Uganda Voucher Plus Activity Quarterly Report

Year 3, Quarter 1 October 1, 2017–Dec 31, 2017

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The **Uganda Voucher Plus Activity** produced this document for review by the United States Agency for International Development. Abt Associates prepared this document with significant input from partners.

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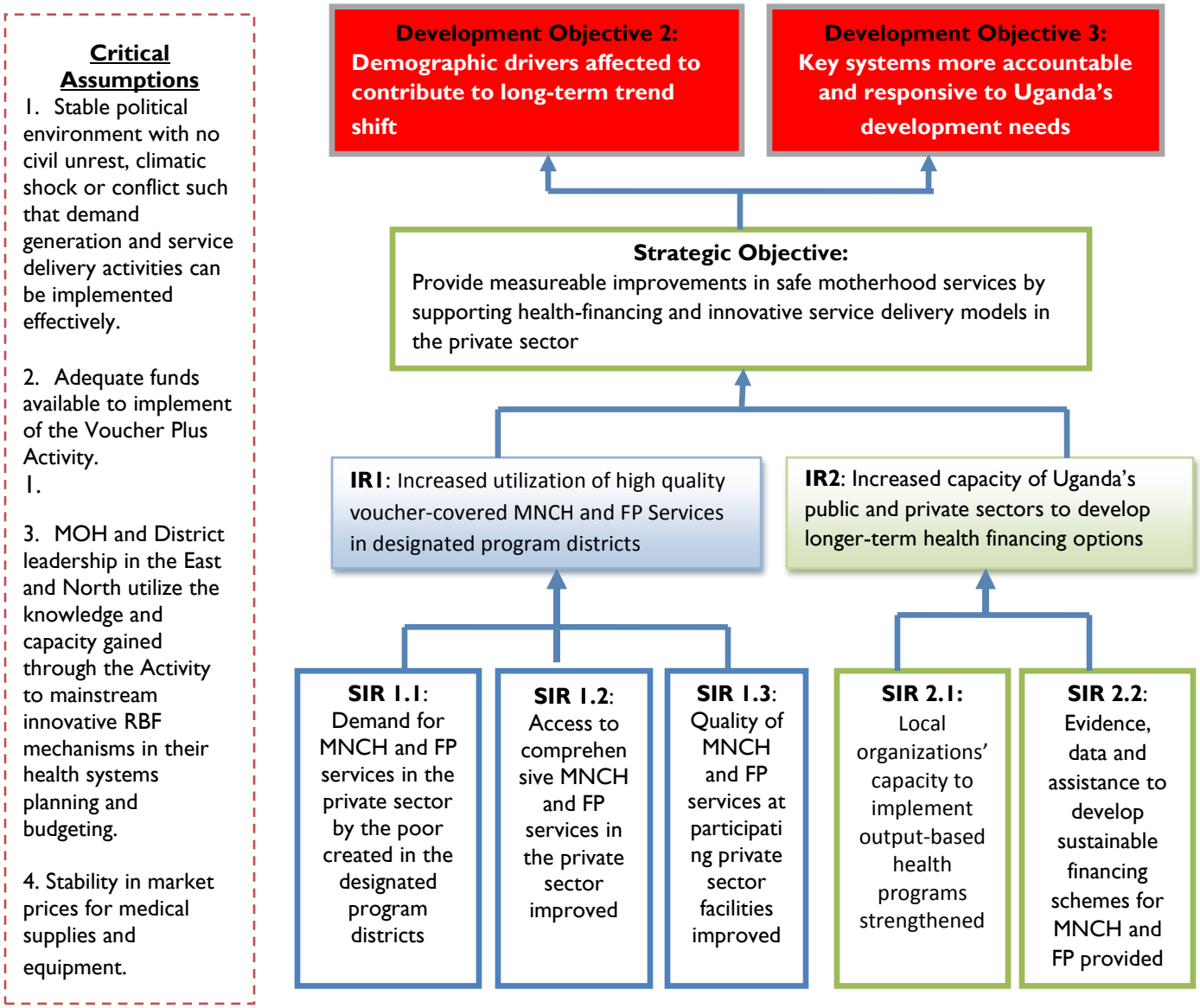
Acronyms

ANC	Antenatal Care
ART	Antiretroviral Therapy
ASSIST	Applying Science to Strengthen and Improve Systems
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CDFU	Communication for Development Foundation Uganda
CHC	Communication for Healthy Communities
CME	Continuing Medical Education
DHIS	District Health Information System
DHO	District Health Office
DHT	District Health Teams
eMTCT	Elimination of Mother to Child Transmission
FP	Family Planning
GBV	Gender Based Violence
GOU	Government of Uganda
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IR	Intermediate Result
IVEA	Independent Verification and Evaluation Agency
LC	Local Council
LOP	Life of Project
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MNCH	Maternal, Neonatal and Child Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NHIS	National Health Insurance Scheme
PNC	Postnatal Care
PPFP	Postpartum Family Planning
QI	Quality Improvement
RBF	Results Based Financing
RCL	Rapid Cycle Learning
RHITES	Regional Health Integration to Enhance Services
SBCC	Social and Behavior Change Communications
SBCCO	Social and Behavior Change Communications Officer
SGBV	Sexual and Gender Based Violence
SMA	Social Marketing Activity
UDHS	Uganda Demographic and Health Survey
UHF	Uganda Healthcare Federation
UHMG	Uganda Health Marketing Group
UGX	Ugandan Shilling
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
VCBD	Voucher Community Based Distributor
VHT	Village Health Team
VMA	Voucher Management Agency
VSP	Voucher Service Provider

Introduction

The Uganda Voucher Plus Activity (the Activity) is designed to increase access to obstetric, neonatal, and postpartum family planning (PPFP) services for poor pregnant women and their partners, and promote safe, facility-based deliveries to reduce maternal and neonatal morbidity and mortality. The Activity improves access to quality maternal and neonatal health services by recruiting private sector providers, building their technical capacity to deliver quality services to pregnant women, and reimbursing them using an output-based financing mechanism.

Figure 1: Uganda Voucher Plus Results Framework



Summary of Year 3 Quarter 1 Achievements

This quarter marked 15 months into the Activity's voucher distribution and service delivery operations. Voucher sales officially started in Y2, as startup, on-boarding Activity partners, and developing operational strategies and systems, took almost eight months.

Achievements this quarter include:

- Distributing 22,878 vouchers, representing 59% of the quarterly target (38,714); in total, 110,489 vouchers have been distributed of the total target of 360,000.
- Registering 9,085 deliveries with skilled attendants, reaching a cumulative 44,763 deliveries.
- Achieving 81.5% antenatal care (ANC) attendance for one visit (ANC1), 46.6% postnatal care (PNC) attendance, and 18.8% uptake of PPFP.

Building strong and enduring partnerships is an important agenda for the Activity to deepen our influence on maternal, neonatal and child health (MNCH) service delivery and utilization. We actively engaged individuals, district and local council leaders, health implementing partners, and local groups to collaborate with their programs, and to integrate Activity interventions within the health system. We continued to pursue key influencers at the Ministry of Health (MOH) and other central level actors to ensure harmonization of voucher processes with national programs.

Re-thinking and re-modeling our community engagement approach was a critical issue that absorbed the Activity's learning and adaptation agenda. Client follow-up assessments and a review of claims processing data indicated low sales progress and utilization of vouchers, attributed to community perceptions and the distribution strategy, including poverty grading assessments, that negatively affected wider reach and voucher redemption.

The Activity also finalized strategies and plans to adapt learnings in service delivery. We revised the service package to include management of neonatal complications and treatment of sexually transmitted infections (STIs) for spouses of voucher mothers. The additional service package will become effective on February 1, 2018. We finalized the mapping and assessment of new private facilities, including private wings of public sector facilities. This will expand MNCH and PPFP services to the poorest women in underserved rural areas, and improve referrals, which remain challenges both for this Activity and in Uganda generally.

Progress by Intermediate Result (IR)

IR1: Increased Utilization of High-Quality Voucher-Covered Maternal, Neonatal, and Child Health (MNCH) and Family Planning (FP) Services in Designated Program Districts

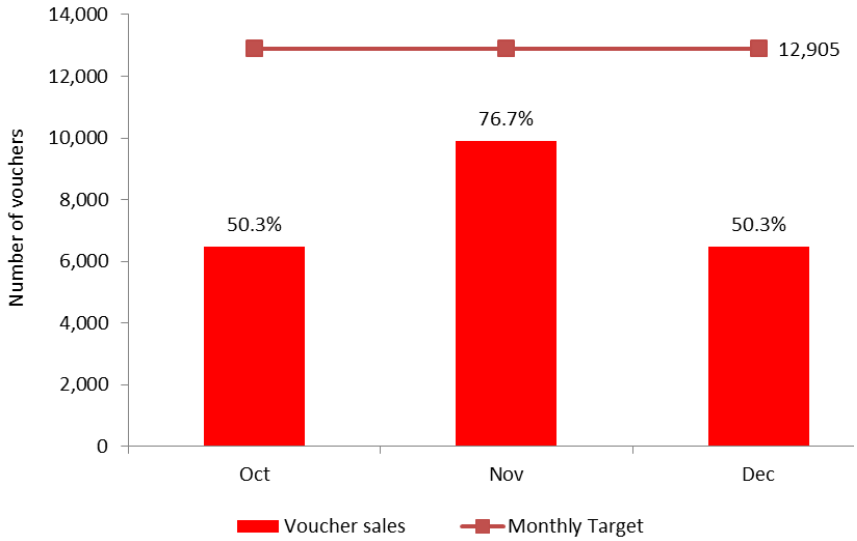
Sub-IR 1.1: Demand for MNCH and FP Services in the Private Sector by the Poor Created in Designated Program Districts

Voucher Sales

The voucher cycle starts with social and behavior change communication (SBCC) teams selling vouchers to voucher community-based distributers (VCBDs). After the SBCC teams and VCBDs sensitize the target population, the VCBD sells the vouchers to clients, who in turn redeem them at voucher service providers (VSPs) for services included in the benefits package. The total number of vouchers sold to clients in the

reporting period was 22,878. This represents 59% of the quarterly target (38,714). Table 1 compares sales performance with targets for Y3 Q1. Monthly voucher sales for Y3 Q1 are summarized in Figure 2.

Figure 2: Monthly Voucher Sales Performance for Y3 Q1



Voucher sales increased by 26.7% between October and November 2017 due to intense mobilization, daily mobile truck advertisements, and follow-up by distributors. The reversal in December 2017 can be attributed to time lost over the seasonal break (2-4 weeks), when operations slowed or shut down.

As shown in Table 1, voucher sales to clients varied significantly between reporting periods depending on the activities implemented. For example, expansion of activities to northern Uganda in Y2 Q2 boosted sales to 98%, while health system issues faced in Y2 Q3 (e.g., poor quality of care in private facilities) affected sales because the Activity halted services of over 30 VSPs.

Table 1: Cumulative Quarterly Voucher Sales against Targets

	Y2 Q1	*Y2 Q2*	*Y2 Q3*	*Y2 Q4*	*Y3 Q1*	*Cumulative*
Voucher Sales	15,866	30,039	16,420	25,286	22,878	110,489
Quarterly Target	30,600	30,600	30,600	30,600	38,714	360,000
Percent of Target Achieved	51.8%	98.2%	53.7%	82.6%	59.0%	30.7%

The Activity is also enrolling 17 new private VSPs and efforts are underway to on-board about nine (9) private wings of public health facilities, adding further catchment areas and VCBDs to boost voucher sales and increase services access for populations currently underserved by quality obstetric, neonatal, and PPFP services. Additional strategy adapations to accelerate voucher sales have been identified through program learning efforts and are outlined in the Key Learnings and Adaptations from IR1 section below.

Demand Generation Activities

Community Dialogues with Key Leaders and Influential Groups

The Activity conducted 53 community dialogues (against a planned 20) during the reporting period. This increase over planned activities was due to a critical need to: 1) address low voucher demand caused by

negative propaganda and misconceptions about the vouchers in some communities; 2) address feedback on poor quality of client care by some providers; and 3) explain conditions exempted under the voucher scheme that may warrant referral or payments for services. By targeting community leaders, the Activity increased support for voucher promotion activities at the local level. A total of 964 local leaders, community members, VHTs, and facility representatives (381 males, 583 females) participated in the meetings. In addition, youth participated in 19 community dialogues, including 31 males and 88 females, who actively participated in the discussions. The improvement in sales in November 2017 is partly attributed to this intensive engagement.

Men remain key partners in the voucher scheme, as they control the resources needed for women to purchase vouchers, or make decisions about using health facilities. Preliminary information from Activity monitoring and client follow-ups indicated that some women were prevented from using MNCH and FP services by their spouses, while others were not supported with transport for ANC or delivery. During the quarter, SBCCOs reached out to groups of men they had not interacted with previously. Six "men only" dialogues were held in five districts (Butaleja, Manafwa, Sironko, Serere and Mbale) to promote male involvement. During these dialogues in common convergence spots (e.g., sports betting centers, "ajono/malwa" drinking places, and "boda" stages), 125 men were educated about MNCH, birth preparedness, and the voucher Activity. They were also encouraged to support women in their communities to access MNCH and FP services.

The Activity continued to mobilize and work with youth. Thirteen "youth only" dialogues were conducted in the districts of Mbale, Kumi, Pallisa, Katakwi and Butaleja to educate young people about sexual and reproductive health issues, and to address myths and misconceptions about the vouchers. The "youth only" dialogues reached 287 youths (152 males, 135 females), helping to address social norms and conditions that lead to school dropout.

Community Sensitization Meetings and Edutainment Events

The Activity conducted community sensitizations and edutainment events to increase awareness about the voucher and to stimulate demand for MNCH and FP services. Fifty-eight community sensitization meetings were held in Acholi, Lango, Bugisu, and Teso sub-regions, with over 35 people attending each event. VCBDs in collaboration with LC1s mobilized people to attend, along with Sub County Community Development Officers and Health Assistants. The meetings attracted 8,754 community members (3,390 males, 5,354 females), and of these, 4,354 (1,870 males, 2,484 females) were aged 14-24 years. Community leaders, including Community Development Officers, Health Assistants, LC III chairpersons, parish and sub county chiefs, religious leaders, cultural leaders, opinion leaders, and VHTs attended the community sensitizations to garner support, build community trust for the Activity, and motivate community members to demand for and use MNCH, and PPFP voucher services.

VCBDs also conducted small group sensitizations as part of their routine voucher sales and promotional activities. VCBDs conducted 310 sensitizations this quarter, meeting with community members during community meetings, weddings, market days, gatherings at places of worship, and burial ceremonies.

Edutainment activities focused on 64 villages surrounding 12 VSPs with low voucher sales and redemption rates, and aimed to raise awareness about the voucher scheme in an up-beat manner, promote VSPs as an access point, and address community issues deterring women from using voucher services. In total, 8,133 people were reached (4,760 men, 3,373 women) within a 5km radius of 12 VSPs in Gulu, Omoro,

Amuru, Kitgum, Manafwa, Pallisa, Soroti, Ngora, and Katakwi districts. This helped to boost voucher sales and redemption—see Table 2 for the results of edutainment events.

Table 2: Facility Performance Before and After Puppetry Activities

Health Facility	Sales		Redemption	
	Before	After	Before	After
Gracious Clinic Maternity	20	50	8	30
Keyo Medical Center	100	250	65	231
Lacor HCIII Opit	80	150	50	132
Lacor HCIII Amuru	150	200	120	183
New Life Medical Center	25	50	13	46
Lukodi HC II	20	50	9	38
Butiru Chrisco Hospital	50	120	35	133
Beatrice Tierney	44	81	63	138
Siloam Nursing Home	20	98	20	60
St Ann Usuku HCIII	30	125	30	211
Galimagi HCIII	33	78	92	160
Janju Family Health Care Center	50	90	10	67

Note: Facility data reflects one month prior to and three weeks following the community edutainment events

Radio Talk Shows

The Activity uses radio talk shows to increase awareness and knowledge about vouchers and corresponding MNCH services. Fifty-five radio talk shows were conducted on 15 radio stations attracting 600 callers (460 males, 140 females). The Activity worked with CHC, benefiting from free CHC-paid radio time through nine radio talk-show programs in Mbale, Gulu, Lira, Kitgum, Apac and Soroti. Talk show guests included four LC V chairpersons; six District Health Officers (DHOs); twelve DHT members; twelve Secretaries for Health, 24 providers from participating health facilities, and 24 VCBDs. Satisfied clients appeared on 24 radio programs and shared testimonies.

Feedback on the Voucher Scheme through the Hotline

Both the hotline and radio remain key avenues for reaching men—caller profile analysis over the last 15 months indicates that men continue to dominate call-ins to the hotline and radios. Reasons for this include: 1) men are more likely to own phones than women; 2) men have better access to radio sets and control use of them; 3) men often own portable battery-powered radios enabling them to listen more often than women; 4) men have access to radios through their peers or at common convergence spots; and 5) men are more likely to inquire about services over the radio because they rarely visit health centers or engage in face-to-face health education.

During this quarter, 832 hotline calls were registered. Of these, 578 were men and 254 were women. Key issues and proposed mitigating actions are highlighted in Table 3 below.

Table 3: Issues Dominating Hotline Calls

Issue	Action by the Activity
Charging mothers for referral transport	-Case-by-case management of clients and their families by an individual provider -Improved communication about exclusions in the voucher service package
Poor provider interactions and negative attitudes of midwives	-Case-by-case management of clients and their families by an individual provider -Planned provider training in collaboration with CHC

	-Facility-community linkage approach introduced to improve facility-consumer relations

Participation in 16 Days of Activism to end Gender Based Violence

As part of USAID's contribution to addressing gender based violence (GBV), the Activity participated in the national 16 Days of Activism. Four radio talk shows, one community dialogue, two "men only" dialogues, and eight "youth only" dialogues were held during the campaign period (November 25 to December 10, 2017). Additionally the Activity logged 80 DJ mentions of ending GBV, which were broadcast during the Activity's MNCH and PPFP radio talk-show programs.

Sub-IR 1.2: Access to Comprehensive MNCH and FP Services in the Private Sector Improved

By the end of the reporting period, there were 130 active facilities (52 in Northern and 78 in Eastern Uganda), with operations in 30 districts. The Activity successfully completed all planned activities under this sub-IR during the quarter.

Accreditation of new Voucher Service Providers

Working with the DHTs, the Activity identified potential VSPs in underserved rural areas. These were recently established private providers, or those that did not meet expected standards during initial facility assessments in 2016. Increasing the number of VSPs will increase reach to the underserved rural poor with voucher services, and subsequently improve the Activity's performance in reaching its targets. During the reporting period, 57 private health facilities were mapped, 41 were considered for self-assessment, and 26 were selected and assessed in accordance with set criteria. Of these, 17 facilities qualified to join the Activity. Many facilities were unsuitable because of their close proximity to existing public health facilities at level III and above, their proximity to existing VSPs, or due to poor quality of services. The Activity will continue to work with the DHTs and medical bureaus to identify more private health providers in underserved areas.

Facility assessment of Karin Medical Centre

Engaging Public Sector Facilities with Private Wings

To improve referral capacity for Comprehensive Emergency Obstetric and Newborn Care (CEMONC), the Activity mapped existing public sector facilities with private wings. The Activity also continued to engage public facilities in strategic locations to prepare them for participation in the Activity. The Activity mapped 13 public health facilities and held discussions with DHOs and hospital management teams to provide information about the voucher scheme. Among the 13 facilities, three were Regional Referral Hospitals (Mbale, Soroti and Gulu), three were District Hospitals (Pallisa, Katakwi and Kapchorwa) and six were HC IVs (Buwasa, Bufumbo, Busiu, Namatala, Amuria and Budadiri). Two Regional Referral Hospitals (Gulu and Mbale) had fully functional private wings. Soroti has a private wing that was not fully functional.

The Activity facilitated an inception meeting with Hospital Directors, Administrators, In-charges of private wings, Medical Superintendents, Health Sub District In-charges of HC IVs (for public sector facilities), and proprietors of new private facilities. The objectives were to ensure managers of prospective VSPs understood how the voucher scheme works, appreciated their obligations, understood claims processing and reimbursement mechanisms, and agreed on the proposed reimbursement rates. The Activity also aimed to educate new VSPs about the national health financing agenda, including RBF and the National Health Insurance Scheme (NHIS). The National Project Coordinator for URMNCHIP/RBF and the Deputy NHIS Coordinator provided updates on the MOH's project and the NHIS.

Over the next quarter, the Activity will on-board new providers and initiate assessments and engage public sector facilities once the public sector service agreement is approved.

Table 4: Phased approach to on-board public sector private wings

Phases	***Timeline***	***Facilities***	***Current status***	***Requirement to be functional***
Phase I	1st April	Bufumbo HC IV	-Completed self-assessment for enrollment	-Conduct physical verification & clinical assessments by Voucher team & DHTs -Sign service agreement -Hold facility-based community entry meetings -Recruit & train VCBDS -Orient staff on voucher Activity claims process and tools -Start voucher distribution & service provision
		Busiu HC IV		
		Kapchorwa Hospital		
		Pallisa Hospital		
		Gulu Regional Hospital		
Phase 2	1ST May	Soroti Regional Hospital	-Completed self-assessment for enrollment	-Follow up with Mbale & Buwasa for self-assessment reports -Conduct physical verification & clinical assessments by Voucher team & DHTs -Sign service agreements -Hold facility-based community entry meetings -Recruit & train VCBDS -Orient staff on voucher Activity claims process and tools -Start voucher distribution & service provision
		Budadiri HC IV		
		Buwasa HC IV	Has not submitted self-assessment report	
		Mbale Regional Referral	Has not submitted self-assessment report	
Phase 3	1ST June	Katakwi Hospital	-Setting up private wing section	-To meet facility management teams to review progress on set up of private wings -Share facility self-assessment tools -Conduct physical verification & clinical assessments by Voucher team & DHTs -Sign service agreements
		Amuria HC IV	-Setting up private wing section	

				-Hold facility-based community entry meetings -Recruit & train VCBDS -Orient staff on voucher Activity claims process and tools -Start voucher distribution & service provision

Voucher Redemption

Table 4 highlights service utilization data for the 88,783 vouchers redeemed for key MNCH and PPFP services, and the corresponding targets. Each voucher includes seven reimbursable benefits or services, allowing each client multiple visits. A numbers of factors affect use of voucher-covered services; including gestational age at the time women buy vouchers, client knowledge, and client motivation for multiple visits.

Table 5: Voucher Redemption by Type of Service

Service type	*Y3 Q1 Client visits*	*Cumulative client visits*	*Y3 Redemption target*	*Y3 Q1 % Redemption target achieved*
ANC1	13,794	72,348	95%	81.5%
ANC2	10,690	49,500	55%	55.7%
ANC3	8,137	33,992	55%	38.3%
ANC4	4,851	19,159	50%	21.6%
Delivery	9,850	44,763	70%	50.4%
PNC	3,794	20,847	50%	46.6%
PPFP	1,853	8,669	40%	9.8%

In December 2017, the Activity conducted a field-monitoring visit and rapid cycle learning (RCL) study to understand redemption patterns and motivation by voucher clients to redeem their vouchers. See IR 1 Learnings section for key findings from this study.

Table 5 below lists voucher sales and redemption by region. The redemption data relates to use of the vouchers for at least one service in the package. Based on this data, the Northern region has continued to perform better than Eastern—the Northern region sells on average 232 vouchers per VSP, while the Eastern region sells on average 139 vouchers per VSP.

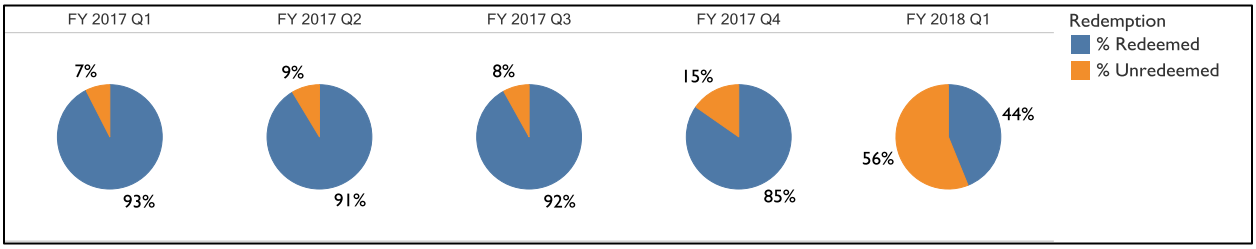
Table 6: Comparison of Y3 Q1 Voucher Sales and Redemption Rates by Region

Region	*# of Providers*	*Sales*	*Redeemed*	*Percent redeemed*
Eastern	78	10,814	4,069	37.6%
Northern	52	12,064	6,015	50%
Total	130	22,878	10,084	44.1%

Figure 3 below compares redemption rates for at least one service by quarter. Over half of all vouchers sold in Y3 Q1 were not redeemed at the time of reporting. This is because voucher sales were still in progress and many of these vouchers were still with VCBDs. The Activity is already following-up with

the VCBDs to ensure timely sale of vouchers. Furthermore, the new distribution and marketing plans mentioned above will improve sales turnaround.

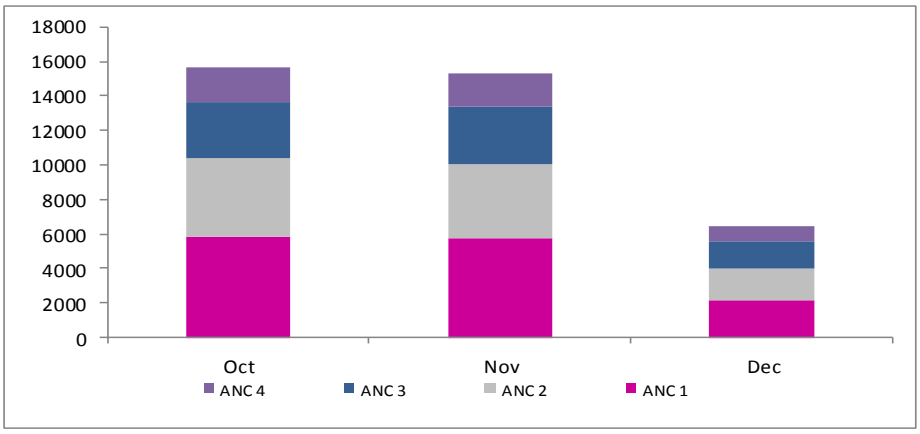
Figure 3: Proportion of Vouchers Sold that Have Been Redeemed, Disaggregated by Quarter



Increasing Access to ANC Services

ANC from a skilled provider is important for reducing morbidity and mortality risks for the mother and child during pregnancy, delivery, and the postnatal period. Figure 4 part 1 and part 2 summarizes ANC service utilization for the period October-December 2017.

Figure 4: Y3 Q1 Voucher Client ANC Service Utilization



The Activity supports poor expectant mothers to access focused ANC services to identify and manage pregnancy-related risks. Over 13,500 poor women utilized ANC1 services using vouchers, and almost 5,000 redeemed vouchers for ANC4 services during this past quarter. Similar to the overall Q1 ANC utilization cascade, the monthly utilization trends in Figure 4 demonstrate a decreasing pattern in utilization of repeat ANC visits. This trend is mainly explained by the late gestation at which women buy vouchers and report for services. Table 3 shows that only 16.7% of women bought vouchers in the first trimester, while 48.6% and 34.6% bought vouchers in the second and third trimesters respectively. The overall ANC4 utilization at 21.6% (from 81.5% ANC1 utilization) is explained by this sales trend. As mentioned, the Activity is supporting early identification of pregnant women to improve use of ANC services with a facility-community linkage approach. In addition, VSP staff are encouraged to improve communication with clients, and counsel them on the importance of subsequent ANC visits.

Figure 5: Y3 Q1 Voucher Client ANC Service Utilization by Age

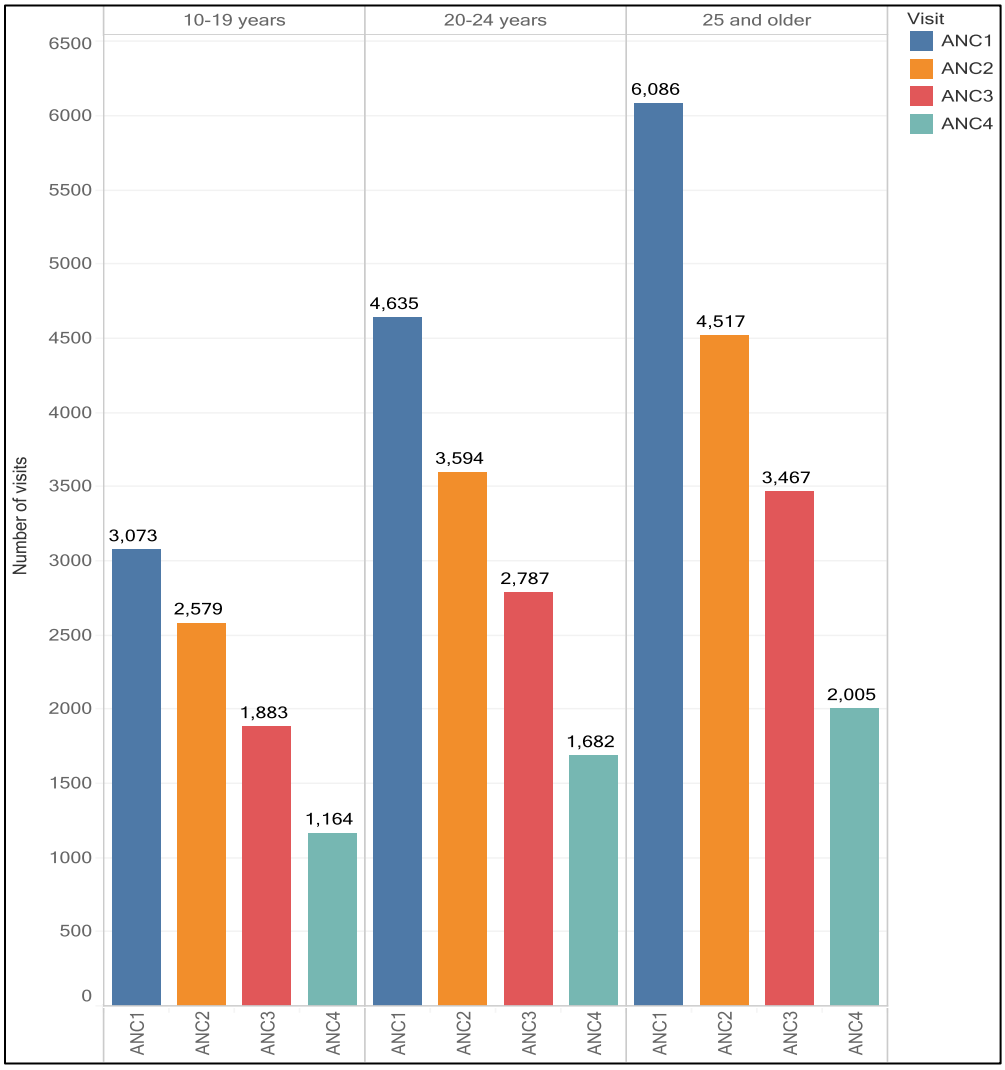


Figure 5, shows that clients over 24 years of age were more likely to use ANC services than those aged 10-19 or 20-24 years. This is in line with findings from other studies in Uganda on ANC service use, which highlight the link between maternal age and ANC uptake. Provider bias and lack of youth friendly services could explain why young mothers do not access ANC as much as older women. The Activity invested in strategies to promote youth friendly service provision, and to encourage youth to access MNCH services early. During the quarter, the Activity started continuing medical education (CME) on youth friendly and sexual and GBV (SGBV) service provision. Topics covered are designed to equip providers with relevant knowledge and skills about providing youth friendly services, and assessing for SGBV within MNCH services. The CME topics were incorporated within the on-site facility mentorship visits. In the next quarter, the Activity will further increase ANC service uptake by building on learning and adaptations from client follow-up visits conducted.

Table 7: Contribution of Voucher Plus ANC 1 & 4 Visits to District Statistics

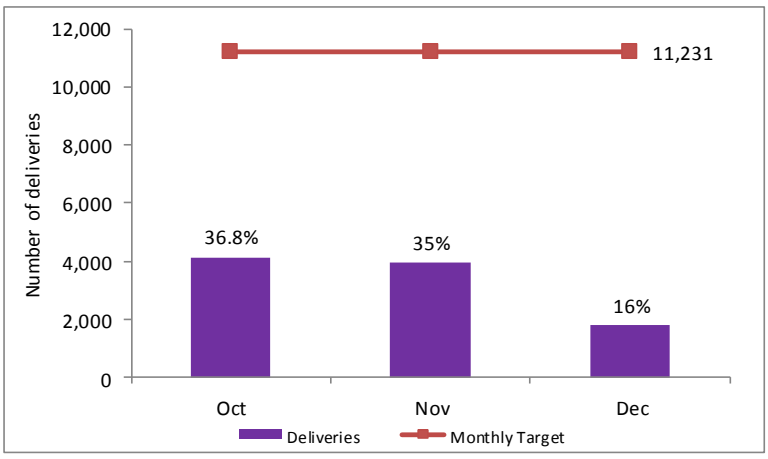
Period	ANC 1			ANC 4		
	Total district* ANC1 visits	ANC1 visits by Voucher clients	Voucher Plus contribution	Total district* ANC4 visits	ANC4 visits by Voucher clients	Voucher Plus contribution
Oct–Dec 2016	82,124	9,028	11%	31,302	236	0.8%
Jan–Mar 2017	88,561	20,073	22.6%	30,019	3,016	10%
Apr–June 2017	87,671	14,149	16.1%	31,256	5,462	17.5%
Jul–Sept 2017	77,254	15,304	19.8%	32,176	5,594	17.4%
Oct-Dec 2017	72,024	13,794	19.1%	29,825	4,851	16.8%

The Activity aims to contribute towards overall MNCH and PPFP performance in each district, and enhance effective public-private partnerships in health. As shown in Table 6, there has been a progressive increase in the contribution towards overall attendance, especially for ANC4 from 0.8% in the first quarter to 16.8% in the last quarter. In addition, some districts (e.g., Kapchowra) have acknowledged the Activity for its significant contribution towards increasing MNCH and PPFP health-seeking behavior. Activity supported facilities, such as Gamatui and Sesmart, also performed higher in ANC4 visits than other non-supported sites in the same district.

Increasing Access to Deliveries with Skilled Attendants

During the reporting period, 9,085 mothers used vouchers for delivery services, which is 29% of the target for the quarter. To date, the Activity has registered 44,763 safe deliveries (18% of the life of project target). Although the number of deliveries in October and November were virtually the same, there was a drop in December by almost 50%, possibly due to some providers who had not yet submitted their December claims, and/or the December holidays mentioned earlier.

Figure 6: Y3 Q1 Voucher Deliveries against Monthly Targets



As shown in Figure 6, the Activity achieved 37% of the monthly target for voucher sales in October 35% in November, and 16% in December 2017. A key learning for the Activity is the importance of strengthening implementation strategies to increase voucher redemption and service utilization.

Table 8: Cumulative Deliveries against Life of Project Targets

	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Cumulative
Deliveries	2,132	9,032	11,897	11,852	9,850	44,763
Quarterly Target	21,420	21,420	21,420	21,420	33,692	250,000
Percent	10%	42%	56%	55%	29%	18%

Although the cumulative deliveries are still low compared the target(as reflected in Table 7), the Activity is doing all it can to improve both voucher distribution and service redemption as we address the challenges highlighted above.

Figure 7: Y3 Q1 Deliveries by Age of Mother

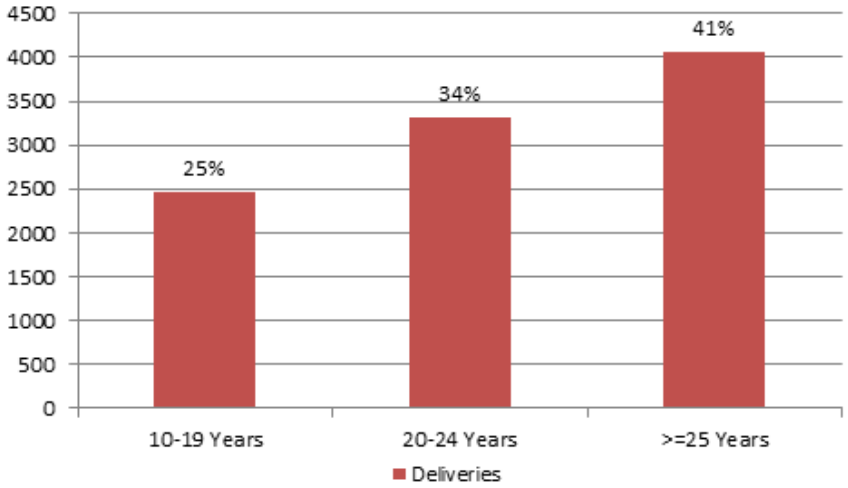


Table 9: Y3 Q1 Voucher Deliveries by Type

Delivery type	Oct 2017	Nov 2017	Dec 2017	Y3 Q1	Cumulative performance
C-section	327	315	144	786	3,122
Assisted	731	733	301	1,765	6,277
Normal	3,072	2,884	1,343	7,299	35,364
Total	4,130	3,932	1,788	9,850	44,763

Of the 9,850 voucher supported deliveries during the quarter, normal deliveries accounted for 74%, while assisted deliveries represented 18%, and caesarean sections, 8%. For the project to date, caesarean sections account for approximately 7% of the total voucher supported deliveries, within the MOH acceptable range (caesareans represent 10-15% of all deliveries nationally).

Table 10: Y3 Q1 Voucher Delivery Outcomes

	Y3 Q1	Cumulative	Outcome measures
Total Deliveries	9,850	44,763	
Live Births	9,822	44,632	

Still Births	28	131	FSBR[1] = 3.0
Maternal Deaths	1	10	MMR[2] = 22.4

Tracking delivery outcomes is an important component for the Activity because it measures the contribution towards reducing maternal and neonatal mortality in supported districts. The cumulative maternal mortality rate is 22.4 per 100,000 live births, which is below the national average of 336/100,000 (Uganda Demographic and Health Survey [UDHS], 2016). Likewise, the cumulative still birth rate is three per 1,000 live births, compared to the national average of 25 per 1,000 live births (WHO 2013). The Activity will continue to help facilities ensure all maternal and perinatal deaths are properly reported and audited, providing facility staff with learnings to avert further deaths. Also, through better tracking of referral outcomes in public facilities, the data on maternal and stillbirth mortality will more accurately reflect all voucher clients, and not only those that are recorded in the voucher management information system.

Table 11: Contribution of Voucher Deliveries to District Statistics

Period	*Total district* deliveries*	*Deliveries paid for with vouchers*	*Contribution of voucher-paid deliveries to district totals*
Oct–Dec 2016	53,968	2,132	4.0%
Jan–Mar 2017	51,554	9,032	17.5%
Apr–June 2017	52,325	11,897	22.7%
Jul–Sept 2017	53,472	11,852	22.2%
Oct-Dec 2017	52,880	9,850	18.6%

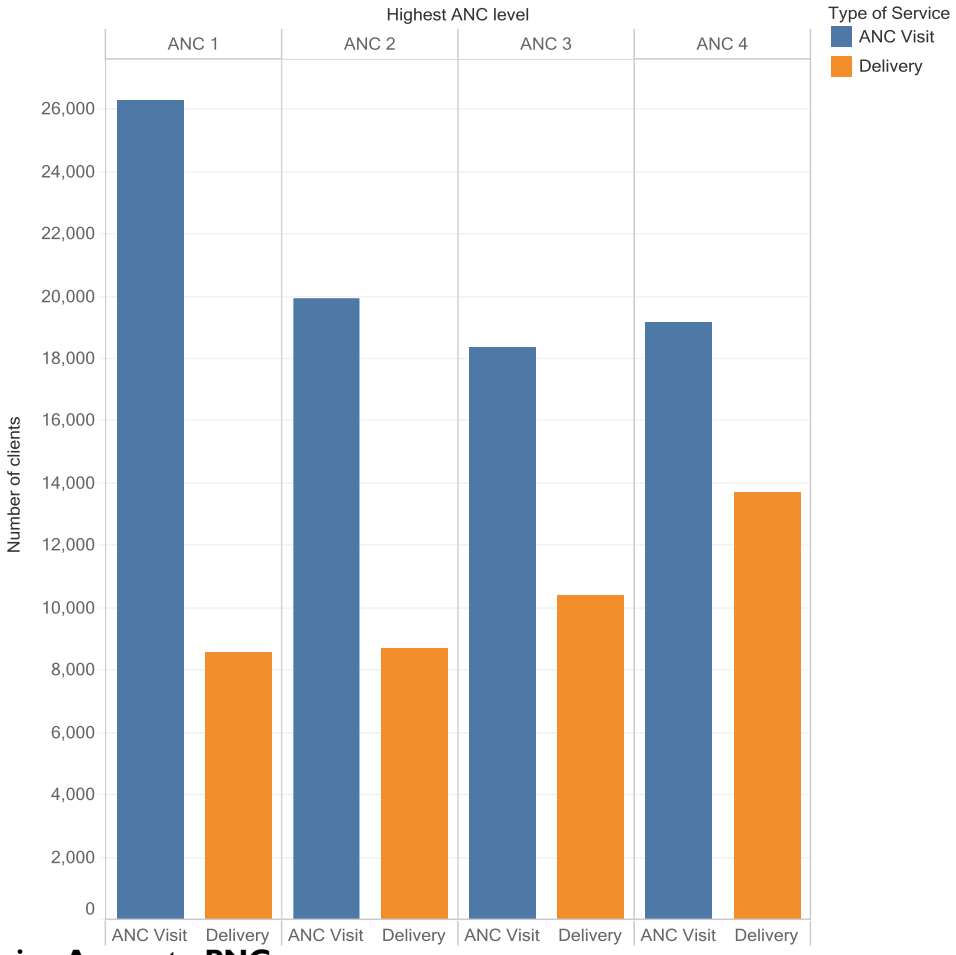
**Total district deliveries = Total deliveries registered across the 30 districts implementing Voucher Plus Activity. Source DHIS2 January 22, 2018*

During the quarter, the Activity continued to monitor its contribution towards increased access to safe deliveries within supported districts. The Activity used collated and aggregated data on deliveries from the District Health Information System 2 (DHIS2) for each of the 30 supported districts to better understand the Activity's contribution, as detailed in Table 10. The Activity's contribution to overall deliveries declined from 22.2%, (n=11,852) in the previous quarter to 18.6% (9,850) in the reporting period. A concomitant reduction in deliveries was observed in DHIS2 data during the quarter. In addition to strategies to increase voucher redemption, the Activity will expand voucher services as described earlier, by including the private wings of public facilities in underserved poor areas to strengthen referrals.

Figure 8 below shows that women who attended progressive ANC visits, especially ANC3 and ANC4 visits, were more likely to deliver at a voucher-supported health facility than those who attended only ANC1 or ANC2. Potential reasons include women buying vouchers in the third trimester, buying the voucher but choosing to deliver at a public health facility, or delivering at home. This learning will be adapted in our demand generation activities and voucher redemption strategies to improve progression in ANC visits and therefore contribute towards better health outcomes.

[1] Facility Still Birth Rate: Number of still births in voucher supported facilities per 1,000 births
[2] Maternal Mortality Ratio: Number of maternal deaths per 100,000 live births

Figure 8: Voucher Client ANC and Delivery Services Utilization Trends



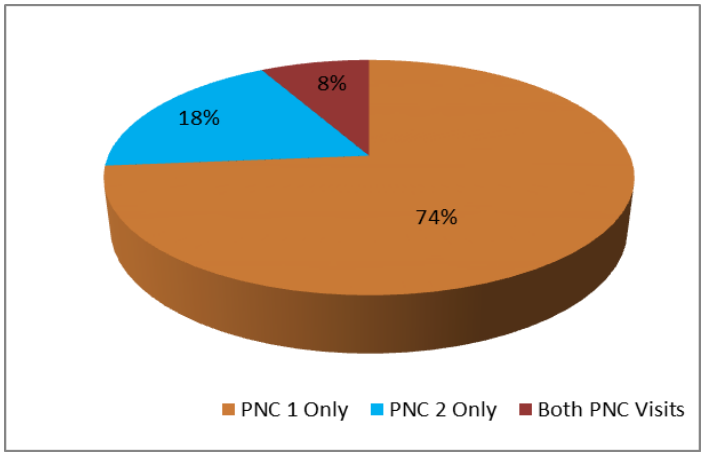
Increasing Access to PNC

During the quarter, the Activity continued to support poor women to access PNC services to avert, detect, and manage postpartum complications. Approximately 45% of mothers who delivered between October and November 2017 returned for at least one PNC visit, dropping to 6.8% in December. The Activity will strengthen its demand generation and voucher redemption strategies, and strengthen provider communication skills especially in counseling clients about the importance of PNC.

Table 12: Y3 Q1 Voucher Client PNC Utilization

	October	*November*	*December*	*Quarter Total*
Total Deliveries	4,130	3,932	1,788	9,850
Total PNC Clients	1897	1776	122	3794
PNC Utilization Rate	46%	45.2%	6.8%	38.5%

Figure 9: Y3 Q1 Voucher PNC Utilization Patterns among Voucher Clients



The Activity promotes the "triple six" PNC policy among providers, which requires that each client and her baby receive PNC at six hours, six days, and six weeks after delivery. As shown in Figure 9, PNC at six days accounts for 74% of all PNC services, while PNC at six weeks continues to be low. This is because providers do not encourage mothers to return for a second PNC visit for fear of not being reimbursed, and the lack of static immunization services at some voucher facilities. Mothers prefer to use facilities that have the capacity to immunize infants during the same visit. In collaboration with RHITES-E and the districts, the Activity will support facilities to access vaccines from nearby public facilities so they can provide static immunization services. This will both improve immunization coverage, and increase uptake of PNC at six days and six weeks.

Table 13: Cumulative Voucher Client PNC Utilization

	Y2 Q1	*Y2 Q2*	*Y2 Q3*	*Y2 Q4*	*Y3 Q1*	*Cumulative*
Total Deliveries	2,132	9,032	11,897	11,852	9,850	44,763
Total PNC Clients	845	4,748	5,873	5,587	3,794	20,847
PNC Utilization Rate	39.6%	52.6%	49.4%	47.1%	38.5%	46.6%

Although PNC uptake was lower than the national average (46.6% compared to 53.4%, UDHS 2016), the Activity is making significant strides in promoting the triple six PNC policy through its "Health education for mothers" strategy. The Activity educates women and communities about the importance of PNC, its availability, and the importance of empowering women to make choices about their own health. This translated to an increase in PNC use from 40% in Y2 Q1 to 47% this quarter.

Increasing Uptake of PPFP

The unmet need for FP is generally high in Uganda. The Activity is addressing this by providing PPFP to voucher clients. However, uptake of FP services remains low with approximately 19% (n =1,853) of the mothers who delivered during the quarter taking up FP services, as detailed in Table 13.

Table 14: Y3 Q1 Voucher Client PPFP Utilization

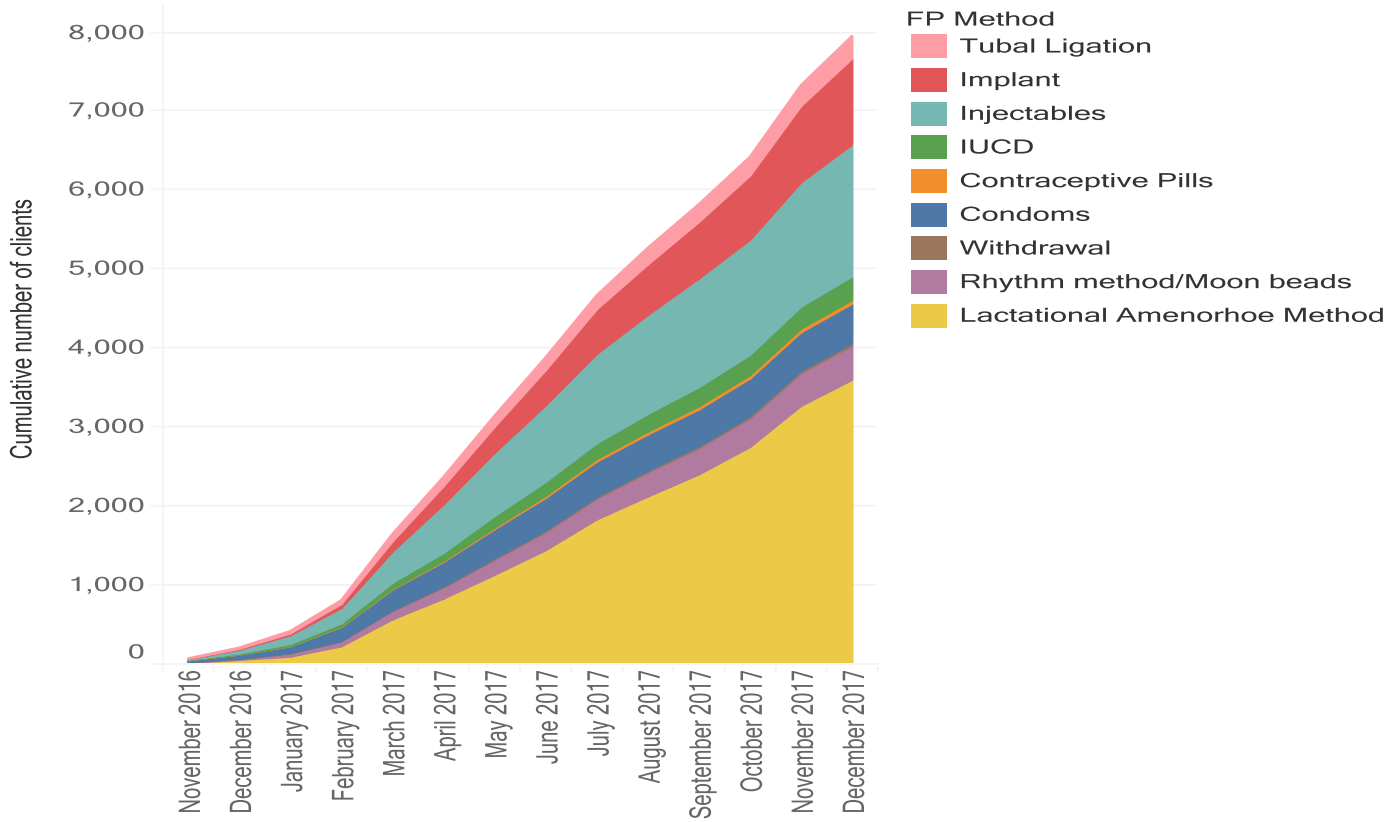
	October	*November*	*December*	*Quarter Total*
Total Deliveries	4,130	3,932	1,788	9,850
Total PPFP Clients	762	755	336	1,853
PPFP Utilization Rate	18.5%	19.2%	18.8%	18.8%

The Activity's contraceptive prevalence rate for modern FP is 19%, which is lower than the national average of 34.8% (UDHS, 2016). Low FP uptake is partly due to persistent myths and misconceptions about FP, the high number of Catholic voucher providers not offering modern FP services, and poor linkage to care for PPFP from the Uganda Catholic Medical Bureau and other non-FP facilities.

Table 15: Voucher Client FP Utilization by FP Method Type

FP Method Type	*No. of Users Y3 Q1*	*Cumulative No. of Users*
LAM	1,023	3,862
Implants	339	1,204
Injectable	272	1,880
Moon Beads	75	466
Tubal Ligation	58	323
IUCD	46	331
Male Condoms	21	474
Female Condoms	11	72
Contraceptive Pills	8	57
Total	1,853	8,669

Figure 10: Cumulative Voucher Client FP Utilization by Method Type



Increasing Access to eMTCT Services

Table 16: Voucher Client eMTCT Service Utilization

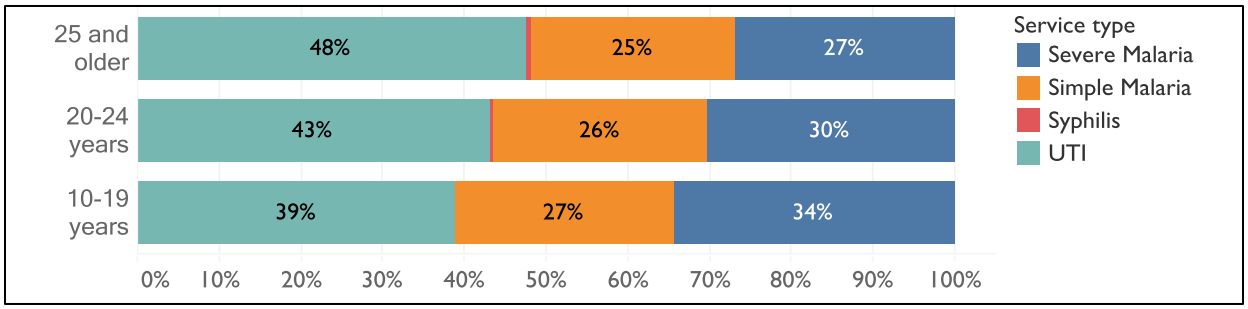
Utilization Outcome	*Y3 Q1*	*Cumulative*
Counselled And Tested for HIV	23,025	87,145
Tested Positive	502	2,403
Positivity Rate	*2.1*	*2.8*
Initiated On eMTCT (Naïve Clients)	126	1,031
Already on ART	104	829
Referred to ART-Accredited Site (non-VSP)	376	1,372

During the quarter, 25% (126) of clients who tested positive for HIV were enrolled in eMTCT services within VSPs. The Activity referred the remaining clients to ART accredited public sector facilities. To date, the Activity has initiated 43% (1,031) of clients testing HIV positive in eMTCT within voucher-supported facilities. To improve access to eMTCT services, the Activity will continue engaging DHOs, in-charges of public health facilities, and RHITES-E partners. The Activity will also continue to improve linkages between VSPs and public sector sites for ART and HIV test kits, and strengthening communication between providers with key contacts for ART services.

Managing Cases of Common Illnesses in Pregnancy

During the reporting period, the Activity treated 4,830 clients for pregnancy related illnesses; malaria and urinary tract infection accounted for nearly 50% of cases. Figure 11 shows the major illnesses.

Figure 11: Common Illnesses Managed by Voucher by Age of Mother



Sub-IR 1.3: Quality of MNCH and FP Services at Participating Private Sector Facilities Improved

During this quarter, the Activity continued to build VSP capacity to improve and sustain the quality of care offered to clients. Capacity building activities centered on provider training, on-site mentorship, and supportive supervision. The Activity continued to work closely with several key partners including the MOH, DHOs, the Regional Health Integration to Enhance Services (RHITES-E) project, UHMG/SMA, the Applying Science to Strengthen and Improve Systems (ASSIST) project, and Marie Stopes Uganda. This

included working with DHOs for joint supportive supervision and monitoring of quality of care, as well as to identify and assess new VSPs, conduct the annual clinical audit for VSPs, and create service linkages for clients from voucher facilities—especially for anti-retroviral treatment (ART), elimination of mother-to-child transmission (eMTCT) services, vaccines, and access to district ambulance services. With RHITES-E, the Activity initiated technical assistance for HIV services for VSPs. This collaboration also enabled dissemination of revised maternal and perinatal death surveillance and response (MPDSR) guidelines to VSPs and identification of training opportunities for VSPs.

Provider Training

A Voucher Plus trainer demonstrating insertion of implant during the FP training held in Lira town

The Activity completed the first wave of FP and CEMONC trainings (initiated in Q4 Y2). Nineteen providers were trained in PPFP and 11 Doctors in CEMONC. The Activity also held the second wave of Option B+ trainings (142 providers) to ensure the required second provider at each supported facility trained in Option B+. The Activity used MOH FP, Option B+ and CEMONC training curricular, with national MOH trainers leading all trainings. These trainings will increase human resource capacity to handle increased clientele at facilities. The Activity's quality improvement (QI) teams will follow-up with trained providers using on-site mentorship for continued improvement of their skills. Table 16 summarizes the MNCH and PPFP training courses.

Table 17: Summary of Provider Trainings

Training Type	*No. Conducted*	*Y3 Q1 No. of Providers Trained*	*Cumulative No. of Providers Trained*
Comprehensive FP	5	19	132
Option B Plus	5	142	353
CEmONC	1	11	21

Technical Mentorship and Supportive Supervision

On-site support for maternity staff at Kidetok Health Center providing training on proper use of BABIES Matrix

On-site mentorship is an effective way of improving health worker competency, including for neonatal resuscitation, management of difficult labor, partograph use, proper clinical documentation, infection prevention and control, goal oriented ANC, and management of complications in pregnancy (e.g., postpartum hemorrhage, APH, obstructed labor, and preeclampsia). By using on-site mentoring, the Activity is able to work with more facility staff—classroom trainings can only accommodate limited numbers. In addition, this approach means mentors can address issues peculiar to each VSP, with focused tracking of improvements using MOH QI tools.

The Activity undertook 117 mentorship visits (42 in the North and 75 in the East) during this quarter. During these visits, the Activity initiated 77 QI projects (22 in the North and 55 in the East). QI projects focused on partograph completion rate, proportion of clients with proper clinical notes, and proportion of clients in ANC using Goal Oriented ANC.

BEFORE: Poor medical waste management practices at VSP facility prior to training and mentorship

AFTER: Improved medical waste management practices at VSP facility following training and mentorship

CME session on QI approaches prior to selection of QI committee at Pallisa health center

Creating Linkages for Supported Facilities to Access FP Products, ARVs and Vaccines

The Activity continued to collaborate with MOH, DHOs, RHITES-E, UHMG/SMA, ASSIST, and other district-level partners, to monitor and strengthen linkages developed last quarter for better integration of eMTCT, immunization, FP, ANC, delivery, and PNC services. The Activity also worked with DHOs to identify transport options for emergency referrals; as a result, a database of district level referral transport linkages was developed. Next quarter, the Activity will develop service referral briefs for display in each supported facility.

Mainstreaming Gender and Youth into Quality of Care Support and Mentorships

As part of routine on-site support visits to facilities, the Activity supports providers to address other structural issues that affect quality of care. This includes providing CME on how to improve access to youth-friendly services, and how to screen for and provide SGBV services. 132 health workers (80 in the East and 52 in the North) participated in CME at 21 health facilities (13 in the East and eight in the North). Each participating facility developed an action plan. The Activity team will continue to reach out to more providers to ensure they understand fully how to make their services youth friendly and gender sensitive. The Activity will also follow-up on implementation of agreed action plans.

Inclusion of Neonatal Care and STI Treatment for Spouses

The Activity is expanding the service package to include neonatal care for 28 days of life, and management of STIs among spouses of voucher clients, including HIV and syphilis testing. This is designed to reduce neonatal mortality and morbidity, and ensure compliance with the National HIV and STI Policy Framework.

Key Learnings and Adaptations from IR1

Voucher Sales

Program learning has identified the following strategies to accelerate voucher sales:

- *Increase the number of VCBDs in each catchment area*. During a field assessment of community engagement activities, feedback from VSPs and community leaders indicated that VCBDs were not covering the full 5km radius stipulated in the distribution strategy, but instead focusing on villages near to their homes. The Activity therefore increased the number of VCBDs per facility from two to a maximum of six, covering all villages in a 5km radius of each facility. The Activity will focus on recruiting vibrant youth and young women as distributors. We will engage local council (LC) chairpersons and other active community leaders as voucher distribution agents.

- *Implement a facility-to-community linkage strategy*. Community leaders were sensitized at the start of the Activity. However, engagement of community leaders and champions in mobilization and implementation of activities has been ad hoc and limited to behavior change communication. Effective January 1, 2018, the Activity adopted a *facility-to-community linkage strategy.* Within target localities, community leaders, LC1s, LC2s, village health team (VHT) members, sub-county council leaders, women and youth champions, religious and cultural leaders, and health unit management committees, will actively support mobilization and voucher distribution. Quarterly community-facility meetings at each facility will identify innovative ways to improve community activities and increase access to and utilization of voucher services. District council leaders and district health team (DHT) members will be invited to participate in these meetings. Facility owners will cost-share and jointly plan these meetings with the Activity and key community leaders. In addition, the Activity will distribute voucher samples to all members of these groups to reinforce education and sensitization about vouchers within their communities

- *Increased visibility of vouchers at community level.* The Activity initially adopted a generic approach to educating communities about the benefits of the voucher program. However, lack of a branded voucher or systematic marketing approach has slowed demand and uptake. Working with FHI 360's Communication for Healthy Communities (CHC) and the Uganda Health Marketing Group/Social Marketing Activity (UHMG/SMA), this Activity is developing a brand to increase voucher recognition in the region and accelerate demand for voucher services among targeted populations. The brand will be launched in Y3 Q2, along with promotional posters and other communication materials.

- *Eliminate voucher stock-outs among VCBDs.* The Activity distribution strategy stipulates that VCBDs should buy vouchers on a cash basis. However, most VCBDS do not have adequate cash to maintain sufficient voucher stocks. This affects sales, as mothers cannot access vouchers when they need them. To address this challenge, a revised guideline will compel VSPs to invest in community activities as partners in the project. Effective January 1, 2018, VSPs will buy vouchers for VCBDs to distribute to eligible pregnant women.

- *Re-think mass media strategy*. The Activity has used radio programming heavily over the last 15 months, educating people in target districts about voucher services, and using key people as guest speakers (e.g., DHT members, community development officers, LC3s, VSPs, and satisfied clients). Effective Y3 Q2, the Activity will use radio to broadcast promotional soundbites from satisfied users and gatekeepers (i.e., voucher clients, spouses, VSPs, and community leaders) to stimulate use of services.

Voucher Redemption

In December 2017, the Activity conducted a field-monitoring visit and rapid cycle learning (RCL) study to understand redemption patterns and motivation by voucher clients to redeem their vouchers. Together, these identified the following key issues affecting use of voucher services:

- *VCBDs lacked adequate knowledge about vouchers and therefore were not encouraging mothers to use the full service package.* Of women who had purchased but not redeemed vouchers for any services, some women considered the voucher insurance for emergencies. Along with employing the facility-to-community linkage strategy (mentioned earlier), Social Behavior Change Communication Officers (SBCCOs) and VSP staff will jointly re-orient and continuously evaluate VCBD knowledge about the voucher service package to ensure accurate knowledge dissemination. Periodic independent client follow-ups by Abt and the Independent Verification and Evaluation Agency (IVEA), BDO, will also evaluate client knowledge about and satisfaction of voucher services.

- The majority of very poor women surveyed mentioned *transportation is a major hindrance to using the full package of voucher services* requiring multiple visits to the health facility.

- *Poor client follow-up to by VCBDs to remind mothers to use voucher services*. After selling vouchers, VCBDs are not motivated to follow-up with clients. VCBDs attributed this to a lack of transport to travel back to clients' homes or villages. The UGX 2000 made from voucher sales is not incentive enough to follow-up clients. VSPs will now purchase the vouchers for VCBDs to distribute instead of the VCBDs using their money to purchase the vouchers. Under this new mechanism, VCBDs will earn Ugx 4000, which we hope will encourage them to follow up mothers as per our expectation of their role and commitment in the Activity. Providers will be asked to reimburse VCBDs for transport costs associated with client follow-ups, given that VSPs (along with voucher clients and their unborn babies) benefit when clients redeem the full package of services.

- *Referral to public health facilities has not been tracked by the Activity*. The Activity protocol requires that facilities refer clients to the nearest facility (public or private) for comprehensive management. However, the Activity does not track clients who access public sector services at facilities not contracted by the scheme, leading to misreporting especially on delivery numbers. Working with VSPs, the Activity will streamline referral and linkages tracking to document the Activity's contribution to comprehensive care.

- To understand redemption trends for voucher services, the Activity analyzed Poverty Grading Tool data for 82,432 clients who had redeemed their vouchers for at least one service. The purpose was to establish the gestational age of clients at the time of voucher purchase. Table 17 below indicates that *eight in every ten mothers (83.2%, n = 68,672) purchased vouchers after their first trimester, making it difficult for them to complete four ANC (ANC4) visits*. Working with community leaders, the Activity is directing VCBDs to target clients in the first trimester to improve ANC4 attendance, as well as voucher redemption and utilization.

Table 18: Clients' Gestation at Purchase of Voucher, Disaggregated by Region

Trimester	Eastern		Northern		Total	
1st	6,123	14.3%	7,637	19.3%	13,760	16.7%
2nd	20,995	49.0%	19,133	48.3%	40,128	48.6%
3rd	15,725	36.7%	12,819	32.4%	28,544	34.6%
Total	42,843	100%	39,589	100%	82,432[3]	99.9%

- *Women in Eastern region view vouchers as insurance mechanism*. Results from the RCL survey show that women were buying vouchers in the Eastern region but not redeeming them because they were seen as an insurance in case of obstetric emergency, or they lived closer to a public facility for emergency and other obstetric services.
- *Expand service package to include neonatal care.* In order to address feedback from clients regarding quality of services, the activity is expanding the service package to include neonatal care for 28 days of life.
- *High VSP staff turnover impacting quality of services*. Some VSPs experienced high staff turnover leading to doubts from voucher clients about the quality of the service package offered.

General Takeaways

Systems-thinking approach: Our experience shows that finances, infrastructure, supplies, human resources, and service delivery, are interconnected. High standards, leadership, and governance are critical components of a functioning health system. While several facilities now understand infection prevention practices, many VSPs continue to compromise standards due primarily to a lack of appreciation that robust prevention practices translate to a healthy business.

Our preliminary assessment of staff turnover and performance shows a correlation between high performance and retention of trained staff. However, facilities with high staff turnover provide poorer care because new staff (sometimes newly graduated) have insufficient capacity. As a result, the Activity is now targeting more QI efforts towards poorer performing facilities. The Activity is also engaging individual proprietors and managers on the importance of staff retention.

In collaboration with UHF, the Activity will facilitate business skills training in Y3 Q2 for private providers using materials adapted from Cardno and covering modules in stock management, finance, HMIS, human resource management, among others. The Activity will use the training to help VSPs understand how and where to invest in improving delivery of quality MNCH and PPFP services.

Community-facility linkage enhances facility response to quality of care issues. The Activity held several meetings at health facilities in Northern Uganda to review performance and identify innovative approaches to improve service uptake. Various community leaders attended the meetings, including sub-county or town council leadership, VHTs, community linkage resource persons, facility staff, VSP proprietors, health unit management committees, and the Activity team. These meetings provided direct feedback to facility management about community experiences in quality of care, and enabled facility staff and proprietors to

[3] Data was analyzed for 82,423 of the 88,783 clients who redeemed vouchers for at least one service. Clients not included in the analysis had missing data.

explain their operations to the community. The meetings were therefore instrumental in building connections between facilities and communities, and in motivating health facility teams to act on issues identified munities. As explained in Sub IR 1.1, the Activity will scale up this approach to all facilities, and will continue on a quarterly basis with full participation of facilities in planning and organizing meetings.

Stringent distribution mechanisms are counter-productive. At present, VCBDs go door-to-door to access women at home before selling vouchers. This is to mitigate an influx of ineligible women in supported facilities. However, given the sparse location of many homesteads, this process is both inefficient and ineffective, resulting in poor sales and low motivation by VCBDs to follow-up with mothers. The Activity has identified an incentive mechanism to boost sales, which will generate cost-share from VSPs, and an incentive matrix for voucher redemption (to be discussed with USAID for approval).

Connectedness with district level is important for health systems improvements in private sector. The Activity has engaged strongly with district health leadership in facility assessments supervision, mentorship, coaching, and other visits. This collaboration improves public-private engagement for health, and improves provider relationships with the district. During the reporting period, the Activity intensified involvement of district health leadership, especially DHTs--this included DHOs (for decision-making), the Assistant DHO (for MNCH), the district focal persons for laboratory management, HIV and EPI services, biostatisticians, Senior Nursing Officers delegated by the district, and Health Inspectors. Many facilities appreciate the increased recognition by, and the improved relationship with district health leadership, towards the private health sector. Facility proprietors are more motivated to make improvements identified during joint facility visits, and to participate in district quarterly progress review meetings.

IR 2: Increased Capacity of Uganda's Public and Private Sectors to Develop Longer Term Health Financing Options

Sub-IR 2.1: Local Organizations with the Capacity to Implement Output-based Financing Activities Strengthened

Collaboration with Uganda Healthcare Federation (UHF)

The Activity worked closely with UHF to include 100 voucher facilities in UHF's planned roll out of the self-assessment QI tool. The tool, launched in August 2015, was developed with support from the USAID/Uganda Private Health Support Program through a partnership between UHF, MOH, and the Uganda Medical and Dental Practitioners Council. The tool will become a government health facility registration and licensing tool, as well as a QI surveillance tool for local government through DHOs and regulatory councils, including the Allied Council and Nursing Council. The outcome of these self-assessments for Activity sites will be shared in the next quarter.

Strengthening VSP Management Capacity

During the quarter, the Activity continued to produce and distribute stationery for claims, and supported providers through on-site mentorship to build capacity in the reimbursement process. The Activity also revised reimbursement rates to harmonize with MOH voucher rates, and expanded the service package to include neonatal illnesses for up to 28 days of life. This new package has been included in revised provider contracts and will become effective in Q2 Y3.

Building Capacity to Implement Output-based Financing Mechanisms

The Activity continued to build provider capacity to participate fully in output based aid mechanisms through provider trainings, on-site mentorship, joint supportive supervision, and joint monitoring visits with DHTs. The Activity has also fostered service links between private and public sector facilities, worked with DHOs to ensure private providers report data into DHIS2, and encouraged biostatisticians to extend their technical support to private sector facilities to improve data capture and reporting. The Activity also actively engaged DHOs and DHT members in facility assessments, accreditation processes, routine service monitoring, and reviews of provider claims. The Activity is also exploring ways of working with RHITES-E implementing partners to strengthen district and provider capacity to conduct MPDSR.

Sub-IR 2.2: Evidence, data and assistance to develop sustainable financing schemes for MNCH and FP provided

Disseminating Successes and Challenges with Stakeholders

The Activity remains committed to strengthening documentation and enhancing learning. During the reporting period, the Activity completed the following:

- After Action Review of learnings from provider mapping and assessment;
- Voucher Redemption and Utilization Rapid Assessment; and
- Client tracing and follow up services.

The Activity will disseminate results from the above during Q2 to stakeholders, including through podcasts and briefs. A dissemination plan has been developed and will be implemented when the products are finalized. The Activity will also continue to produce and disseminate periodic learning briefs and newsletters containing evidence and lessons from implementation.

Program Management

Abt Associates continued to hold coordination meetings with all sub-contractors to ensure robust and effective partner management, review the Voucher Plus Activity critical path and performance, address challenges in a timely manner, and foster teamwork.

Abt remains passionate about excellence, especially in clinical quality and business processes; we embrace a spirit of learning and adaption, innovation, efficiency, cost-effectiveness, and a commitment to quality and measurable results. While many programmatic challenges in clinical quality and community mobilization continue to arise, the Activity has remained vigilant in ensuring clinical quality, and in developing, adapting, or adopting best practices for increasing community awareness and demand for vouchers. Cognizant of the fact that voucher schemes (like insurance and RBF) are prone to financial risk, we adopted forward-thinking approach to managing such risks on multiple levels, from the perspective of individual team members, VSPs, VCBDs and other stakeholders. In this quarter, the Activity finalized and documented standard operating procedures for managing undesirable circumstances at multiple levels of our operations.

Voucher System Management

Provider Reimbursements

Reimbursements continued to increase as more providers learned the reimbursement process and adhered to required standards of care. Table 18 provides a summary of provider reimbursements.

Table 19: Summary of Year to Date Payments Made to VSPs as of December 31, 2017

Reporting Period	Amount Expected	Amount Paid	Amount Quarantined	Amount Rejected
Y2 Total in UGX	5,702,155,720	4,013,057,867	497,696,857	118,512,167
Y3 Q1 in UGX	2,248,741,771	1,770,753,626	165,007,110	77,322,501
Total in UGX	7,950,897,491	5,783,811,493	662,703,967	195,834,668
Total in USD**	2,152,976	1,566,164	179,450	53,029

*** Used exchange rate of $1 USD to 3692.98 UGX from OANDA currency converter as of Jan, 2018*

Key Learnings and Adaptations from IR2

Revision of Reimbursement Rates

In response to VSP feedback, and after benchmarking with the existing MNCH voucher project rates, the Activity revised VSP reimbursement rates to align more closely with the current market. The Activity also revised rates for drugs and medical consumables to respond to changes in market prices for some commodities. The new rates will become effective February 1, 2018. The Activity is also working on including management of STIs for partners of voucher mothers.

Learning and Adaptions in Claims Processing and Reimbursements Processes

Throughout Y2, the Voucher Management Agency (VMA) improved work processes to achieve optimal claims processing using the Voucher Management Information System. Through continued learning and adaptation improvements, the VMA was able to reduce average claims processing turnaround time from more than 60 days to less than 20 days.

It became apparent that further improvements were needed in the system for it to function optimally, as well as to facilitate the kind of reporting required. The Activity worked with an information technology contractor to institute the required system modifications, which focus mainly on reports generated and routine system functioning.

Independent Inspection of Services and Claims Management Processing by BDO

BDO is the Activity IVEA responsible for providing independent verification using appropriate tools. During the reporting period, BDO undertook field inspections and reviewed claims management processes at 25 voucher supported health facilities. BDO also conducted Health Service Inspections and Claims Management Processing using tools that were developed, piloted, and subsequently approved by Abt Associates.

Overall, the IVEA determined that most facilities were compliant with minimum health system requirements. However, the quality of care fell short of the minimum score of 70% in most facilities, mainly due to poor infection control. Medical waste management also remains a challenge at many facilities. The claims processing management audit confirmed that named patients were obtaining stated services.

The IVEA also developed verification tools to generate data and carried out pre-testing with selected providers to learn lessons from facilities and voucher beneficiaries. The data gathered will inform Abt Associates about the voucher program. In the forthcoming quarter, the IVEA will carry out a beneficiary satisfaction survey; the data will generate client feedback about the voucher program, health services, and beneficiary's eligibility and satisfaction with the Activity. Among other issues, the IVEA will discuss lessons learnt and how to improve targeting to the poorest and most vulnerable. This will inform Activity strategies to achieve measureable improvements in safe motherhood services.

Monitoring, Evaluation, and Learning

Supporting HMIS Reporting for the Private Sector

The Activity remains committed to supporting the private sector to adhere to MOH reporting requirements through use of MOH tools to capture facility data. During the quarter, the Activity distributed a consignment of HMIS tools received from the METS Program. These were taken to Activity field collection centers for collection by providers to replenish stocks, or replace expired or missing tools. Tools distributed included Integrated Maternity, Antenatal, Postnatal, outpatient department, in-patient, HIV testing and counselling, stock books and Family Planning Registers among others.

DHIS2 Reporting for the Private Sector

The Activity continued to support private providers to submit timely and accurate monthly reports to their respective districts for capture in DHIS2. The Activity works closely with district biostatisticians through joint supportive supervision of private sector facilities. This helps to strengthen provider adherence to district reporting requirements, enhances data quality assurance processes, and provides an opportunity for on-site mentorship and coaching of providers in data management. Of the 130 supported providers, 119 actively report into DHIS2, four are in DHIS2 but inactive, and seven are yet to be included. The Activity wrote to the DHOs requesting activation of the relevant providers and inclusion of missing providers. However, districts highlighted that providers have to be consistent in submitting reports before they can be added or activated in DHIS2. The Activity will continue engaging the districts and the MOH Resource Centre to ensure that inactive facilities are activated, and for providers not in DHIS2 to be included. All of the the six terminated providers were actively reporting by the end of this reporting period. Tables 19 and 20 summarize the status of providers.

Table 20: Inactive Facilities in DHIS2

District	Facility name
Amuru	Lakang Community HC II
Budaka	Iki-Iki HC
Serere	Atira Medical Centre
Soroti	Soroti Medical Chambers

Table 21: Facilities not in DHIS2

District	Facility name
Bukedea	Cross Emergency Medical Centre
Butaleja	Kalif Medical Centre
Manafwa	Kim-Tab Maternity Home
Ngora	Asianut Medical Centre
Ngora	Community Care Medical Services
Ngora	Janju Family Health Care
Pallisa	Pallisa Medical Centre

Collaboration, Learning and Adapting

Inclusion of Neonatal Care and STI treatment for Spouses of Voucher Clients in the Voucher Service Package

The Activity is expanding the service package to include neonatal care for 28 days of life and management of STIs among spouses of voucher clients (including HIV and syphilis testing). This is designed to reduce neonatal mortality and morbidity, and ensure compliance with the National HIV and STI Policy Framework.

Supporting Youth Access to MNCH and PPFP Services

Analysis of Activity data shows that clients aged over 24 years were more likely to use ANC services than those below 24 years. This is in line with findings from a number of studies in Uganda on ANC uptake, which also highlight the influence of maternal age on ANC service use. Through this learning, the Activity has invested in activities to involve the youth in accessing MNCH and PPFP services.

Joint Field Partner Support Visits to Increase Demand for Voucher-covered Services

During the quarter, Communication for Development Foundation Uganda's (CDFU's) M&E team conducted a joint supportive supervision visit with FHI 360's CHC. The visits were undertaken prior to joint communication activities to mobilize service demand, and aimed to: strengthen the collaboration between partners to increase demand for voucher-covered services; help CHC understand the roles of VCBDs; assess voucher client satisfaction through client follow-ups; and orient CHC on the services offered by supported health facilities.

Action Review of the Private Provider Mapping and Accreditation for Contracting

Prior to starting implementation, the Activity needed to identify and engage private providers as VSPs. MOH currently does not maintain a national private provider database. Therefore, in order to identify potential VSPs with appropriate service delivery capacity and geographic reach, the Activity conducted a mapping in May 2016, which included an assessment and selection/approval of VSPs. An After Action Review was conducted to document lessons learned.

Major Lessons Learned

- It would have been more efficient if providers had conducted a self-assessment prior to the Activity assessment, thus avoiding traveling to facilities that did not meet the minimum criteria;
- Involvement of the DHOs throughout the entire process is critical to effective mapping and accreditation of providers to participate in any output based financing mechanism, including the involvement of DHTs in the development of facility assessment tools and directly participating in the data collection process;
- Involvement of the medical bureaus in mapping and identifying private providers;
- Effective supervision of assessment teams is critical for ensuring the validity of results;
- Rather than focusing the assessment on one facility staff member (i.e., the midwife, who in most cases was not the in-charge), the assessment should have included in-charges and proprietors to ensure assessment results reflected the capacity of the facility as a whole;
- Prior to final VSP selection, different staff from the Activity should have conducted a verification visit to all facilities to validate assessment results; and

- Determination should have involved more than two staff members from the Activity to maximize objectivity, and DHOs should have played a greater role in this process.

Activity Adaptations from the Provider Mapping and Assessment:
The above learnings were adapted after a recently concluded mapping, assessment after action review, and we are applying the learning to new providers enrolling into the Activity. We will disseminate findings in a knowledge and learning brief to other partners to inform similar future exercises.

Client Tracing

The Activity uses client tracing and follow-ups extensively as an integral part of the learning agenda. In mid-2017, the Activity conducted the first round of tracing and follow-ups to validate client existence, assess satisfaction with voucher services, and understand how the Activity could improve voucher utilization. Key learnings that have since been adopted include;

- Motivating VCBDs to follow-up mothers in communities to boost voucher redemption and utilization;
- Improving VCBD the supervision by SBCCOs to enhance performance, including voucher sales; and
- Recruiting additional VCBDs for providers with large catchment populations.

Voucher Redemption and Utilization Rapid Assessment
The Activity conducted a second round of client tracing in December 2017. This was a quick but rigorous study using RCL to establish why many vouchers were not used at the end of Y2 (23% or 20,000), and why there was a long gap between when some clients purchased and used vouchers.

Preliminary results suggest the following reasons for low use of vouchers:

- Inadequate information provided to the mothers by VCBDs about voucher utilization;
- Sale of vouchers by VCBDs to mothers outside the 5km radius resulting in long distances for mothers to travel to access services from accredited facilities;
- Poor provider-client instruction and inadequate information provided to mothers by health workers about their next appointment or visit date;
- Low motivation of staff at voucher facilities and laborious data capture processes resulting in loss of data on actual clients served;
- Lack of motivation of VCBDs to conduct follow-ups and promote voucher redemption;
- Long waiting hours at voucher facilities is off-putting for repeat services; and
- Voucher mothers are made to wait for group counselling and services while cash clients are served immediately.

Plan to Adapt Learnings:

- To improve motivation of voucher distributors to conduct client follow-ups and promote voucher redemption, a motivation strategy for VCBDs has been developed and will be implemented;
- To improve staff motivation at voucher facilities, business training has been planned for proprietors, focusing on how proprietors can motivate their staff to better handle the increasing clientele and workload at facilities; and

- Routine review meetings between SBCCOs and VCBDs to refresh knowledge about the voucher service package and the types of information VCBDS should give to the clients regarding voucher utilization.

Year 3, Quarter 2 Planned Activities

1. On-board new facilities including private wings of public facilities.
2. Conduct operations research to inform Activity Learning Agenda implementation
    a. The Activity will initiate processes to document learnings from the following themes:
        i. Are targeting mechanisms effectively reaching the beneficiary population? If not, what are the challenges, lessons learnt and what has or can be tested to improve targeting to the poorest and most vulnerable?
        ii. What demand generation and sensitization activities are most successful in increasing service utilization and retention in safe motherhood care, for mothers, including youth?
        iii. What does the voucher activity reveal about poor clients' willingness and ability to pay for quality healthcare services?
3. Implement the Activity Knowledge and Learning Strategy. The Activity has initiated processes to identify additional potential areas of learning (programmatic learning) in addition to the Learning Agenda questions from the AMELP. Through the rapid cycle learning approach, we will identify resourceful informants for each of the additional learning areas, agree on the tools, methods and techniques to be adopted for data collection, analysis and documentation of the learnings.
4. Conduct performance review meetings with program staff
5. Facilitate quarterly facility-community linkage meetings at VSP facilities to foster collaboration, learning and adaptation
6. Develop branding for vouchers to better promote MNCH and PPFP vouchers in target districts
7. Implement marketing and promotional campaigns through print and mass media to increase visibility, demand, and use of MNCH and PPFP vouchers
8. Strengthen collaboration at operational level with other implementing partners, such as CHC, RHITES-E, and SMA to functionalize synergies, learning and adaption, and to accelerate achievement of and the Activity's annual objectives.
9. Continue offering quality assurance support to facilities
10. Implement business skills training for providers
11. Introduce a mobile system for distribution and tracking of vouchers in collaboration with Living Goods
12. Actively engage the local and global reproductive health and health financing community, learning from and catalyzing others to collaborate in providing services to the underserved using effiecient and cost effective models.
13. Mobiise communities and exisiting local saving groups to adopt health saving stratgeies, and empower voucher families to start saving for health through identified savings groups
14. Recruit new team members with clinical, communication, and project management skills and experiences to complement our existing teams and improve depth of management and operations.

Annex 1: Roles of Partners

- Abt Associates is the prime contractor, responsible for activity management and sequencing, oversight, M&E, and learning to inform the Government of Uganda on health financing schemes. Abt Associates is also responsible for the training, quality assurance, and accreditation of private providers, ensuring the delivery of quality services.
- CDFU is the community engagement agency responsible for mobilizing communities. CDFU utilizes VHTs to distribute vouchers as VCBDs.
- PricewaterhouseCoopers is the VMA, responsible for managing provider claims and reimbursement processes.
- BDO Uganda is the IVEA that audits and ensures accountability in the voucher activity to USAID. On boarded in Q4, 2017, the Activity team is working closely with them on initiation of activities.

Annex 2: Stakeholder Meetings to Foster Collaboration, Coordination, and Joint Learning

Partnerships continue to be an opportunity for leveraging our resources to serve vulnerable women in northern and eastern Uganda. During this quarter, the Activity engaged other implementing partners and stakeholders at the local level (in the districts) where strengthening the overall health system is a priority.

Central level stakeholder Liaison

Stakeholder	*Main contacts*	*Objectives*
URMCHIP project MOH/WB	John Sengendo Coordinator MOH/RBF Unit	Continued strong collaboration to foster joint planning and learning as the MOH plans rollout of RBF, and to ensure harmonization in the start-up districts where both program will co-exist. Training of VSPs (public and private) on MOH RBF project and the five-year strategic plan to get buy-in and understanding of RBF and the role of vouchers in umbrella RBF programs.
MOH/ National Health Insurance desk	Aliyi Walimbwa	Training VSPs (public and private) on the National Health Insurance Plan to help VSPs understand the NHIS agenda, embed innovative health financing mechanisms in their work, and participate in other future health financing options.
CHC Project	Amos Zikusoka Deputy Chief of Party	Continued collaboration and integration of communication activities in areas where both programs co-exist. The Activity is also working with CHC to develop a brand for the voucher.
USAID/Health Partners Uganda	Dr. Stella Regina Nakiwala Chief of Party	Training opportunity for VSPs on cooperative/community health insurance in Q2

Stakeholder	Main contacts	Objectives
UHF	Grace Ssali Kiwanuka Executive Director, UHF	Testing the Self-regulatory Quality Improvement System toolkit with 50 VSPs. UHF will share results and learnings of this exercise in Y3, Q2 for possible adoption by the Activity.
UHMG		Development of a common voucher brand. The Activity is also looking at benefitting from social marketing training for SBCCOs in Y3 Q2

District Stakeholder Engagement

Stakeholder	Objective	Comments
Doctors with Africa-CUAAM	Transport voucher for PNC in Oyam district QI in MNCH services (formation of QI teams, MPDSR committees)	Formation of QI teams, MPDSR committees Conducting medical reviews for maternal and perinatal deaths which occur in facilities
Maries Stopes International	Mentorships in data management/segregation and infection prevention practices for FP	Joint supportive supervision to some facilities where activities co-exist, for example God's Mercy Clinic
URC-SUSTAIN	Sharing best practices in QI tools and in improving MNCH services at facilities supported by URC-SUSTAIN	Learning from each other's experiences Shared list of facilities, mentors, and district QI officers where activities co-exist for collaboration
UHMG	Sharing mentorship experiences in data management/segregation and infection prevention practices, improving access to FP commodities for VSPs and extending other SMA services and products to VSPs	Meetings to share experiences Shared list of facilities, distributors of good life products and FP commodities they offer. Facilities have made orders to UHMG as an alternate distributor of FP products
AVIS	Transport vouchers for emergencies during pregnancy for voucher women in Kitgum and Pader districts. AVIS VHTs and community health workers to identify vulnerable women in the communities, and refer to VCBDs for voucher sales	Stakeholders to formalize the collaboration between St. Joseph Hospital in Kitgum, AVSI and USAID/Uganda Voucher Plus Activity
RHITES-E	Mentorships, coaching and trainings. QI in MNCH services and MPDSR committees and rollout	Formation and functionalization of QI teams and MPDSR committees Carrying out of maternal and perinatal death reviews at the facilities

Stakeholder	Objective	Comments
	CMEs on SGBV and provision of IEC materials	Conducting SGBV trainings at facilities
RHU	Mentorships in primary data source and use, infection prevention practices in Mbale and Kapchorwa districts. QI in MNCH services and formation of MPDSR committees	Creation of QI teams, MPDSR committees, data usage at source, quality MNCH services offered.
TASO	Access to community outreach on HIV testing and linking pregnant women (and their spouses) to care in Mbale and Soroti districts	Shared areas of coverage and involving facilities in community outreach.

Annex 3. Demand Generation Images

VCBD - Dokolo Maternity interacting with Parpii Anyim village savings and loans group on Voucher Plus Package in Bacere Village, Dokolo Town Council

Health Assistant giving health talk with members of Nandala savings group in Nandala Village, Mbale District

Facility-community linkage meetings initiated in northern Uganda. The meetings were well-attended by key influencers, including Mayors, council speakers, Health Secretaries and assistants, LC3 chairpersons, DHOs or their representatives, various LC1s and VHTs from villages in the 5km radius of VSPs, as well as religious and cultural leaders.

Above left, the COP addresses the meeting at Lacor Pabbo in Amuru district, and left, the LC3 chairperson for Opit garners support from local leaders in Lacor Opit in Omoro district

Below left; the Town Clerk of Lira Municipality appreciates the Voucher Plus Activity for increasing access to MNCH services for poor pregnant women. Left; the proprietor of Charis medical center responds to issues from community leaders while the COP looks on.

Voucher Plus BCC collaboration activity with CHC and RHITES-E in Butebo district

Annex 4: Success Stories

Life-Threatening Complications Motivate Mother of 10 to Use Voucher Services for Next Pregnancy

Acom Florence, 37, delivered her first 10 children at home because she could not afford the costs involved in giving birth at a government health facility. Florence is married to Omoit Micheal and they live in Bukedea district in Eastern Uganda.

Florence says she almost died giving birth to her 10th child because the baby was too big, and the traditional birth attendant who was assisting her was not skilled.

"When I heard about voucher program from a friend who had used it and [said] that it helps poor mothers to attend ANC, PNC, FP and delivery from health facilities free of charge … I quickly got in touch with the voucher distributor (Mary Kongai) who came and assessed me from home, sold me the voucher, and advised me to go immediately to St Mather." - Florence

Florence, who was five months pregnant, managed to report to St Martha health center as advised by the Voucher Community-Based Distributer (VCBD). Florence attended three ANC visits, and gave birth to a healthy baby boy without any complications. She is planning to go back for PNC and FP services.

Florence's positive experience using the voucher has encouraged many other women in the community to embrace the program since they know "it's real". She has personally encouraged five other mothers to buy vouchers.

Voucher Allows Mother of Nine to Deliver in Health Facility for the First Time

Koli Semmy, 36, lives with her husband Ayo Bosco and their nine children in Oyam District. Semmy delivered her first eight children at home where she experienced intense pain and excessive bleeding after delivery. Semmy would not seek health services when these complications occurred, putting her at a high risk for more serious health threats.

"When I heard about voucher program from church and that it helps poor mothers to deliver from health facilities free of charge...I quickly got in touch with the voucher distributor (Oceng Denish Bob) who came and assessed me from home and found me. I was already four months pregnant and had not attended any ANC." reports Semmy.

She adds, *"After assessment and qualifying for the voucher, I received the voucher from Bob, the voucher distributor, at UGX 4000. He also gave me a free brochure on pregnancy care [and] planner, which he had explained to me earlier. This brochure had details of how to deliver from health facility. The voucher distributor advised me to report immediately to Apostolic maternity clinic, which I did within three days".*

When Semmy reached Apostolic maternity clinic, the midwives who provided basic maternal and child health information, and check-up procedures welcomed her. This was a surprise to Semmy, since she had never been welcomed in such a positive way at a health facility before. Using the voucher, Semmy managed to attend all four ANC visits, receive free treatment for malaria in pregnancy, and deliver her healthy baby girl at no extra cost. She did not experience excessive pain or bleeding as she did during her previous deliveries. Semmy also received an implant for postpartum family planning.

Semmy and her husband Bosco thank the Voucher Plus Activity for contributing to the overall health of their family. Their oldest daughter Brenda, who has a child of her own, also used voucher services during her pregnancy.

The family highly recommends the voucher program to other poor women as an easy-to-use mechanism to receive comprehensive maternal health services.

Justine and Baby Receive Life-Saving Care through Voucher Activity

Chelanghat Justine, 32, and her husband Bukose David live in Kapchorwa district in Eastern Uganda. Justine gave birth to her first three children at the home of a traditional birth attendant (TBA) because her family could not afford services at the government health facility.

"During giving birth at the TBA's home, the TBA did not know when to push the baby…one time the TBA referred one of her clients to the hospital after failing to manage the complications as a result of untimely pushing the baby, so my life was really in danger with the TBA" reported Justine.

"When I heard about the voucher program from a Voucher Community-Based Distributer (VCBD) (Hairat Chebeti) who came home and shared with me the benefits of a voucher, I decided to

accept the idea and allowed her to assess me…The VCBD returned the following day and gave me the voucher at UGX 4000 and she also advised me to go immediately to Gamatui Health Centre, which I did".

While at Gamatui, Justine was well attended by facility staff, which was something she had never experienced before. She attended all four ANC visits and received postnatal care at the private facility. When she went into labor, skilled attendants quickly identified complications, and she was taken by ambulance to Marsha Clinic in Kampchorwa district. Justine delivered her fourth baby safely at the reference clinic without paying any extra costs. Justine believes that without the voucher, she may not have survived the complicated delivery.

Justine has referred two other women to the voucher program who have also had positive experiences. She promises to tell more women about how the voucher program saved her life.

Annex 5: Y3 Q1 Progress by Indicators

The table below captures the AMELP and project relevant indicators required for quarterly reporting. Performance for each of the indicators is detailed below

PMP/Project Indicator Progress - USAID Standard Indicators and Project Custom Indicators

Strategic Objective: Provide measurable improvements in safe motherhood services by supporting health financing and innovative service delivery models in the private sector

Indicator	Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
		Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
Intermediate Result (IR): Increased utilization of High Quality Voucher-covered MNCH and FP Services in Designated program Districts								
Number of deliveries in participating facilities that are paid for by the Voucher Plus	Maternity register	2016	0	134,768	9,850	9,850	7.3%	Performance represents 29% achievement of quarter's target. The performance is partly because some providers may not have submitted their December claims at the time of report compilation. In addition, the level of activity at facilities generally tends to slow down in December due to holidays. Cumulatively, 44,763 deliveries have been registered by the Activity representing 17.9% of the LOP target (250,000).
Cesarean Section Rates	Maternity Register	2016	0	13%	8%	8%		Overall, cesarean section rates for the Activity are with the recommended rates of 10-15%
Facility still birth rate (per 1000)	Maternity Register	2016	0	12	2.0	2.0		Still birth rate for the quarter dropped from 3 to 2 per 1000 births. This is attributed to the improvement in the quality of care by VSPs
Percent of deliveries attended by skilled health personnel	Maternity Register	2016	0	100%	100%	100%		Observed performance explained by the fact that all deliveries paid for by voucher plus are attended to by skilled health personnel
Percentage of births delivered at a health facility	Maternity Register	2016	0	100%	29%	29%		Performance is due to the low attainment of the expected/ targeted deliveries (reasons highlighted in first indicator). The Activity will

[4] When applicable

Indicator	Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
		Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
								intensify client follow-ups to boost voucher redemption and utilization.
Percentage of mothers initiating breastfeeding within 1 hour after birth	Maternity Register	2016	0	90%	91.8%	91.8%		Performance explained by the Activity's efforts to ensure that providers adhere to MoH quality of care guidelines. However, computation of the indicator was done for only clients with complete data. Of the 9850 deliveries, registered only 6,949 clients had complete data. This being a new indicator, the Activity will continue providing support to providers to improve documentation and data capture.
Percentage of women who attended at least four times for antenatal care during pregnancy	ANC Register	2016	0	50%	21.6%	21.6%		Performance mainly due to the fact that over 80% of the voucher clients purchase vouchers after their 2nd or 3rd trimester which makes it impossible to complete all the 4 antenatal visits. The Activity will strengthen the demand creation to ensure that clients are identified at early stages of gestation.
Percentage of infants born to women living with HIV receiving ARVs as prophylaxis for elimination of mother-to-child transmission (eMTCT)	HIV-Exposed Infant Register	2016	0	80%	36.5%	36.5%		The performance is explained by the fact that data is reported for infants and mothers who received services within ART voucher accredited sites only. Clients testing positive from unaccredited voucher sites are referred to public facilities for ART services, However these numbers are not tracked by the Activity
Percentage of pregnant women living with HIV who received antiretroviral drugs to reduce the risk of mother-to-child transmission (MTCT)\ with HIV	ANC Register	2016	0	100%	25%	25%		
Percentage of Mothers receiving PNC check-ups within 6 weeks of childbirth	Postnatal Register	2016	0	45%	38.5%	38.5%		PNC attendance largely affected by the fact that most of the VSPs do not provide immunization services. Mothers prefer to go to public facilities where they receive immunization services for the infants during the PNC visit.

Indicator	Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
		Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
Number of newborns not breathing at birth who were resuscitated in USG-supported programs	Postnatal Register	2016	0	840	292	292	34.8%	292 of the 328 (89%) newborns not breathing at birth were resuscitated. Knowledge gap by providers and lack of equipment affected the resuscitation process in some facilities.
Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs	Maternity and postnatal registers	2016	0		5,191	5,191		Performance affected by poor documentation and data capture practices among providers. Of the 9,850 deliveries registered in the quarter, only 5,191 deliveries had data reported on uterotonic use. This being another of the new indicator, support to providers will be strengthened to improve data capture and documentation.
Sub-IR 1.1: Demand For MNCH and FP Services in the Private Sector by the poor Created in the Designated program Districts								
Number of individuals attending community mobilization events conducted to increase uptake of maternal health vouchers	Activity reports	2016	0	93,236	29,201	29,201	31.3%	During the quarter, over 29,000 individuals attended community mobilization events conducted to increase uptake of maternal health vouchers. This represents 31% achievement of PY 3 target
Number of vouchers distributed	Activity reports	2016	0	154,856	22,878	22,787	59%	Performance represents 59% achievement of the quarter's target. Performance explained by the fact that there are fewer VCBDs actively distributing vouchers due to many facilities terminated and yet to be replaced, the practice of health facilities charging clients discourages other women from buying the vouchers, some VCBDs acknowledged that they have covered almost all clients within 5 km. Cumulatively, 110,812 vouchers have been sold, representing 19% achievement of the LOP target
Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year	Activity Training Reports	2016	0	120	311	311	259%	By the end of the quarter, 311 VCBDs were active promoting the voucher and increase demand for voucher-covered services, including providing FP information t6o clients.

Indicator		Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
			Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
Number of additional USG-assisted community health workers (CHW providing family planning (FP) information and/or services during the year		VCBD Registers	2016	0	20	8	8	40%	8 additional VCBDs were recruited to fill existing gaps but to also increase voucher sales and utilization
Percentage of vouchers redeemed	ANC1	Claims data	2016	0	95%	71.1%	71.1%		Redemption for ANC 3 & 4, PPFP and deliveries remains low partly because the practice of health facilities charging clients discourages other women from utilizing their vouchers and clients are not given adequate information regarding voucher utilization. The Activity will continue to motivate VCBDs to follow up mothers to ensure full utilization of voucher especially for services with low redemption rates
	ANC2			0	55%	18.3%	18.3%		
	ANC3			0	55%	7.5%	7.5%		
	ANC4			0	50%			21.6%	
	Delivery			0	70%			50.4%	
	Postnatal care			0	50%	38.5%	38.5%		
	Postpartum FP			0	40%	18.8%	18.8%		
Sub-IR 1.2: Access to Comprehensive MNCH and FP Services in the Private Sector Improved									
Percentage of voucher covered pregnant women tested for HIV during any ANC visit and received results		Antenatal register	2016	0	100%	94%	94%		Performance is due to the Activity's efforts to ensure that providers adhere to MoH guidelines including ensuring that all expectant mothers are tested for HIV during antenatal. In a few facilities, stock out of test kits registered affecting the HTC service utilization.
Percentage of babies born to women participating in the Voucher Plus Activity started on immunization within 6 weeks of the postpartum period		Maternity and postnatal registers	2016	0	100%	90%	90%		Majority of the babies born to voucher mothers were started on immunization. The performance is partly due to the strong collaborations with the DHOs were some providers received vaccines from the districts to immunize the babies.
Percentage of USG-assisted service delivery sites providing adequate family planning (FP) counseling and/or services		Family Planning Register	2016	0	75%	70%	70%		This excludes all the 39 catholic facilities according to the new guideline on "adequate counselling" for FP. The Activity fell short of the target due stock out of FP commodities in a few facilities.

Indicator	Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
		Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
Number of USG supported service delivery points offering any modern contraceptive method among postpartum women	Family Planning Register	2016	0	112	91	91	81.3%	By the end of the quarter, 91 providers were providing modern FP services out of the 130 active providers. The number excludes UCMB facilities while some facilities dropped off the Activity
Percentage women who received postpartum counselling for FP	Family Planning Register	2016	0	100%	80.0%	80.0%		Performance for clients counselled for FP is affected by poor documentation and data capture practices among providers. Some providers do not indicate on the claim forms whether the client was counselled for FP. The low demand for FP services is mainly due to wide spread community myths about FP and poor linkage and referral to facilities providing FP services, stock out of FP commodities and significant number of providers that are UCMB and don't provide FP services. The Activity will continue linking supported facilities to UHMG to access free FP commodities
Number of clients provided with FP services	Family Planning Register	2016	0	42,000	1,853	1,853	4.4%	
Percentage pregnant women who received all the three doses of intermittent preventive treatment (IPT) for malaria	Antenatal register	2016	0	70%	118%	118%		Clients receiving IPT3 are more than those who received ANC 4 services. Since majority of the clients buy voucher late in pregnancy, it is likely that majority of the clients complete the ITP3 dose in their 2nd or 3rd visit and deliver before completing the 4th visit.
Sub-IR 1.3: Quality of MNCH and FP Services at Participating Private Sector Facilities Improved								
Number of providers trained in MNCH and family planning	Training attendance forms and activity reports	2016	0	200	172	172	86%	Performance represents 86% achievement of the target. The target could not be attained because some of the providers that were to be trained were from terminated facilities, which reduced the number of staff trained
Intermediate Result (IR) 2: Increased Capacity of Uganda's Public and Private Sectors to Develop Longer Term Health Financing Options								
Sub-IR 2.1: Local Organizations' Capacity to Implement Output-Based Health Programs Strengthened								

Indicator	Data Source	Baseline data		PY 3		Quarterly Status – PY 3	Annual Performance Achieved to Date (in %)	Comment(s)
		Year	Value	Annual Cumulative Planned target[4]	Annual Cumulative Actual	Q1		
Number of private facilities that report data on health indicators into the DHIS2	DHIS2	2016	0	120	124	124	103%	By the end of the quarter, 124 providers were actively reporting facility data into DHIS2. This includes 5 providers terminated by the Activity were initially supported by the project to get into DHIS2. 91.2% submitted timely reports into the system
Percent timeliness of health facility HMIS reporting	DHIS2	2016	0	100%	91.2%	91.2%		
Sub -IR 2.2: Evidence and implementation lessons from the Voucher Plus Activity documented and disseminated								
Number of voucher supported mothers linked to existing local Village Saving Schemes to encourage saving for their health	Activity Monitoring Reports	2017	0	-	0	0	0%	The Activity is currently undertaking a mapping of Village Saving Schemes (that are within a radius of 5km from voucher facilities). 5km is critical to ensure clients can access these Saving Schemes. Once the mapping is finalized, the Activity will engage the schemes to partner with them to enroll voucher mothers
Proportion of voucher clients linked to local saving schemes that report to be actively saving for their health within the schemes	Activity Monitoring Reports	2017	0	-	0	0	0%	
Number of routine monitoring reports produced to disseminate Voucher Plus Activity results	Activity reports	2016	0	4	2	2	50%	During the Quarter, the Activity disseminated successes, lessons learnt and challenges with district stakeholders through quarterly progress reports to DHOs and at District Committee meetings. The Activity also held three annual stakeholder review meetings, including one meeting with stakeholders from the Uganda Catholic Medical Bureau (UCMB) affiliated facilities together with the UCMB secretariat leadership, and two meetings with stakeholders from northern Uganda