);	Measures number of pregnant women referred against total number of women delivered under the project
Claims reimbursed timely (%)	Measures claims redeemed within 20 days of submission
Timely verification reports provided.	Measures IVEA reports submitted in time ie within 50 days after the end of the six month reporting period

1. **A results framework to monitor project implementation progress has been developed and agreed with the government.** The results framework focuses on accountability for results and places emphasis on intermediate outcomes. The project will collect routine data using existing tools already place from the participating service providers and community based distributors. In addition, the project will conduct household surveys in the beginning and at the end of the project to assess overall project impact.

2. **The VMA is charged with the responsibility for data collection, analysis and reporting**. The VMA will also be responsible for training service providers and distributors in data collection and reporting and ensuring quality assurance of the system. In discharging its roles, the VMA will work under the guidance of the MoH and collaborate closely with the District Health Offices. In order to ensure that the project outputs are captured in the district records, the participating service providers are expected to send copies of the reports to the District Health Offices. Every quarter, the VMA is expected to submit quarterly reports to the ICC/MoH.

3. **Every quarter, the IVEA will verify project outputs on the basis of the VMA's report and make recommendations on disbursement of the OBA subsidy**. In carrying out its functions, the IVEA will carry out on-site physical verification of a randomly selected number of service providers. It is expected that all CEmOC facilities will be visited every 6 months and that 50 percent of BEmOC facilities will be visited each year. These numbers will be adjusted at the start of each year to ensure the numbers of facilities to be visited reflect the numbers of facilities in the project. The purpose is to ascertain service providers' existence and their activities as they relate to payment of claims. For each service provider visited, the IVEA will physically certify that it is properly functioning according to the applicable required standards in terms of staffing, skills, facilities, equipment, and care protocols, and will verify the associated records kept at the offices of the service provider. The IVEA will also verify that the claim processing agency has appropriate processes and fraud mitigation detection measures in place. These surveys will be carried out at random intervals and reports will be made available when they have been analyzed and completed as part of the quarterly IVEA report. The IVEA will also carry out exit and focus group interviews with patients attending the health facilities to gain information on their experiences with the voucher scheme.

4. **The following are the project outcome indicators**:

a) Number and percentage of deliveries assisted under the project (%);
b) Number and percentage of vouchers distributed and redeemed for deliveries under the project (%); and
c) Number and percentage of women attending at least one ANC visit under the project (%).

5. **In addition, the project will track eight other intermediate outcome indicators.** These, however, are not the only indicators that will be tracked in the project, or that will be needed to successfully demonstrate the results chain in support of the outcome indicators. As such, an additional set of project-level indicators will be tracked by the project team. The indicators are consistent with the project objectives and are attributable to the project. Two of the indicators; namely, number and percent of women attending at least one ANC visit under the

project and number of project beneficiaries are core indicators. The denominator and numerator for each indicator have been clearly specified to ensure that definitions do not change over time. Baseline data are available and targets have been set for all indicators. The project team intends to conduct an impact evaluation of the project and plans to seek funding for the exercise internally within the Bank.

Annex 2: Detailed Project Description
UGANDA: Uganda Reproductive Health Voucher Project

1. **The project comprises two components**. These are: (1) Package of safe delivery services to poor pregnant women, and (2) Capacity Building and Project Management. The proposed activities under each component are presented below.

2. **Component One - Package of Safe Delivery Services to Poor Pregnant Women (GPOBA US$9.5 million).** The objective of the component is to provide 132,400 pregnant women access to a defined package of safe delivery services from contracted private and public providers. The package of services consists 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 includes services for EMTCT as part of antenatal care.

3. **Voucher scheme.** The component will be implemented through a voucher scheme administered by a Voucher Management Agency (VMA). The VMA is responsible for managing the overall scheme including the contracting of selected service providers and training of community distributors to distribute vouchers to eligible clients in the targeted communities. The voucher entitles pregnant women to access a defined package of safe delivery services from contracted service providers. Upon providing the specified services, the service providers submit claims together with the appropriate voucher coupons to the VMA for settlement on the basis of the negotiated rates.

4. **Advantages of voucher schemes.** A recent review of existing voucher programs demonstrated their potential to increase utilization of health services among beneficiary populations[14]. Vouchers were found to assist with targeting services to vulnerable population groups; providing consumer choice and facilitating greater transparency in the service delivery process while ensuring the services meet the specified standards and for which the participating service providers receive commensurate financial rewards.

5. **Service Provider Selection Criteria**. The scheme will use both public and private service providers licensed to practice by the relevant medical councils[15]. The selection of service providers will be guided by the following principles:

a) Location in the areas mapped under the project;
b) Expression of interest to provide safe delivery services;
c) Licensed to practice by the appropriate medical council; and
d) Capacity to provide the defined package of services.

6. **The service providers shall be invited through public notices to express interest to provide services,** and upon meeting the selection criteria, be approved to participate in the scheme. Service providers will be selected from poor and rural communities/areas where access

[14] Nicole M. Bellows et al, The Use of vouchers for reproductive health services in developing countries: systematic review; Tropical Medicine and International Health, vol 10 no 1 pages 84-96 January 2011.
[15] Uganda Medical and Dental Practitioners Council and Allied Health Professional Council

to safe delivery services is low with attention paid to ensuring that selected service providers have the requisite capacity to provide the defined range and quality of safe delivery services. To remain in the scheme, participating service providers will undergo annual clinical audits to assess quality of care and adherence to service guidelines and protocols, determine service provider training requirements and inform contract management decisions. Both public and private providers will be selected using the same criteria without giving preference to either. The 85 active service providers contracted under the pilot scheme will be eligible to join the scheme after reassessment.

7. **Service providers will be mapped to create functional referral networks** between the health facilities providing basic emergency obstetric care (BEmOC) services and those providing comprehensive emergency obstetric care (CEmOC) services. These functional CEmOC/BEmOC clusters are essential if women are to be provided with safe and adequate maternity care including emergency services, which are the key prerequisites to reducing maternal morbidity and mortality. As a result of the mapping exercise, the program will be based around the service providers and will not necessarily cover the whole population of a particular district or geographical region. According to current projections, the project will require approximately 35 clusters of service providers. The clusters will be composed of 35 CEmOCs and 176 BEmOCs selected on the basis of 1 CEmOCs to 4-6 BEmOCs. The project will start in Western Region and later be rolled out to Eastern Region. It is anticipated that 18 clusters will be selected in the Eastern Region and 17 in Western Region.

8. **Public service providers, hitherto excluded from the pilot scheme, will form part of the new scheme.** Public providers will be inducted in a phased manner starting with facilities providing comprehensive emergency obstetric services. Including public providers will improve the pool of potential providers under the scheme, increase access to services and provide an opportunity to strengthen performance and introduce accountability mechanisms in the public sector. In order to address the unique challenges faced by public providers, the MoH will issue guidelines to regulate the provision of services and use of resources generated through the scheme by public providers. The public providers will use the guidelines for private wings in the hospitals. In determining the fees the VMA will take account of the funding provided by government to public providers.

9. **The project will use a combination of geographical targeting and a customized poverty grading tool to select eligible beneficiaries.** Eligibility for geographical targeting will be determined through the use of poverty maps prepared by the Uganda Bureau of Statistics (UBOS) using the 2002 census, and are updated periodically using the national household surveys. The poverty grading tool was developed during the pilot. The following criteria will be used to determine eligibility for subsidies under the project:

a) Pregnant women residing in sub-counties where over 60 percent of households are deemed poor shall be eligible to join the scheme without undergoing household assessment.
b) Pregnant women resident in sub-counties where poverty is not deemed widespread will undergo a poverty assessment using the poverty grading tool. Eligible beneficiaries will be selected by scoring individual households on a number of different variables, and

those with a score of 12 or less will be eligible to join the scheme.

10. **The voucher design and distribution.** The design of vouchers includes coupons to accommodate multiple visits: four antenatal visits, delivery and post natal visit as well as transport for referral of cases and provide expiry dates so that unused vouchers are cancelled after the expiry date. The design will incorporate sophisticated security, making the vouchers durable and difficult to reproduce fraudulently. In addition, the vouchers will include clear instructions in English and the languages of the targeted regions; contact information for questions and feedback; bar-codes for tracking and reporting; and clearly displayed prices. The MoH and the VMA developed a robust computerized claims processing system under the pilot scheme. The claims processing software is open and available for use by the new VMA to be contracted under the project.

11. **The VMA will establish a distribution network to distribute vouchers within the catchment areas of the service providers**. Trained Community Based Distributors (CBDs) contracted by the VMA will be responsible for selling vouchers to pregnant women living within the defined catchment areas of approved providers. All distributors will receive training in effective marketing approaches and communications skills to promote voucher sales and their use by clients. Additionally, publicity campaigns will be organized in the same catchment areas to augment the work of the CBDs. An appropriate Behavioral Change Communication (BCC), marketing strategy and distribution system will be developed and implemented as an ongoing activity during project implementation. BCC and Marketing activities will focus on the key population groups, emphasize behavior change messages, promote voucher sales, and leverage relationships with existing community groups and institutions. Lessons learnt from the previous project include the important finding that local radio stations were the most effective way to reach the rural population.

12. **User contribution.** The pregnant mothers will purchase the vouchers at UShs 4,000 (US$1.60) inclusive of a markup for the CBD as an incentive. The voucher scheme targets the poorest and most vulnerable women and the cost of the voucher is thus nominal, given the potential negative impact on service utilization. However, user contribution is important as it makes getting a voucher an "active" exercise – the price is discussed, money is found and payment made – and this makes the voucher 'valuable' and not just a 'giveaway', and it also provides a mechanism to pay distributors who take a percentage of the money received as a form of output-based payment. In the previous project, clients were willing to buy vouchers once their benefits were understood. A willingness to pay analysis conducted in 2007 revealed mothers were ready to pay the equivalent of US$1.60. On further consultation with key stakeholders (mothers, service providers, partners) during the costing exercise and using the earlier analysis, the price of the voucher was increased modestly from UShs 3,000 in the pilot project to UShs 4,000. This price will apply to all schemes. The project is targeting 132,400 deliveries over the project period. Based on the redemption rate of 70 percent, it is estimated that a total of 189,100 vouchers will be printed and sold, which will raise US$290,000 as user/community contribution towards the project.

13. **Service provider reimbursement mechanism.** The subsidies payable to service providers for ANC, deliveries and PNC were calculated based on a review of the costs of the

pilot project[16]. The recommended Weighted Average Cost (WAC) for safe delivery package is US$ 60 and for a package including Caesarean is US$ 130. These figures were derived after analysis of the market prices for the various services in the package and take into account inflation, exchange rate fluctuations, and price trends of medical supplies in the country. The costs cater for complications and transport for emergencies and provide a framework for the VMA to negotiate reimbursement rates with the service providers. These estimates exclude costs for EMTCT drugs as the providers will obtain the drugs from the National AIDS Control Program in line with government policy. There is no provision for advance payment, nor will the subsidies pay for capital investments. A summary of the suggested average unit costs for the service delivery package is provided below in Table 3.

Table 3. Suggested Average Unit Costs for the Service Delivery Package

Service Type	Unit Costs US$	Total
ANC 1	8.6	ANC 1-4 USD 17.2
ANC 2	2.9	
ANC 3	2.6	
ANC 4	3.1	
Severe Malaria	14.3	Treatments & Complications USD 24.1
Routine Malaria	7.2	
UTI	2.6	
Complicated Delivery	86.0	
Normal Delivery	16.7	
PNC	2.4	

14. **The VMA shall use the suggested unit costs in Table 3 to negotiate service contracts with the service providers**. First, the VMA will propose service provider reimbursement rates for various services in the package taking consideration of the following: (a) ownership of the health facility (private, public and private-not-for-profit); (b) level of service provider (Clinic, Health Centre and Hospital); and (c) geographical location and infrastructure of specific districts. Second, the VMA will hold negotiations with the different categories of the service providers to agree on the fixed reimbursement rates for each category of service providers. Finally, the VMA will sign contracts with the service providers on the basis of the negotiations. With the fixed reimbursement rates, the VMA does not need to negotiate with each service provider. The fixed reimbursement rates serve as a useful tool to track voucher redemption rates and monitor expenditures.

15. **Providers will be reimbursed on the basis of fee-for-service.** Compared to the case based payment model, the fee for service model was selected because of the need to ensure providers actually provide the defined package of services. A large share of the project budget (70 percent) will go to reimbursement of service providers. Voucher management costs (as part of service related costs) on the other hand will take up about 25 percent of the budget, which is less than the proportion spent during the pilot project. Because of the already existing management systems, voucher management costs are unlikely to increase (total administrative

[16] Cost analysis report for the Reproductive Health voucher pilot project in Western Uganda**,** Report for the World Bank and the Ministry of Health of Uganda, May 2013

costs for this project are 30 percent compared to 44 percent for the pilot, as noted in the ICR of the pilot project). Transport will only be catered for in emergency/referral situations. Although provision of non-emergency transport to mothers can improve access of mothers to delivery services, the cost analysis shows that it is expensive and will not be covered under the project.

16. **Component one only caters for subsidy payments to service providers**. Other service related costs: service provider selection and training, quality assurance and BCC are covered under component two. In comparison to the Kenya Reproductive Health Output Based Aid Project, launched in 2006 and implemented with funding from KfW and Government of Kenya, the Uganda pilot project was seen to have high overhead costs and much lower subsidies. The Kenya program on the other hand had higher subsidies but lower overhead costs. This variation is partly explained by the fact that the Kenya program is largely implemented through hospitals in an urban/peri-urban setting, while the Uganda program was implemented through health centers and clinics in a rural environment.

17. **The service provider reimbursement rates will undergo periodic reviews**. This will allow costs to be adjusted for inflation and exchange rate variation, while maintaining the principle of shared risks. The VMA will monitor exchange rate variation and voucher redemption rates in order to control the cost per voucher to achieve average cost targets as specified in this document. By monitoring the voucher redemption rates on a quarterly period, the VMA will be able to regulate the distribution/sale of vouchers and avoid cost overruns. In case of failure, the VMA will bear the associated financial risks. In the event of not attaining the average cost figures after a minimum period of six months, the VMA will duly present the underlying reasons and proposed measures for dealing with the matter to the MoH and the cooperating development partners. These standard costs of the service package will be available to all upcoming Reproductive Health Voucher programs that may be funded and implemented by other entities.

18. **The negotiated signed contracts will form the basis for reimbursing service providers.** The reimbursement of providers will be on the basis of fee-for-service. Claims with rates that are inconsistent with the signed contracts will be returned to the service provider or quarantined to give the service provider the opportunity to correct the variation. The pilot project revealed that very few cases of complicated deliveries may require care originally unanticipated when negotiating the contracts. In such cases service providers are expected to first contact the VMA to agree on the management approach. To guide the VMA, a ceiling/cap of US$350 will be set for management of unexpected emergency deliveries. The ceiling for a normal delivery will be set at US$60. Regarding workload, the VMA and an Independent Verification and Evaluation Agent (IVEA) will assess and determine reasonable workload limits for individual service providers i.e., the limit needed to ensure the safety of clients and to promote good quality care as too many clients per day for the space and staff available will inevitably compromise both safety and quality.

19. **Subsidy payments will be triggered as described in the Table 4 below**. The claims processing will be handled as follows: (a) receipt of claims by the VMA; (b) vetting of the claims and classification into the following categories: payment, quarantine for clarification or rejection; (c) processing of claims for payment electronically and transfer of funds to the

accounts of the service providers; and (d) for rejected or quarantined claims, the VMA informs the service provider. The vetting process involves verifying (a) the mother's details; (b) appropriateness of the services for which the claims are made; and (c) claimed amount against the negotiated service contracts. The claims processing system will undergo periodic reviews of the claims processing system by the IVEA.

Table 4. Payment Mechanism of the Subsidies to Service Providers

Subsidy payment trigger	**Verification mechanism**	**Amount of subsidy**
Providers will submit completed claims forms (which include the client's identification data) to the VMA for validating, processing and payment. Questionable claims will be quarantined, checked with providers and rejected or adjusted and paid.	IVEA will make 3 monthly reviews of the program to check claims by the VMA, and every 6 months physically verify provider performance.	This is determined by the claim but will stay within the contracted amounts.
Maximum subsidy payable	(Including ANC and PNC), the maximum payment for a normal delivery will be 60 US$ and for a complicated delivery 350 US$.	
Subsidy cap	See Above. In addition, the VMA and IVEA will assess the reasonable workload limits for individual providers.	

20. **Component Two - Capacity Building and Project Management (USD 3.8 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. The MoH as the implementing agency will oversee project implementation but delegate day-to-day management of the scheme to the VMA. Under the component, the project will finance (a) specific project management activities including: oversight functions by the MoH, project administration and management by the voucher management agency, verification activities by the independent verification evaluation agent, service provider selection, audit, and monitoring and evaluation; and (b) capacity building activities including training and quality assurance activities to streamline and harmonize implementation processes for scaled up implementation of the voucher scheme in the sector. The main reason for harmonizing implementation arrangements is based on the need to avoid fragmentation of the different schemes in the country given the heightened interest on using vouchers.

21. **The project will play a pivotal role to scale up and mainstream implementation of the safe delivery voucher scheme in the health sector**. The VMA will support the team constituted by the MoH from the Health Planning Department and Reproductive Health Division

to oversee the project at the Ministry and also support the public providers. It is critical for the MoH to strengthen its capacity to oversee the project but also other schemes to avoid fragmentation. Public providers will join the scheme for the first time and specific actions will be required to address their unique challenges. The study on public sector engagement with the reproductive health voucher program in Uganda by Population Council (January 2012) found broad support for the program, but noted that the successful scale-up of the Uganda voucher program lies with negotiating and engaging with relevant government agencies at various levels. There is also need to sensitize key stakeholders on the potential benefit of the voucher program to ensure general acceptance. In addition, the public providers will need training geared to addressing the structural challenges they face in ensuring they can provide services that meet the specified standards. Guidelines specific to the public providers will be prepared and issued.

22. **Robust Behavioral Change Communication (BCC) and Voucher Marketing and Distribution Strategies.** There will be need to promote and market the RHVP in the new districts. A comprehensive BCC/marketing strategy will be carried out as an ongoing activity during project implementation. Marketing activities will focus on the key population groups, emphasize behavior change messages, promote voucher sales, and leverage relationships with existing community groups and institutions. A distribution network will be established to deliver vouchers to distributors within the catchment areas of the service providers. The process will target distributors catering to poor and high-risk segments of the population. All distributors will be trained on the protocols on the correct methods of selling vouchers and communication with clients on the best way to use vouchers.

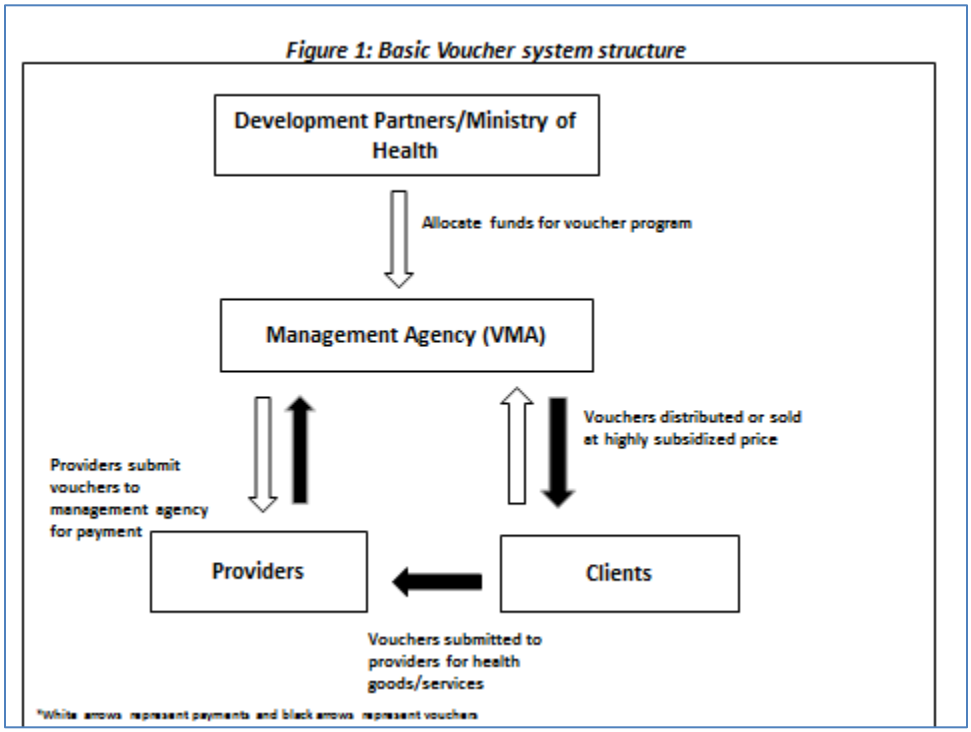
23. **The Implementation Completion Report (ICR) of the pilot notes high administrative costs for the pilot project but these would reduce in a scale-up as systems have already been established**. In view of its key role, the claims processing system will continually undergo improvements to enhance capacity for fraud detection, claims tracking and reporting. The project relies on small facilities located in the rural areas, and because of the increased number of service providers, the VMA will need to enhance its capacity particularly for quality assurance. Remotely located areas will make communication and training more difficult, and are more likely to have less highly trained personnel, requiring more support supervision. Using the lessons drawn from the VMA, the professional medical councils are expected to mainstream quality assurance functions and the continuing medical education program.

24. **Cost categories under component 2**. The cost categories under component two are highlighted in Table 5.

Table 5. Cost Categories under Component 2

Project Management Costs	Amount
VMA Fixed costs - furniture, computers and other assets.	100,000
VMA Administrative costs - staff time, consultants, rent, utilities and office running costs.	1,550,000
VMA Field Supervision and monitoring.	400,000
MoH oversight activities	100,000
Total Project Management Costs	**2,150,000**
BCC and Voucher Marketing and Sales - field allowances, fuel for generators, audio visual equipment, radio media and print media.	550,000
Voucher Administration and Billing - claims software, technical support, training of staff and maintenance.	300,000
Service provider selection, training and quality assurance.	400,000
IVEA	400,000
Total Service Related Costs	**1,650,000**
Total Costs	**3,800,000**

Figure 1. Describes the basic operations of a Voucher



Annex 3: Implementation Arrangements
UGANDA: Uganda Reproductive Health Voucher Project

1. **The project will be administered by the Ministry of Health.** The terms and conditions for implementing the project will be governed by the Grant Agreement. In addition to the Grant Agreement, the detailed Operations Manual will describe the *modus operandi* of the project. The MoH will contract a VMA through a competitive process to serve as the project implementing agency. The service providers contracted by the VMA will be responsible for providing safe delivery services to clients. To verify project outputs and the quality of service provision, the MoH will recruit an IVEA. The MoH in the interim will rely on the existing management team established in the ministry to support implementation of the IDA projects[17] to coordinate and facilitate recruitment of the VMA and IVEA and to review the VMA and IVEA reports. This will assist the MoH mainstream voucher management functions within its structures.

2. **The project is designed to be implemented as a partnership between the MoH and cooperating development partners.** The design of the voucher scheme takes into account the fact that partners may join the scheme at different times. In order to ensure adherence to using common implementation arrangements, the partners will sign a MoU setting out the obligations of the main parties and the agreed common implementations arrangements. Common implementation arrangements in terms of: (a) service package; (b) voucher management; (c) reimbursement rates; (d) service provider selection etc. will make it easier for other interested partners in future to join the scheme. USAID is running a safe delivery scheme in four districts supported under the pilot project, and has indicated to government their plans to scale up RHVP in collaboration with other partners including the Bank. In addition, DFID and USAID are running a separate nationwide Family Planning Voucher Scheme. The voucher schemes are currently managed by the same VMA. The Family Planning scheme will continue as a separate program from the safe delivery scheme as 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. However, both schemes will be implemented under the coordination of the MoH and the ICC. Figure 2 is the project organization chart describing the main implementation arrangements of the project.

3. **The MoH will oversee and coordinate implementation of the project**. It will also set up an Inter-Agency Coordinating Committee (ICC). The membership to the ICC will be drawn from government, cooperating development partners, representatives of the service providers and also include the VMA and IVEA. The committee will provide strategic guidance and oversight to the project and other voucher schemes in the sector.

4. **The responsibility for the day to day running of the project is delegated to the VMA**. The main roles of the VMA include the following: (a) select and contract service providers; (b) design the voucher and ensure its security; (c) negotiate reimbursement costs with service providers; (d) manage claims processing systems; (e) market the scheme and distribute vouchers through community based distributors; (f) train service providers and voucher distributors; and (g) quality assurance and monitoring and evaluation. The VMA will also provide quarterly progress and financial reports including results of clinical audits and other relevant audit data and

[17] Uganda Health Systems Strengthening Project and the East African Public Health Networking Project

semi-annual forecasts of treatments to all the key stakeholders and ensure that annual financial audits of the scheme are undertaken in a timely manner.

5. **The IVEA will be responsible to verify project outputs and integrity of the processes and systems.** The IVEA will conduct periodic implementation reviews to assess the effectiveness and efficiency of the project's implementation systems, processes and outputs including the quarterly reports by the VMA and provide independent quarterly reports to the ICC and cooperating development partners. The main functions for the IVEA are the following: (a) verify that agreed outputs are achieved; (b) verify that participating service providers perform in accordance with agreed standards; (c) validate performance of the claims processing system; (d) make recommendations on disbursement of the OBA subsidy; and (e) assess BCC and training activities carried out by the VMA. The IVEA will not review each and every claim submitted by the service providers before settlement of payment, but will on a regular basis review a sample of claims to verify the integrity of the claims processing system.

6. **Existing service providers both public and private will be responsible to deliver services**. Only registered service providers licensed to practice by the relevant medical bodies will be contracted and certified to provide services. The providers are expected to adhere to service guidelines and protocols in delivering services and ensure that claims are submitted to the VMA in a timely manner. The contracts with service providers will be negotiated based on uniform provider reimbursement rates according to facility level and category of provider. The initial contracting process for service providers will involve mapping, selection, induction training and contract negotiations. A contract will be signed on completion of induction training with each service provider that clearly defines responsibilities in providing quality care based on the scheme's guidelines and protocols at agreed prices. Contracts will be terminated in cases where service providers do not meet the scheme's requirements. The reimbursement rates will be set such that the providers feel incentivized to provide quality services but not too high as to create inflationary pressures and drive up prices.

7. **Figure 2 is the project organization chart describing the main contractual and implementation arrangements of the project**. The following are the main contractual arrangements for the project:

a) **Grant Agreement**. A Grant Agreement will be signed between IDA, as the administrator of GPOBA, and the Recipient represented by the Ministry of Finance, Planning and Economic Development.
b) **Responsibility for implementation**. The Ministry of Health will be responsible for implementing the project on behalf of the Government of Uganda.
c) **Contract between the MoH and VMA**. The MoH will select and contract a 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 costs and reporting obligations (in accordance with the Operational Manual) will be specified.
d) **MoU between the Main Parties**. Cooperating Development Partners will sign a MoU with the MoH setting out the obligations of the main parties and the agreed common implementations arrangements.

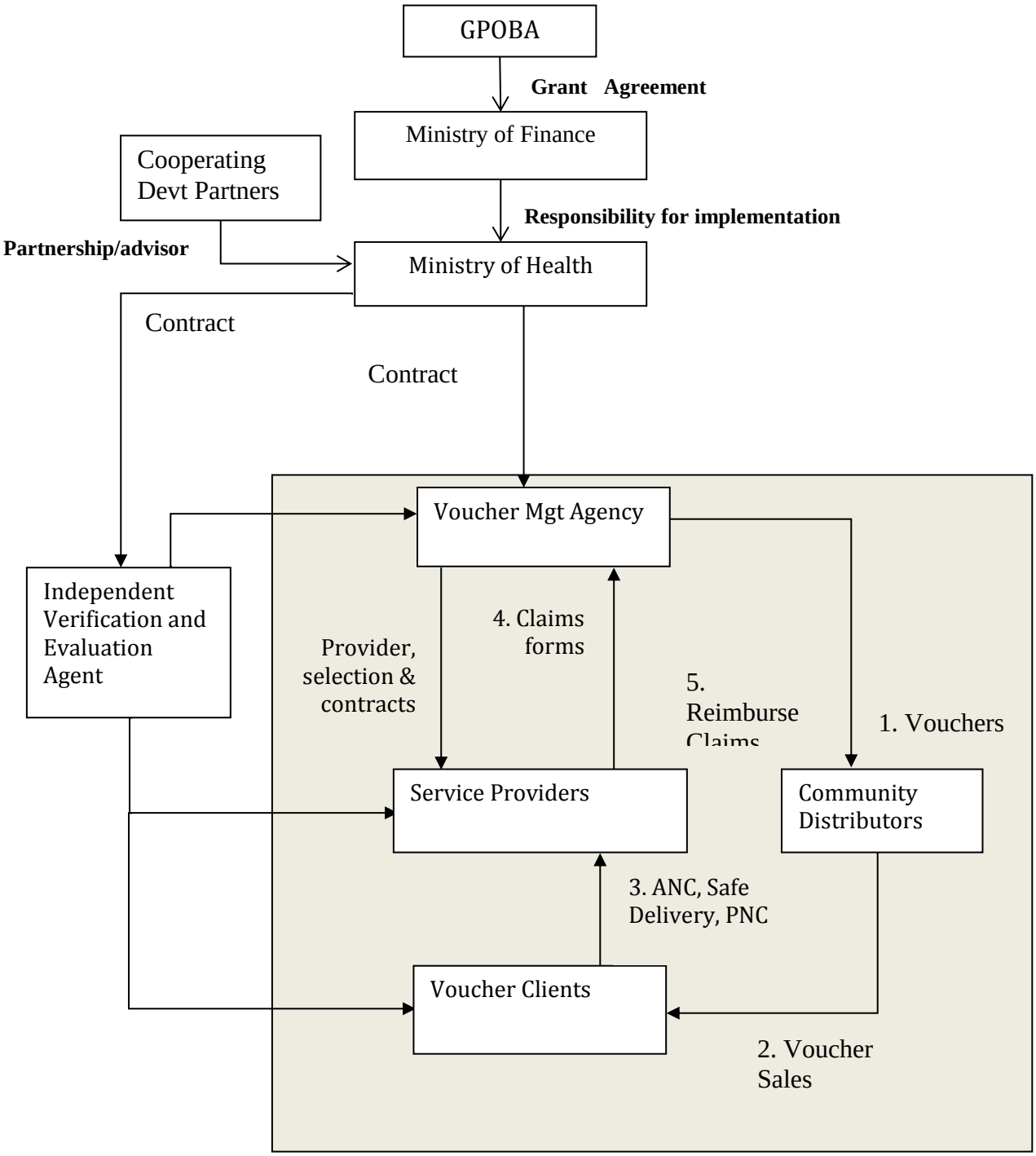
e) **Contractual Arrangements between the VMA and Service Providers**. The VMA will sign agreements with the service providers, addressing the description of the services, obligations of the service providers, compliance with the rules of the system (adherence to standards and protocols, the Health Care Waste Guidance Note 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.

f) **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.

g) **IVEA Contract**. The MoH will select and contract an IVEA that will provide on-going project support as well as Output Verification Reports.

8. **Figure 3 in the FM assessment section (annex 5) summarizes the funds flow arrangements for the project.** The VMA will prepare Withdrawal Applications, which are endorsed by the MoH before being sent to the World Bank. These are then reviewed and verified against the IVEA reports, and upon which advances/reimbursements are made to the MoH and VMA respectively. Service providers will submit completed claim forms (which include the client's identification data) to the VMA for validation and processing and upon satisfactory verification the VMA will reimburse the service provider for the services rendered. The IVEA will not verify every claim for payments by individual service providers; instead the IVEA will periodically assess the integrity of the claims processing system from a sample of claims. During the assessment the IVEA will also assess the effectiveness of fraud control arrangements.

Figure 2. Voucher Scheme Organization Chart



Annex 4: Financial and Economic Analyses
UGANDA: Uganda Reproductive Health Voucher Project

A. COST ANALYSIS

1. **The government undertook a cost analysis of the previous project to inform project design.** The main objectives of the analysis were to: (a) review service provider reimbursement rates; (b) review voucher management agency costs; and (c) assess and recommend implementation arrangements for the expanded voucher scheme. The analysis also considered additional costs related to scaling up the program. The analysis covered three main provider categories: private for profit, private not for profit (faith based) and public providers allowing for standardization, comparison, and validation. The unit costs were adjusted for inflation, voucher redemption/utilization rate and the probability of and cost associated with complications.

2. **According to the analysis 63 percent of the pilot project expenditures were spent on service delivery**. On the other hand 29 percent was spent on program management overheads, 4 percent on indirect spending and 4 percent on voucher specific costs like voucher production, administration and billing. Further disaggregation of costs into fixed and variable costs showed that 25 percent of the pilot project costs were fixed whereas the 75 percent were variable costs. The actual VMA costs amounted to 37 percent of the total project expenditure. It is important to note that fixed costs remain constant only within ranges. Eventually, if programs grow large enough, additional layers of administration and support are needed. Empirical evidence is currently unavailable to suggest at what point fixed costs no longer remain constant. The biggest asset that the VMA that piloted this project retains is the experience and human capital. The project also used a specialized claim processing software and therefore has gained experience and expertise in timely processing of claims. Some of these assets cannot be quantified but would greatly contribute to the marginal cost of scaling up the programme.

3. **The Weighted Average Cost (WAC) of delivering a healthy baby in the pilot project was US$53.5 compared to the contracted WAC of US$70**. The majority of the safe deliveries took place in BEmOCs compared to CEmOCs. It was also noted that the unit cost for transport (US$ 31 per claim) was high and second to caesarean sections in comparison to other services. The analysis also confirmed that only 33 percent of the vouchers sold were fully utilized and reimbursed. In comparison to the market pricing[18] information collected from the service providers, the voucher costs were substantially less than the market prices of the services. The detailed costs are highlighted in Table 6 below.

[18] A price is a value assigned by the seller and may or may not be accepted by the buyer so even in health service delivery different facilities will set different prices and in most cases will have a minimum price (rack rate) at which they will accept a client

Table 6. Average Voucher Service Unit Costs

Service Type	Utilization Rate	Average VSP Unit Costs
ANC 1	85%	6.61
ANC 2	60%	2.20
ANC 3	41%	2.00
ANC 4	23%	2.39
Severe Malaria	20%	11.02
Routine Malaria	25%	5.51
UTI	60%	2.00
Complicated Delivery	15%	66.13
Normal Delivery	55%	12.86
PNC	8.9%	1.84
Normal Delivery package	Sum of ANC 1-4, Malaria+UTI, Normal delivery and PNC	46
C/S Delivery Package:	Sum of ANC 1-4, Malaria+UTI, complicated delivery and PNC	100
Weighted Average VSP Cost:		53.5

4. The recommended Weighted Average Cost for safe delivery is US$60 and for Caesarean is US$130. These costs in Table 7 take into account inflation, exchange rate fluctuations, and price trends of medical supplies in the country. The costs cater for complications and transport for emergencies and provide a framework within which the VMA can negotiate reimbursement rates with the service providers. In negotiating service provider reimbursement rates, the VMA will take into consideration the location and infrastructure of specific districts. Location will affect the cost of transport, supervision and training. Remotely located areas will also make communication and training more difficult, and are more likely to have less highly trained personnel, requiring more support supervision. These standard costs of the service package will be available to all upcoming Reproductive Health Voucher programs that may be funded and implemented by other entities.

Table 7. Recommended Unit Costs for the Service Delivery Package

Service Type	VSP Unit Costs US$	Total
ANC 1	8.6	ANC 1-4 USD 17.2
ANC 2	2.9	
ANC 3	2.6	
ANC 4	3.1	
Severe Malaria	14.3	Treatments & Complications USD 24.1
Routine Malaria	7.2	
UTI	2.6	
Complicated Delivery	86.0	
Normal Delivery	16.7	
PNC	2.4	
Safe delivery	60	
C/S Delivery Package:	130	
Weighted Average Cost:	70.5	

5. **Providers will be reimbursed on the basis of fee-for-service.** The fee-for-service model tends to lead to higher quality of care, but has the potential of escalating costs and is also administratively burdensome to manage. Case based payment model where providers are reimbursed per visit/case addressed, while easy to negotiate and administer, has a major drawback, in that it usually does not take into account the quality of service delivered i.e., providers get paid for treating a case irrespective of *how* they treat. According to current projections, the project will require approximately 35 clusters of service providers. The clusters will be composed of 35 CEmOCs and 176 BEmOCs selected on the basis of 1 CEmOC to 4-6 BEmOCs. The project will start in Western Region and later be rolled out to Eastern Region. It is anticipated that 18 clusters will be selected in the Eastern Region and 17 in Western Region.

Table 8. Proposed Budget According to the Costing Analysis

Cost Items	Budgeted Amount	Percentage
Project Management Costs*	2,430,635	18%
Service Related Costs**	1,559,365	12%
Subsidies	9,333,333	70%
Total	13,333,333	100%

N.B. The proposed budget based on the analysis conducted and on the assumption that the Scale up will be run based on the same approach used as in the pilot especially with regards to voucher marketing, sales and BCC. The analysis excludes the revenue from user contribution. (* Staff salaries and other fixed Costs including office space;
** Provider Selection and Training, Quality Assurance; BCC; and Claims Processing)

6. **The proposed budget of the program is highlighted in Table 8**. Seventy percent of the budget will go to reimbursement of service providers, 18 percent on program management costs and the balance on service related costs (BCC, service provider selection, training and supervision). The voucher specific costs are not likely to change substantially. The increase will be due to the software upgrading, and management. Assuming that the VMA that piloted the pilot project wins the tender for scaling up, the fixed Assets that were purchased during the pilot

phase can still be used for the program. The specific administrative costs will increase mainly due to the increased number of staff and rent for field offices that may need to be established, costs of IVEA, auditors and any other outsourced services. These costs will also be directly related to the number of service providers selected and their location. Indirect costs are variable costs and include costs like training of service providers, voucher distributers etc., and are for ensuring that the voucher scheme is well managed. Training content/curriculum as well as the trainers is already in place. Transport will only be catered for in emergency/referral situations. Although transport provision can improve access of mothers to services, the cost analysis shows that it is very expensive and will be excluded from the package of services.

7. **The project will target 132,400 deliveries over the project period as per available budget (USD 13.3M)**. Based on the redemption rate in the pilot project of 70 percent, it is estimated that a total of 189,100 vouchers will be printed for this purpose. The recommended voucher cost to the user is set at UShs 4,000 (USD 1.6) as compared to the UShs 3,000 that was charged in the pilot project to cater for inflation and other changes in the economy. If all the planned 189,100 vouchers are sold, then USD 290,000 will be realized as user/community contribution towards the project.

B. COST EFFECTIVENESS ANALYSIS

8. **Maternal deaths disproportionally affect the poor, both between and within countries**. Ninety-five percent of mortality occurs in poor countries with 50 percent taking place in sub-Saharan Africa alone. In addition, for every case of maternal death, 16 women suffer complications related to pregnancy and deliveries. Three-quarters of all maternal deaths are caused by hemorrhage, obstructed labor, hypertensive disorders, puerperal sepsis and complications of abortion. By scaling up good quality ante natal care and skilled attendance at birth, especially emergency obstetric care, the majority of the deaths can be averted. Many low-income countries are however particularly challenged with achieving routine facility-based deliveries for the majority of the population for various reasons ranging from poor quality services, shortages of health workers and general underfunding of the health sector, to proximity barriers, financial barriers, and low perception of the benefits by the general population.

9. **The major causes for the high disease burden are preventable, if women can access obstetric services of good quality**. For most of the conditions, cost effective interventions exist and can be provided at the primary care level. Due to high poverty levels, a majority of women are unable to afford these basic and essential services. According to WHO, interventions that avert one DALY for less than average per capita income for a given country are generally considered as very cost-effective. Based on this, the interventions supported under the project are cost-effective as Uganda has a GDP of US490 per capita. Estimates based on analysis conducted in Uganda in 1999[19] reveal that costs per DALY averted for antenatal care was US$2.26 per pregnant woman per year in public facilities and US$6.43 per pregnant woman per year in PNFP hospitals. The costs per DALY averted through strengthening facilities to deliver emergency obstetric care was US$73 per emergency episode in a public hospital and US$86 in PNFP.

10. **Voucher schemes are amongst several noticeable maternal health programming**

[19] Jamison, D.T., J.G. Breman, A.R. Measham, G. Alleyne, M. Claeson, D.B. Evans, P. Jha, A. Mills, and P. Musgrove. 2006. Disease Control Priorities in Developing Countries. Second edition. Washington, DC: World Bank and Oxford University Press

initiatives being implemented to increase access, especially amongst the poor. At least six countries in South Asia and sub-Saharan Africa now operate voucher schemes for facility-based delivery. Voucher programs are thought to offer a number of potential advantages for scaling up access to safe delivery care in suitable contexts. Voucher schemes are seen as a vehicle to target subsidies to pregnant women hindered by financial barriers and to encourage appropriate use of services. Voucher programs have been shown to improve investment in health facility capacity. On the other hand, voucher programs are complex and require effective administrative arrangements, which come with additional costs. Operating costs have been suggested as the main threat to the viability of vouchers for scaling up access. A clear need thus exists to evaluate the cost-effectiveness of voucher programs.

11. **A cost effectiveness analysis[20] of the Uganda Reproductive Health Voucher Project was carried out** with the aim of establishing the cost-effectiveness of safe delivery services in terms of costs and consequences between the Output-Based Aid voucher intervention arm and the non-intervention arm (only existing government and private sources of delivery care operating with status quo funding arrangements). The study adopted a provider's perspective and was conducted in the six districts under the OBA project. For the public facilities, the costs were derived from national sources of data[21] and underwent further adjustments in the study area. To estimate project effects, the study refers to a national survey of 197 public and private hospitals[22]. Due to data limitations the analysis only focuses on the four major conditions of maternal mortality: hemorrhage, obstructed labor, puerperal sepsis and complications of abortion, and excludes hypertensive disorders, as well as, the costs and effects of managing fetal distress, neonatal sepsis, birth asphyxia, preventing stillbirth, and managing any indirect complications in pregnancy. The OBA voucher intervention arm costs were derived from the voucher management agency (VMA) and the non-intervention arm facility costs (public and private providers) for safe delivery services were drawn from national sources of data and validated through interviews with staff in the facilities. The study used a hypothetical cohort of 25,000 women of median childbearing age with a projected life expectancy of 37 additional years. For measurement of cost effectiveness the study chose to utilize cost per disability-adjusted life years[23] (DALYs) averted, discounted at 3 percent. Incremental costs-effectiveness ratios were calculated by dividing the difference in DALYs averted by the difference in the costs experienced in the comparator arm.

12. **Analysis of the Costs**. Analysis of reimbursement expenditure for OBA delivery in the study districts yielded an average cost of $18.18 USD for uncomplicated delivery and $87.37 USD for complicated delivery over the implementation period. With reimbursements, program and referral transport costs included, the total average OBA cost for normal delivery was estimated at $29.40 and $111.85 USD for a complicated delivery. The adjusted average costs for public providers were $19.17 for a normal delivery and $71.22 for a complicated delivery (Table 9). The public costs per case exclude management costs, utilities, training, and quality assurance.

[20] The cost-effectiveness of a voucher program for facility based delivery in six districts of Western Uganda: A critical analysis. Preliminary Report.
[21] Costing the National Roadmap for Reducing and Neonatal Morbidity and Mortality (2008).
[22] Mbonye et al. Emergency obstetric care as the priority intervention to reduce maternal mortality in Uganda. International Journal of Gynecology and Obstetrics. March 2007 96 (3) 220-225.
[23] The disability-adjusted life year (DALY) is a measure of overall/aggregate disease burden, expressed as the number of years lost due to ill-health, disability or early death.

Table 9. Summary of average cost estimates for safe delivery care

Cost breakdown per case	Average cost estimates (US$) OBA (N=15,477)	Average cost estimates (US$) Public (N=194,039)
Normal Delivery	29.40	19.17
Complicated delivery	111.84	71.22

NB. Public cost estimates exclude program management, training, and referral costs.

13. **Analysis of the Effects**. A woman entering delivery in Western Uganda was estimated to face an average risk of losing 0.14 DALYs without access to any care, according to DALY calculations used in the baseline analysis. The recorded facility maternal mortality associated with postpartum hemorrhage, obstructed labor, puerperal sepsis and pre-eclampsia/eclampsia was 33 deaths per 100,000 deliveries in the OBA program and 379 per 100,000 deliveries in government and other private facilities. The difference was highly significant at the $p<0.001$ level. All observed differences in complication rates were similarly statistically significant suggesting they were unlikely due to chance.

Table 10. Direct obstetric complications and mortality (95% CI)

	OBA Facilities (N=39,905)		Public Facilities (N=194,034)	
	Cases	Ratio	Cases	Ratio
Mortality	13	0.03%	735	0.38%
Complications	3,589	8.89%	26,001	13.4%

14. **Incremental cost-effectiveness ratio:** On the basis of the baseline assumptions used in the analysis 838 DALYs were averted and 761 life years gained for the hypothetical cohort of 25,000 pregnant women at an additional cost of $131,154 USD (2008/11) when compared to the alternative of not offering the OBA voucher program. The incremental cost-effectiveness ratio (ICER) for the baseline analysis was $156 USD (2008-11) per DALY averted and US$172 per life year gained. The findings are fairly robust according to the sensitivity analysis (using low and high cost scenarios and the exclusion of start-up year costs) as the ICER remained within the range of $132 and $172 per DALY averted.

15. **Conclusion**. Notwithstanding the data limitations, the findings suggest the OBA program is cost effective for a low income country like Uganda with a GDP of US490 per capita, which is more than three times the cost per DALY averted of US$156. In terms of thresholds for considering an intervention to be cost-effective, WHO recommends interventions that avert one DALY for less than the average per capita income for a given country or region are considered very cost-effective; interventions that cost less than three times average per capita income per DALY averted are still considered cost-effective; and those that exceed this level are considered not cost-effective.

16. **In addition to users' contribution of approximately US$290,000 (from the sale of vouchers), the project is likely to benefit from additional financing from other development**

partners. Project viability is also guaranteed given the high interest expressed by other development partners in Uganda. It is expected that after the first year of implementation, the project will leverage significant donor co-financing, further enhancing project's viability and effectiveness. The voucher scheme also led to significant reductions in out of pocket expenditures. The proportion of women from the communities that had a birth in the past 12 months preceding the 2010-2011 survey, delivered at a private health facility, and paid for the services was significantly lower among those who had used the voucher (23 percent) than among those who had never used the voucher (69 percent).[24]

[24] From the findings of the two evaluation reports: i) The reproductive health vouchers program in Uganda. Summary of findings from program evaluation. Reproductive Health Vouchers Evaluation Team. Population Council. May 02, 2012; and ii) Impact Evaluation of the population-level impact of the maternal health voucher program in Uganda. Reproductive Health Vouchers Evaluation Team. Population Council. April 18, 2012.

Annex 5: Financial Management Assessment
UGANDA: Uganda Reproductive Health Voucher Project

Introduction

1. This report is the summary of the assessment of the proposed financial management arrangements for the Uganda Reproductive Health Voucher Project implemented by the MoH. The MoH will procure the services of a Voucher Management Agency to manage the voucher operations of the project. The assessment reviewed: (a) adequacy of the financial management arrangements in ensuring project funds are used for purposes intended in an efficient and economical way; (b) whether project financial reports will be prepared in an accurate, reliable and timely manner; and (c) whether the project's assets will be safeguarded. The assessment was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on March 1, 2010.

COUNTRY ISSUES

2. The 2012 Public Expenditure and Financial Accountability (PEFA) Reports reveal the key reforms carried by Government in public service, decentralization and public financial management. The public service reforms aim to improve services delivery by instilling modern management practices into Uganda's public service and properly motivating and tooling the public servants. Decentralization is meant to improve the services delivery that local governments provide to the people through taking services close to the people and empowering them to have a say in deciding and monitoring the services that are provided to them. The Office of the Prime Minister coordinates all GoU programs and Ministries, Departments and Agencies (MDA) activities and carries out an annual performance management assessment to ensure that they are achieving their agreed objectives and outputs. The public financial management reforms support and benefit all the other GoU reforms because they provide the means of ensuring that the resources allocated to the various reforms are applied effectively and efficiently to achieve the intended purposes and attain value for money. The Public Financial Management (PFM) reforms cover the whole of the budgeting cycle functions: budget preparation, budget execution and oversight and scrutiny. The reforms have been pursued since the early 1990s and are continuing. The current reforms build on past achievements and are currently concentrating on: improving the credibility of the budget; ensuring that public financial management legislation is complied with; and ensuring that audit recommendations are implemented. GoU is carrying out the PFM reforms with the support of several donors. The more notable reforms include the ongoing review and revision of the Public Finance and Accountability Act and the upgrade of the Integrated Financial Management System (IFMS) financed through Financial Management and Accountability Program (FINMAP), a project supported by a number of development partners. Despite the reforms, the recent cases of corruption in the Office of the Prime Minister (OPM) and Ministry of Public Service suggest that corruption still remains a major challenge.

RISK ASSESSMENT AND MITIGATION

3. The IDA projects under the MoH experienced FM challenges in terms of: (a) management of FM records including quality of IFRs; (b) delay in payment of contractors,

operationalizing Navision and preparation of financial statements and submission of audit reports for FY ended June 30, 2012; (c) management of advances to staff; and (d); delayed submission of internal and external audit reports. As outlined below, the MoH has taken concrete steps to address the risks. The project will use the Treasury Accounting Instructions 2003, issued under the Public Finance & Accountability Act 2003 and Financial Management Guidelines developed under UHHSP in January 2011 and adopt the output based disbursement principles outlined, which involves independent verification of outputs. In addition, disbursement will be done directly to the VMA from the Designated Account (DA). The table below identifies the key risks that the project may experience and the proposed mitigation measures.

4. The overall residual risk is assessed as **Substantial** upon the mitigation of identified risks in the risk assessment and mitigation table below.

Table 11. Risk Assessment and Mitigation Measures

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
Inherent Risk			
Country-The 2012 PEFA report identified weaknesses in government PFM systems in enforcement of procurement and payroll rules and procedures. Allegations of fraudulent actions were reported in OPM and Ministry of Public Service.	**Substantial**	To address the high level of country risk, a government led PFM Reform Program is under implementation. The VMA will manage day to day operations of the project outside mainstream govt arrangements through an output based approach involving independent verification.	**Substantial**
Entity level- The MoH has had financial management challenges in implementing current Bank Projects. Annual statutory audits highlighted various internal weaknesses regarding accountability.	**Substantial**	Professional and experienced staff in finance, accounting and procurement have been hired on contract. Migration to Navision has been completed. The involvement of the MoH is limited to providing oversight and implementing a small portion of the project with most activities being done by the VMA.	**Substantial**
Project level- This is the first time the MoH is running a voucher program which may present some uncertainties.	**Substantial**	The project includes a component on capacity building of the MoH in voucher management. There is already VMA management capacity in country.	**Moderate**

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
Overall inherent risk			**Substantial**
Control risk			
Budgeting MoH. There are huge variances between the budgeted and actual expenditure. Expenditure outside the approved budget.	**Substantial**	Project budget plans to be prepared in sufficient detail and be used as a management tool. The IFRs will be used to monitor variance analysis with budget. Both the MoH and VMA will be expected to adhere to the budgeting process and execution.	**Moderate**
Accounting and Information system. Inability for the MoH to manage the Project Accounts with sound systems, which will slow down the project activities.	**Substantial**	The MoH installed Navision Accounting system for all project accounting. ToRs for the VMA and IVEA include adequate FM provisions.	**Substantial**
Staffing at MoH may be stretched to implement the requisite control procedures as intended such as accounting and internal controls	**Substantial**	Project accountant is qualified and experienced in Bank funded projects. Recruitment of accounts assistant underway. The VMA will employ adequate and qualified accounting staff to manage the project and put in place the required controls.	**Moderate**
Funds Flow Delays in disbursing funds to the VMA. Delays in effecting payments to suppliers and contractors.	**Substantial**	Funds will be paid to the VMA directly from the DA when it becomes operational.	**Moderate**
Reporting- financial information may be unreliable and submitted late.	**Substantial**	The project reports will be verified by the IVEA. The VMA will submit report to MoH for consolidation within 30 days after end of each quarter.	**Moderate**
Internal control: The MoH lacks a comprehensive fixed assets register and may lose track of assets procured under the project. There are weaknesses in the management of advances.	**High**	The project is based on OBA model and will not advance funding to MoH entities to implement project activities. The MoH is developing a fixed assets and enforcement of advances regulations. The Internal Audit department will incorporate the project in their annual work plans.	**Substantial**

Risk	Risk Rating	Risk Mitigation measures incorporated into project design	Risk after Mitigation
Delays in submitting internal audit reports		The VMA will ensure there are strong internal control requirements. The IVEA will conduct independent verification and report regularly	
External Audit Delays in the submission of audit reports for FY ended June 30, 2012 for the two projects. While the Audit report for EAPHLNP was Unqualified that of UHSSP was Qualified.	**Substantial**	The project will submit the annual financial statements to the Auditor General within the submission deadline of September 30th every year and to the Bank within 6 months after the end of the FY.	**Substantial**
Overall control risk			**Substantial**
Overall Project Risk Rating			**Substantial**

H – High S – Substantial M – Modest L – Low

INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

5. The MoH will have overall responsibility of managing the project. The Permanent Secretary (PS) MOH will be the "Accounting Officer" for the project, assuming the overall responsibility for accounting for the project funds. The project will be managed through the existing financial management arrangements established for the IDA projects (Uganda Health Systems Strengthening Project and East Africa Public Health Laboratory Network Project) within the MoH in the Accounts Department headed by the Assistant Commissioner. The MoH will contract a VMA with the requisite financial management capacity to manage the day to day operations of the voucher scheme. The IVEA will also provide additional fiduciary oversight on project implementation by the VMA and service providers. During project execution the MoH shall coordinate project implementation and manage: (a) project monitoring, reporting and evaluation; (b) contractual relationships with IDA and other co-financiers; and (c) financial management and record keeping, accounts and disbursements.

BUDGETING ARRANGEMENTS

6. The project will follow the government planning and budgeting procedures documented in the government's Treasury Accounting Instructions, 2003. These arrangements are adequate. The unit responsible for budgeting in the MoH has adequate capacity. The MoH will liaise with the VMA to ensure timely and realistic budgets/projections are prepared.

ACCOUNTING ARRANGEMENTS

a) **Books of Accounts:** The MoH and VMA will maintain adequate books of accounts to those

for other IDA funded projects including: a cash book, ledgers, journal vouchers, fixed asset register and a contracts register.

b) **Staffing Arrangements**: The designated accountant assisted by an accounts assistant will manage project accounts and report to the Assistant Commissioner Accounts. The VMA will be required to have adequate qualified accounting staff to manage the project.

c) **Information system**: The MoH will prepare the accounts for the project using the Navision Accounting software. The team in MoH is conversant with using the accounting software. The VMA will be required to have an operating accounting system capable of managing the project.

FUNDS FLOW AND DISBURSEMENT ARRANGEMENTS

Bank Accounts

7. Because of the long outstanding lapsed loans that require settlement, the Designated Account advance is temporarily suspended as a disbursement option for new projects. The project in the interim will use direct payment and reimbursement modes of disbursement. The Designated Account (DA) denominated in US dollars where disbursements from the IDA/GPOBA will be deposited and payments made in USD will be opened after resolution of the matter. The signatories for the project accounts will be in accordance with the Treasury Accounting Instructions/ Public Finance and Accountability Act, 2003. Payments will be approved and signed by the Accounting Officer (Permanent Secretary) as the principal signatory and the person designated by the Accountant General.

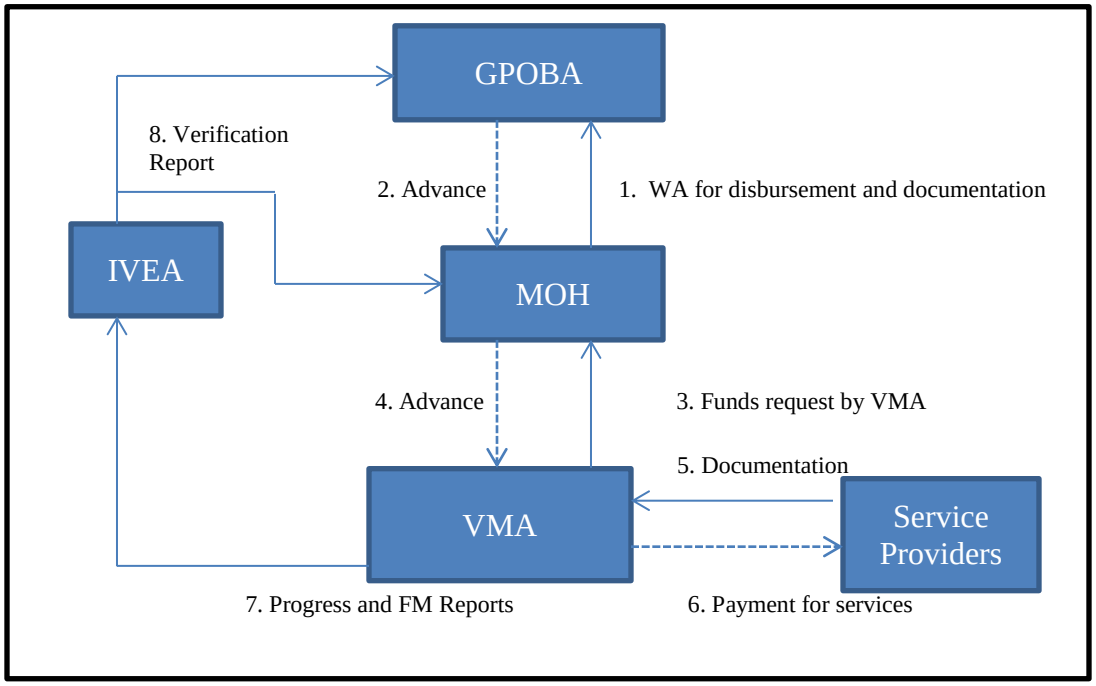
8. The VMA will open a bank account in a commercial bank acceptable to the Bank to which the advances will be deposited and payments made from.

Flow of Funds and Disbursements

9. **Disbursement Arrangements**. The project will be on a report based disbursement method. Subject to settlement of the lapsed loans, an initial disbursement will be deposited in a RHVP project Designated Account (DA) based on a six month cash flow forecast for the project based on the approved work plan. Subsequent disbursement will be based on the quarterly IFRs submitted to the Bank together with the relevant WAs and the IVEA reports. Direct payment method may be used for payments to contractors or service providers (VMA and IVEA) upon recommendations of their satisfactory performance by the RHVP project authorized officials. The project may also use the reimbursement method. The Accountant General in the MoFPED together with his delegated officials shall be co-signatories for disbursement/withdrawal applications. The disbursement arrangements will be described in detail in the Disbursement Letter.

10. If ineligible expenditures are found to have been made from the Designated Account, the Client will be obligated to refund the same. If the Designated Account remains inactive for more than six months, the Client may be requested to refund to IDA amounts advanced to the Designated Account. IDA will have the right, as reflected in the Financing Agreement, to suspend disbursement of the Funds if reporting requirements are not complied with.

Figure 3. Funds Flow and Reporting Arrangements*



*NB. Advance method of disbursement will apply after settlement of the lapsed loans.

FINANCIAL REPORTING ARRANGEMENTS

11. The RHVP project will submit quarterly interim financial reports (IFRs) in an acceptable format to the Bank within 45 days after the end of each calendar quarter. The report will include: (i) a statement of Sources and Uses of Funds; and (ii) a statement of uses of funds by project activity/component.

12. In addition to the above reports, the MoH will submit to the Bank; (i) Designated Account (DA) Activity Statement; (ii) Designated Account and Project Account Bank Statements; (iii) Summary Statement of DA Expenditures for Contracts subject to Prior Review; and (iv) Summary Statement of DA Expenditures for contracts not subject to Prior Review.

13. The annual financial statements should be prepared in accordance with International Public Sector Accounting Standards (which *inter alia* includes the application of the cash basis of recognition of transactions) for external audit. The IDA Financing Agreement will require the submission of audited financial statements to the Bank within six months after the financial year end.

14. These Financial Statements will comprise of: (i) A Statement of Sources and Uses of Funds / Cash Receipts and Payments; (ii) A Statement of Affairs/ Balance Sheet; (iii) Statement of Fund Balance; (iv) Designated Activity Account Statement; and (v) Notes to the Accounts.

INTERNAL CONTROLS

15. **Internal Controls:** The existing Financial Management Guidelines of January 2011 developed under UHSSP together with the Financial Management Manual (FMM) in the MoH as the Government's Treasury Accounting Instructions 2003 issued under the Public Finance and Accountability Act 2003 have documented the internal controls for the management of this project.

16. **Internal Audit:** The MoH has qualified and experienced internal auditors; (three in number) and will incorporate the RHVP project into the internal audit work plan. The unit will be supervised by the MoFPED under the Commissioner Internal Audit. The VMA will be required to maintain strong internal controls systems to manage the project that will be periodically verified by the MoH, Bank, IVEA and any other authorized agents.

EXTERNAL AUDITING ARRANGEMENTS

17. The Auditor General is primarily responsible for the auditing the project. The audits are done in accordance with International Standards on Auditing. The ToRs for the external audit have been agreed between the Bank and the Ministry. The audit reports that will be required would be submitted by the Ministry of Health within six (6) months after the end of each financial year, i.e. December 31st, given that the accounts will be prepared for the year ended 30th June. The audit report for the year ending June 30, 2013 noted several of the issues reported in the previous report had been resolved. The report, however, was qualified on two accounts: unaccounted for fuel expenditures relating to counterpart funding and unacknowledged tax remittances. The issues were discussed with government and measures agreed on proper documentation and reporting of fuel expenditures and tax remittances.

Financial Management Action Plan

18. The action plan below indicates the actions to be taken for the project to strengthen its financial management system and the dates that they are due to be completed by.

No.	Action	Date Due	Responsibility
1	RHVP audited project Financial Statements submitted by MOH.	December 31 each year	MoH
2	Quarterly IFR	45 days after the end of quarter.	MoH

EFFECTIVENESS CONDITIONS AND FINANCIAL COVENANTS

Effectiveness Conditions

a) The Recipient has appointed the Voucher Management Agency in accordance with the

provisions of the Financing Agreement; and

b) The Recipient has adopted the Operations Manual in accordance with the provisions of the Financing Agreement.

Financial Covenants

19. Financial covenants are the standard ones as stated in the Financing Agreement Schedule 2, Section II (B) on Financial Management, Financial Reports and Audits and Section 4.09 of the General Conditions.

SUPERVISION PLAN

20. A supervision mission will be conducted at least once every year based on the risk assessment of the project to ensure that strong financial management systems are maintained for the project throughout its life. Reviews will be carried out regularly to ensure that expenditures incurred by the project remain eligible for IDA funding. The Implementation Status Report (ISR) will include a financial management rating for the components.

CONCLUSION OF THE ASSESSMENT

21. The above assessment rates financial management risk as Substantial while the mitigated residual risk rating remains Substantial. The proposed action plan on the improvements to be effected to the system are adequate to provide, with reasonable assurance, accurate and timely accounts/information on the status of the Project as required by the Bank and it satisfies the Bank's minimum requirements under OP/BP10.00. The recommended improvements are detailed in the Financial Management Action Plan above.

Annex 6: Procurement Arrangements
UGANDA: Uganda Reproductive Health Voucher Project

Implementation Arrangements and Nature of Procurement

1. The Bank conducted a procurement assessment of the project in April 2013, and overall procurement risk is rated as low. Procurement under the project will be conducted mainly by the Ministry of Health through the Project implementation Support Unit that has been established within the Ministry under the Uganda Health Systems Strengthening project. Key procurement stages will be adjudicated by the Delegated Contracts Committee in the Ministry. The planned major procurements include the Voucher management Agent (VMA) and the Independent Verification Agent.

2. The VMA will be responsible for hiring of voucher service providers throughout the country and paying them against outputs. In order to ensure open participation and equal opportunity for all, the VMA shall publish an invitation in newspapers of wide national circulation inviting interested medical service providers to express interest in participating. The detailed procedures for selection of providers shall be specified in the operational manual. As part of the project, MoH has conducted an assessment of the costing of the different medical packages and established price ceilings to be used as a basis for determining the prices of the different service providers.

Applicable Guidelines

3. Procurement under the Project will follow the *Guidelines: Procurement under IBRD Loans and IDA Credits* (January 2011) and *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 2011).

Procurement Thresholds to be applied in the Procurement Plan

Expenditure Category	Contract Value Threshold (US$)	Procurement Method	Contracts Subject to Prior Review (US$)
Consulting Services[25] and Training	• With firms above US$ 300,000 • With individuals above US$ 100,000 • With firms up to US$ 300,000 • With Individuals up to	• Quality and Cost Based Selection • Individual • Qualifications/Other • Individual	• All contracts • All Contracts • None • None

[25] A shortlist of consultants for services estimated to cost less than US$ 200,000 equivalent per contract may consist entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Expenditure Category	Contract Value Threshold (US$)	Procurement Method	Contracts Subject to Prior Review (US$)
	US$ 100,000		
All types of contracts	• All contracts	• Sole source / direct contracting and terms of reference	• As specified in PP[26]

Procurement Plan and Procurement Packages

Consulting Services

1	2	3	4	5	6
Ref No	**Description of Assignment**	**Estimated Cost (US$)**	**Selection Method**	**Review by Bank (Prior/Post)**	**Expected Proposals Submission Date**
1	Voucher Management Agent (VMA)	3,400,000	QCBS	Prior	30-Oct-14
2	Independent Verification of project outputs and integrity of the processes and systems. (IVEA)	400,000	CQBS	Prior	30-Oct-14

Procurement Risks and Mitigation Measures

4. The Project Implementation Unit in the Ministry of Health was established in 2010 in response to the procurement and project implementation risks identified under the Health Systems Strengthening project. Therefore use of this unit to implement the project already mitigates most of the risks. Further, OBA nature of the project also reduces risks to implementation. The outstanding risks to procurement include the following:

Risk	Action	Timeframe	Responsibility
Inadequate staffing in the Reproductive Health Unit to support procurement and Contract Implementation	Hire a consultant as a Project Technical officer to oversee coordination of the project and take responsibility for	Within 3 months from grant signing	Ministry of Health, UHSSP PIU

[26] Consultancy services estimated to cost below US$ 5,000 equivalent will not be subject to prior review by the Bank subject to their inclusion in the agreed Procurement Plan.

Risk	Action	Timeframe	Responsibility
	contract management		
The VMA agreeing high prices with the Service Providers resulting in overall increase in cost for the services to the project and limiting the number of packages under the project	MoH conducted a survey of prices to establish the average cost and has based on this set a price ceiling to be used in negotiating prices by the VMA. This ceiling shall be reviewed and updated at least once every 2 years	Annual updates	MoH
Delayed claims processing by the VMA resulting in medical service providers losing interest in providing the services	Claims processing system was developed under the predecessor pilot and is to the provided to the selected VMA. IVEA will monitor and report on timeliness of claims processing against benchmark established in VMA ToR	Upon VMA recruitment Quarterly	MoH IVEA, MoH
Payment delays by MoH constraining the services of the VMA and IVEA	To be mitigated under FM by establishment of a performance standard on payments and regular monitoring of adherence to this.	Throughout implementation	MoH
Potential conflict of interest in the event that the selected VMA also operates franchises of service providers that cannot be excluded	In the event of this, the MoH rather than the VMA will take responsibility for negotiating and agreeing rates with the franchisees. IVEA to be required to verify higher proportion of services for such franchisees	Throughout implementation	MoH and IVEA

Frequency of Procurement Supervision

5. Based on the assessment, procurement supervision shall be through 12 monthly supervision missions every year. With all procurement subject to prior review, no post procurement review shall be conducted for the project.

Annex 7. Operational Risk Assessment Framework (ORAF)

UGANDA: Uganda Reproductive Health Voucher Project (P144102)

Project Stakeholder Risks						
Stakeholder Risk	**Rating**	**Low**				
Risk Description: The project comprises many diverse stakeholders who will need a good understanding of the scheme and to work together for its successful implementation. Secondly, there is a growing interest in the use of vouchers in the provision of safe delivery services, which could potentially lead to development of parallel programs running.	**Risk Management:** The MoH has set up an Inter-Agency Coordination Committee bringing together the key stakeholders and charged with the responsibility of coordinating of the parties on the basis of an agreed MoU. The roles and responsibilities of project stakeholders will be clearly described in the operational manual. The VMA will also conduct awareness raising among the beneficiary districts and communities. The project is designed as scalable and replicable program with other partners able to join the scheme in the future.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	In Progress	Preparation	☑		Quarterly
Implementing Agency Risks (including Fiduciary Risks)						
Capacity	**Rating**	**Substantial**				
Risk Description: Uganda has built strong capacity for voucher management and claims processing. Voucher claims processing systems are, however, generally perceived as complex, and need to be able to handle complicated conditions associated with deliveries without causing the tendency to inflate claims. There were challenges of high staff turnover and compliance by providers with reporting requirements in the previous scheme. The project will also involve public providers for the first time.	**Risk Management:** The capacity building component under the project is dedicated to building national capacity for a scaled up voucher national program. The MoH will establish a dedicated team to support public providers and also issue guidelines on payment of bonuses to staff in public facilities. The proprietors of the facilities will be encouraged to better manage and motivate staff. The scheme will only enroll certified providers who will undergo continued medical education and periodic clinical audits to retain their certification status. The claims processing system will remain simple and easy to administer. It will include a pro-active fraud and misuse detection system, with authority and power to put reimbursements immediately on hold in the case of suspected fraud.					

	Claims processing will be monitored for the timeliness as a key project output to ensure adherence to agreed timelines and ensure payment to service providers are processed on a timely and regular basis.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Preparation	☑		Continuous
Governance	**Rating**	**Substantial**				
Risk Description: The project relies on vouchers, and thus there is the potential for distributors to abuse the voucher sales process and for providers to make fraudulent claims.	**Risk Management:** The project design includes the key governance structures (VMA, IVEA etc) and provides adequate safeguards. The voucher design will incorporate sophisticated security, making the vouchers durable and difficult to reproduce fraudulently. In addition, the IVEA will undertake separate QA of the scheme. There is already an effective customized claims processing system with an open management software developed as part of the previous project with capacity to manage and track claims and report project results. The system will continually undergo improvements to enhance capacity for fraud detection, claims tracking and reporting. The service providers will receive training in filling and submitting claims. The agreement with distributors will clearly stipulate their terms of service as well as measures to deter fraudulent activities including the possibility of immediate contract termination.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Preparation	☑		Continuous
Project Risks						
Design	**Rating**	**Moderate**				
Risk Description: The project design is consistent with the OBA principles: reimbursement of claims upon satisfactory verification of outputs; service provider contracts; and allocation of risks to participating entities.	**Risk Management:** Project implementation will follow the agreed OBA principles outlined above. A robust monitoring and evaluation system will be put in place including instituting an independent verification process. The Operational Manual will guide project implementation and providers will be provided with treatment protocols for the					

	different service packages financed under the project.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	In Progress	Preparation	☑		Continuous
Social and Environmental	**Rating**	**Moderate**				
Risk Description: The project will involve handling medical products and thus contribute to increased generation of medical waste in the contracted health facilities.	**Risk Management:** To manage the environmental aspects of medical waste, the project will promote implementation of the National Health Care Waste Management Plan for 2009/2010 – 2011/2012 completed and disclosed under the Uganda Health Systems Strengthening Project. The approved HCWMP (April 13, 2010) will apply to the project throughout the duration of the project, unless agreement is reached to adopt an updated or revised version of the HCWMP. The VMA will be responsible for the implementation of activities designed to prevent and/or mitigate potential negative impacts of waste management. The VMA will engage in awareness raising activities and training of service providers on the treatment of medical waste. In order to isolate harmful waste, service providers will use a three bin system, each with specified color, to ensure proper waste disposal. The Integrated Safeguards Data Sheet approved and disclosed on July 7, 2013.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	In Progress	Preparation	☑		Continuous
Program and Donor	**Rating**	**Low**				
Risk Description: The project brings together cooperating development partners financing the Uganda RH Voucher Program.	**Risk Management:** The cooperating partners will sign a MoU stipulating their respective roles and the modus operandi of their interactions as part of the scheme. They will also be part of the Inter Agency Coordination Committee.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	Not Yet Due	Preparation	☐	31-Dec-2014	

Delivery Monitoring and Sustainability	Rating	Moderate
Risk Description: Service Providers in the previous project experienced difficulties with documentation and reporting of the claims process. Subsidies will require to be sustained over a longer period, and call for longer term commitment by partners and government, especially since the subsidies are targeted to the poor who cannot on their own afford the services. Service Providers will inflate the costs of providing health services under the scheme which will drive overall prices up.	**Risk Management:** The project will operate a robust M+E system and monitor the claims processing system for timeliness to ensure adherence to agreed timelines and ensure payment to service providers are processed on a timely and regular basis. Government is directly contributing funding towards the scheme. The project is designed to be implemented as a partnership, with partners pooling resources and using common implementation arrangements. There will be a focus on building capacity of key national institutions to institutionalize key functions. The health financing strategy under preparation has singled out the use of voucher schemes to target services to the poor and strengthen result orientation of the programs. VMA will be responsible for surveying of provider prices prior to their contracting and ensuring that the prices under the scheme do not exceed 10% of the normal cash prices charged by the providers.	

Resp:	Status:	Stage:	Recurrent:	Due Date:	Frequency:
Client	Not Yet Due	Preparation	☑		Continuous

Overall Risk		
Overall Implementation Risk:	**Rating**	**Moderate**

Risk Description:

Appropriate implementation arrangements are required to meet the challenges posed by the coming on board of public providers and more partners. However, Uganda has built capacity to successfully implement a reproductive health voucher program. Since the new project builds on the previous one, no major challenges are envisaged during project implementation with the exception of public providers who will pose an additional challenge.

Annex 8: Implementation Support Plan
UGANDA: Uganda Reproductive Health Voucher Project

1. **Regular Bank supervision will take place at a minimum frequency of two times per year**. The first year of project implementation will involve intensive supervision in order to ensure there is a sound institutional arrangement for timely initiation of project implementation. Special attention will be given to provider selection and training, voucher distribution and claims processing, financial management, monitoring and evaluation and verification.

2. **The core supervision team will include the following members**: (i) task team leader; (ii) GPOBA Transaction Advisor; (iii) financial management specialist; and (iv) procurement specialist. The Bank once every year will contract a voucher management expert to review the scheme. In addition, the Bank will as needed involve a reproductive health specialist.

3. **The implementation support plan for the project for the first 12 months is summarized in the Table below**.

Table: Implementation support plan for first 12 months

Focus	Skills Needed	Resource Estimate	Partner Role
Technical and procurement review of bidding documents, capacity building	Procurement	4 SW	N/A
FM supervision, technical support, capacity building	FM	4 SW	N/A
Project supervision	TTL GPOBA Transaction Advisor Reproductive Health Specialist	24 SW	Government and other partners funding the voucher scheme are expected to participate
Technical assistance	Voucher Expert	4 weeks	N/A