FAILING TO REACH THE POOREST?

ASSESSMENT OF THE WORLD BANK FUNDED UGANDA REPRODUCTIVE HEALTH VOUCHER PROJECT

REPORT
JULY 2020
FAILING TO REACH THE POOREST?

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The World Bank has lauded voucher schemes as a proof of concept that private actors can and should be involved in working towards universal health coverage. Vouchers have become emblematic of a growing reliance on the use of public funds to finance private sector involvement in health care amidst a public health system struggling to receive the funds it needs. As this report shows, the World Bank and others who advocate for the possible role of for profit entities in extending quality healthcare to poor and rural populations also often fail to consider evidence that has shown that private for profit is unlikely to deliver better health outcomes for the poor people and exacerbates inequalities, resulting in the rich able to access better healthcare and the poor excluded. In fact the World Bank supported Uganda Reproductive Health Voucher Project promoted user fees, despite overwhelming evidence that user fees regardless of how supposedly “nominal” are a barrier to access healthcare, particularly for poor women and ultimately failed to reach the poorest.

This report cautions against employing such Public Private Partnerships as a vague panacea. As the team concluded writing this report, the COVID19 pandemic broke out, resulting in catastrophic number of deaths and countries scrambling to strengthen health systems and institute lock downs. The COVID19 pandemic signals the need for a paradigm shift in health governance. COVID19 has spotlighted the importance of a resilient health sector. To do that we need three things: access to healthcare for all regardless of ability to pay; a strong resilient public health system at home that caters for everyone; and strong preventative mechanisms. This all requires sustainable financing and Government, donors, and lenders working together, deploying maximum available resources to progressively realize the state’s capacity to build and sustain a healthcare system that realizes the right to health and ensures no one is left behind.

To achieve universal health coverage, investing in a quality and equitable public health system should be prioritized—both by the government and donors. The public health system is often the first point of call for the poor and vulnerable. As the response to the Pandemic has shown, the public health system can deliver when there is political will and financing. Government of Uganda and donors should take this opportunity to rethink piecemeal approaches like the vouchers and seize the opportunity to truly transform the health sector. They must ensure any approach undertaken does not heighten inequality in access and perpetuate discrimination. Ensuring the most vulnerable are prioritised is not only necessary from a human rights and public health approach but is sound public policy. Vouchers are not the solution.

Salima Namusobya
Executive Director
ISER appreciates experts, government officials, community members, private sector, donors who generously took time out to speak with the team and assisted in understanding the issues that informed this research.
C-section: Caesarian Section
DHO: District Health Officer
DLT: District League Table
EMHS: Essential Drugs and Health Supplies
FGD: Focus Group Discussion
GoU: Government of Uganda
GPOBA: Global Partnership on Output Based Aid
H/C: Health Centre
HC II: Health Centre Level Two
HC III: Health Centre Level Three
HC IV: Health Centre Level Four
HSDP: Health Sector Development Plan
ISER: Initiative for Social and Economic Rights
JMS: Joint Medical Stores
MoH: Ministry of Health
NDP: National Development Plan
OAG: Office of the Auditor General
PNFP: Private Not for Profit
PPP: Public Private Partnership
STI: Sexually Transmitted Infection
SDG: Sustainable Development Goal
SIDA: Swedish International Development Agency
URHVP: Uganda Reproductive Health Voucher Project
USh: Uganda Shillings
VHT: Village Health Team
VSP: Voucher Service Provider
WB: World Bank
EXECUTIVE SUMMARY

The World Bank funded Uganda Reproductive Health Voucher Project (URHVP) is a form of Public Private Partnership (PPP) whose target is poor women failing to access sexual reproductive health services. For a nominal fee, the mother is given a voucher that entitles her to antenatal care, delivery and post delivery care. The World Bank claims it provides good lessons on how the government can contract with the private providers to deliver reproductive health services to poor women living in underserved areas.”

This research assesses the 17.3 Million USD World Bank supported URHVP, finding it failed to reach the poorest. Some of the key findings include:-

1. From a poverty and vulnerability perspective, the districts and some of the regions the program focused on, for example the western region are not the poorest. Uganda Bureau of Statistics distribution of poverty across regions found Karamoja has the highest concentration of poverty at 60.2%, followed by Elgon (43%), Busoga (37.5%) and Bukedi (35%). The least poor region is the west with Ankole (6.2%) and Kigezi (12.2%).

2. The selection of districts was problematic. Districts that were persistently the worst performing according to the Ministry of Health District League Table, which ranks districts according to health performance indicators, were not included. Among the districts selected for URHVP, all but Buhweju were not among the worst preforming districts. Some of the selected districts like Mitooma and Buyende were already among the top performing districts in health according to government data. Within the areas, the project focused on, they still did not focus on areas where the poor are concentrated, particularly if they are hard to reach.

3. The project left out areas without health facilities despite the fact that they host the poorest and most vulnerable in society. Indigenous minority groups and areas where they are based face higher levels of poverty and multiple levels of vulnerability and should have been a target area. However, according to the project documents, with regard to indigenous peoples, the response was that they often resided in places without facilities able to meet requirements and accordingly could not be focused on.

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4. **Even in areas where the URHVP was present, the vouchers did not reach the poorest mothers.** 68% percent of beneficiaries were either middle class or rich. Only 32% could be classified as poor but even those were not the poorest. Only 29% of the beneficiaries in the Eastern region were poor compared to 33% in the Western region.³

5. **Cost was a significant barrier.** While 4000USh for a voucher seems like a nominal amount, mothers who already struggled to feed their families could not afford it, particularly where poverty levels had risen and people were struggling with failing harvests. In fact by insisting on fee for voucher services, the project promoted health user fees, despite overwhelming evidence that user fees regardless of how supposedly “nominal” are a barrier to accessing healthcare, particularly for poor women. Aside from the cost of the voucher, attendant costs like transport, feeding and other costs hindered women from accessing services. Despite the promise of free services at point of care for voucher beneficiaries, the Office of the Auditor General found 7.2% of beneficiaries on average paid USh.20,050 extra money at the VSP.⁴

6. **Mothers who could have afforded the 4000USh but still relatively poor were often unable to obtain vouchers due to others gaming the systems.** Respondents noted some voucher beneficiaries owned cars. This was attributed to distributors selling vouchers to those who could afford to pay more than the set fee to maximize profit. The Office of the Auditor General found 4.5% of the beneficiary mothers paid more than the prescribed price for the voucher (USh 4,000) spending up to USh.100,000.⁵

7. **There was limited stewardship and involvement of the government in planning and executing the project, particularly local government.** Local government was consulted at a later stage and usually only involved in confirming if a facility selected already operated within the district.

8. **Despite the high consumer satisfaction index touted by the World Bank, there were shortcomings that detrimentally affected quality.** ISER noted facilities with blood caked tools. The Office of the Auditor General found that 30% of facilities visited did not have functional adult resuscitation equipment nor copy of healthcare protocol.⁶ All respondents agreed that if there was any improvement in how patients were handled, it was only for mothers on the vouchers, raising concerns of discrimination.

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9. **The URHVP is partly funded through GoU, and World Bank funds, and these public funds have been diverted towards the private sector, often eschewing public health facilities.** Office of the Auditor General found that in South Western Uganda 74% (90/122) are private and 26% (32/122) are from public sector. Respondents ISER interviewed noted the project initially started with only private but included government as a pilot after pressure. In Bugiri, the government hospital was left off the providers and the bulk of providers were private. In Mbarara, only 3 out of 16 were government. World Bank documents confirm this skew towards private with 56 percent of the 253 health facilities selected private and 44 percent public. While the reasons given were facilities were selected according to quality, some private providers that were just started to take advantage of the project funds, with no history of how they operated or assurance of quality, were awarded contracts. Yet some private providers engaged in unethical practices to secure profit e.g by delaying referrals, poaching patients from public health centres, and preference for C-sections.

10. **Selection of providers raises questions about the efficacy of the project in increasing access, suggesting the program was operating in areas already well served and poor women were less likely to use the service than those already better off.** The fact that the project was provider based, excluded areas without health facilities yet these often hosted the poorest. In contrast, in some places, providers within proximity of each other were selected, for example multiple private facilities within proximity of a public health facility.

11. **The design of the voucher program facilitated commercialization of the project, resulting in exclusion of the poor.** VHTs were told to purchase the vouchers at 2700USh and resell them. The fact that they had to purchase the vouchers incentivized them to sell them to the highest bidder to recoup their investment and make profit.

12. **Poor reimbursement of service providers affecting quality and continuity of services provided.** Private facilities were reimbursed at higher rates than public ones.

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All respondents indicated delays in reimbursements. ISER found it took over 60 days for a number of them. On average, the Office of the Auditor General found Marie Stopes took 50 days to settle claims in breach of the 20 days stipulated. The delay in reimbursements affected service providers’ attitudes towards patients. Some sent away the patients, mistreated them or refused to attend to them, leaving many beneficiaries stranded and scrambling to find alternatives. The Office of the Auditor General found some providers were over reimbursed but there was no evidence of recovery of overpayment, raising questions about whether there was misappropriation of funds.

13. **Limited access to information and participation of beneficiaries.** The Ministry of Health monitored the project to some extent but only met with the District Health Office and did not meet with the purported beneficiaries or members of the communities where the project was implemented. Some beneficiaries were not aware of project ending. The limited information provided and the lack of community participation not only detrimentally affected some beneficiaries but also undermined efforts to ensure accountability and community oversight. The limited participation of the community in the design and implementation of this project raises questions about whether the allocation and design of aid within the health sector is shaped by priorities and the ideological stance of donors rather than purported beneficiaries.

14. **Poor exit planning or ending of the project.** Some of the beneficiaries were not aware of project ending and had bought vouchers that could not be used after the project closed.
15. **Lack of Sustainability.**
A critical shortfall of the World Bank Funded URHVP is the lack of sustainability of this and similar voucher initiatives since they depend on ongoing donor aid, subject to the interests of the donor and with limited government or community ownership. In this project, a number of private providers have or will be closing now that the voucher project ended since their services were already considered too expensive for the communities.

The high project operational costs also raises questions about whom this money ultimately serves and whether such interventions are sustainable. While the expenditures for 2019 are not publicly available, as can be seen from the table below, between 2016-18, close to 50% (48.5%) of the project funds went to operational costs (Voucher Management Agent (Marie Stopes, Independent Evaluation Agent (BDO) and Ministry of Health. In 2016, 66.2% of the funds went to the implementing agency, Marie Stopes.\(^8\)

The high operational costs are not sustainable once the project ends and makes it difficult to scale it to cover the entire country. This money could have been channeled to finance the public health system to benefit more people.

16. **Amidst a backdrop of insufficient investment in the health sector, the project, which favored private health facilities as service providers, raises questions about whether this is the most effective use of money.** There are concerns that it weakens the public health system and perpetuates discrimination. ISER’s prior five-year analysis of health budgets found significant shortfalls in financing the public health system with budget as a percentage of total government expenditure hovering between 6-9%.\(^9\) Current financing only covers 30% of what is needed according the costed Health Sector Development Plan budget.\(^10\) All respondents noted fixing the public health system would help more people and was a more sustainable solution.

17. **COVID 19 has reinforced the need to focus on public health systems.** Management of COVID patients has taken place in public health facilities and the long term success of the country’s COVID response will depend on the resilience of its public health systems, which are often first point of call for the poor. Piecemeal market based approaches like vouchers are not the most effective use of state funds.

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\(^8\) ISER's compilation from the Auditor General's Reports on the Financial Statements of the Uganda Reproductive Health Voucher Project (URHVP) for the Financial Years starting 2015/16 – 2018. See also infra Table 3


This report makes the following recommendations

**Government**

1. **Address the gaps in the public health system, particularly the following:**
   - Increase financing of the public health system, focusing on poor and geographically remote and hard to reach areas. This is in line with World Health Assembly resolution of 2005 on UHC and sustainable health financing and as well as revisiting the Paris Declaration that calls for greater Investments in the Health Sector and Social Health Insurance and Financing.
   - Have a functional referral system. The Uganda National Ambulance Service established in 2014 by Ministry of Health has been chronically underfunded. As COVID 19 has revealed, ambulances and functional referral systems should be prioritized to ensure everyone can easily access healthcare when they need it.
   - Increase staffing. In 2016/17, absence of critical human resource was a cause of 18% of maternal deaths. This should include prioritising staff accommodation at health centres.

2. **Institute a National Health Insurance Scheme that covers all persons, particularly cover the poor and the most vulnerable from the onset.**

3. **Provide government stewardship.** Limited government stewardship causes gaps in regulation, detrimentally affecting the poor. Donors’ setting the agenda is problematic from a governance perspective, resulting in uncoordinated approaches to implementation, duplication and leaving out the most vulnerable.

4. **Government should rethink the use of PPPs as a model for health service delivery** given the high costs of implementation, yet there is no guarantee that they will serve the poor. There is also evidence that they are not sustainable and there is no guarantee of quality.

5. **When PPPs must be used, it should be as a last resort and there should be detailed regulatory framework for PPPs.** This includes regulating private actors and putting in place measures to ensure vulnerable groups are not detrimentally impacted, harmonizing indicators and benchmarks with Health Sector quality improvement framework and strategic plan 2015/16–2019/20, monitoring, ensuring access to information.

6. **Consult with affected communities or their representatives.** Consultation with communities before and during interventions makes sure the response chosen is meeting their needs.

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7. Rethink the use of vouchers as a model for health service delivery, particularly where they involve cost sharing – which has been found to leave out the poorest.

**Donors**

1. Finance the public health system according to the plans set out by the GoU to avoid duplication of resources and to ensure financing goes towards the most vulnerable.

2. Refrain from conditionalities that directly or indirectly promote privatization of the health sector. For example requiring private actor involvement as pre-condition to providing funds.

3. Enable independent and participatory evaluation of projects you have funded and critically assess the PPP and Voucher models of health service delivery as there is no evidence that they result in better results than an adequately resourced public health system in contributing to UHC.

4. Consult with affected groups and leaders and provide platforms for meaningful participation before designing the projects. Consultation should be before, during and after project cycle.

5. Ensure programs designed and implemented with your support will help the most vulnerable by exercising due diligence including conducting human rights impact assessments. The gaps revealed in the Voucher Project and the failure to reach the poorest were apparent right from the design of the project.

6. Ensure policy processes are transparent including ensuring access to information.

**For community and advocacy organizations**

1. Demand for the Government and donors to invest in quality public health care.

2. Be wary of Public Private Partnership in Health (PPPH) proposals that do not shift resources toward remote areas where the human rights situations are most dire or those that utilize public resources yet do not serve poor and marginalized groups.

3. Demand access to information through access to information requests and other strategies to ensure meaningful participation.
INTRODUCTION

Vouchers are a demand-side financing mechanism by design. Borrowed from the education sector for which vouchers were initially designed, they were seen as an alternative to place purchasing power in the hands of the consumer. The theoretical context of the voucher mechanism is found in the basic economics theories of supply and demand, aiming to use market mechanisms to efficiently subsidize health services for individuals.

The issue of demand side financing in healthcare is increasingly contested. Proponents of demand side financing have argued that public health systems do not deliver desired outcomes due to the lack of efficiency, quality and questioned whether they should be maintained through significant taxation. Since the early 2000s, there has been a shift towards Output Based Aid and Public Private Partnerships including the use of vouchers. The World Bank has also used Output Based Aid (OBA), which combines consumer led, and provider led demand side financing mechanism. Key donors including the World Bank, Bill and Melinda Gates Foundation, UK Department for International Development (DFID) have supported the use of public private partnerships to address sexual reproductive health, and as important financing mechanisms to achieve SDG 17.3 and the Addis Ababa Declaration of the Third United Nations Financing for Development Summit, July 2015. Proponents have posited that voucher schemes may be one of the ways to achieve the provision of the essential services to the less privileged because they are likely to stimulate demand of priority health services among the underprivileged through channeling subsidies from government or donors in a form of PPP.

In the voucher PPP arrangement, the private sector provides services purchased by the public sector with donor assistance. Accordingly a voucher scheme is one whose objective is to utilise the large but unregulated private sector by incentivizing providers to deliver key health services to make them affordable. Initially maternal health services seemed great for such arrangements because they had a well defined time period, evidence base for package requirements and predictable typical costs that the private sector could seek reimbursement for, like child birth.

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13 Ibid
14 Rebecca Njuki, Timothy Abuya, James Kimani, Lucy Kanya, Allan Korongo, Collins Mukanya, Piet Bracke, Ben Bellows, and Charlotte E. Warren; Does a voucher program improve reproductive health service delivery and access in Kenya? At https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4443655/ (last accessed 30 June 2020)
16 Voucher Schemes for Sexual and Reproductive Health Services: A Marie Stopes International (MSI) Perspective (last accessed 30 June 2020)
A voucher scheme will have four core actors/components: the funders, the voucher management agency, providers of a health care service and voucher recipients. Each of these plays a very vital role as the government or donor gives funds and in conjunction with a governance structure contracts a voucher management agency whose role is to target populations, identify service providers, contract the providers and conduct marketing and voucher distribution to the target population at a subsidized price. These subsidies go directly to the consumer in the form of a voucher – a certificate, coupon or other token – which the consumer exchanges for the specified goods or services from an accredited or approved health facility (public or private). The provider then claims payment for services provided. To be accredited, facilities must meet certain standards such as having running water, laboratory capacity, electricity amongst others.\textsuperscript{17}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{voucher_schemes.png}
\caption{Structure of Voucher Schemes}
\end{figure}

In Uganda, there have been at least two voucher supported programs by the World Bank and others by actors like USAID,\textsuperscript{18} MSU,\textsuperscript{19} all costing millions of USD.

The World Bank funded Uganda Reproductive Health Voucher Project (URHVP) is a form of Public Private Partnership (PPP) whose target is poor women failing to access sexual reproductive health services. The Project is funded by the World Bank and the Swedish International Development Agency through Global Partnership on Output Based Aid, which extended a grant of 13.3 million USD to Uganda to implement it. This coupled with additions from UNFPA and Government of Uganda (The Ministry of Health under Uganda Health Systems Strengthening Project (UHSSP) provided USD $3,058,950\textsuperscript{20}) resulted in availing USD 17.3 Million USD to deliver the Uganda Reproductive Health Voucher Project.

\textsuperscript{18} Saving Mothers Giving Life Project,31 million USD IN Western Uganda from January to December 2012
\textsuperscript{19} Family Planning Long Term Methods Project, 10 million USD from USAID to implement family planning countrywide; Strides for Family Health Project funded by USAID with vouchers in central districts.
\textsuperscript{20} Okuny, Michael Eriu, 2019. AG Report on the Fin Statements of URHVP GPOBA TF015995 For the Year Ended June 30,2018 at p.17 (last accessed 30 June 2020)
The Government offers tax inclusive procurement. Government pays the tax for any import done with donor funds.\textsuperscript{21}

This Public Private Partnership between the government and private provider sought to aid poor women who face challenges “accessing safe delivery services,” noting that in addition to geographical barriers, women face significant financial barriers.\textsuperscript{22} The project sought to “mainstream and scale up” implementation of safe delivery voucher systems in the health sector. The World Bank claims it provides good lessons on how the government can contract with the private providers to deliver reproductive health services to poor women living in under served areas.”\textsuperscript{23} After paying 4000USh, a mother is given a voucher that entitles her to a predefined package of four antenatal visits, safe delivery (normal/caesarean) and one post delivery visit.\textsuperscript{24} To implement the project, Marie Stopes was selected as the voucher management agent and would handle selection of providers, review work plans, process and approve claims provide reimbursement. An independent evaluation agency, BDO, would carry out the auditing and accounting and assist in the evaluation of the program. The Ministry of Health was supposed to coordinate the program and provide overall coordination.

\textbf{Fig. 2 Structure of Uganda Reproductive Health Voucher project}

Independent evaluation Agency, BDO

\textsuperscript{21} Interview with Ministry of Health Official; Interview with World Bank Official
URHVP targeted 25 districts in the eastern and western part of the country: Kiruhura, Mbarara (this has now been split into Mbarara and Rwamgara), Ibanda, Sheema, Buhweju, Rubirizi, Mitooma, Isingiro, Ntungamo, Kabale, Kanungu, Jinja, Kamuli, Buyende, Luuka, Iganga, Mayuge, Kaliro, Namutumba, Namayingo, Bugiri, Kibuku, Tororo and Busia. There were 253 health facilities contracted (125 health facilities in Eastern Uganda and 128 in South Western Uganda). It followed up on the earlier reproductive health voucher project also funded by the World Bank, which focused exclusively on private service providers and also provided services to combat STIs.

URHVP was heralded as a success in Uganda. Marie Stopes website currently praises the project for having strengthened the health system, enhanced transparency and accountability and strengthening referral systems. The World Bank documents indicate that the project provides “good lessons on how the government can contract with the private providers to deliver reproductive health services to poor women living in underserved areas.” The project should have closed on 29 December 2017 but it was extended for two more years and closed on 15 December 2019.

ISER conducted field research in November 2019 assessing the project from a human rights perspective. This research follows up on initial research conducted in 2018 and early 2019 on Public Private Partnerships in Health which featured this voucher program.


The team conducted field research in randomly selected districts in eastern and western Uganda where the program is implemented. In the eastern region, the team conducted research in Iganga, Bugiri, and Tororo. In the West, the team visited Mitooma, Mbarara, and Rwampara.

**Key Informant Interviews and Focus Group Discussions**

The team conducted key informant interviews with district officials, beneficiaries, community leaders, healthcare providers and project implementers. Key informants were selected based on their direct involvement in the planning, management, formulation and delivery of services in the voucher scheme and in the districts. Focus Group Discussions were held with community members and beneficiaries of the scheme.

**Random Sampling of Health Centres in the Program**

The team visited a random sampling of healthcare centres enrolled on the program in the districts. In the eastern region, the team visited implementing facilities in Iganga district, Bugiri, Tororo. In Iganga, Iganga Hospital, Namungalwe HC III, Mercy Clinic, New Hope (closed), Nambale HC III, Mwebaza Clinic (closed), St. Peters Clever – PNFP, Nakalama Domiciliary. In Tororo, the scheme was implemented at Malaba HC III; Tororo General Hospital; Iyolwa HC III; Merikit HC III; Osukuru HC III; Nangongera HC III; Kwapa HC III; Divine Mercy clinic (private); Papoa HC (Private); Mifumi HC III (private); Mukuju HC IV in Mukuju sub-county; Pison HC III which is in the poorest areas. In Bugiri, it was implemented at Fastline Medical Centre, Bwungo HC III, Nakalama HC IV, Polycare Clinic.

In the Western region, the team visited Mitooma, Mbarara and Rwampara district formerly part of Mbarara district. In Mitooma, the scheme was implemented at Mitooma Health Centre IV, Kati Trinity Health Centre, Nyakatsiro Health Centre III (PNFP), Tumusiime Health Centre, Ishaka hospital. With the exception of Mitooma Health Centre IV, the rest were private. Mitooma District lacks a district hospital. In Mbarara, which has since been split into two districts: Mbarara and Rwampara, the program was implemented in 12 private health centres, 3 government facilities and one private not for profit (PNFP) public private partnership.

These included the following: Mission hospital (PNFP); Mayanja memorial; Mbarara Community hospital; Bwizibwera HC IV; Bugamba HC IV; Kinoni HC IV; Cathy Medical clinic; Nyeihanga community medical ; Angella Domiciliary clinic; Sheema clinic; DIISI medical center.

**Observation**

Eyewitness details were recorded during visits to health centers that were part of the program. Notes were taken by the fact finding team highlighting the state of physical infrastructure, the facilities available at selected health centres, the general out look of the health facility, water and sanitation facilities, drug storage facilities, availability of latrines, electrification and lighting, among others.
Research Literature Review

Literature was reviewed to further contextualize observations and provide grounds for analysis of the team’s findings. Resources consulted during the review included, among others, the following: Publicly searchable archives of Ministry of Health communications and policy documents; Marie Stopes documents, Office of the Auditor General, World Bank, Ministry of Finance, Planning and Economic Development.

**FINDINGS**

1. **Limited Stewardship and Involvement Of The Government In Planning And Executing The Project.**

There was limited involvement of government officials, particularly local government in the planning, implementation and monitoring of the project. Technically the government was involved since the Ministry of Health signed a Memorandum of Understanding (MOU) with the Voucher Implementing Agency, Marie Stopes. However, the money initially all went to the implementing agency, Marie Stopes. This was later changed to have the money go directly to the Ministry which would then approve for it to be paid to Marie Stopes.

> Originally the funding was coming directly from the donor to Marie Stopes, but we have a contract, it is a running contract between us and the ministry. If you look at the voucher project it is a $17 million dollar project. Out of the 17 million dollars, 3 million are government contributions. UNFP has one million so the rest are SIDA and WB. It’s beneficial because originally the vouchers were 100% of the funding. The government puts in some money so that it will also be responsible. Right now, all the money goes through the ministry and then to Marie Stopes.”
> Paul Nyombi, Director of Programs, Marie Stopes

The Inter-agency coordination committee was never formulated and no evidence of reviews or approvals made. The project used different indicators from the Ministry of Health’s indicators in the Health Sector quality improvement framework and strategic plan 2015/16 – 2019/20 so data could not be properly assessed. For example its indicators were mostly outputs e.g. number of vouchers distributed; number of deliveries by skilled personnel. The indicators lacked baseline data.

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31 Office of the Auditor General (2018) Report of the Auditor General To Parliament for the Financial Year Ended 30 June 2018; Global Partnership on Output Based Aid Grant Agreement between Republic of Uganda and International Development Association (acting as Administrator of the Global Partnership on Output Based Aid, December 18, 2014 GPOBA Grant Number TFO15996 (on file with author);
This was also pointed out during the annual government audit by the Office of the Auditor General who noted the failure to harmonise indicators impeded service providers reporting on outcomes, thereby limiting Ministry’s ability to truly assess the project.

The Ministry of Health monitored the project to some extent but only met with the District Health Office and did not meet with the purported beneficiaries or members of the communities where the project was implemented.34

“\textit{The MOH monitors but they are not very effective here. They give us support in the different areas but they are also complaining of resources. The project worked with both private and public facilities.}” DHO

Local government officials interviewed indicated they were barely involved in planning or selecting providers beyond confirming whether or not the health providers selected operated in the district.

“It was hatched by Marie Stopes unilaterally. They introduced it to us with the details; that there will be a voucher which we shall be selling to mothers at this much so that the community contributes and owns.” DHO

“The only involvement we had was to approve that the health centers were in our district. If we were very much involved in it, we would be selecting the health centers but it was advertised in the papers and people made applications and they selected themselves there. It was not the DHO’s office that selected the facilities. Marie Stopes made those decisions and we were not part of it. I, for example, do not know why the prices are different for services provided in public verses private facilities.” DHO

“At the district, we were not given a chance to choose who would be in the project. We were only recommending. People applied except for the public HC IVs which were just given apart from the municipal HC IV.” Assistant DHO

34 Interview with Ministry of Health Official
The monitoring was left to Marie Stopes but that only happened at facility level upwards.

“The project was under our docket but it was being supervised by Marie Stopes themselves. They were working closely and directly with the facilities.” Assistant DHO

“Marie Stopes used to call meetings but I was still in Hospital by then. They would call once in a while and maternity was involved. They would call for meetings, air out their grievances. I cannot tell how often the meetings were. It is Marie Stopes that would call for meetings and it would manage their thing.” Assistant DHO

“It was upon the district to devise means to monitor and supervise the facilities. I saw the former assistant DHO when she came to the government facility. I do not know about the other facilities.” Private Provider

“Monitoring was abrupt. But when they could come officially, I would receive a communication. Sometimes, they would come and drop a mother from the field and check the facility. The only scheduled visits were for reconciliation of claims.” Administrator, Private provider

Rather than work with local government to identify some of the most vulnerable districts and extremely poor communities, the lack of coordinated government involvement led to a haphazard approach that resulted in exclusion of the poorest as we will see below.

II. Failed To Reach Poorest

Going by the project indicators used by the World Bank, on the one hand, access to health services for pregnant mothers temporarily increased. 71% of vouchers were distributed and redeemed for deliveries during the project duration. However the increase in access was not equitable. They failed to reach the poorest. Although the project development objective was to increase access to skilled care for pregnant women living in disadvantaged areas, the Office of the Auditor General found that only 32% of the mothers reached could be classified as poor while remaining 68% were classified as medium or rich. The Eastern region was most affected with only 29% of the beneficiaries poor compared to 33% in the Western region.

This echoes findings by the research team, which found significant flaws in project design and implementation that prevented the project from reaching the poor and vulnerable.

**The selection of districts was problematic.** Districts that were persistently the worst performing according to the Ministry of Health District League Table, which ranks districts according to health performance indicators, were not included. Between 2012/13-2016/17, the northern region is the worst performing with a number of districts continuously in the bottom 10 and hard to reach: Amudat, Kaabong, Moroto, Adjumani, Nakapiripirit, Napak, Ntoroko, Kotido, Kobok, Moyo, Yumbe. Others in the bottom 10 worst performing over the last six years include Kween, Amuria. Those in the east ranked in the bottom 10 include Luuka, Budaka, Kakumiro, Buliisa, Bulambuli, Bukomansimbi, Sironko. In the central, Buvuma, Sembabule, Wakiso. In the west, it is only Buhweju that featured in the worst ten performing districts over that period of time. In 2015, Kisoro also featured. Aside from Buhweju, none of the other 24 selected districts in URHVP were among the worst performing districts in health between 2012/13-2016/17. Districts selected for URHVP like Mitooma, Buyende were among the top ten districts in the District League Table and Iganga ranked 13th in FY 2015/16 at the program inception. This raises questions about the criteria used to select districts.

Similarly from a poverty and vulnerability perspective, some of the regions the program focused on, for example the western region, are not among the poorest. Uganda Bureau of Statistics distribution of poverty across regions found Karamoja has the highest concentration of poverty at 60.2%, followed by Elgon (43%), Busoga (37.5%) and Bukedi (35%). The least poor region is the west with Ankole (6.2%) and Kigezi (12.2%).

“If it was not focused on hard to reach. I am not very familiar on criteria for selection of beneficiary areas and populations.” World Bank Official

If the project had not focused on regions, indigenous minority groups and areas where they are based face higher levels of poverty and multiple levels of vulnerability and should have been a target area. However, according to the project documents, with regard to indigenous peoples, the response was that they often resided in places without facilities able to meet requirements and accordingly could not be focused on:

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Within the areas, the project focused on, they still did not focus on areas where the poor are concentrated. In Iganga district, one of the selected districts in the east, the poorest areas are Nawandala and Nabitende sub counties. In Nawandala, Mwira, Nakalama. Buseyi Parish, Bukaye, Bulamagi sub counties, people walk more than 5km to access the nearest health facility. None of these have voucher programs. In Namungalwe, Iganga district, only 3 of the 10 women in a focus group discussion had heard of the vouchers. The vouchers were instead predominantly available in the town areas like Iganga town council.

In Tororo, the villages considered more vulnerable, where the poor predominantly would be found include Fungwe village–Iyolwa Sub county; Paya village–Paya sub-county; Amuro village–Merikit sub-county; Akarabayi village–Kalait sub-county. None of those areas have the voucher system. The health centres are often far from the populace. From Amuro to Merikit, it is USh 3,000 for a single journey on a motorcycle. Others are more expensive.

In Bugiri, the vouchers were offered at predominantly private facilities and did not include Bugiri hospital where the poorest are referred when there are complications.

“Voucher schemes are ‘provider-led’, i.e., there must be facilities in the area able to provide the contracted services. The IPs in Uganda reside in areas where facilities with the capability to provide comprehensive emergency are lacking. The issue here is not about population characteristics but the fact that there are no facilities that can be contracted to provide services.”  


Interview with District Health Office,
In Mitooma, they did not reach the poor in hard to reach areas like Kanyabwanga, Bitereko, Kiyanga, Mayanga, Nyakizina, Rwengerero in Katunda, Rwabiragara villages, Kibingo and Rwakaruku. Reaching people in these areas who face barriers due to poverty, which is compounded by the hilly terrain and impassable roads during the rain season, would have been more impactful. In Mitooma, it was implemented at Mitooma HC IV, Kati Trinity Health Centre (level HC III), Nyakatsiro HC III, Tumusiime Health Centre, Ishaka hospital. With the exception of Mitooma HC IV and Nyakatsiro HC III, the rest were private. In Mbarara, they were predominantly available in the town areas where people were employed or owned land and were often not where the poorest were found.

**Even in areas where the vouchers were present, they did not reach the poorest mothers. Cost was a significant barrier.** The rationale for the cost often repeated among those involved in implementing the program was “people only value what they pay for.” While 4000 USH seems like a nominal amount, mothers who struggled to afford food could not afford it, particularly in regions like the East where poverty levels had risen and were facing failing harvests. There did not seem to be exemptions for vulnerable groups, for example, poor women with disabilities.

“The cards have not helped every vulnerable mother. Those villages I have mentioned have many vulnerable mothers. The project has not met its target.” VHT, Rwampara

“When you look at the community, there is not much income. They get money from digging and maize. The women also do the digging. They dig on their husbands’ land. Some of the women are educated, some stopped in primary school, some in secondary while others are not educated. This is a small town so most people depend on digging. Harvest season is coming; so they will have some money. In the first season, the people made a loss. Even this season, the rains were so much and the crops were destroyed so the people do not have crops even food. There are some places like Namutumba side where people’s crops were destroyed. In Budaya, there was so much rain, also in Bugiri and in Nabukalu.” Health worker, Bugiri

“I heard about the voucher system from my neighbor who used to use it. I did not use the voucher card because I had no money.” Mother, Iganga district
The length of time it takes poor mothers to save or work to afford the voucher can have detrimental impact on their ability to receive services like ANC. While mothers should attend their first ANC within 3 months of pregnancy, the Office of the Auditor General found that there were cases of delayed attendance of the first ANC, with “more mothers in the Eastern region attending their first ANC very late in their pregnancy compared to the Western region.”

Even for mothers who could have afforded the 4000USh, the failure to institute systems to identify the poorest led to others gaming the systems. All respondents indicated that some people who should not be beneficiaries and could not be considered poor were able to access the vouchers, resulting in vouchers running out for the mothers who genuinely needed them.

“Sometimes you would find that those who can afford to pay would also have a voucher yet she is able. Someone who does not deserve a voucher would be the one to come with it. Someone driving would also come with a voucher and say here is my voucher. Really is that for such a woman? Yet the voucher was meant to be for the poorest. The VHT would say that for them they want to sell and if the poor one does not have the money, they would sell to … you know.” District Health Officer

Sometimes they were sold by VHTs and other times by scrupulous health workers as one mother noted:

“The Office of the Auditor General found that 4.5% of the beneficiary mothers paid more than the prescribed price for the voucher (USh 4,000) spending up to USh.100,000.”

“I heard about the card from Kati clinic. I dug in someone’s garden to get the money. In 2018, I was two months pregnant and I got the card. Nowadays those who want the voucher cards pay some money and they get them. They pay like USh 50,000.” Woman, FGD, Mitooma District

The MOU between service providers and Marie Stopes required them to notify the voucher management agent of any abuses of the system especially by voucher beneficiaries that do not deserve services. However, health workers noted that even when they noticed that the person who came with a voucher was above the targeted social economic strata, they did not intervene since it was not their role, but that of VHTs.

All respondents indicated that some people who should not be beneficiaries and could not be considered poor were able to access the vouchers, resulting in vouchers running out for the mothers who genuinely needed them.


Clause 4.16, Memorandum of Understanding
“The people used to come from far so it was hard for me to ascertain that the patient was doing well and did not deserve a voucher card. This was for the VHT. Some of the VHTs in towns used to sell the voucher cards at USh 10,000. There were situations in town where well to do women came with the cards.” Health Worker, Tororo

“For us when the mothers come here, we do not know who is poor or not for them to use a voucher. Once a mother comes with a voucher, we were working on her. We know that she has already passed the interview. It is the VHT who know the status of the mothers.” Private Healthcare Provider, Bugiri

“But sometimes the health workers would confiscate them. If they assess an able person they would say that much as you have the card, it was not meant for you and they would not register that one under the voucher system. This depended on the health workers not being very busy and also being vigilant.” District Health Officer

Marie Stopes worked with VHTs to come up with criteria to identify the poor (means testing), asking questions for example whether they sleep in a house with iron sheets, solar panels, do they have cows, goats, land they own. It was hoped that using VHTs who know the communities would enable them to identify the poorest.

“I had a poverty Grading Tool which I would use to see which mothers I should sell the cards to. We had marks. If the person exceeded 9 marks or 12, I was not supposed to sell to them the card. I faced a challenge of transport since the government facilities were not enrolled in the system. Going to see the mothers was a challenge. I had to reach the mothers’ homes. I was not supposed to sell the cards from the facility. I was in town and so I did not find so many women who were very poor. The Doctor at the facility at some point started buying for us the cards so that we could give them to a poor mother but to get a very poor woman, one had to go very far in the village. I had to spend USh 10,000 to reach a faraway village yet I was to sell the card at USh 4,000. I know that most of the mothers who got the voucher cards are not the most vulnerable. Money is the issue. I think that the catchment area should be removed because if I move within 5km, it is difficult to meet the poor people. In town, they should remove the restriction. In the villages, it is very deep for example Lwanika village costs USh 8,000 to and fro. Most people in the villages have boda bodas so they take me and bring me back. In 2017, I found a mother deep in the village that had many children and she was too poor. I still had to sell to her the voucher card.” VHT
“The VHTs also have screening score sheets that they were using to assess the mothers. Not everyone who wanted a voucher card got one. The VHTs were meant to visit these women’s homes and ask them some questions but sometimes they were not going there.” Proprietor of Private Facility, Iganga district

In one Focus Group Discussion, it was observed only one of thirteen voucher beneficiaries lived in a grass-thatched house. Others resided in houses with iron sheets, often an indicator of a higher income strata according to their criteria.

Despite the Voucher fraud protocol prohibiting voucher service workers from voucher distributor recruitment, private providers offered patients who came to see them the vouchers without even undertaking poverty assessments. They did this, hoping to recoup the investment from the reimbursed costs, particularly for C-sections that were reimbursed highest among services offered.

“I was six months pregnant in May, 2018 when I went to Nankoma HC III and a health worker gave me a voucher and I was told that I would be treated for free. I was required to give money.” Beneficiary

“We use this as a catch because it does not cost me much to lose USh 5,000 when I know that women are going to deliver and will come and give me USh 150,000 or USh 400,000 for cesarean section.” Health Provider

Even Marie Stopes acknowledged that there were some gaps in reaching the extreme poor, noting they found a leakage of like 2% where people aren't really poor. This failure to reach the poorest due to flaws in the design and implementation negated the proposed impact of the project.

Fig. 3: House of a poor family in Mitooma that was not on the voucher program because they could not afford the voucher.

47 Annex: 7 (on file with author)
48 Interview with Marie Stopes Official, February 21, 2019
High Out Of Pocket Costs Incurred By Poor Mothers

Mothers who managed to scrap together the 4000 USh found themselves with additional costs they were not prepared for and could not afford.

“I had a voucher card but when I needed to go into the scan at Mayanja Memorial, they told me that I had to pay USh 25,000. I was told that even after giving birth, I was supposed to pay for the medicines I had used; it was USh 100,000. I paid this money through the help I got from some relatives.” Mother, Mbarara

“I know of mothers who were on the voucher card and they were referred to Tororo and they paid money. One paid USh 100,000. Another mother was operated from the HC IV while delivering and she had to pay USh 250,000.” VHT, Tororo.

“Even the people who register us ask for money USh 3,000 to write in the patients’ books.” Community member

“Marie Stopes should continue to include mama kits at Dr. Isabirye’s [Fastline Medical Centre] since they ask us for USh 20,000 for the mama kits.” Beneficiary Mother, Bugiri

These findings were corroborated by the 2019 report of the Office of the Auditor General to Parliament\(^49\), which found that although beneficiaries were supposed to access the services for free, 7.2% of them paid on average USh 20,050 extra money at the voucher service provider.

Some procedures were not covered.

“There was also another challenge and it was not clear in the MoU about the position of a mother who delivers under elective scissor. There was a question whether such a woman could get a card or not. The project stated that she was not supposed to get a card yet there’s also a situation where such a woman cannot afford the delivery services. There were vouchers that we would submit and they were not paid because they were elective scissors. This was a challenge and they said that that woman on elective should be able to prepare herself.” Administrator, Private Healthcare Provider

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“Some mothers would deliver and we had to wrap their babies in curtains. It would reach that level. For the mama kits, if we assessed and saw that a mother was well off, we’d remove the towel from her kit and keep it for another mother who would come with nothing which was also not good. A voucher mother was entitled to a mama kit but Marie Stopes was not supplying any other items. It was upon the service provider to avail those things to the mother. I used to buy second hand bed sheets and cut them into pieces that I used to give a pair to each mother to motivate them to join the program. I would not get reimbursed for buying the bed sheets and I could not give them to every mother.” Private Provider, Iganga

“You need to have a lot of resources, to the extent that these mothers come with their attendants and they tell you that they do not have food yet they have come for services and I need to foot those bills because you cannot treat someone who is not feeding. The person has attendants who have been here for a full week. Marie Stopes would not cover for the meals, they would cover the medical part.” Private Provider

“There are people who are poor but there are some who are very badly off. These should be given transport and something to eat. For example a mother may produce from and she does not have anything to eat. They should provide for such a mother what to eat. This should be included in the voucher.” VHT, Rwampara

“Some of the mothers used to come with totally nothing, no money for scan then we would call Marie Stopes and get a reference number. She would also come with no clothes for the baby then the nursing director would collect some money from the staff. I would also provide the mothers with porridge, and the administration used to give us some sugar. There was nothing for a mother who would give birth on a c-section. Marie Stopes should have a welfare team in place.” Private Healthcare Provider

Transport to the facility was a barrier for many mothers. URHVP only covered transport for referrals within facilities. The mother had to incur transportation costs from her home to the facility and back to her home and for the poor this posed challenges. For example in Mitooma, a number of Health Centre IIIs close to the population were not on the program. Nyakatsiro HC III was the only government HC III. The other private facilities were not situated in hard to reach areas like Kati, Kiyanga so mothers from those areas would have to incur their own costs to get to the facility on the voucher and Marie Stopes would only reimburse referral from the facility on their program.
According to the Ministry of Health data from Maternal and Prenatal Death Reports, transport from home to the facility was a major delay factor that contributed to maternal mortality and comprised 42% of cases in both 2014/15 and 2015/16 and rose to 45% in 2016/17.\(^{50}\)

The transport costs and their detrimental impact on access even for those who got the vouchers had been pointed out during an evaluation of an earlier World Bank Funded voucher program in western Uganda that had preceded and informed the current voucher project. It had found that over a third of women who bought the vouchers did not utilize them due to long distance to health facilities, high transport costs and among others. It recommended “other factors that influence use of delivery services should be taken into consideration in project design.”\(^{51}\)

Despite this prior recommendation, the URHVP project failed to take into account these costs and to adequately communicate its inability to assist with these costs to mothers who bought the vouchers on the assumption that everything would be covered. This left many mothers unprepared and struggling to cover these additional costs.


The World Bank has been a strong proponent of supporting the private sector, arguing doing so would strengthen the health system. Its prior voucher program on reproductive health and sexually transmitted diseases in Western Uganda from 2008-2012 had only used private providers. Respondents indicated there was a bias in selecting private facilities over public facilities. World Bank documents confirm this skew towards private with 56 percent of the 253 health facilities selected private and 44 percent public.

Initially the voucher program predominantly had private providers only later accepting public providers as a result of pressure by politicians.

“Private facilities were more than government. Public facilities were few.” Assistant DHO.

“Marie Stopes in the beginning did the assessment and gave mostly to private for profit facilities. I realised when I was at the HC III that mothers get services at the HC IIIs but at the time of delivery, they go to private.” DHO.

“The voucher project started with private then it went to the government facilities because the previous project was in private. The government was more of a pilot project.” Assistant DHO.

In Mbarara and Rwampara, of the 16 health facilities on the voucher program, 12 were private health centres, one private not for profit (PNFP) public private partnership and only 3 government facilities which were all Health Centre IVs. The Office of the Auditor General found that in South Western Uganda, 74% (90/122) of facilities are private and 26% (32/122) are from public sector.

In Bugiri, the government hospital was left off the providers and the bulk of providers were private. Instead a private facility, ironically owned by the medical superintendent of the government Bugiri hospital and located within proximity to the Bugiri Hospital, was selected as the highest referral facility on the URHVP in the district. While the reasons given were quality, private providers that had started with no history of how they operated or assurance of quality were awarded contracts.

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53 Marie Stopes had criteria to select providers including whether the facility has a designated area for drugs; Laboratory; Clinician; Placenta pit; Qualified personnel.
For example a private provider told the research team that she had heard that they were going to implement the scheme and quickly asked a VHT to find her shops in a trading centre that she converted into a clinic, quickly buying equipment and hiring a midwife. She got everything ready just before inspection day.

“For I heard of the project, I had to quickly put up the structure and we entered an MoU with the landlord of the building. When Marie Stopes came, they were really impressed. I had qualified personnel and I hired more for the project. I am now going to close the clinic totally because I cannot afford to maintain the building if people are not coming for the services. I have been renting and I have been here for four years since the project started.” Private Healthcare provider

Focusing on private providers was also problematic given the inherent profit motive was the underlying motivation for private healthcare providers.

“The biggest challenge for us in the private sector is the cost of managing health centers. We generate our own resources to pay worker’s salaries. Recently, the government increased the salaries for its health workers and this makes it difficult for us. We cannot pay the doctor that figure.” Administrator, Private Healthcare Provider

“In a bid to hold on to patients as long as possible with the hope that they will give birth at their facility and the facility would get reimbursements, private facilities delayed referrals as long as possible, sometimes endangering the patient’s life and resulting in further complications when the mother was finally referred. There was in fighting and poaching of patients from government facilities by private providers using deceptive claims all with the hope of increasing the patients delivering at the facilities and thereby increasing the money paid to the facility, regardless of the patients’ best interest. In Iganga, it was particularly pronounced necessitating a sit down between Nakavule General Referral Hospital and Mercy Clinic, a private facility. This animosity further complicated referrals particularly from private to public facilities. Similarly in Bugiri, the government hospital

“Interview with Health Worker, Iganga Hospital Focus Group Discussion”

54 Interview with Health Worker, Iganga Hospital Focus Group Discussion
was left off the providers and the bulk of providers were private. A private facility, minutes from the government one, Fastline Medical was selected as the highest referral facility. The other facilities are Nankoma HC IV, Polycare Namayembe (Private), Buvunga. The owner of the private facility, Fastline, also works in the government hospital. This raised conflicts of interest that permeated more than the voucher program

“Even for operations, we are recommended to other private facilities and the person recommending us is the owner of that private facility for example in Bugiri, we have Dr. Isabiry, the medical superintendent at Bugiri Hospital who recommends us to his own facility to get services. If you reach and you need an operation, it is almost USh400,000.” Mother, Bugiri

There is reasonable concern that the introduction of vouchers might degrade the public system. The URHVP is partly funded through GoU, and World Bank funds, and these public funds have been diverted towards the private sector, often eschewing public health facilities. While the World Bank and SIDA invested 17.3 million USD in the Marie Stopes program, the public health system is underfinanced and poorly managed. Almost all interviewees noted the persistent underfinancing of the public health system was weakening it. In fact the quality issues in the public health system, which are a result of underfinancing, is what initially made the vouchers attractive to the beneficiaries.

“We got the voucher cards because we knew the system at Nakavule was not nice. There are no drugs, no treatment.” Beneficiary

However, the majority of interviewees thought strengthening the public system should be prioritized over ad hoc measures, particularly strengthening the financing and supervision of the public health system.

“I would tell the government to bring better services. They bring mama kits but they pluck out the essential supplies. The cotton is also reduced.” Woman, FGD, Tororo

“I want the government to bring more drugs to the health centers and follow up these drugs. I think that the drugs are being sold by the government.” Woman FGD

“The requirements in the government centers should be provided because some people cannot afford these [voucher] services. There is Kanyabwanga HC III. There are also villages that are very far.” Private Health Care Provider, Mitooma District.

“I prefer a government [facility] because I expect to find the best expertise in case of any complications. There times when you go to the private and still don’t get best services.” Community Member
V. Poor Quality Among Service Providers, Particularly Private

A fundamental premise of the Uganda Reproductive Health Voucher Project is that this promotes supply side solutions where facilities will compete with each other for patients thereby improving quality.

“You may ask what is difference between these and government free services. Here there is an obligation to ensure they attend to the mother and a tool to track those services. This is more like Results Based Financing. Facilities get more money for mothers attended to. When they attend to a mother that has been delivered to, they get extra money. The voucher project ushered in results based financing from the demand side. It has proven that RBF works and delivers. Based on that, the government was convinced to borrow from the World Bank under AMCHIF. These are both PPPs and there are contracts that are written with facilities.” World Bank Official

Marie Stopes in its criteria for selection emphasized quality, using indicators that were attached to the reimbursement of claims.55 It stated it would work with District Health teams to monitor as a safeguard. To curb fraud, they used BDO as a third party verifier.

In practice, there were significant shortcomings that detrimentally affected quality. The team observed providers who did not maintain quality standards, for example finding tools caked in blood for days in the theatre ward. The Office of the Auditor General found that 30% (6/20) facilities visited did not have functional adult resuscitation equipment nor copy of healthcare protocol provided by Marie Stopes.56 Only approximately 25% of Basic Emergency Obstetric and Neonatal Care (BEmONC) facilities were providing elimination of mother to child to child transmission (EMTCT) services.57

Rather than hire additional qualified staff to meet the demand, some private providers tried to cut corners

“I am a clinical officer but I used to help mothers give birth since my midwives would get overwhelmed.” Private Provider

55 Interview with William Nyombi, Programs Director Marie Stopes, 21 February 2019.
Beneficiaries complained of private providers favoring C-sections over normal deliveries because they were reimbursed more for C-sections than normal deliveries.

“They should remove the C-section for mothers who are able to push their baby. We were told that any expectant mother who was due was always taken for C-section even if she could push the baby and that is why we got scared. The VHT told us that when time of birth comes, we should move to the hospital. If I can push my baby, why should I be operated? That is why we used to say it was illuminati.” Beneficiary of voucher, Iganga

Beneficiaries reported being afraid to go to private facilities on the program because of the prevalence of unnecessary C-sections. Health workers confirmed the increased number of C-sections, however, they attributed this to complications.

“We had more C-sections than normal deliveries because of the referrals. Many were referrals and whoever would come, there would be no solution apart from operation. They would say that whoever was coming here was being operated. We could talk to the mothers – the people (men) were also scared of us because they said that we only operated because we wanted money. They would say that we were just interested in operating.” Health worker, Private Provider

Moreover, the limited focus of the program did not holistically address reproductive health issues but only covered certain conditions, for example treating mothers’ STIs but not covering partner testing and treatment.

“We had the voucher system but it was very fake. On reproduction, it could only help the women who were about to give birth. The voucher card could also be used to only treat the women for venereal diseases but the man would not be treated and she would get it again.” Private Provider, Torooro

While the voucher program sought to link reproductive health to family planning, there were reports of coercion where mothers on vouchers were told they had to agree to family planning or pay what would have been the costs without the voucher.

“My daughter-in-law got complications at Mitooma HC IV and she was referred to KIU after C-section. The doctor told her that if she was not put on family planning after three days, she would pay the whole amount of USh600,000. She accepted to be put on family planning (the implant) because they had no money.” Community Member
Quality is a multi-dimensional indicator, however, throughout the course of the project, Marie Stopes focused on client satisfaction. While there were some positive reactions about how patients were treated while on the voucher, others were negative.

“I know the voucher system and I have ever seen the card but it didn’t help. I gave birth from home, the voucher system did not help. I personally bought the card but it did not help me. They used to say that the people with the voucher cards would be worked on first and not spend a lot of time in the lines but this was not done.” Beneficiary, Bugiri

“I have heard about the voucher cards but even if one got the card, there was no help given to them. We decided to look for other alternative facilities to help us.” Mother, Bugiri

When I got the voucher card in 2017 from a VHT, he sent me to Bugiri at Dr. Isabirye’s health facility [Fastline Medical Centre]. I was nine months pregnant by then. When I reached the facility, I was worked on very well. I was examined, worked upon then discharged. I had gone for ANC for the first time. When I went back for the second time in August 2017, I was having labour pains. I reached at the gate and I was asked if I had ever had a C-section and I said no. I was asked if I was bleeding and I said yes. I reached and I was checked when they finished examining me, I was admitted and I kept feeling pain. I told my sister My sister told me to go and take some black tea and I replied that I was badly off. Then the medical worker told me to remove the she is not like other health workers who keep on checking on patients every time. I kept on feeling bad and my sister decided to pour me a cup of black tea to help with the pains but it was all useless. I went back to the health worker and pleaded with her but she was actually sleeping at her desk. I kept calling the nurse to help me but she refused. Nearby, there was a man who was attending to his wife who was also due. The man told the nurse that he could see that I was in a lot of pain and that she should help me and just because the nurse heard that it was a man’s voice, she told me to climb up to the bed. As soon as I got up on the bed, I pushed the baby but the nurse had no gloves. She was so embarrassed and she got annoyed with my attendant and she said that “why do you people come with stupid attendants?” The nurse finally cleaned the baby and handed it over to my sister. The afterbirth was very slow (the expulsion of the placenta took thirty minutes). After the placenta was expelled, the nurse attended to me. I really do not know if that was the nurse’s usual mannerism. I think the nurse wanted me to get to the point of a C-section because the way she tortured me was unbelievable. I reached the facility at midnight and I gave birth at 4 am in the morning. It usually happens that most people go for c-section. The C-section mothers were many at the facility so I thought that it was my fate. Beneficiary Mother, Bugiri
All, however, agreed that if there was any improvement in how patients were handled, it was only for mothers on the vouchers, raising concerns of discrimination.

“When we go to the hospital and the doctors see the voucher card, they attend to us quickly. . . .When you go to Mitooma HCIV, the health workers attend to you quickly when you have a voucher.”

To address quality, part of the funds were ideally supposed to be provided to staff to motivate them to provide better quality services. The government health facilities had to spend the money reimbursed in three ways: a percentage (30%) went to the health workers to motivate them, another percentage went to maintenance, a percentage (30%) for drugs and one to support the district to come and supervise. However, the private facilities did not have restrictions on how to spend the money they were reimbursed. Staff in public facilities indicated it motivated them to work on the patients better.

Staff in private facilities on the program, like the midwives, did not receive the money that was supposed to serve as a ‘top up’ to motivate the health workers. Instead the reimbursement was provided lump sum to the proprietor who often pocketed it to use at their discretion and sometimes invested it in expanding the facility.

“We did not get a top up as a “thank you”. For us, we are workers and that is the job that brought us here. They were paying us salary which we used to get.” Midwife, Private healthcare Provider

“That little percentage should pass through the personal accounts and not the administration but this never gets to the maternity. This percentage of motivation never reaches the midwives. Yet the midwife leaves late and comes back early and they do a lot of work.” Administrator, Private Healthcare Provider

Similarly whether private facilities sent some of the money to the District Health Office to support its monitoring role depended on the proprietor.

“It was the Incharges that had to bring some money to the DHO. I used to do it as an Incharge but the Incharges were not motivated to work. The Incharges used not to provide accountability and the money that would come would be theirs.” In Charge of Private Facility.

As a result of the discretion afforded to the private sector as to whether and how much they provided a “top up” to health workers or supported the DHO in its monitoring role, the expected trickle down effect on quality envisioned by the World Bank program designers did not materialize.

58 Interview with William Nyombi, Programs Director Marie Stopes, 21 February 2019.
VI. Poor or Delayed Reimbursement of Service Providers Affecting Quality of Services Provided

The voucher system is based on providing services first then reimbursement on pre-agreed upon rates. The reimbursements differed between public and private with private getting 25% more on the basis that they incur costs that public do not have like salaries and facilities costs. 59

Graph 2: Reimbursement of Services

Reimbursements for complication depended on the type of complication. A number of complications were not covered.

“There were some cases like malaria and UTIs, these were the only complications they told us to treat. For others, we had to call Marie Stopes. Post partum – this was on case by case basis, we did not have a fixed amount.” Private Provider.

According to the World Bank data on the project, 70% of claims were reimbursed timely as of 31 March 2019 and the number was maintained at the close of the project. 60 However, all healthcare providers we spoke to complained that they were not reimbursed on time.

59 Interview with William Nyombi, Director of Programs, Marie Stopes, 21 February 2019.
The Office of the Auditor General’s report confirms the research team findings, noting on average, the Voucher Management Agency (VMA) was taking 50 days to settle service providers’ claims which was significantly breaching the stipulated 20 days.61

The delay in reimbursements affected service providers’ attitudes towards patients. Some sent away the patients or refused to attend to them, leaving many beneficiaries stranded and scrambling to find alternatives.

Limited Access to Information and Participation of Beneficiaries

There was a significant lack of information about the project among purported beneficiaries and the communities. The Office of the Auditor General found 32% of the non-beneficiary women did not acquire the voucher because they did not know about it.

Even among beneficiaries and local leaders, all but one of the ones interviewed did not know this was a project funded by money availed to government and had been told it was funded by Marie Stopes.

“It was Marie Stopes that would pay the facilities depending on the vouchers. I do not know if the Government has ever put in money in the project.” DHO

Beneficiaries/communities did not participate in the design or monitoring implementation of the program. As a result they held misconceptions about how the program worked. Initially the project faced enrollment challenges as people considered it a form of “illuminati.” A number held on to the vouchers after using them having been told by the Village Health Teams that they were reusable.

Beneficiaries did not know that the project was closing. While Marie Stopes website had a notice that the vouchers would expire 30 October 2019, the beneficiaries the research team interacted with were not aware that the program was closing. They had been simply told there was a lull in distributing vouchers and were waiting to receive more. The research team often faced questions about the vouchers concerning when they would be brought back and complaints about how the system was monitored.

In particular, the failure to communicate the end of the project to beneficiaries had a detrimental impact on beneficiaries. Some had gotten vouchers that were yet to be fully used and others had paid for vouchers hoping to use them in the future.

“It was Marie Stopes that would pay the facilities depending on the vouchers. I do not know if the Government has ever put in money in the project.” DHO

“Those cards that were given out in May had the expiry date of December, when I asked Marie Stopes about this expiry date, they told me that this expiry date only works for Marie Stopes and their project, not the women who have the cards. There are some women who have the cards now but they will not get the services.” VHT, Rwampara

62 https://www.mariestopes.or.ug/who-we-are/uganda-reproductive-health-voucher-project/ (last accessed 30 June 2020)
The limited information provided and the lack of community participation not only detrimentally affected some beneficiaries but also undermined efforts to ensure accountability and community oversight.

More broadly, the limited participation of the community in the design and implementation of this project reveals how the allocation and design of aid within the health sector is a highly political process, shaped by priorities and the ideological stance of donors rather than purported beneficiaries.

### Choice of Providers

A key component of the project was to empower women by enabling them to choose their service provider. This is part of a broader marketization discourse that would give the woman “purchasing power” and “choice of provider.” This, however, was not often the case in the areas where we conducted the research. Some of the women indicated they were told to only go to a particular provider. This was in part due to collusion between VHTs and some providers, particularly private ones who either directly sold the vouchers to the women on that pretext or worked with VHTs to communicate that message to them.

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The fact that the project was provider based, excluded areas without health facilities. In some places, providers within proximity of each other like private facilities within proximity of a public health facility were selected yet there were areas with no nearby facilities. The selection of providers raises questions about the efficacy of the project in increasing access, suggesting the program was operating in areas already well served and poor women were less likely to use the service than those already better off.

**IX** Increased Commercialization of Healthcare

The design of the voucher distributed facilitated privatization and commercialization of health. The vouchers seem to be another market based reform to reenact user fees. Implicit in this model is profit making. A Village Health Team member buys a voucher at 2700USh and is supposed to sell it at 4,000USh to recoup their investment and make profit.

*The selling of the vouchers to the VHTs incentivized them to sell them to those outside the purported beneficiaries since they would recoup more from their investment if they sold it to a mother willing to pay 50,000USh or any amount higher than the 4,000USh rather than selling to poor mothers, who sometimes said they could only pay 4,000USh in installments over months. Even those that sold at 4000 noted that in a bid to lower costs, they would not travel to the more remote parts or seek out the poorest since that would result in another transport expense that would reduce their profit margin so they would offset the transport cost to the beneficiaries.*
For those who could not afford to pay the 4,000USh, the VHT would make an arrangement to give them the voucher if the mother worked for them.

“I would buy each card at USh 2,700 and sell it at USh 4,000 each. Most of the mothers would not manage this money but a few would manage. Those who could not manage, I would invite them to come and work in my plantations and after working, I would give them the vouchers.” VHT, Rwampara

This was problematic and could result in exploitation of poor mothers. How was the poor mother’s work quantified? There was no way to know whether the mother had to offer services beyond the stated 4000USh in order to get a voucher.

Other examples of the commercialization have been discussed earlier above. Private providers rushing to quickly set up clinics to benefit from the project, private providers choosing to favour C-sections over normal delivery since they were reimbursed earlier.
Lack of Sustainability

A critical shortfall of the World Bank Funded URHVP is the lack of sustainability of this and similar voucher initiatives since they depend on ongoing donor aid, subject to the interests of the donor and with no/limited government ownership. In this project, a number of private providers have or will be closing now that the voucher project ended since their services were already considered too expensive for the communities. For example at a private clinic in Iganga that charged USh30,000 for normal delivery planned to close since the community could not afford it. The community has reverted to the public health facility, which is a long distance away.

Most of the respondents the team interacted with noted that fixing the public health system is a more sustainable solution to improving communities' access to healthcare. They recommended building/upgrading more HC IIIs to reduce the long distances and investing in strengthening quality in public facilities.

“Increase the drugs at the health centers.” Mother, Bugiri

“I prefer government because I expect to find the best expertise in case of any complications. There are times when you go to the private and still don’t get best services.”

They should re-stock drugs at the government facilities like Igombe HC III, Nakavule hospital. The government should also put in place strong restrictions and penalties for those workers who steal government drugs. Stronger monitoring mechanisms by government are a requirement. The hospitality in government facilities should be improved so that we are treated the way private facilities treat us.” Mother, Iganga

Despite the World Bank’s country profile noting that the public health system is the first point of call for the poor, by funding projects like this, the World Bank has adopted a piecemeal approach that fragments resources that could be used to strengthen the public health system. A 2010 World Health Organisation report warned about such piecemeal approaches detracting from public healthcare.64

Clearly the government investment in public health was aimed at subsiding care for the poor and vulnerable. The Ministry of Health has highlighted strengthening the public health system as a key priority. The Ministry of Health’s mid-term sector development plan review found that as a result of limited funding to the health sector, the attendant poor functionality of public services has resulted in high out of pocket costs and wide disparity in quality of care, disproportionately affecting the rural areas.65


Current investments in health remain inadequate resulting in high out of pocket costs and detrimentally affecting quality of services.66 ISER’s prior five-year analysis of health budgets found significant shortfalls in financing the health system with budget hovering between 6-9%.67 Current financing only covers 30% of what is needed according the costed Health Sector Development Plan budget.68

Table 1: Health Budget as Percentage of Total Government Budget

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Budget (Bn Ush)</th>
<th>Growth</th>
<th>Total Gov't Budget (Bn Ush)</th>
<th>Growth</th>
<th>Health as % of total budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>660</td>
<td>--</td>
<td>7,377</td>
<td>--</td>
<td>8.9%</td>
</tr>
<tr>
<td>2011/12</td>
<td>799</td>
<td>21%</td>
<td>9,630</td>
<td>31%</td>
<td>8.3%</td>
</tr>
<tr>
<td>2012/13</td>
<td>829</td>
<td>4%</td>
<td>10,711</td>
<td>11%</td>
<td>7.7%</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,128</td>
<td>36%</td>
<td>13,065</td>
<td>22%</td>
<td>8.6%</td>
</tr>
<tr>
<td>2014/15</td>
<td>1,281</td>
<td>14%</td>
<td>14,986</td>
<td>15%</td>
<td>8.5%</td>
</tr>
<tr>
<td>2015/16</td>
<td>1,271</td>
<td>-1%</td>
<td>18,311</td>
<td>22%</td>
<td>6.9%</td>
</tr>
<tr>
<td>2016/17</td>
<td>1,827</td>
<td>44%</td>
<td>20,431</td>
<td>12%</td>
<td>8.9%</td>
</tr>
<tr>
<td>2017/18</td>
<td>1,950</td>
<td>6.7%</td>
<td>29,000</td>
<td>42%</td>
<td>6.7%</td>
</tr>
<tr>
<td>2018/19</td>
<td>2,310</td>
<td>18%</td>
<td>32,700</td>
<td>13%</td>
<td>7.1%</td>
</tr>
<tr>
<td>2019/20</td>
<td>2,610</td>
<td>13%</td>
<td>40,500</td>
<td>24%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance Budget Documents

In contrast, the total project cost of this World Bank funded URHVP is 17.3 million USD. This money, rather than strengthen gaps in the public health system that would sustainably serve the majority, focused on the private sector with the hope that doing so would have a trickle down effect. However, as discussed earlier, this has not happened, particularly for the poorest. In fact it promoted health user fees, despite overwhelming evidence that user fees regardless of how supposedly “nominal” are a barrier to access healthcare, particularly for poor women. This was compounded by the high administrative costs raises questions about whom this money ultimately serves and whether such interventions are sustainable.

While the expenditures for 2019 are not publicly available, as can be seen from the table above, between 2015-2018, 34.8% of the money disbursed went to the voucher management agent, Marie Stopes and 5.2% to the Independent Verification Evaluation Agent, BDO. The MoH received 8.5%. In total, 48.5% of the money disbursed between 2015-18 went to the administration of the project.

There have been at least two voucher supported programs by the World Bank in Uganda and others by actors like USAID, MSU, all costing millions of USD. An evaluation of the World Bank and Kreditanstalt für Wiederaufbau (German Development Bank, KfW) funded pilot voucher scheme in Western Uganda found that they “do not entail a one off subsidy but require ongoing subsidies by development partners or the Government.” GoU subsidizing such projects while struggling to raise the funds to strengthen its public health system would not make sense.

69 Saving Mothers Giving Life Project, 31 million USD IN Western Uganda from January to December 2012
70 Family Planning Long Term Methods Project, 10 million USD from USAID to implement family planning countrywide; Strides for Family Health Project funded by USAID with vouchers in central districts.
Despite the World Bank’s claims, vouchers have had limited impact on health outcomes for the vulnerable poor. There are flaws in the design and implementation that result in them failing to reach the poorest and make them unsustainable. In the long run, it is important to question whether piecemeal approaches like this do not ultimately undermine and enable the further deterioration of public health systems that have the potential to serve large numbers. Amidst a public health system struggling due to the lack of funds, it is questionable whether piecemeal approaches that only reach a few like vouchers should be invested in. This report makes the following recommendations:

**Government**

1. Address the gaps in the public health system, particularly the following:
   - Increase financing of the public health system, focusing on poor and geographically remote and hard to reach areas. This is in line with World Health Assembly resolution of 2005 on UHC and sustainable health financing and as well as revisiting the Paris Declaration that calls for greater Investments in the Health Sector and Social Health Insurance and Financing.
   - Have a functional ambulance referral system. The Uganda National Ambulance Service established in 2014 by Ministry of Health has been chronically underfunded. As COVID 19 has revealed, ambulances and functional referral systems should be prioritized to ensure everyone can easily access healthcare when they need it.
   - Increase staffing. In 2016/17, absence of critical human resource was a cause of 18% of maternal deaths. This should include prioritising staff accommodation at health centres.

2. Institute a National Health Insurance Scheme that covers all persons, particularly cover the poor and the most vulnerable from the onset.

3. Provide government stewardship. Limited government stewardship causes gaps in regulation, detrimentally affecting the poor. Donors’ setting the agenda is problematic from a governance perspective, resulting in uncoordinated approaches to implementation, duplication and leaving out the most vulnerable.

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4. Government should rethink the use of PPPs as a model for health service delivery given the high costs of implementation, yet there is no guarantee that they will serve the poor. There is also evidence that they are not sustainable and there is no guarantee of quality.

5. When PPPs must be used, it should be as a last resort and there should be detailed regulatory framework for PPPs. This includes regulating private actors and putting in place measures to ensure vulnerable groups are not detrimentally impacted, harmonizing indicators and benchmarks with Health Sector quality improvement framework and strategic plan 2015/16–2019/20, monitoring, ensuring access to information.

6. Consult with affected communities or their representatives. Consultation with communities before and during interventions makes sure the response chosen is meeting their needs.

7. Rethink the use of vouchers as a model for health service delivery, particularly where they involve cost sharing—which is has been found to leave out the poorest

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**Donors**

1. Finance the public health system according to the plans set out by the GoU to avoid duplication of resources and to ensure financing goes towards the most vulnerable.

2. Refrain from conditionalities that directly or indirectly promote privatization of the health sector. For example requiring private actor involvement as pre condition to providing funds.

3. Enable independent and participatory evaluation of projects you have funded and critically assess the PPP and Voucher models of health service delivery as there is no evidence that they result in better results than an adequately resourced public health system in contributing to UHC.

4. Consult with affected groups and leaders and provide platforms for meaningful participation before designing the projects. Consultation should be before, during and after project cycle.

5. Ensure programs designed and implemented with your support will help the most vulnerable by exercising due diligence including conducting human rights impact assessments. The gaps revealed in the Voucher Project and the failure to reach the poorest were apparent right from the design of the project.

6. Ensure policy processes are transparent including ensuring access to information.
For community and advocacy organizations

1. Demand for the Government and donors to invest in quality public health care.

2. Be wary of Public Private Partnership in Health (PPPH) proposals that do not shift resources toward remote areas where the human rights situations are most dire or those that utilize public resources yet do not serve poor and marginalized groups.

3. Demand access to information through access to information requests and other strategies to ensure meaningful participation.
FAILING TO REACH THE POOREST?
JULY 2020

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