



**ISER**

Facilitating Social Justice

INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS



# FAILING TO REACH THE POOREST?

ASSESSMENT OF THE  
WORLD BANK FUNDED  
UGANDA REPRODUCTIVE  
HEALTH VOUCHER  
PROJECT

## REPORT SUMMARY

JULY 2020 ►



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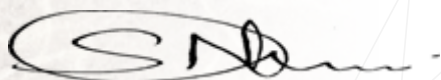
Initiative for Social and Economic Rights (ISER) 2020, Failing To Reach The Poorest? Assessment of The World Bank Funded Uganda Reproductive Health Voucher Project

## FOREWORD

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 lockdowns. 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

# ACRONYMS

<b>BEmONC</b>	Basic Emergency Obstetric and Neonatal Care
<b>CEmONC</b>	Comprehensive Emergency Obstetric and Neonatal Care
<b>C-section</b>	Caesarian Section
<b>DHO</b>	District Health Officer
<b>DLT</b>	District League Table
<b>EMHS</b>	Essential Drugs and Health Supplies
<b>FGD</b>	Focus Group Discussion
<b>GoU</b>	Government of Uganda
<b>H/C</b>	Health Centre
<b>HC II</b>	Health Centre Level Two
<b>HC III</b>	Health Centre Level Three
<b>HC IV</b>	Health Centre Level Four
<b>HSDP</b>	Health Sector Development Plan
<b>ISER</b>	Initiative for Social and Economic Rights
<b>JMS</b>	Joint Medical Stores
<b>MoH</b>	Ministry of Health
<b>NDP</b>	National Development Plan
<b>OAG</b>	Office of the Auditor General
<b>PNFP</b>	Private Not for Profit
<b>PPP</b>	Public Private Partnership
<b>STI</b>	Sexually Transmitted Infection
<b>URHVP</b>	Uganda Reproductive Health Voucher Project
<b>USH</b>	Uganda Shillings
<b>VHT</b>	Village Health Team
<b>VSP</b>	Voucher Service Provider

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# INTRODUCTION

Vouchers are a demand-side financing mechanism by design.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

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 (PPP) 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.<sup>5</sup>

In the voucher PPP arrangement, the private sector provides services purchased by the public sector with donor assistance. 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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<sup>1</sup> Indrani Gupta, William Joe, Shalini Rudra

(2010), Demand Side Financing in Health: How Far Can it Address the Issue of Low Utilization in Developing Countries, WORLD HEALTH ORGANISATION, World Health Report, Background Paper, 27 [https://www.who.int/healthsystems/topics/financing/healthreport/DSF\\_No27IEG.pdf?ua=1](https://www.who.int/healthsystems/topics/financing/healthreport/DSF_No27IEG.pdf?ua=1)

<sup>2</sup> Ibid

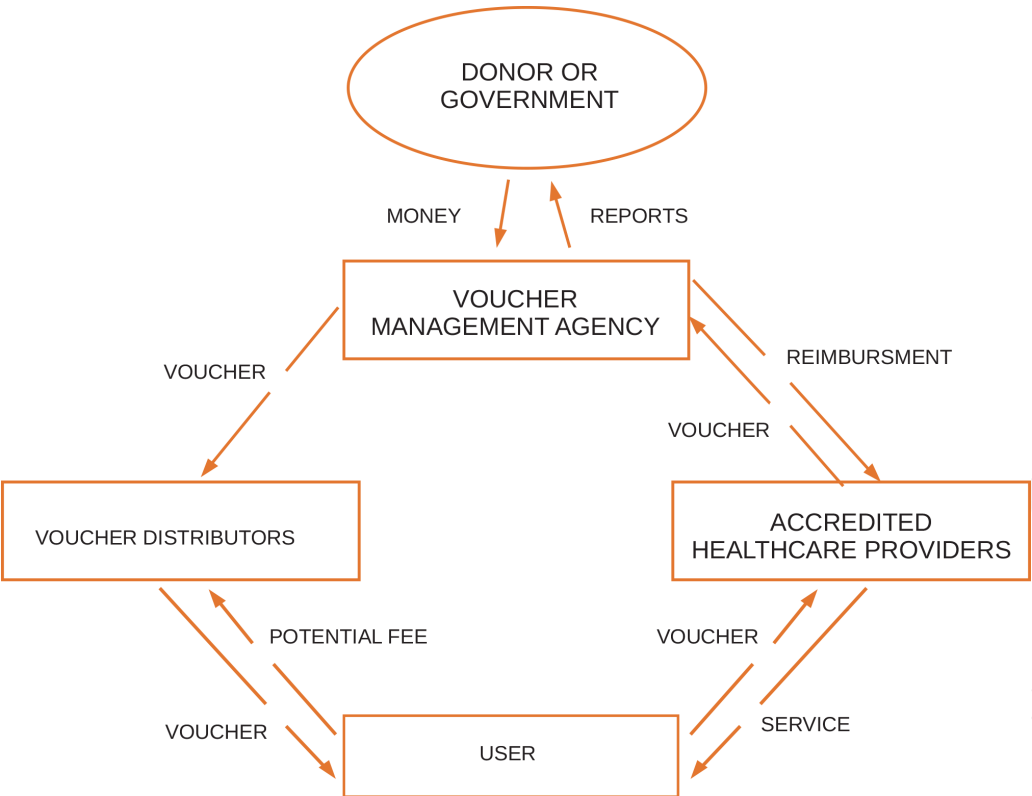
<sup>3</sup> Rebecca Njuki, Timothy Abuya, James Kimani, Lucy Kanya, Allan Korongo, Collins Mukanya, Piet Bracke, Ben Bellows, and Charlotte E. Warren; Does a voucher program improve reproductive health service delivery and access in Kenya? At <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4443655/>

<sup>4</sup> Voucher Schemes for Sexual and Reproductive Health Services: A Marie Stopes International (MSI) Perspective

<sup>5</sup> Grainger C, Gorter A, Okal J, Bellows B. Lessons from Sexual and Reproductive Health Voucher Program Design and Function: A Comprehensive Review. International Journal for Equity in Health 2014

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.<sup>6</sup>

**Fig. 1 Structure of Voucher Schemes**



<sup>6</sup> Grainger C, Gorter A, Okal J, Bellows B. Lessons from Sexual and Reproductive Health Voucher Program Design and Function: A Comprehensive Review. International Journal for Equity in Health 2014

In Uganda, there have been at least two voucher supported programs by the World Bank and others by actors like USAID,<sup>7</sup> MSU,<sup>8</sup> 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<sup>9</sup>) resulted in availing USD 17.3 Million USD to deliver the Uganda Reproductive Health Voucher Project. The Government offers tax inclusive procurement. Government pays the tax for any import done with donor funds.<sup>10</sup>

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.<sup>11</sup> The project sought to “mainstream and scale up” implementation of safe delivery voucher systems in the health. 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.<sup>12</sup> 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.<sup>13</sup> To implement the project, Marie Stopes was selected as the voucher management agent and would handle selection of providers, review workplans, 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 provide overall coordination.

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<sup>7</sup> Saving Mothers Giving Life Project, 31 million USD IN Western Uganda from January to December 2012

<sup>8</sup> 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.

<sup>9</sup> Okuny, Michael Eriu, 2019. AG Report on the Fin Statements of URHVP GPOBA TF015995 For the Year Ended June 30, 2018 at p.17

<sup>10</sup> Interview with Ministry of Health Official; Interview with World Bank Official

<sup>11</sup> World Bank. 2014. Uganda - The Uganda Reproductive Health Voucher Project (English).

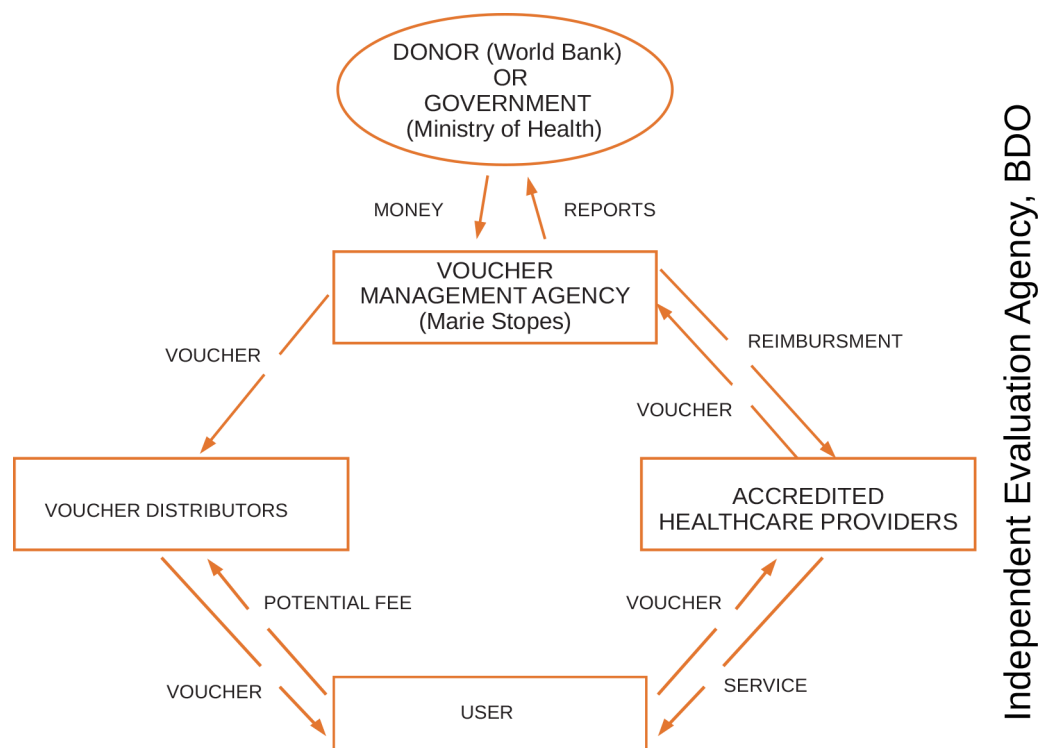
Washington, DC: World Bank Group, <http://documents.worldbank.org/curated/en/387111468115145982/pdf/842950PAD0P1440ucherPADFinal0Oct03.pdf>.

<sup>12</sup> World Bank, World Bank Reproductive Health Voucher Project (P144102), 12 December 2019, <http://documents.worldbank.org/curated/en/792201576764110658/pdf/Disclosable-Version-of-the-ISR-Uganda-Reproductive-Health-Voucher-Project-P144102-Sequence-No-10.pdf>

<sup>13</sup> Olayo, Bernard O. 2019. Disclosable Version of the ISR - Uganda Reproductive Health Voucher Project - P144102 - Sequence No: 10 (English). Washington, D.C. : World Bank Group. <http://documents.worldbank.org/curated/en/792201576764110658/pdf/Disclosable-Version-of-the-ISR-Uganda-Reproductive-Health-Voucher-Project-P144102-Sequence-No-10.pdf> at pg. 1.



**Fig. 2 Structure of Uganda Reproductive Health Voucher project**



### **URHVP targeted 25<sup>14</sup> districts in the eastern and western part of the country:**

Kiruhura, Mbarara (this has now been split into Mbarara and Rwampara), Ibanda, Sheema, Buhweju, Rubirizi, Mitooma, Isingiro, Ntungamo, Kabale, Kanungu, Jinja, Kamuli, Buyende, Luuka, Iganga, Mayuge, Kaliro, Namutumba, Namayingo, Bugiri, Kibuku, Tororo and Busia. <sup>15</sup>

There were 253 health facilities contracted (125 health facilities in Eastern Uganda and 128 in South Western Uganda). <sup>16</sup> 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.

<sup>14</sup> The Ministry of Health reported 27 districts in its mid term progress report. Ministry of Health(2018) Mid Term Review Report for the Health Sector Development Plan 2015/16-2019/20.

<sup>15</sup> Okwero, Peter. 2017. Disclosable Version of the ISR - Uganda Reproductive Health Voucher Project - P144102 - Sequence No: 06 (English). Washington, D.C. : World Bank Group. <http://documents.worldbank.org/curated/en/671271513793791840/pdf/Disclosable-Version-of-the-ISR-Uganda-Reproductive-Health-Voucher-Project-P144102-Sequence-No-06.pdf> at pg. 2

<sup>16</sup> Okwero, Peter. 2016. Uganda - Uganda Reproductive Health Voucher Project: P144102 - Implementation Status Results Report: Sequence 04 (English). Washington, D.C. : World Bank Group. <http://documents.worldbank.org/curated/en/148931481627994963/df/1481627993482-0000A8056-ISR-Disclosable-P144102-12-13-2016-1481627985603.pdf> at pg.2

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.”<sup>17</sup> The project should have closed on 29 December 2017 but it was extended for two more years and closed on 15 December 2019.<sup>18</sup>

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.<sup>19</sup>

## METHODOLOGY

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:

Key informant interviews with district officials, beneficiaries, community leaders, healthcare providers and project implementers.

### Random Sampling of Health Centres in the Program:

The team visited a random sampling of healthcare centres enrolled on the program in the districts.

### 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.

### 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.

<sup>17</sup> World Bank, World Bank Reproductive Health Voucher Project (P144102), 12 December 2019, <http://documents.worldbank.org/curated/en/792201576764110658/pdf/Disclosable-Version-of-the-ISR-Uganda-Reproductive-Health-Voucher-Project-P144102-Sequence-No-10.pdf>

<sup>18</sup> Okwero, Peter. 2017. Disclosable Version of the ISR - Uganda Reproductive Health Voucher Project - P144102 - Sequence No: 06 (English). Washington, D.C. : World Bank Group. <http://documents.worldbank.org/curated/en/671271513793791840/pdf/Disclosable-Version-of-the-ISR-Uganda-Reproductive-Health-Voucher-Project-P144102-Sequence-No-06.pdf> at pg. 2.

<sup>19</sup> Initiative for Social and Economic Rights (ISER) 2019, “Achieving Equity in Health: Are Public Private Partnerships the Solution?

Kampala, Uganda, <https://www.iser-uganda.org/publications/reports/397-achieving-equity-in-health-are-public-private-partnerships-the-solution> (last accessed July 6 2020)

## KEY FINDINGS

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%).<sup>20</sup>
- 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 performing 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.
- 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.<sup>21</sup>

<sup>20</sup> Uganda Bureau of Statistics (2019), Distribution of Poverty in Uganda Across Regions; Uganda Bureau of Statistics, Statistical Abstract 2018, [https://www.ubos.org/wp-content/uploads/publications/05\\_2019STATISTICAL\\_ABSTRACT\\_2018.pdf](https://www.ubos.org/wp-content/uploads/publications/05_2019STATISTICAL_ABSTRACT_2018.pdf) (last accessed March 24,2020).

<sup>21</sup> Office of the Auditor General(2019), Report of the Auditor General to Parliament for the Financial Year Ended July 2019 at page 74, <http://www.oag.go.ug/wp-content/uploads/2020/01/AG-Consolidated-Report-2019.pdf>

**5. Cost was a significant barrier.** While 4000 USH 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 UGX.20,050 extra money at the VSP.<sup>22</sup>

**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 (UGX 4,000) spending up to UGX.100,000.<sup>23</sup>

**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.<sup>24</sup> 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.

**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

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<sup>22</sup> Office of the Auditor General. 2019, Report of the Auditor General to Parliament for the Financial Year Ended July 2019 at page 74, <http://www.oag.go.ug/wp-content/uploads/2020/01/AG-Consolidated-Report-2019.pdf>

<sup>23</sup> Office of the Auditor General. 2019, Report of the Auditor General to Parliament for the Financial Year Ended July 2019 at page 74, <http://www.oag.go.ug/wp-content/uploads/2020/01/AG-Consolidated-Report-2019.pdf>

<sup>24</sup> Office of the Auditor General. 2016, Report of the Auditor General on the Financial Statements of Uganda Reproductive Health Voucher Project (URHVP) for the FY ended 30th June 2016, <http://pubdocs.worldbank.org/en/664801523260084099/URHVP-Audit-Report-June-30-2016.pdf>

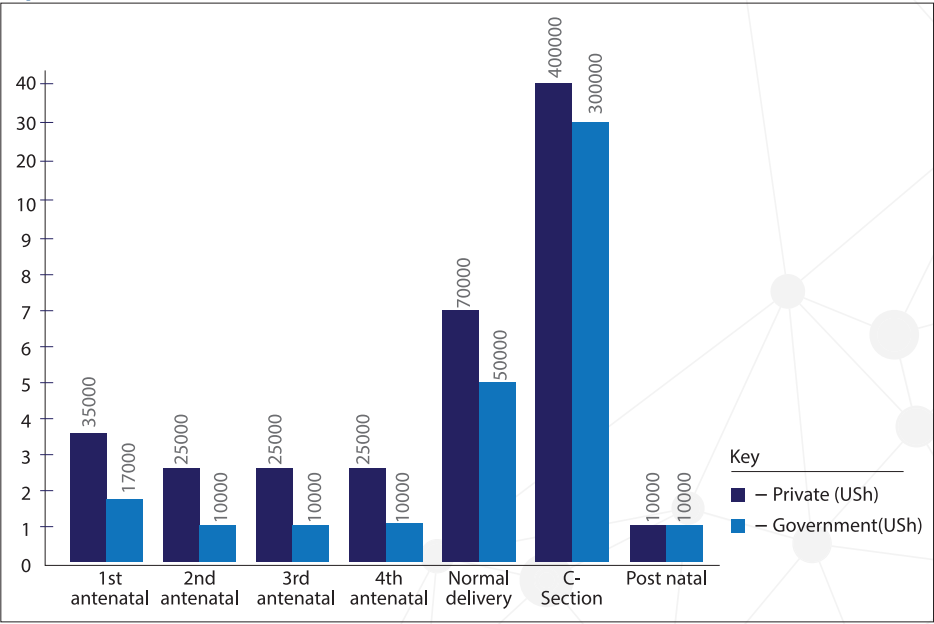
private. In Mbarara, only 3 out of 16 were government. World Bank documents confirm this skew towards private with 56 percent of the 253 health facilities selected private and 44 percent public.<sup>25</sup> *While the reasons given were facilities were selected according to quality, some private providers 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.*

**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.

**Graph 1: Reimbursement of Services**



<sup>25</sup> Okwero, Peter. 2016. Uganda - Uganda Reproductive Health Voucher Project: P144102 - Implementation Status Results Report: Sequence 04 (English). Washington, D.C. : World Bank Group. <http://documents.worldbank.org/curated/en/148931481627994963/pdf/1481627993482-0000A8056-ISR-Disclosable-P144102-12-13-2016-1481627985603.pdf> at pg.2



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.

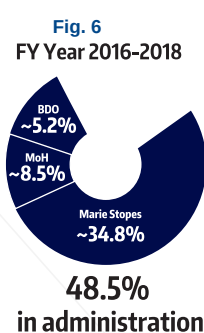
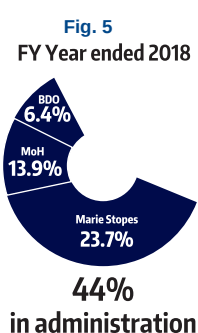
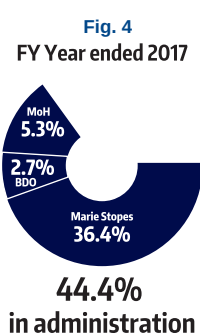
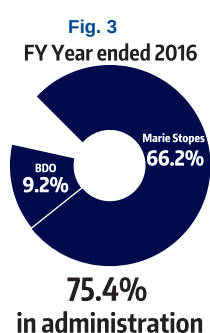
**15. Lack of Sustainability.**

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.

**Table 1: Project Operational Costs as a Percentage of Total Project Cost 2016-2018**

FY Year ended	Total Expenditure (USD)	Voucher Management Agent Cost & % of total expenditure	Service Providers Disbursement & % of total expenditure	BDO East Africa – IVEA Cost & % of total expenditure	Ministry of Health costs & % of total expenditure	Suplus of Income over expenditure
2016	1,131,869	749,549 (66.2%)	87,928 (7.7%)	104,992 (9.2%)	--	189,400
2017	3,639,112.48	1,327,833 (36.4%)	2,016,023 (55.3%)	99,454 (2.7%)	195,802.48 (5.3%)	
2018	3,796,067.73	902,144.79 (23.7%)	2,119,586.02 (55.8%)	243,996.00 (6.4%)	530,340.92 (13.9%)	
Total	8,567,049.21	2,979,526.79 ~34.8%	4223537.02 ~49.3%	448,442 ~5.2%	726,143.4 ~8.5%	189,400 (2.2%)



*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.*

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%.<sup>26</sup> Current financing only covers 30% of what is needed according the costed Health Sector Development Plan budget.<sup>27</sup>

<sup>26</sup> ISER. 2018. 'Are We Failing to Progressively Realise the Right to Health in Uganda; An Analysis of Health Sector Budget Trends' at p. 40 <https://www.iser-uganda.org/publications/reports/399-are-we-failing-to-progressively-realise-the-right-to-health-in-uganda>

<sup>27</sup> Ministry of Health. 2018. Mid Term Review Report for the Health Sector Development Plan 2015/16-2019/20 at p.V, <http://library.health.go.ug/publications/annual-quarterly-performance-reports/mid-term-review-report-health-sector-development>.

All respondents noted fixing the public health system would help more people and was a more sustainable solution.

**Table 2: Health Budget as Percentage of Total Government Budget**

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

**Source:** Ministry of Finance Budget Documents.

#### **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.

**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.<sup>28</sup> 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.
  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.

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<sup>28</sup> Maternal and Perinatal Death Review Reports, MoH ; Ministry of Health. 2018. Mid Term Review Report For the Health Sector Development Plan 2015/16-2019/20 at p.22, <http://library.health.go.ug/publications/annual-quarterly-performance-reports/mid-term-review-report-health-sector-development> (last accessed 30 June 2020)

## 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.





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