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Report No: PAD1795

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 78.5 MILLION (US$110.0 MILLION EQUIVALENT)

AND A PROPOSED GRANT IN THE AMOUNT OF US$30 MILLION

FROM THE MULTI-DONOR TRUST FUND FOR THE GLOBAL FINANCING FACILITY (GFF) IN SUPPORT OF EVERY WOMAN EVERY CHILD

TO THE

REPUBLIC OF UGANDA

FOR A

UGANDA REPRODUCTIVE, MATERNAL AND CHILD HEALTH SERVICES IMPROVEMENT PROJECT

July 14, 2016

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective May 31, 2016)

Currency Unit = Ugandan Shillings (UGX)
UGX3,365 = US$1
US$1.402 = SDR1

FISCAL YEAR

July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BCC	Behavior Change Communication
BDR	Birth and Death Registration
BEmONC	Basic Emergency Obstetric and Neonatal Care
BoU	Bank of Uganda
BTC	Belgian Technical Cooperation
CBA	Cost-benefit Analysis
CDC	United States Centers for Disease Control
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHEW	Community Health Extension Worker
CORDAID	The Catholic Organization for Relief and Development Aid
CPF	Country Partnership Framework
CRVS	Civil Registration and Vital Statistics
DA	Designated Account
DFID	United Kingdom Department for International Development
DHT	District Health Team
DHMT	District Health Management Team
DHO	District Health Officer
GNI	Gross National Income
ED	Executive Director
EAPHLNP	East Africa Public Health Laboratory Networking Project
EDHMT	Expanded District Health Management Team
EHD	Environmental Health Division
EMTCT	Elimination of Mother-To-Child Transmission
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
FM	Financial Management
FP	Family Planning
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GFF	Global Financing Facility
GNI	Gross National Income
GoU	Government of Uganda
GH	General Hospital
HC	Health Center

HCWM	Health Care Waste Management
HFQCAP	Health Facility Quality of Care Assessment Program
HFS	Health Financing Strategy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPC	Health Facility Procurement Committee
HSBWG	Health Sector Budget Working Group
HSC	Health Service Commission
HUMC	Health Unit Management Committee
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICCM	Integrated Community Childhood Management
ICD	International Classification of Diseases
IDA	International Development Association
IEC	Information, Education and Communication
IFMS	Integrated Financial Management System
IFR	Interim Financial Report
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IP	Indigenous People
IPF	Investment Project Financing
IPP	Indigenous People's Plan
IPPF	Indigenous People's Policy Framework
IPT	Intermittent Preventative Treatment
KMC	Kangaroo Mother Care
LLIN	Long-Lasting Insecticide Treated Bednets
M&E	Monitoring and Evaluation
MoFPED	Ministry of Finance, Planning, and Economic Development
MoH	Ministry of Health
MPDR	Maternal and Perinatal Death Reviews
MVRS	Mobile Vital Records System
NCB	National Competitive Bidding
NDP	National Development Plan
NIRA	National Identification and Registration Authority
NMS	National Medical Store
OIG	Office of the Inspector General
OOP	Out-of-pocket Payment
PAC	Post-abortion Care
PC	Project Coordinator
PDO	Project Development Objective
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PFP	Private-for-profit
PHC	Primary Health Care
PIM	Project Implementation Manual
PNC	Post Natal Care
PNFP	Private-not-for-profit
PPDA	Public Procurement and Disposal of Assets
PS	Permanent Secretary
RAP	Resettlement Action Plan
RBF	Result-based Financing
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RPF	Resettlement Policy Framework
SCM	Supply Chain Management

SDG	Sustainable Development Goals
SDI	Service Delivery Indicator (survey)
Sida	Swedish International Development Cooperation Authority
SGBV	Sexual and Gender Based Violence
TA	Technical Assistance
TFR	Total Fertility Rate
ToR	Terms of Reference
UHSSP	Uganda Health Systems Strengthening Project
USAID	United States Agency for International Development
VAT	Value-added Tax
VHT	Village Health Team

Regional Vice President:	Makhtar Diop
Country Director:	Diarietou Gaye
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Magnus Lindelow
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REPUBLIC OF UGANDA
Uganda Reproductive, Maternal and Child Health Services Improvement Project

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PAD DATA SHEET

Uganda

Uganda Reproductive, Maternal and Child Health Services Improvement Project (P155186)

PROJECT APPRAISAL DOCUMENT

AFRICA

Report No.: PAD1795

Basic Information			
Project ID P155186	EA Category B - Partial Assessment		Team Leader(s) Peter Okwero
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 04-Aug-2016	Project Implementation End Date 31-Dec-2020		
Expected Effectiveness Date 04-Dec-2016	Expected Closing Date 30-Jun-2021		
Joint IFC No			
Practice Manager/Manager Magnus Lindelow	Senior Global Practice Director Timothy Grant Evans	Country Director Diarietou Gaye	Regional Vice President Makhtar Diop
Borrower: Ministry of Finance Planning and Economic Development			
Responsible Agency: Ministry of Health			
Contact: Dr. Asuman Lukwago		Title:	Permanent Secretary
Telephone No.: 256414340872		Email:	ps@health.go.ug

Project Financing Data(in USD Million)					
[ ] Loan	[ ] IDA Grant	[ ] Guarantee			
[X] Credit	[X] Grant	[ ] Other			
Total Project Cost:	140.00		Total Bank Financing:	110.00	
Financing Gap:	0.00				

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	110.00
Global Financing Facility Trust Fund	30.00
Total	140.00

Expected Disbursements (in USD Million)

Fiscal Year	2017	2018	2019	2020	2021
Annual	10.00	20.00	30.00	40.00	40.00
Cumulative	10.00	30.00	60.00	100.00	140.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Proposed Development Objective(s)

The Project Development Objectives (PDOs) are to: (a) improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts; and (b) scale-up birth and death registration services

Components

Component Name	Cost (USD Millions)
Component 1: Results-Based Financing for Primary Health Care Services	68.00
Component 2: Strengthen Health Systems to Deliver RMNCAH Services	54.50
Component 3: Strengthen Capacity to Scale-up Delivery of Births and Deaths Registration Services	10.00
Component 4: Enhance Institutional Capacity to Manage Project Supported Activities	7.50

Systematic Operations Risk- Rating Tool (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial

7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Other	
OVERALL	Substantial

Compliance

Policy

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

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

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Financial management training		04-Mar-2017	

Description of Covenant

The Recipient shall, not later than three (3) months after the Effective Date, provide financial management training for MoH and NIRA staff involved in financial management under the Project, under terms of reference acceptable to the Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Appointment of the internal auditor		04-June-2017	

Description of Covenant

The Recipient shall, not later than six (6) months after the Effective Date, appoint an internal auditor, in

accordance with the provisions of Section III of Schedule 2 to the Financing Agreement.

Name	Recurrent	Due Date	Frequency
Safeguards	Recurrent		

Description of Covenant

The Recipient shall ensure that Project activities are carried out in accordance with the Indigenous People's Plan (May 2016).

Name	Recurrent	Due Date	Frequency
Safeguards	Recurrent		

Description of Covenant

The Recipient shall, in each Fiscal Year (FY) commencing FY2017/2018: (a) through the Ministry of Health, establish and thereafter maintain at all material times during the implementation of the Project, a budget line item for Resettlement Action Plan (RAP) compensation costs under Part 2(d) of the Project; and (b) through Ministry of Finance, Planning, and Economic Development (MoFPED), allocate counterpart funds required for said RAP compensation costs under said Part 2(d) of the Project, until payment(s) for said RAP compensation costs shall fall due.

Conditions

Source Of Fund	Name	Type
IDA	Subsidiary Agreement Executed - Financing Agreement Article V. 5.01 (a)	Effectiveness

Description of Condition

The Subsidiary Agreement has been executed on behalf of the Recipient and the National Identification and Registration Agency (NIRA).

Source Of Fund	Name	Type
IDA	Grant Agreement Executed - Financing Agreement Article V. 5.01 (b)	Effectiveness

Description of Condition

The Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.

Source Of Fund	Name	Type
IDA	Operational Manual - Financing Agreement Article V. 5.01 (c)	Effectiveness

Description of Condition

The Recipient has adopted the Operational Manual in accordance with the provisions of Section I.C.1 of Schedule 2 to this Agreement.

Source Of Fund	Name	Type
IDA	Establishment of RBF Unit - Financing Agreement Article V. 5.01 (d)	Effectiveness

Description of Condition

The Recipient has, through MoH, established and operationalized an RBF Unit, in accordance with the provisions of the Operational Manual.

Source Of Fund	Name	Type
IDA	Independent Verification Agent - Schedule 2. Section IV. B. 1 (a)	Disbursement

Description of Condition

No withdrawal shall be made under Category 1, unless and until the Recipient, through MoH, has appointed an Independent Verification Agent in accordance with the provisions of Section I.F.2 of Schedule 2 of the Financing Agreement.

Source Of Fund	Name	Type
IDA	Accounts Assistant and Project Officer - Schedule 2. Section IV. B. 1 (b)	Disbursement

Description of Condition

No withdrawal shall be made under Category 3, unless and until the Recipient, through NIRA, has appointed an Accounts Assistant and a Project officer, all in accordance with the provisions of Section III of Schedule 2 of the Financing Agreement.

Team Composition

World Bank Staff

Name	Role	Title	Specialization	Unit
Peter Okwero	Team Leader (ADM Responsible)	Senior Health Specialist		GHN01
Grace Nakuya Musoke Munanura	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist		GGO01
Paul Kato Kamuchwezi	Financial Management Specialist	Financial Management Specialist		GGO31
Catherine Asekenye Barasa	Safeguards Specialist	Senior Social Development Specialist		GSU07
Christine Makori	Counsel	Senior Counsel		LEGAM
Collins Chansa	Team Member	Health Specialist		GHN01
Harriet E. N. Kiwanuka	Team Member	Program Assistant		AFMUG
Herbert Oule	Environmental Specialist	Environmental Specialist		GEN01
Joyce Cheruto Bett	Team Member	Program Assistant		AFCE2
Lombe Kasonde	Team Member	Operations Analyst		GHNGE
Son Nam Nguyen	Team Member	Lead Health		GHN01

		Specialist		
Issa Thiam	Team Member	Finance Officer		WFALA
Christiaan Johannes Nieuwoudt	Team Member	Finance Officer		WFALA

Extended Team

Name	Title	Office Phone	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consultants will be required

I. STRATEGIC CONTEXT

A. Country Context

1. With its high fertility levels and large youth cohort, Uganda is currently a pre-demographic dividend country. Almost half (48.5 percent) of Uganda's 34.6 million[1] population is below the age of 15 years. The population growth rate, estimated at slightly above 3 percent between 2002 and 2014, is mainly driven by the high total fertility rate (TFR) of 5.8 children per woman (2014 Census Report), and is especially high in the Eastern and West Nile regions. Uganda is expected to continue experiencing significant population growth, as relatively large cohorts of children enter reproductive age. The slow pace of demographic transition (from high to low birth and death rates) is undermining Uganda's growth prospects as population growth increases the demand for social services and outstrips the capacity of the economy to generate jobs for the 500,000 new labor market entrants annually.

2. Headcount poverty in Uganda has declined from 56.4 percent in 1993 to 19.5 percent in 2013. However, inequality as measured by the Gini index increased from 0.36 to 0.40 over the period. The majority of the population (80 percent) live in rural areas where poverty is prevalent (22.8 percent compared to 9.3 percent in urban areas). In addition, a large share of the population (43.3 percent) remains highly vulnerable and at a risk of falling back into poverty. While the gross domestic product (GDP) grew at an average annual rate of 4.6 percent during 2013–2015, the gross national income (GNI) per capita increased at a much slower pace, and in 2014, was estimated at US$670, slightly above the average (US$629) for low-income countries.[2] Although the structure of the economy is gradually changing, the majority of the population (80 percent) rely on low-paying jobs in the agriculture sector, employed mainly in subsistence farming, which contributes to 25 percent of the GDP.

3. The district councils in Uganda perform legislative, administrative, and service delivery functions under the decentralization framework. In addition, the districts are responsible for personnel management and local revenue generation. The quality of the decentralization framework has been seriously eroded in the recent past, mainly because of a proliferation of districts without the provision of commensurate operational resources. The number of districts has more than doubled since 2000, bringing the total number to 112 districts, including Kampala City Council Authority. This has taken place at a time when the share of budgetary allocation to local governments is falling. In the 2015/16 budget, the share of local government transfers (excluding interest payments) was just 14 percent of the total budget compared to 34 percent in 2007/08. As a result, many districts, especially new and remote ones, are severely under-resourced and understaffed, and are unable to fulfill their mandates in service delivery.

[1] Uganda National Population and Housing Census 2014
[2] World Economic Outlook, available at http://www.imf.org/external/datamapper/index.php

4. Uganda's development agenda is elaborated in the National Development Plan (NDP II) 2015/16 to 2019/20. The NDP is aligned with the National Vision 2040 and the Sustainable Development Goals (SDGs), and is aimed at propelling Uganda to middle-income status by 2020. Enhancing human capital development and strengthening mechanisms for high-quality, effective, and efficient service delivery are two of the four primary development objectives of the NDP. The NDP highlights the need to address the challenges of weak public sector management to improve service delivery.

B. Sectoral and Institutional Context

5. Uganda is among the countries with the highest burdens of HIV/AIDS, malaria and tuberculosis globally. Other key conditions contributing to its burden of disease are lower respiratory infections, meningitis, peri/neonatal complications and diarrheal diseases.[3] Women and children are the most affected and bear a disproportionate burden of disease in Uganda. While communicable diseases remain prevalent, non-communicable diseases are a growing concern. The high disease burden is further complicated by disparities in health outcomes across regions (Table 1).

Table 1: Regional Reproductive and Child Health Disparities

	TFR (%)	FP Unmet need (%)	CPR (%)	PNM (per 1,000)	NMR (per 1,000)	U5MR (per 1,000)	Teenage Pregnancy (%)
Kampala	3.30	16.60	48.20	33	27	65	21.60
Central 1	5.60	26.50	37.30	47	44	109	19.10
Central 2	6.30	35.40	33.70	44	31	87	22.60
East Central	6.90	41.90	32.00	28	23	106	30.60
Eastern	7.50	38.30	26.10	32	24	87	30.30
Karamoja	6.40	20.50	7.80	48	29	153	29.70
North	6.30	42.50	23.90	22	31	105	25.60
West Nile	6.80	42.50	14.60	39	38	125	26.40
Western	6.40	30.40	32.70	54	30	116	22.60
Southwestern	6.20	36.90	29.60	48	33	128	14.60

Source: Revised RMNCAH Sharpened Plan, March 2016.
Note: CPR = Contraceptive Prevalence Rate; U5MR: Under-five Mortality Rate; NMR = Neonatal Mortality Rate; PNM = Post Neonatal Mortality.

6. The burden of disease remains high despite significant progress. Malnutrition, infant mortality and under-five mortality rates have steadily dropped since 1995 (Table 2 page 3). The reduction in child mortality is attributed to improved immunization, expansion of the activities for elimination of mother-to-child transmission of HIV, as well as malaria and diarrhea control. However, various challenges remain. First, despite malaria control progress, malaria is still the

[3] The Global Burden of Disease Study 2010 and Health Management Information System (HMIS). The diseases together accounted for over 50 percent of all disability-adjusted life years in 2010. These years quantify both premature mortality (years of life lost) and disability (years of life lost to disability).

top cause of under-five morbidity and mortality. Second, neonatal mortality, estimated at 27 deaths per 1,000 live births in 2011, has remained relatively unchanged mostly due to inadequate neonatal care. Third, progress with tackling pneumonia has been limited, and its share of deaths has increased from 10 percent in 2008 to 23 percent in 2011. Fourth, nutrition is a major challenge with (i) 33 percent of stunting among children; (ii) an increase in vitamin A deficiency from 19 percent to 38 percent in children and from 20 percent to 36 percent in women between 1995 and 2011; and (iii) malnutrition as the underlying cause of nearly 60 and 25 percent of infant and maternal deaths, respectively.[4]

Table 2: Reproductive, Maternal, Neonatal, Child and Adolescent Health Outcomes

Outcome Indicators	1995	2001	2006	2011
Under-five mortality rate per 1,000 live births	152	158	137	90
Infant mortality rate per 1,000 live births	85	88	76	54
Neonatal mortality	-	33	29	27
Maternal mortality ratio per 100,000 live births	505	-	435	438
TFR (children per woman)	6.9	6.9	6.7	6.2
Stunting (height for age < -2SD, %)	-	39	38	33
Underweight (weight for age < -2SD, %)	-	23	16	14
Wasting (weight for height < -2SD, %)	-	4	6	5
Service Coverage Indicators				
Skilled birth attendance (% of pregnant women)	-	39	42	58
Contraceptive prevalence rate (% of women ages 15-49 years)	15	19	24	30
Full immunization coverage (% of children aged 12-23 months)	-	37	44	52
Prevalence of malaria (% of under-five children)	-	-	42.4	19
Share of under-five who slept under an ITN last night	-	-	32.8	74.4

Source: Demographic and Health Surveys 1995, 2001, 2006 and 2011 and Malaria Indicator Surveys 2008 and 2014
Note: RMNCAH = Reproductive Maternal Neonatal Child and Adolescent Health; SD = Standard Deviation; ITN = Insecticide Treated Net.

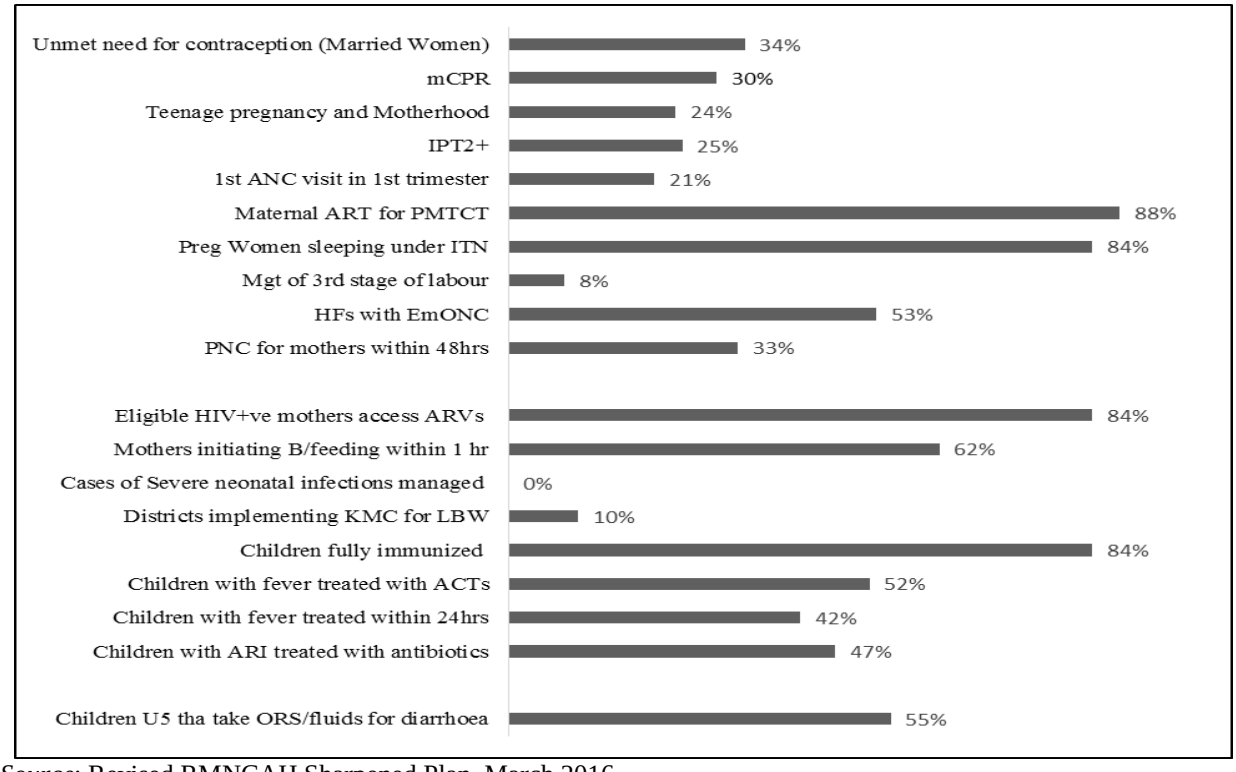
7. The maternal mortality ratio has stagnated over the last decade. Between 2006 and 2011, despite increases in the share of (i) skilled birth attendance (from 42 percent to 58 percent) and (ii) mothers receiving postnatal care (from 27 percent to 33 percent), the maternal mortality ratio remains unchanged at 435-438 per 100,000 live births. The low coverage of quality emergency obstetric care services is the main driver of the high maternal mortality.[5] In 2013, only 47 percent of hospitals and health center (HC) IVs were able to provide comprehensive emergency obstetric care.[6] High TFR (6.2 percent), teenage pregnancy (24 percent) and unmet need for family planning (34 percent) coupled with early marriages are the other major factors

[4] Uganda Nutrition Action Plan 2011–2016.
[5] The direct causes of maternal mortality are hemorrhage, obstructed labor, and abortion-related complications while malaria, anemia, sepsis and HIV are the most important indirect causes.
[6] Uganda Services Availability and Readiness Assessment 2013.

increasing the exposure to the risks of pregnancy and pregnancy-related morbidity and mortality. Despite a drop in teenage pregnancies, the median age at first marriage among women of reproductive age has remained fairly stable at 17.9 years for the past 30 years. The variation of teenage pregnancy by background characteristics is also large. For instance, in 2011, among girls (ages 15–19 years) with no education, 45 percent had begun their reproductive life compared with 16 percent among girls with secondary education.

8. A key constraint in RMNCAH services delivery is suboptimal coverage of priority interventions. Out of 19 RMNCAH key interventions identified by the RMNCAH Sharpened Plan, 11 interventions achieved coverage of less than 50 percent while only 4 achieved coverage of 80 percent and above (Figure 1). There are four main underlying reasons for this. First, the sector is poorly resourced and does not have adequate resources to effectively respond to the high disease burden. Second, pronounced capacity constraints, especially at the frontline has rendered the majority of districts unable to deliver services as mandated. Third, while the policy and institutional framework for service delivery is sound, compliance is poor and accountability is generally low. Fourth, household poverty, women disempowerment, and harmful traditional practices hamper the utilization of health services, especially those for RMNCAH.

Figure 1. Coverage of Selected Reproductive, Maternal, Neonatal, Child and Adolescent Health Interventions along the Continuum of Care



Source: Revised RMNCAH Sharpened Plan, March 2016

Note: mCPR = CPR based on modern contraceptive methods; IPT2 = Second dose of intermittent prophylaxis therapy for malaria during pregnancy; ART – Antiretroviral Therapy; ARVs = Antiretroviral Drugs; PMTCT = Prevention of mother-to-child Transmission of HIV; ITN = Insecticide Treated Nets; KMC = Kangaroo Mother Care; HFs = Health Facilities; LBW = Low Birth Weight; EmONC = Emergency Obstetric and Neonatal Care; ARI = Acute Respiratory Tract Infections.

9. Uganda's total health expenditure is estimated at US$50.1 per capita per year. This is below the recommended level of US$86 per capita per year (expressed in 2012 US dollar terms) for low-income countries to provide a basic package of health services and operate a functioning health system.[7] Public expenditure on health was estimated at US$9 per capita or 15 percent of the total health expenditure in FY2011/12.[8] Although there has been a steady growth in the government's health budget by an average of 15 percent per year in nominal terms during the period 2011-16, there has been a decline in non-wage recurrent spending as a share of government health spending at the district level, which coincided with district proliferation and expansion of health infrastructure. Together, these factors have constrained the capacity of districts to deliver quality health services.[9]

10. Households in Uganda significantly rely on out-of-pocket payments (OOPs) for health. In 2013/14, OOPs accounted for 41 percent of total health expenditures compared to Government contribution of 17.4 percent.[10] Households incur a large share of RMNCAH expenditures through OOPs, and contributed 62 and 74 percent of total spending on child and reproductive health, respectively in 2010.[11] This increases household exposure to catastrophic spending on health in general and RMNCAH in particular. Each year, about 1 million Ugandans are pushed below the poverty line as a result of paying for health care.[12] While the government has piloted voucher schemes and implemented small scale community prepayment programs, these efforts need to be scaled up and additional public financing mobilized to reduce high OOPs for health.

11. Development assistance for health is significant in Uganda. In 2013/14, development partners contributed to 41.5 percent of total health expenditures. Four key programs: HIV/AIDS, malaria, tuberculosis and immunization are the most dependent on external funding, raising questions on sustainability. A large share of the development assistance for health is off-budget and requires robust fiduciary systems for its management.[13] Due to its significant share, external funding will remain important in the short to medium term and will require consistently large increases in Government expenditure (in real terms) over a number of years to overturn the trend. Given the importance of external resources, the Government has initiated measures to align and harmonize different donor programs. This includes the establishment of a basket fund to finance RMNCAH services using a Results Based Financing (RBF) approach.

[7] McIntyre, D., and F. Meheus 2014. "Fiscal Space for Domestic Funding of Health and Other Social Services." Centre on Global Health Security Working Group Paper 5. Chatham House, London.
[8] Ministry of Health. 2015. Uganda Health Financing Strategy 2015/16-2024/25.
[9] Non-wage allocations at district level have dropped by over 50 percent in real terms between the early 2000s and 2015/16.
[10] Uganda Health Accounts: National Health Expenditure 2012/13 and 2013/14.
[11] National Health Accounts, FY 2008/09 and FY 2009/10, Ministry of Health, March 2013. The National Health Accounts included sub-accounts on reproductive and child health.
[12] Kwesiga B, C. Zikusooka, and J. Ataguba., 2015. Assessing Catastrophic and Impoverishing Effects of Health Care Payments in Uganda. BMC Health Services.
[13] Global Alliance for Vaccines and Immunization (GAVI), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) , The United States President's Emergency Plan for AIDS Relief, and President's Malaria Initiative.

12. Health services are decentralized and delivered through a mix of public, private-not-for-profit (PNFP) and private-for-profit (PFP) providers. District governments are responsible for health service delivery, including the management of general hospitals and Health Centers II–IV.[14] The central government is in charge of policy formulation, standards, regulations and oversight of national and regional referral hospitals. The PNFPs are predominantly faith-based and coordinate their operations through the respective medical bureaus.[15] The PFPs mainly comprise small clinics, drug shops and informal vendors. Out of 5,230 health facilities in the country, 55 percent are public, 17 percent PNFPs and 28 percent PFPs.[16] Under the decentralized arrangements, the Ministry of Finance, Planning and Economic Development (MoFPED) transfers funds directly to the accounts of the health facilities.

13. Uganda's health sector faces various systems bottlenecks to health service delivery. With 0.87 health worker per 1000 population, Uganda has one of the world's lowest clinical health worker to population ratios. Midwives, anesthetist officers and laboratory technicians are especially in short supply. The World Bank's Service Delivery Indicators (SDI) survey revealed a high absenteeism rate of 52 percent for health workers. It also showed that 49 percent of health workers in lower level public facilities could not accurately diagnose and treat five tracer conditions according to clinical guidelines. While there has been a steady improvement in logistics management of essential medicines since 2011, 36 percent of health facilities had stock outs of any of the six tracer medicines in 2014/15.[17] The Village Health Team (VHT) program, which is the main vehicle for community-based health services and a key citizen engagement mechanism for the sector is beset by several shortcomings, including: (i) lack of proper institutionalization of the VHT strategy; (ii) inadequate supervision of the VHTs; and (iii) reliance on volunteers.[18] Referral systems and ambulance services are weak. In the context of district proliferation without commensurate increases in district funding, the above challenges are more pronounced in new and remote districts with low capacity.

14. Various initiatives have been launched to improve health service delivery. The government in 2015 (i) established the Department of Human Resource Management in the MoH, (ii) introduced an e-recruitment system at the Health Service Commission (HSC), and (iii) accelerated the roll-out of the Human Resources for Health Management Information System (HRHMIS). Medicine management supervisors have been trained and equipped to monitor and report on drug supply chain management (SCM) in 75 districts.[19] A new system has been introduced to distribute reproductive health commodities to private providers. As part of the efforts to improve referrals, the Government of Uganda (GoU) is in the process of establishing a national ambulance service. A Health Facility Quality of Care Assessment Program (HFQCAP) was recently developed.[20] HFQCAP involves (i) a quality assessment tool with ten modules,

[14] There are three categories of health centers: II, III and IV.
[15] Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, and Uganda Muslim Medical Bureau.
[16] MoH, Health Facility Inventory, 2012. The inventory underestimates PFPs as it excludes clinics, a majority of which are small and informal.
[17] MoH, Annual Health Sector Performance Report, 2014/15.
[18] MoH (Ministry of Health). 2015. *National Village Health Teams (VHT) Assessment in Uganda*.
[19] Uganda Health Supply Chain Management Project.
[20] Ministry of Health, Health Facility Quality of Care Assessment Program Implementation Manual, January 2015; and the Health Facility Quality of Care Assessment Program Facility Assessment Tool, January 2015.

including one for RMNCAH and (ii) continuous quality improvement methodology and plans for health facilities. The MoH is also planning to establish a formal cadre of community workers -- Community Health Extension Workers (CHEWs) to be employed by the districts. A draft CHEW policy and strategy are under preparation. However, it will take time to obtain broader government buy-in for CHEW in light of the wage bill's fiscal implications. In order to strengthen citizens' engagement and beneficiary feedback, the sector will continue using the VHT approach, constituency task forces and client charters.[21]

15. Uganda has implemented a number of supply and demand side RBF initiatives focusing on RMNCAH with encouraging results.[22] The pilot programs were initially started in PNFP health facilities and later expanded to public health facilities. A review of the RBF programs in Uganda showed that they have contributed to improving (i) managerial autonomy of public facilities, (ii) data management and reporting, and (iii) utilisation and quality of health services.[23] For example, the RBF project by Catholic Organization for Relief and Development Aid (CORDAID) increased outpatient utilization, antenatal care (ANC) visits, institutional deliveries, and quality of healthcare in public health facilities.[24] The voucher scheme resulted in increased safe deliveries and reduced OOPs related to deliveries in private facilities.[25] Despite noteworthy successes, there was no uniformity in the design and implementation of RBF projects in Uganda. In response, the government has developed a National RBF Framework to provide a common RBF platform.[26] On the basis of this platform, the government is planning to scale-up RBF in the health sector using non-wage conditional grants to health facilities in the upcoming years in 2018/19.

16. The National Health Financing Strategy (HFS) has been finalized. The main objective of the HFS is to facilitate the attainment of universal health coverage by making available the required resources to deliver an essential package of services in an efficient and equitable manner. The strategy proposes various actions in the areas of increased revenue collection, risk pooling, and strategic purchasing. These include increased domestic resource

[21] Client charters are published by the health facilities and inform clients about the services available in the facilities. They also serve as a tool for clients to provide feedback to service providers.

[22] The World Bank financed Performance-Based Contracting (PBC) Programme (2003-05), the CORDAID-financed RBF project (2009-15), the Northern Uganda Health (NuHealth) RBF Project (2011-15) financed by U.K. Department for International Development (DFID), and the Strengthening Decentralization for Sustainability RBF Project (2010-16) implemented by the Ministry of Local Government. The voucher projects include: the Reproductive Health Vouchers in Western Uganda Project (2008-12) co-financed by the World Bank and Kreditanstalt für Wiederaufbau (German Development Bank), the Safe Deliveries Project (2009-11) by the Future Health Systems Research Consortium, Saving Mothers Giving Life Project (2012-17) by U.S. Agency for International Development (USAID), and the Uganda Reproductive Health Voucher Project by the World Bank (2014-17).

[23] (a) Unpublished Evaluation Report, Contracting for Primary Health Care in Uganda, February 6, 2007; (b) Northern Uganda Health Programme, 2015. *Insights from a Controlled Trial in Northern Uganda*, Health Partners International.

[24] World Health Organization, 2014. *Report on the National Consultative Workshop on RBF in Uganda*.

[25] Reproductive Health Vouchers Evaluation Team, Population Council, 2012. *Evaluation of the Population-Level Impact of the Maternal Health Voucher Program in Uganda*, Technical Report.

[26] The Belgian Technical Cooperation (BTC) has finalized the development of a new health sector project that is to be implemented through RBF modalities. Other partners including USAID and Sida have expressed interest to use the RBF approach.

mobilization, better alignment of donor funding for health, and establishment of prepayment mechanisms including social health insurance. The strategy identifies RBF as one of the mechanisms to improve sector efficiency and accountability by focusing on strategic purchasing of results. In addition, the strategy proposes the creation of a basket fund to align and harmonize donor funding to the sector. The strategy identifies the key inefficiencies in human resources, pharmaceuticals and health supplies, and procurement and management of infrastructure and equipment. Addressing these challenges will save the sector from financial loss and enable the government to increase its fiscal space.

17. In July 2015 Uganda was chosen as one of eight countries globally to receive support from the Global Financing Facility (GFF) Trust Fund. The GFF in support of the Every Woman Every Child movement is a country-driven partnership that aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve their health and quality of life. The GFF seeks to support countries with an integrated health system approach that looks for evidence-based solutions to improve RMNCAH outcomes. The GFF uses a financing model that combines domestic financing, external support, and innovative sources of resource mobilization and delivery (including the private sector) in a synergistic way, and promotes measures to reduce inefficiency in health spending through smarter financing. The GFF also aims to mobilize additional funding through the combination of grants from a dedicated multi-donor trust fund (the GFF Trust Fund), financing from IDA and IBRD, and the crowding-in of additional domestic and external resources.

18. The government has revised the 2016-2020 RMNCAH Sharpened Plan in the context of the GFF. The plan developed jointly with key stakeholders has the potential to improve alignment between key financiers, and engage a broad set of stakeholders in supporting a common set of priorities. The plan describes the magnitude of the disease burden from the main RMNCAH-related conditions, highlights gaps in service utilization and coverage for the main RMNCAH interventions, defines the key health systems bottlenecks for delivery of RMNCAH services, and establishes the priority RMNCAH interventions.[27] The plan introduces five strategic shifts for RMNCAH: (i) emphasizing evidence-based high-impact solutions; (ii) increasing access for high-burden populations; (iii) geographical focusing/sequencing; (iv) addressing the broader context- education, empowerment, economy and environment within a multisectoral approach, with a particular focus on adolescents; and (v) strengthening mutual accountability for ending preventable deaths. The plan covers the key service delivery shifts that will need to occur to improve RMNCAH outcomes, including scaling up RBF for facilities and vouchers to address demand-side constraints.

19. Several partners have expressed interest to finance the RMNCAH programs as outlined in the revised Sharpened Plan. The World Bank will finance (from both IDA and the

[27] The plan recommends skilled birth attendance, post-abortion care (PAC), use of magnesium sulphate in pre/eclampsia, and management of sepsis for women; and for children, kangaroo mother care, neonatal resuscitation, hygienic postnatal practices, intermittent prophylaxis therapy for malaria (IPT), and antenatal corticosteroids for prematurity. The plan also recommends childhood immunization, use of insecticide treated bed nets and indoor residual spraying, case management of malaria, elimination of mother to child transmission of HIV, breast feeding, oral antibiotics for pneumonia, and oral rehydration salts. The above investments will go hand-in-hand with family planning, nutrition, water and sanitation, and women education and empowerment.

GFF Trust Fund) the implementation of the Sharpened Plan. Discussions are underway with a number of other potential financiers that could provide complementary financing, including the U.K. Department for International Development (DFID), the United States Government (through United States Agency for International Development, USAID, and U.S. Centers for Disease Control and Prevention, CDC), the Belgian Technical Cooperation (BTC), and the Swedish International Development Cooperation Agency (Sida). The target is to increase the coverage of prioritized interventions to a minimum of 85 percent over a period of 5 years at a total cost of US$1,875 million.[28] This translates into an additional investment cost of US$274 million over a period of 5 years or an additional cost of US$6.10 per capita per year. The total RMNCAH commitments are estimated at US$1,028 million for the initial 3 years representing US$231 million (22 percent) from the Government and US$797 million (78 percent) from development partners. If funding commitments remain the same over the last 2 years of the RMNCAH Sharpened Plan, the total commitments and financing gap over a 5-year period will be US$1,594 million and US$280 million, respectively. A key aspect of this plan is to harmonize donor programs with an emphasis on results. In this regard, the government will hold annual RMNCAH assemblies to review the programs. The assemblies will be guided by the compact signed between the government and development partners providing the framework for coordination of development assistance for health in Uganda.

20. The Government's sectoral and sub-sectoral plans and strategies emphasize expansion of access and coverage for under-served populations. Moreover, in 2014, the MoH issued a Ministerial Directive which emphasized that service providers are expected to adhere to the national health policy and existing ethical and professional codes of conduct to deliver health services without discrimination. The Directive states that "no health facility or health care provider shall discriminate on the basis of patients' disease, religion, political affiliation, disability, race, sex, age, social status, sexual orientation, ethnicity, nationality, and country of birth or other such grounds." The Directive includes guidelines for handling complaints and was distributed to all health facilities in the country, and together with the client/patient charters publicly disclosed in the facility notice boards form the basis for handling complaints at the facility level and strengthening accountability of health providers to patients.[29]

21. Capacity for civil registration and vital statistics (CRVS) is limited in Uganda.[30] Currently, about 60 percent of children under five years of age are registered, and the majority of these children do not possess birth certificates. The existing system is unable to provide the key vital statistics on births and deaths necessary for health services planning, disease surveillance, and more specifically, delivery and monitoring of RMNCAH services. The weaknesses are

[28] The cost analysis in the RMNCAH Sharpened Plan weighs three scenarios (baseline, accelerated and full funding) of which scenario 2 is adopted as the best buy for investment. It assumes rapid scale-up of prioritized interventions to a minimum of 85 percent coverage and matching health system investments to reduce key system bottlenecks.

[29] Every health facility is expected to publish a client charter to: inform the public about services offered by the health facility, serve as an accountability framework for the facility to account to the public on a regular basis, and enable the public to provide feedback to the health facility. The Directive and client charters include contact details for the public to call in case there is a breach in service delivery.

[30] Civil registration is defined by the United Nations as the "Universal, continuous, permanent and compulsory recording of vital events provided through decree or regulation in accordance with the legal requirements of each country" and includes birth, marriage, divorce, adoption, and death.

attributed to human, logistical and financial resource constraints, as well as, system deficiencies. The 2015 national CRVS assessment revealed that registration of deaths in Uganda is passive and mechanisms for enforcement are weak. Births and deaths registration (BDR) services (manual, mobile phone and web based) are currently operational in all 135 government and faith based hospitals, and in 58 district local governments. Several hospitals conduct maternal death audits but the information is not used for purposes of death registration. Low demand for CRVS, and inadequate supply of CRVS tools and materials are some of the envisaged obstacles to scaling up CRVS in Uganda. The main disincentives for death registration are the cost of registration, time and travel expenses, the lengthy process, and limited awareness of the public on the importance of civil registration.

22. The government in 2015 established the National Identification and Registration Authority (NIRA) as a specialized agency for civil registration. It has the mandate to register births and deaths, and issue appropriate certificates. Hitherto, BDR was performed by the Uganda Registration Services Bureau. The new law (Registration of Persons Act of 2015) provides for compulsory registration of all births and deaths and issuance of appropriate certificates and mandates all medical facilities to record vital events and file returns to registration officers within their jurisdictions. Similarly, it mandates reporting of vital events occurring outside medical facilities. NIRA officially started operations in January 2016 and is in the process of recruiting staff and establishing systems. NIRA has also prepared an interim proposal to guide its operations, pending the development of a national CRVS strategy.

23. The World Bank has a long history supporting the health sector in Uganda. The project builds on the ongoing multisectoral IDA portfolio, and will continue to deepen the World Bank's engagement in the sector and country. The project will complement on-going operations including the Uganda Multisectoral Food Security and Nutrition Project (P149286). The lessons from the project on using the RBF approach are expected to inform the government's broader plans to adopt performance-based financing in key sectors as well as inform the World Bank's proposed Program for Results on decentralization. With its regional and global experience in supporting client countries to accelerate action toward achievement of universal health coverage, the World Bank is in a good position to assist the government in translating global best practice into context-specific solutions for Uganda.

C. Higher Level Objectives to which the Project Contributes

24. The project is consistent with the Country Partnership Framework (CPF, 2016–21). The project focuses on improving health services delivery and supports engagement under the CPF strategic focus area A, which prioritizes improving governance, accountability, and service delivery, and the CPF's strategic objective on improving social service delivery. The project is consistent with the World Bank's twin goals of ending extreme poverty and boosting shared prosperity and is aligned with the objectives of the World Bank's 2011 regional strategy for Africa. The project will contribute towards improving use of affordable and quality RMNCAH and CRVS services especially for the poor, thereby helping to reduce preventable maternal and child-related morbidity and mortality.

25. The project is aligned to the national development agenda and vision. The project is consistent with the NDP II (2015/16-2019/20) objectives of enhancing human capital

development and strengthening mechanisms for quality, effective and efficient service delivery. The project is also aligned to the National Health Policy (2010/11–2019/20) and the Health Sector Development Plan (2015/16–2019/2020), which are premised on supporting Uganda's efforts toward achieving universal health coverage, and prioritize controlling major communicable diseases, improving maternal and child health and addressing governance and health systems bottlenecks which include: (i) improving the management of human resources for health and addressing constraints facing frontline service providers; (ii) improving sector financing; and (iii) enhancing quality of care. The project is designed for implementation within existing national systems to build national capacity and achieve ownership and sustainability.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

26. The Project Development Objectives (PDOs) are to: (a) improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts; and (b) scale-up birth and death registration services.

B. Project Beneficiaries

27. The primary project beneficiaries are women of childbearing age, adolescents, and children under-five (including newborns and infants) from selected districts in the country with a high disease burden. The beneficiaries will benefit from a package of high impact quality and cost-effective RMNCAH interventions. In addition, communities will benefit from enhanced BDR services.

C. PDO Level Results Indicators

28. The following are the PDO-level results indicators:

(a) Births (deliveries) attended by skilled health personnel, (Percentage) - (Core)[31]

(b) Pregnant women who received intermittent preventive therapy - second dose (IPT2) (Percentage)

(c) Couple years of protection (CYP) (Number)

(d) Children under one year immunized with third dose of pneumococcal conjugate vaccine (PCV3) (Percentage)

(e) Children under five years with birth registration (Percentage)

(f) Total number of deaths registered (Percentage)

[31] For the indicator, the project will measure deliveries in health facilities (Percentage)

III. PROJECT DESCRIPTION

A. Project Components

29. The project will support the national efforts to scale-up essential RMNCAH services described in the RMNCAH Sharpened Plan. The project will assist the government to (a) address critical health systems bottlenecks constraining RMNCAH service delivery, including strengthening supervisory functions and improving quality of care; (b) contribute to improved health for children and women, as well as reduced levels of stunting in children; and (c) strengthen institutional capacity for CRVS to scale-up provision and utilization of BDR services. The project targets districts with high RMNCAH disease burden and low RMNCAH service coverage and utilization and will be implemented in close collaboration and coordination with other RMNCAH programs to ensure alignment of the programs to the RMNCAH Sharpened Plan. The existing technical working groups and proposed RMNCAH Assembly will be critical in promoting alignment and strengthening coordination among the programs.[32] The theory of change is underpinned on supporting central level agencies to address key systems bottlenecks to RMNCAH services delivery and incentivizing service providers using RBF to enhance delivery and utilization of RMNCAH services. The focus on addressing major systems bottlenecks to RMNCAH service delivery and paying for results is expected to reinforce compliance with service delivery standards and promote accountability for results in the context of decentralized service delivery. The project consists of four components and its pathway for PDO achievement is summarized in Figure 2 (page 18). The detailed project description is in Annex 2.

Component 1: Results-Based Financing for Primary Health Care Services (IDA: US$43 million; GFF: US$25 million)

30. The objective of this component is to scale-up and institutionalize RBF with a focus on RMNCAH services. Based on the National RBF Framework, the RBF design for the project aims to incentivize the District Health Teams (DHTs) and HC III and IV to expand the provision of quality and cost-effective RMNCAH services. As part of RBF, the project will incentivize health centres to support the VHTs in their catchment areas to promote community-based RMNCAH services, including services to address nutrition in general and stunting in particular.[33] The district selection is based on predefined criteria which include: district poverty levels, access/coverage of RMNCAH services, disease burden, and presence/absence of other RBF schemes.[34] The selection of health facilities in the designated districts will be based on a RBF readiness assessment using a tool adapted from the health facility quality of care program. In

[32] RMNCAH Assemblies are semi-annual meetings of government with key partners to review implementation of RMNCAH programs in the country.

[33] The government is considering adopting CHEWs. The project will support the CHEWs when the change takes effect.

[34] Reproductive health voucher schemes are currently under implementation in 50 districts (26 under the World Bank financed project (P144102) and 24 under the USAID-funded project. In addition, the BTC is implementing a supply-side RBF in 10 districts and CORDAID in the Busoga Region. These exclude small schemes by partners in the districts. In addition, the USAID will implement an integrated and comprehensive RMNCAH program in 61 districts, DFID will continue supporting delivery of family planning services using a combination of approaches, and United Nations Population Fund will focus its RMNCAH support to 25 districts. Eventually, when voucher and supply-side RBF schemes are scaled up nation-wide, any given district will benefit from both schemes.

accordance with government policy and current practice, both public and private-not-for-profit providers which meet RBF readiness threshold will be eligible to participate. To further strengthen the referral system, strategically located hospitals with adequate capacity will be selected to provide ambulance and RMNCAH referral services based on criteria outlined in the Project Implementation Manual (PIM). As part of the RBF institutionalization, the government will establish an RBF unit in the Health Planning Department to oversee and coordinate RBF operations in the sector.

31. The RBF package of high-impact interventions is part of the RMNCAH Sharpened Plan. The package comprises RMNCAH interventions at health facilities and the community level: (i) ANC; (ii) safe delivery; (iii) comprehensive emergency obstetric care; (iv) essential newborn and postnatal care services; (v) post-abortal care; (vi) family planning; and (vii) community-based RMNCAH services including nutrition, prevention and treatment of common childhood diseases and provision of adolescent health services. A summary of the core package of services is described in Table 2.1 of Annex 2. The list of quantity and quality performance indicators reflects such RMNCAH interventions and is elaborated in the PIM. It is subject to periodic revision during implementation to push the performance frontier of providers. Performance-based payments to HCs will be a function of quantity and quality of services and an equity coefficient which takes into account district remoteness and level of development. In the payment formula, underperforming areas such as neonatal care and family planning will be prioritized. The DHTs will be rewarded to supervise RBF facilities on key health systems governance indicators on a quarterly basis.

32. RBF payments will be made against verified outputs. The Expanded District Health Management Team (EDHMT) will verify outputs (quantity and quality) of health facilities on a monthly basis. Regional RBF teams will review reported outputs and validate performance of the EDHMTs every quarter by assessing a small sample of health facilities based on the verification reports of the EDHMTs and trigger payment. An independent firm will be contracted to carry out external verification of the outputs by the DHTs and health facilities on a semi-annual basis. Discrepancies in results detected by the regional teams and the independent verification firm may trigger penalties and sanctions in the event of misreporting and falsification of data. Health facilities may use the RBF incentive payments to cover basic operational costs, including staff incentives, maintenance and repairs, drugs and consumables, outreach activities, and the VHT program based on the guidelines issued by the MoH. The PIM will provide details on the selection criteria and contracting process for DHTs and health facilities, list of quantitative and qualitative performance indicators, payment formula, the performance assessment framework and reporting arrangements, internal and external verification, disbursement and utilization of funds, and the sanction regime.

33. This component will finance: (i) assessment, selection and strengthening capacity of RBF health providers; (ii) performance-based payments to health facilities, hospitals and the DHTs based on verified results; (iii) RBF supervision and mentorship; and (iv) external verification. The RBF approach with enhanced supervision and capacity building activities is expected to improve service delivery of both public and private-not-for-profit providers and strengthen DHT capacity to supervise HCs. The approach is expected to enhance compliance of providers to the existing regulatory framework in terms of: (i) registration of the facilities, (ii) licensing of health workers, and (iii) standards of practice. By institutionalizing RBF, the

component will also support the implementation of an element of the recently approved health financing strategy.

Component 2: Strengthen Health Systems to Deliver RMNCAH Services (IDA: US$54.5 million)

34. The objective of this component is to strengthen institutional capacity to deliver RMNCAH services. The project will support the MoH to address the most critical health systems bottlenecks to RMNCAH service delivery identified in the RMNCAH Sharpened Plan. These include four key areas described below. The actions to address these bottlenecks will be included in the annual plans and budgets of the MoH.

(a) **Improving availability of essential drugs and supplies (US$10 million).** The project will support the MoH to: (i) procure and distribute essential RMNCAH commodities, including mama kits, manual vacuum aspiration kits, commodities for integrated community childhood management, and contraceptives for public and private providers; (ii) strengthen district supply chain management capacity; and (iii) upgrade the warehousing system in National Medical Stores (NMS).[35] In accordance with existing practice, Uganda Health Marketing Group will distribute RH commodities to private providers. In order to strengthen district capacity to quantify drug needs, the MoH will support the districts to assign medicines management supervisors to the DHTs and complete the roll out of the electronic logistics management system in the remaining districts.

(b) **Improving availability and management of the health workforce (US$4.5 million).** The MoH will (i) facilitate understaffed districts to recruit staff and fill vacancies within the available annual wage bill allocation in a timely manner;[36] (ii) train RMNCAH cadres in short supply (midwives, anaesthetists, and laboratory technicians); and (iii) facilitate local institutions and organizations to provide in-service training and mentorship programs targeting RMNCAH services.[37] The use of local organizations will help build national capacity.

(c) **Improving availability and functionality of medical equipment in health facilities (US$9 million).** The project will support the MoH to: (i) procure and distribute critical RMNCAH equipment to selected facilities; (ii) redistribute basic medical equipment from districts/health facilities where they are not in use; and (iii) strengthen the inventory management system for equipment.

(d) **Improving health infrastructure of PHC health facilities (US$22.5 million).** The project will support the MoH to: (i) construct maternity units in 80 HC IIIs (in non RBF districts) after establishing a clear justification and rationale; and (ii) develop guidelines for RBF health facilities to perform simple renovation of health facilities to enhance their functionality.

[35] This will integrate financing and logistics managements systems.
[36] The project will not provide salaries.
[37] Using Association of Gynecologists, Pediatricians, Private Midwives, RMNCAH non-governmental organization service providers and regional referral hospitals.

(e) **Improving quality of care and supervision (US$8.5 million).** The project will support the MoH to: (i) effectively supervise and support DHTs in a coordinated and systematic manner through the area supervision teams;[38] (ii) roll out the HFQCAP in both public and private facilities; (iii) issue service standards/protocols including maternal and perinatal death audits, health care waste management (HCWM) and client charters; (iv) develop and issue guidelines to the districts to contract eligible hospitals to provide ambulance and referral services on a fee-for-service basis; (v) support DHTs to strengthen their community health outreach programs through properly trained, equipped, motivated and supervised VHTs; and (vi) strengthen citizen engagement through the Health Unit Management Committees (HUMCs), constituency task forces and client charters.[39]

Component 3: Strengthen Capacity to Scale-up Delivery of Births and Deaths Registration Services (IDA: US$5 million; GFF: US$5 million)

35. The objective of the component is to strengthen institutional capacity for CRVS and scale-up BDR services. The project will support government efforts to strengthen capacity of the principal CRVS institutions at central and subnational levels to carry out their mandate to provide BDR services and to scale-up BDR services countrywide.

Sub-component 3.1: Strengthen Institutional Capacity to Deliver BDR Services (US$2 million).

36. The key objective of this sub-component is to strengthen the key CRVS institutions to carry out their mandates in BDR. The strengthened CRVS system is expected to improve the production of statistics on population dynamics, health, and inequities in service delivery on a continuous basis for the sector, and provide more accurate data for assessing progress with plans in the health sector. The project will support NIRA at the national level to enhance its oversight and coordination functions and its affiliate offices at subnational level (district and sub-county) to provide BDR services, giving priority to:

(a) development and dissemination of a national CRVS policy, strategy and communication strategy;

(b) development of the BDR protocols and manuals; and

(c) establishment and operationalization of a CRVS monitoring and evaluation (M&E) system, and use of CRVS data for planning and accountability purposes.

Sub-component 3.2: Scale-up Birth and Death Registration Services (US$8 million)

37. The objective of the sub-component is to support NIRA to scale-up BDR services in health facilities and communities. The project will support NIRA to (i) establish BDR mobile outreach services in 63 districts; (ii) scale-up the electronic vital records system for birth registration to additional remaining districts; (iii) expand birth registration to 218 HC IVs, and 1,300 HC IIIs; (iv) expand mobile/outreach birth registration services to remote and underserved

[38] Area Teams comprise central level staff and are responsible for the quarterly supervision of the districts.
[39] These citizen engagement tools are already in use. The project will support expansion of their implementation.

communities; (v) train facility and community-based registration personnel on BDR; (vi) design a death registration module within the existing electronic vital records system; (vii) train clinical staff and Maternal and Perinatal Death Audit Committees on cause-of-death reporting according to International Classification of Diseases (ICD) guidelines; (viii) develop a customized DHIS2[40] module for reporting cause of death and ICD coding; and (ix) acquire the necessary materials, tools and equipment for BDR.

Component 4: Enhance Institutional Capacity to Manage Project Supported Activities (IDA: US$7.5 million)

38. The objective of the component is to enhance institutional capacity for management of project-supported activities. This component will support costs related to overall project management, training, safeguards, M&E, citizen engagement, and other project operational issues to ensure that the intended objectives are achieved in a sustainable manner. The project will address the skills gaps in project management and build institutional capacity of the relevant units for efficient and effective project implementation. This will include the following:

(a) *Strengthen project management, including fiduciary capacity*. This will entail enhancing capacity for project management, financial management (FM), procurement, and both internal and external audit functions.

(b) *Strengthen capacity to implement RBF programs*. Special attention will be paid toward building capacity of key staff in RBF design and implementation, as well as national coordination of the various RBF programs/schemes in the country.

(c) *Strengthen capacity for management of environmental and social safeguards related activities*. This is to enable the MoH to coordinate, monitor, and report on implementation of the Indigenous Peoples Plan (IPP), Indigenous Peoples Policy Framework (IPPF), Environment Social Management Framework (ESMF), and Resettlement Policy Framework (RPF).

(d) *Enhance monitoring and evaluation functions*. The project will support the MoH to generate reliable data to facilitate routine project monitoring, verification of RBF outputs, and coordination and implementation of the mid-term and end-of-project evaluation.

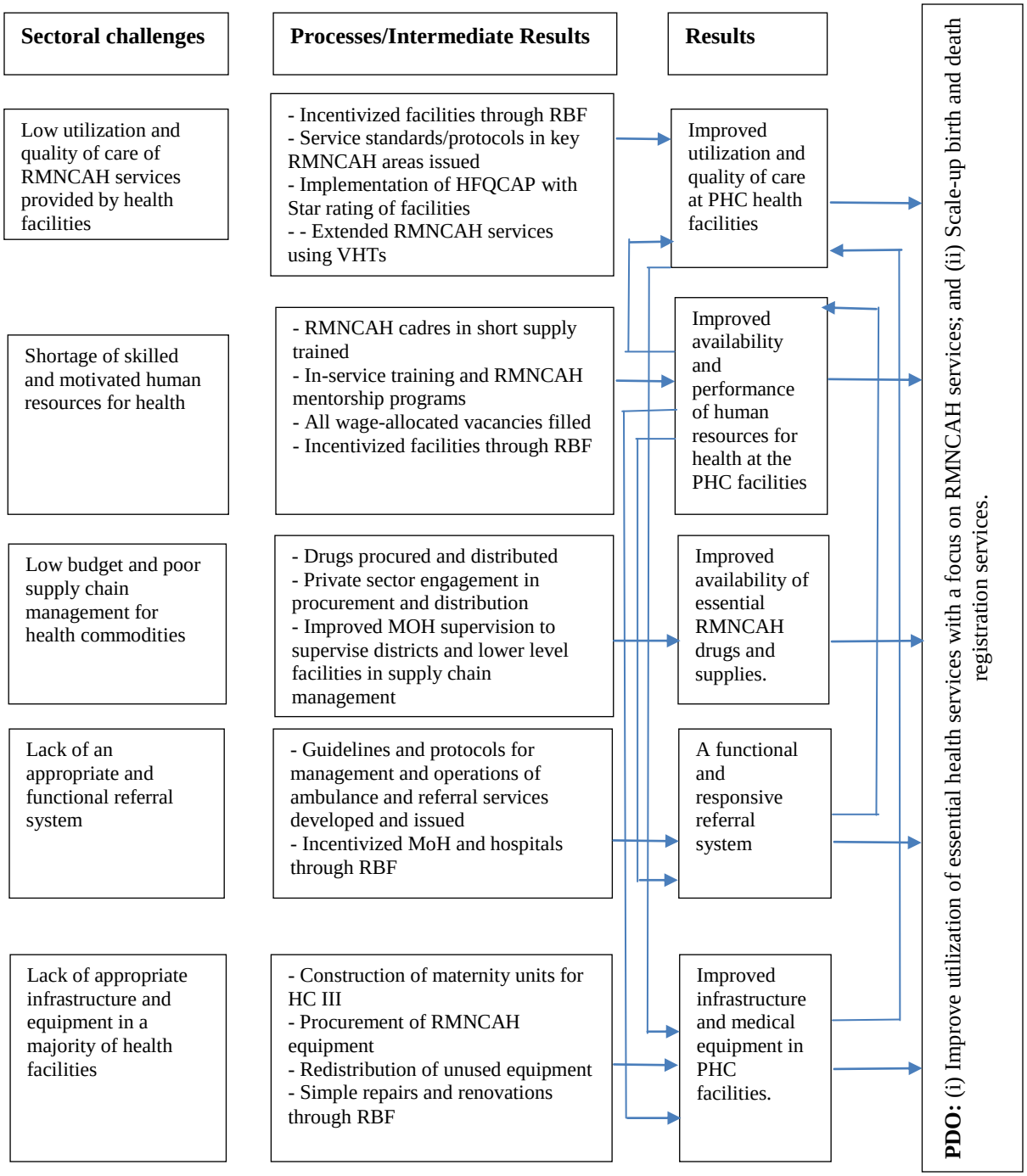
(e) *Support information, education and communication and citizen engagement*. This will involve engaging the media, revision and dissemination of appropriate tools, and materials on citizen engagement, and monitoring of citizen engagement related activities.

39. Careful attention will be paid to the geographical coverage and complementarity of different components. The RBF scheme under Component 1 initially targets districts with high RMNCAH disease burden and low service coverage and utilization. During the project, it will be rolled out to cover sixty districts in a phased manner (see Table 2.2, page 43 for the full list of RBF districts)**.** The RBF scheme will be implemented in close collaboration and coordination

[40] DHIS2 is the health management information system used in 47 countries including Uganda, and used by 23 organizations

with other RMNCAH activities to ensure its alignment with the Sharpened Plan. The RBF districts will therefore also receive inputs from complementary RMNCAH activities financed by the GoU and other development partners to ensure delivery of the comprehensive package of RMNCAH services. The government has started an initiative to promote the alignment and coordination of activities under the Sharpened Plan at the district level. This approach will continue during project implementation. The activities under Components 2 and 3 are nation-wide but prioritized for low capacity and disadvantaged districts.

Figure 2. Project Results Chain



B. Project Financing

40. The Project uses the Investment Project Financing (IPF) instrument. The support for RBF through the use of the IPF instrument will help promote a culture of accountability for results while ensuring robust fiduciary arrangements.[41] The total project cost is US$140 million equivalent, with US$110 million equivalent financed by an IDA credit of US$110 million and US$30 million by a grant from The GFF Trust Fund (Table 3).

Table 3: Project Cost and Financing (US$, Millions)

Project Components	Project Cost	IDA Financing	GFF TF Financing	IDA Financing (%)
1 (a). Results-Based Financing for Primary Health Care Services	60.00	35.00	25.00	58
1 (b). Results-Based Financing for Primary Health Care Services	8.00	8.00	-	100
2. Strengthen Health Systems to Deliver RMNCAH Services	54.50	54.50	-	100
3. Strengthen Capacity to Scale-up Delivery of Births and Deaths Registration Services	10.00	5.00	5.00	50
4. Enhance Institutional Capacity to Manage Project Supported Activities	7.50	7.50	-	100
Total	140.00	110.00	30.00	79

C. Lessons Learned and Reflected in the Project Design

41. The following lessons informed project preparation:

(a) **Global and local RBF implementation experience.** Global evidence shows that RBF programs have the potential to improve performance of health workers and strengthen health systems. As shown by pilots in Uganda, RBF can contribute to improving health facilities' managerial autonomy, accountability for results, M&E and service delivery.

(b) **National RBF Framework**. There has been no uniformity in the design and implementation of RBF pilots in Uganda. In response, the GoU developed a National RBF Framework to guide RBF implementation in the health sector. The design of Component 1 is based on this Framework.

(c) **Use of country systems to ensure ownership and sustainability.** Project implementation is aligned with national processes and systems as much as possible

[41] The Program for Results (PforR) instrument was considered but not pursued; as it would require reliance on the government's fiduciary arrangements which at the moment are inadequate at the district and health facility levels.

to facilitate coordination with other initiatives and to enhance project sustainability. The arrangement also ensures coordination and harmonization of policy proposals and decisions which affect the implementation of the project.

(d) **The Project builds on lessons from earlier and ongoing IDA health projects in the country.**[42] They include: (i) the use of the fiduciary systems already in place under the existing IDA projects for implementation, (ii) capacity building and institutional strengthening and (iii) strengthening accountability for results in the context of decentralization.

(e) **Focus on evidence-based interventions**: The RBF performance package comprises a set of high impact and cost-effective interventions selected from the National RMNCAH Sharpened Plan. These interventions were identified by a rigorous analytical and prioritization exercise during the preparation of the Sharpened Plan.

(f) **Governance and accountability**: The Office of the Inspector General (OIG) in the audit report of the GFATM grants in Uganda noted a number of fiduciary problems, including poor grant oversight by the MoH and unaccounted funds which resulted in lapses in service delivery.[43] These concerns were taken into account in the project design and appropriate mitigation measures established, including the use of an external verification agent, value for money audits, and biannual audits by the Directorate of Internal Audit in the MoFPED.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

42. The project will be implemented by the MoH and the NIRA. The MoH as the main recipient will be responsible for overall project coordination as well as FM and procurement functions. NIRA will be the sub-recipient under the MoH. Each agency will execute specified activities in line with their respective mandates. The MoH will be responsible for activities under Components 1, 2, and 4 while NIRA will be responsible for Component 3. The roles and obligations of the two agencies will be spelt out in the Subsidiary agreement.

43. The Permanent Secretary (PS) of the MoH, as the "Accounting Officer" of the Project, is responsible for overseeing implementation. The PS will delegate the day-to-day management of the Project to a full-time Project Coordinator (PC). Senior officers at the rank of Commissioner or Head of Department (and above) will be assigned as Component Coordinators to coordinate implementation of project activities under the respective components. The Component Coordinators will be supported by Focal Persons assigned to lead specific tasks within the components.

[42] Uganda Health Systems Strengthening Project (UHSSP) (P115563), Uganda Reproductive Health Voucher Project (P144102), and East Africa Public Health Laboratory Networking Project (EAPHLNP).
[43] Audit Report, GFATM Grants to the Republic of Uganda (GF-OIG-16-005), February 26, 2016, Geneva, Switzerland.

44. The GoU will establish a Project Steering Committee (to meet biannually) comprising PS (MoH, Chair), the Director General (MoH), Executive Director (NIRA), and senior officials from the two agencies as well as other relevant government entities will oversee overall Project implementation.[44] In addition, the government will establish a Project Implementation Committee (to meet quarterly) comprising the Director General (MoH, Chair) and senior MoH and NIRA officials to coordinate day-to-day Project implementation. To harmonize financing of RBF projects in the country, the government will establish an RBF Interagency Coordination Committee (to meet biannually) comprising the Permanent Secretary/Secretary Treasury (MoFPED, Chair), MoH officials and relevant development partners to oversee and coordinate the implementation of different RBF initiatives in the country.

45. Project implementation will be mainstreamed in MoH and NIRA operations. This is to ensure that Project implementation is aligned with national processes and systems, thus enhancing its coordination and sustainability. Where necessary, consultants will be recruited to support Project implementation. The existing Technical Working Groups and the RMNCAH Assembly will provide avenues for promoting alignment and coordination of the Project with other RMNACH activities under the Sharpened Plan.[45] For Component 3 under NIRA, coordination will be through the existing Technical Working Groups in NIRA under the supervision of the Senior Management Committee.

46. A dedicated RBF Unit in the MoH will be responsible for overseeing and coordinating RBF activities in the sector. This unit under the Health Planning Department will (i) provide technical support and coordinate the implementation of all RBF activities in the country, not just those supported by the Project and (ii) serve as the secretariat to the RBF Interagency Coordination Committee. The RBF unit will further be supported by Regional RBF teams which are responsible for supervision and coordination of EDHMT in RBF activities. The Health Sector Budget Working Group (HSBWG) will perform the function of the National RBF Steering Committee.

47. The District Health Officer (DHO) will oversee the implementation of Project activities at the district level. The DHO assisted by the EDHMT will oversee and coordinate Project activities at the district level. At the health facility level, the HUMC will oversee all project-related activities. The operations of the RBF at the district level will be based on the Memoranda of Understanding between (i) MoH and districts and (ii) districts and health facilities.

B. Results Monitoring and Evaluation

48. The project's results framework is a subset of the M&E frameworks of the MoH and NIRA. The majority of Project indicators are derived from the existing list of indicators

[44] Ministry of Finance, Planning and Economic Development, Ministry of Local Government, Ministry of Gender, Labor and Social Development and Ministry of Public Service.

[45] The key ones include: (sector budget technical working group, RMNCAH technical working group, PPPH technical working group and human resources for health technical working group, and the members are drawn from government, development partners and private providers including NGOs.

routinely collected and reported by the MoH and the NIRA. Data will be collected from three main sources: (i) the health management information system (HMIS) under the MoH; (ii) the civil registration database under NIRA; and (iii) the project-specific database. Additional data based on facility-level performance indicators will be provided by RBF facilities to facilitate RBF payments after verification of the reports. The Division of Health Information in the MoH and the M&E Unit under NIRA will be responsible for coordinating M&E activities under the project. An M&E specialist will be recruited to provide support to MoH and NIRA under the Project.

49. The MoH will submit quarterly progress reports and Interim Financial Reports (IFRs) to the World Bank in accordance with the reporting requirements set out in the Operations Manual. Under Component 1, RBF facilities will be reimbursed quarterly on the basis of reports submitted to the MoH after (i) verification by the Regional RBF teams and (ii) certification by the RBF unit. An independent agent will conduct external verification of results and prepare semi-annual external verification reports. The mid-term review will provide the opportunity to assess progress for appropriate mid-course corrections as needed. Please see Annex 1 (Results Framework and Monitoring) and Annex 3 (Implementation Arrangements) for more details.

C. Sustainability

50. The consolidation and scale-up of cost-effective RMNCAH interventions using existing institutional mechanisms will contribute to the project's technical sustainability. The majority of these interventions are not new and have already been under implementation. By addressing key cross-cutting health system bottlenecks, the project will help frontline service providers to improve RMNCAH service delivery in a more sustainable manner. Implementing the project's RBF activities under a common National RBF Framework will also contribute to RBF sustainability.

51. Project financial sustainability is likely in the long term. The project is an integral part of (i) the Government's broader health program under the Sector-wide Approach and (ii) the Government's medium-term expenditure framework. The GoU is committed to institutionalizing RBF, and in FY 2018/19 will start financing RBF activities from its own budget. As outlined in the National RMNCAH Sharpened Plan, the total committed resources for RMNCAH is US$1,018 million over the 2016-2020 period, with US$231 million from the Ugandan government (23 percent), US$140 million from the project (14 percent) and US$647 million from other development partners (63 percent).[46] Increases in government funding for health in general and RMNCAH in particular are therefore paramount to the project financial sustainability. Under the optimistic scenario (20 percent annual growth in the government health budget), the government's per capita health expenditure is projected to double between 2015 and 2020 (from US$11 to US$24). If the prevailing 15 percent annual growth in the Government health budget is maintained, the government's health expenditure is expected to increase to US$20 per capita. In both cases, Uganda should be able to absorb the Project's costs in the

[46] United States government, DFID, Sida, BTC, United Nations Children's Fund, United Nations Population Fund, GFATM, GAVI, World Vision, Marie Stopes, and Save the Children.

longer term (see Annex 5 for more details). However, in the short to medium term, there are several prerequisites for the Project's financial sustainability including: (i) continued support from development partners, (ii) further Government commitment to health; (iii) prioritization of RMNCAH, including non-wage RMNCAH recurrent expenditures; and (iv) reduction of waste in health spending.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

52. The overall project risk rating is substantial. The risk related to "institutional capacity" is high while "political and governance" is rated substantial. Among Sub-Saharan African countries, Uganda is a pioneer in decentralization. However, decentralization implementation has lately been constrained by the proliferation of districts in the absence of commensurate increase in the resources. The majority of the new and remote districts lack the requisite capacity for service delivery. Furthermore, while the existing legal and institutional frameworks related to governance are quite robust, poor compliance and weak implementation pose a key challenge to service delivery in a decentralized setting.

Table 4. Risk Rating Summary Table

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Other	N/A
OVERALL	Substantial

53. Risks related to "technical design", "fiduciary" and "stakeholders" are substantial. The project involves many institutions and stakeholders at the national, district and facility levels. Good coordination and adequate implementation support for various implementers is therefore required. Most of the RBF pilots so far have been in the PNFP sector with limited MoH involvement. Under the National RBF Framework, the GoU will need to be in the driver seat for the design, implementation and roll-out of the RBF program. The sector has previously experienced fiduciary challenges involving donor funds. The recent GFATM audit report by the Office of the Inspector General revealed many issues in the management of the GFATM grants by the MoH.[47]

[47] Audit Report, Global Fund Grants to the Republic of Uganda, GF-OIG-16-005, 26 February 2016, Geneva, Switzerland

54. The risks related to "macroeconomic", "sector strategies" and "environment and social" are moderate. While Uganda is vulnerable to external shocks, the country has managed to effectively respond to the shocks, mitigate the associated risks and maintain macroeconomic stability. The key sectoral strategies are in place and are consistent with the National Development Plan and Vision 2040.

55. The project will mitigate these risks in various ways. First, for "technical design", the Project design has a strong focus on accountability and results. Second, gaps in implementation will be mitigated through capacity building and institutional strengthening. Third, for "stakeholders", the creation of a RBF Unit in the MoH will facilitate the coordination of RBF activities among various stakeholders and implementers. The use of relevant Technical Working Groups will also help ensure proper linkages between the project and other RMNCAH initiatives supported by other partners. Fourth, to address the fiduciary risks, the project will use the existing MoH fiduciary arrangements for current IDA projects which are deemed to be robust.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Economic Analysis

56. The health benefits of investing in RMNCAH services are well documented. High-impact, cost-effective interventions reduce maternal deaths, improve child survival, reduce chronic morbidity for mothers and children, and lower the incidence of non-communicable diseases later in life. The Project will help achieve such health benefits by supporting a range of cost-effective interventions highlighted in Uganda's RMNCAH Sharpened Plan.

57. The Project will contribute to the country's long-term economic growth in the form of higher GDP arising from increased labor force participation, higher productivity and saved health care costs. By reducing maternal mortality and morbidity, women will be more productive in the labor force, better support their children through the critical development stages and contribute to other non-income generating activities that are critical for economic growth. (See Annex 5 for more details on the potential pathways of the Project's development impacts). One maternal death is estimated to reduce the annual GDP per capita by US$ 0.42 (in 2015 prices) in Sub-Saharan Africa.[48] The indirect costs of maternal deaths in Africa were estimated at US$4.5 billion in 2010.[49] With close to 6,000 maternal deaths in Uganda annually, the costs of maternal mortality to the Ugandan economy can be substantial.

58. A cost-benefit analysis (CBA) shows that the project is a sound economic investment. The present value of the project benefits is US$2,515 million, while the present value of the project costs is US$128.2 million. This results in a net present benefit of

[48] Kirigia J.M, D. Oluwole, G.M. Mwabu, G. Gatwiri, L.H. Kainyu, (2006). Effects of Maternal Mortality on Gross Domestic Product in WHO African Region. *African Journal of Health Services* (13): 86-95.

[49] Kirigia J.M, G.M. Mwabu, J.N. Orem, and M. Muthuri, (2014). Indirect Costs of Maternal Deaths in the WHO African Region in 2010. *BMC Pregnancy and Childbirth* (14): 299.

US$2,386.8 million and a benefit-cost ratio of 19.6:1. The latter means that the Project has the potential to achieve a return of US$19.6 for every US$1 invested.

59. The project will promote equity and shared prosperity. This will be achieved by (i) addressing access to and quality of RMNCAH services which disproportionately affects the poor, (ii) allocating more resources (through RBF) to lower levels of care (health centers) where the poor most often access services, and (iii) prioritizing disadvantaged districts. Through these mechanisms, the Project is expected to improve allocative efficiency. In addition, by rewarding performance, it can also improve technical efficiency.

Financial Analysis

60. A financial sustainability analysis established that the project is potentially financially sustainable. The project's average annual funding is US$0.8 per capita which is 7% of the 2015/16 government health spending at US$11 per capita. The justification for financial sustainability is seen in light of the growth in the government health budget by 93 percent in nominal terms during the 2011-2016 period (annual average of 15 percent) and the expected improvements in the country's future fiscal space. The latter would be due to: (a) projected increase in GDP with and without oil revenues (8.8 percent and 6.4 percent, respectively); (b) growth in tax revenue of about 0.5 percent of GDP as a result of increased VAT compliance, and a potential increase in tax revenue by US$38 per capita[50] if the tax to GDP ratio rises from 11.9 percent to 20 percent; and (c) efficiency improvements in the health sector. However, while the total project amount is a potentially financially sustainable investment, there is need for more government commitment if the project's benefits are to be sustained. In addition, the government needs to allocate a larger share of funds to non-wage recurrent expenditures at the district and health facility levels to reduce the high levels of out of pocket expenditures among poor households.

B. Technical

61. The Project supports the implementation of RMNCAH technically sound interventions in a pro-poor manner. The Project will support selected high-impact and cost-effective interventions as identified in Uganda's RMNCAH Sharpened Plan. The Sharpened Plan was prepared through a rigorous and consultative process, with the participation of all key RMNCAH stakeholders in the country. It was informed by a thorough situational analysis and a review of the global evidence based on what works in RMNCAH. As discussed in paragraph 56, such technically sound interventions from the Sharpened Plan will be implemented under the project in a pro-poor manner.

62. The theory of change is centered on supporting implementers at different levels in the system in a complementary manner to expand RMNCAH interventions. To overcome key bottlenecks in the scale-up of interventions, the project will support national institutions, districts and frontline facilities in tandem to address a number of cross-cutting topics. These include strengthening management of human resources for health, referral system, supply chain

[50] Background paper: First Universal Health Care Financing Forum. World Bank/USAID, April 14-15, 2016

management, quality of care, supervision outreach and community health programs. Particular attention will be paid to ensuring that existing health facilities meet minimum quality of care requirements in service delivery. An enhanced community approach to RMNCAH service delivery will be promoted and supported to increase the coverage of RMNCAH services using VHTs as a link between communities and the health system.

63. Strengthening CRVS under the project will benefit health and development. A well-functioning CRVS system registers all births and deaths, compiles and disseminates vital statistics, including cause-of-death information. Such a system is critical to the design, implementation and monitoring of many national development initiatives, not just those related to RMNCAH or health. The project's focus on BDR capacity building, development of a death registration module and corresponding tools; as well as the implementation of BDR mobile services under Component 3 is appropriate for Uganda's country context, current level of CRVS and NIRA's vision for BDR scale-up in the country.

C. Financial Management

64. A financial management assessment was conducted at the MoH which will be the primary implementing agency. An FM assessment was also conducted at NIRA and concluded that, as a relatively new entity, NIRA will be a sub-implementing agency under the MoH for Component 3. Similarly, an assessment was conducted for sampled districts and health facilities. The FM assessment reviewed: (a) the adequacy of FM arrangements in ensuring project funds are used for their intended purposes, and in an efficient and economical way; (b) the capacity of the agency to prepare accurate and reliable project financial reports in a timely manner; and (c) the capacity of the agency to safeguard the project assets. The assessment was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on March 1, 2010, and retrofitted on February 4, 2015.

65. Project FM arrangements will remain within the existing set-up in the MoH, **with the Permanent Secretary (PS) as the overall accounting officer**. Day-to-day accounting functions will be undertaken by the Accounts Division headed by the Assistant Commissioner. The Accounts Division is staffed by experienced personnel, including a senior accountant, an accountant and accounts assistants. These staff will be supplemented by the current project accountant and assistant accountant recruited under the ongoing World Bank projects. NIRA will recruit an accounts assistant to support project accounting and reporting requirements before disbursement is made by the MoH. Participating districts will be required to ensure that the key positions of chief finance officers/senior finance officers are filled promptly by fast tracking the ongoing recruitment process. The districts will also be expected to nominate an accountant from the existing pool of departmental accountants to support the Project. For participating health facilities with no accounting staff, hands on training in financial management will be offered to existing staff nominated to support the accounting function with close supportive supervision from the sub-county and district accountants. To enhance transparency and accountability at health facilities with adequate staff, finance sub-committees will be formed to handle FM matters before being submitted to the health management units. Social accountability will be enhanced through the current practice of displaying funds received and expenditures in the district, health facilities, and through the promotion of client charters.

66. The MoH internal audit division, through staff seconded from the MoFPED provides internal audit services to World Bank projects. However, due to the increasing scope of work, and inadequate staffing, the internal audit division has not been able to provide timely internal audit reports for the ongoing World Bank projects. Given the fiduciary demands of the current project, this will be mitigated by recruiting an internal auditor for the project(s) to support the current establishment. The internal audit department will be expected to conduct risk based reviews and share semi-annual internal audit reports with the World Bank within 30 days after the end of the semester.

67. The GoU accounting policies and procedures as well as the World Bank guidelines will be used for FM under the Project. These are detailed in the Government's Public Financial Management (PFM) Act 2015 and the Treasury Accounting Instructions 2003, among others. The specific IDA FM Guidelines are specified in the Financing Agreement and Project Implementation Manual. Simplified FM guidelines will be prepared for the health facilities. Project teams at the MoH, NIRA, districts and health facilities will be trained on the guidelines. The financial reports of the project will be prepared on a cash basis in accordance with International Public Sector Accounting Standards. The MoH FM system consists of two electronic systems: (i) the Integrated Financial Management System (IFMS); and (ii) Navision, the stand-alone accounting software. The project financial reports are expected to be managed using IFMS following the decision by the MoFPED to discontinue using separate accounting software for projects once the IFMS is fully operational for donor projects.

68. Disbursements under the project will use the report-based format. The disbursement methods available to the MoH include advance, reimbursement, special commitment and direct payment. The MoH will open a Designated Account (DA) at the Bank of Uganda to which IDA funds will be credited. NIRA, districts and health facilities will also be required to maintain project specific bank accounts into which funds will be transferred for project activities.

69. The MoH will submit consolidated quarterly Interim Financial Reports (IFRs) to the World Bank in the agreed format within 45 days after the end of each quarter. Withdrawal applications will be submitted through e-signature and e-disbursement.

70. The Office of the Auditor General will carry out an annual statutory external audit on the financial statements of the Project. The terms of reference (ToRs) for the external audit have been agreed with the MoH. The audit will be conducted in accordance with the International Standard on Auditing. The Ministry will ensure that the audited financial statements together with the Management Letter are submitted to IDA within six months after the end of the financial year. Additionally, the Office of the Auditor General will carry out at least two value for money audits during the lifetime of the Project.

71. The conclusion of the assessment is that FM arrangements in place meet the World Bank's (IDA's) minimum requirements under OP/BP 10.00, and are therefore sufficient to provide, with reasonable assurance, accurate and timely information on the status of the Project as required by the World Bank (IDA). The overall financial management residual risk rating is Substantial. The detailed FM assessment report, including the risk assessment and mitigating measures, are included in Annex 3.

D. Procurement

72. Procurement for the Project will be carried out in accordance with the following: 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011 (revised July 2014); 'Guidelines: Selection and Employment of Consultants Under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011 (revised July 2014); 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants' dated October 15, 2006 and revised in January 2011; and the provisions stipulated in the Legal Agreements. The capacity assessment of the MoH, which reviewed the adequacy of procurement and technical staffing and the suitability of internal systems and controls, established that the risk for procurement is High, but would reduce to Substantial upon application of acceptable mitigation measures.

73. The national legislation on public procurement as laid out in the Public Procurement and Disposal of Assets (PPDA) Act is generally consistent with the World Bank's Procurement Guidelines, with the exception of some provisions that are listed in Annex 3.

74. The key risks to project implementation with respect to procurement are: (a) the limited experience of technical staff in procurement management of IDA-financed projects in the departments responsible for the Project including NIRA; (b) delays in the procurement cycle due to inadequate numbers of technical staff; and (c) inadequate involvement and buy-in of targeted stakeholders.

75. These risks will be mitigated by: (a) conducting procurement under the MoH using the arrangements put in place under the UHSSP (delegated Contracts Committee and Procurement Specialist) which are deemed to be effective and efficient; (b) processing NIRA procurements through the MoH; (c) recruiting additional staff/consultants in technical departments to augment existing staff capacity; (d) detailing the roles of key parties/stakeholders in the Project Implementation Manual; (e) setting up a procurement tracking system to monitor timely processing of contracts by the Procurement and Disposal Unit; (f) raising awareness among the stakeholders at different levels (policy, strategy or implementation) regarding the Project; (g) constituting a Health Facility Procurement Committee in the health centers; and (h) preparing and disseminating a Health Facility Procurement Handbook.

E. Social Safeguards

76. The project involves minor civil works that include the construction of maternity units in existing HC IIIs, as well as minor renovations. While the probability of land acquisition under the project is low, since the exact sites and land needs are uncertain, the Project may have resettlement and land acquisition impacts and therefore triggers the social safeguards policy OP/BP 4.12. To mitigate potential adverse impacts of the Project on communities, a Resettlement Policy Framework (RPF) has been prepared to guide resettlement and compensation of Project affected persons in a sustainable manner. The resettlement policy framework will apply to Components 1 and 2 of the project, whether or not they are directly

funded in whole or in part by the World Bank; and compensation will be a prerequisite for implementation to begin.

77. The Project's geographical coverage includes districts traditionally occupied by indigenous people (IPs): IPs include the Ik in Kaabong District and the Batwa in some districts in western Uganda. To ensure social inclusion for IPs, the project triggers safeguards policy OP/BP 4.10. To address this, an Indigenous People's Plan (IPP) and an Indigenous People's Policy Framework (IPPF) have been prepared for the Ik and Batwa, respectively. Free, prior and informed consultations with indigenous peoples' communities were carried out with the Ik and the Batwa communities. Some of the identified potential positive effects of project implementation on Indigenous Peoples include increased use of available health care services, delivery of culturally appropriate services including nutrition related interventions, and improved access to health services through outreach activities. The project will promote socio-cultural interaction, coordination and consultation with traditional leaders prior and during implementation. For this, it is essential that districts employ staff in the health facilities who speak the local dialects and are compliant with local socio-cultural interaction norms and belief systems of the IPs. The RPF, IPP (Ik) and IPPF (Batwa) were approved by the Regional Safeguards Advisor on May 28, 2016 for the first two safeguards documents, and May 29, 2016 for the third, and disclosed on June 1, 2016.

F. Environment Safeguards

78. The interventions under the project involve improvement in the provision of health services, construction and renovation of health facilities, and handling of medical products. While these activities will contribute to improved health services, they will also lead to increased generation of medical waste by the health facilities. Components 1 and 2 involve, among others, small-scale infrastructure works, renovations/expansion, electric power extension, water supply, fencing, and HCWM. The project also expects to construct maternity units at HC-IIIs. The civil works may pose health and safety risks, including construction waste, while health care waste may pose health risks to the patients, attendants, health workers and the public in the event of poor management practices. Consequently, the Project triggers the following Environmental Safeguards Policies: Environmental Assessment OP/BP 4.01, and Physical Cultural Resources OP/BP 4.11 because of the civil works that may encounter unknown physical and cultural resources. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. Due to the overall limited likelihood of environmental and social impacts, the Project is rated as Environmental Assessment Category B.

79. Because the participating facilities and their exact locations are currently unknown and it is not clear whether or not the project might lead to land acquisition and/or loss of livelihoods of some individuals or communities, an Environmental and Social Management Framework (ESMF) was prepared through a consultative process to guide the handling of Project environmental and social aspects during implementation. The ESMF includes environmental and social management tools such as screening procedures activities, assessment checklists, environmental and social management plans (ESMPs), simplified/practical health facility (HC-III/IV) HCWM guidelines, a chance finds procedure, environmental and social reporting formats, a stakeholder and community engagement plan, HIV/AIDS management plans, a child protection and a gender responsive plan, and grievance redress mechanism. Given that the Project may

involve construction and labor concentrations and movement, the ESMF provides guidance that is in line with the national labor laws and management of workers, including a Code of Conduct. Upon identification of the participating health facilities, site specific environmental assessments and respective Environmental and Social Management Plans (ESMPs) shall be prepared during Project implementation. The Environmental and Social Management Framework was approved by the Regional Safeguards Advisor on June 3, 2016 and disclosed on June 6, 2016.

80. In addition to the National Health Care Waste Management Plan (2007/8 – 2011/12) prepared and disclosed under the previous IDA projects, the MoH has the following documents on HCWM and infection control: Approaches to Health Care Waste Management, Health Workers Guide, Second Edition (2013); Uganda National Infection Prevention and Control Guidelines (December 2013); and the National Policy on Injection Safety and Health Care Waste Management (2014). These documents shall guide the management of HCWM and shall form part of the Project ESMF. The listed guidelines shall be harmonized into one basic practical guide in the Project Implementation Manual used at both HC-IIIs and HC-IVs to manage HCW. HCWM shall be part of the assessment criteria for participating health facilities including development of a site specific HCWM-Plan.

81. Environmental compliance is the responsibility of the Environmental Health Division (EHD) of the MoH, which is charged with coordination of health care waste management activities under the overall policy guidance of the National Environment Management Authority. The capacity of the MoH to handle environmental and social safeguards requirements was assessed during preparation of the ESMF and appropriate remedial measures were suggested to address the identified gaps. To ensure proper implementation and management of the environmental and social aspects of the project, the MoH will hire an environmental health specialist (or assign an officer) as part of the project coordination team. The specialist shall closely work and coordinate with the District Environment Officers and Community Development Officers and related partners on a day-to-day basis. Relevant safeguards training of project staff, participating health facilities and local governments shall be undertaken early on in the Project. During Project implementation, the MoH shall ensure clear coordination between the MoH and relevant national and/or local government agencies.

82. Climate change and disaster risk screening. The Project was screened for short and long-term climate change and disaster risks. The results indicate Uganda may be slightly exposed to climate risks with regards to drought, flooding and precipitation, and landslides, however, the overall risk is low with low potential impact. Therefore, no regular assessments of potential climate change impacts will be carried out during the Project period.

G. Citizen Engagement

83. The Project will pay attention to strengthening capacity for citizen engagement. The government already has a number of instruments in place including: client/patient charters; the VHT program, constituency task forces; open public meetings (barazas); and client surveys conducted by the civil society organizations. The Project will strengthen citizens' engagement and beneficiary feedback through the Health Unit Management Committees (HUMCs), constituency task forces and client charters. Support for information, education and communication, and citizen engagement will involve engaging the media, revising and

disseminating appropriate tools and materials on citizen engagement, and monitoring citizen engagement-related activities.

H. World Bank Grievance Redress

84. Communities and individuals who believe that they are adversely affected by a World Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of the World Bank's non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

Uganda

Uganda Reproductive, Maternal and Child Health Services Improvement Project (P155186)

Results Framework

Project Development Objectives						
PDO Statement						
The project development objectives are to: (a) improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts; and (b) scale-up birth and death registration services.						
These results are at	Program Level					
Project Development Objective Indicators		**Cumulative Target Values**				
Indicator Name	Baseline 2014/15	YR1 2016/17	YR2 2017/18	YR3 2018/19	YR4 2019/20	End Target 2020/21
Births (deliveries) attended by skilled health personnel (Percentage, Number) - (Core)	50%	53%	55%	58%	61%	65%
Pregnant women who received IPT2 (Percentage)	53%	58%	64%	70%	75%	80%
Couple years of Protection (Number)	3,308,142	4,200,000	4,350,000	4,400,000	4,450,000	4,500,000
Children under one year immunized with third dose of pneumococcal conjugate vaccine (PCV3) (Percentage)	79%	82%	85%	90%	90%	90%
Children under five years with birth registration (Percentage)	58%	60%	65%	70%	72%	75%
Total number of deaths registered (Percentage)	1%	5%	10%	15%	20%	25%

Intermediate Results Indicators		**Cumulative Target Values**				
Indicator Name	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**
Pregnant women receiving antenatal care during a visit to a health provider (Number) - (Core)	1,500,000	1,520,000	1,580,000	1,600,000	1,630,000	1,650,000
RBF health facilities with functional HUMCs with citizen representation (Percentage)	45%	50%	60%	70%	80%	100%
Health Center IVs offering caesarian sections (Percentage, Number)[51]	50%	53%	58%	64%	70%	75%
Health facilities attaining at least 2-star rating under the Quality Assurance Program (Percentage)	0%	10%	15%	20%	25%	30%
Health facilities without stock-outs of any of the six tracer drugs in the previous three months (Percentage)	64%	67%	70%	73%	76%	80%
Health facilities with placed orders that are fulfilled by National Medical Stores (Percentage)	65%	68%	72%	75%	78%	80%
Health facilities constructed, renovated, and/or equipped (Number) - (Core)	0	0	20	50	100	150
Health personnel receiving training (Number) - (Core)	0	50	200	300	350	400
Approved posts in public facilities filled by qualified health workers (Percentage)	65%	71%	73%	73%	75%	75%
Districts with contracted ambulance and referral system (Number)	0	20	30	40	50	60
Reported maternal deaths that are audited (Percentage)	33.%	39%	45%	51%	57%	65%

[51] This a proxy indicator to assess capacity to provide comprehensive emergency obstetric care services

Indicator Description				
Project Development Objective Indicators				
Indicator Name	**Description (indicator definition)**	**Frequency**	**Data Source / Methodology**	**Responsibility for Data Collection**
Births (deliveries) attended by skilled health personnel (percentage, number)*	Measures the cumulative number of women who delivered with the assistance of a health provider.	Annual	Annual Health Sector Performance Report/HMIS	Ministry of Health
Pregnant women who received IPT2 (Percentage)	Measures the proportion of pregnant women who received IPT2 during the ANC.	Annual	Annual Health Sector Performance Report	MoH
Couple Years of Protection (Number)	Measures the sum of Couple Year Protection by type of FP commodities dispensed/offered during the year.	Annual	Annual Health Sector Performance Report	MoH
Children under one year immunized with third dose of pneumococcal conjugate vaccine (Percentage)	Measures the proportion of children under one year of age immunized with third dose of pneumococcal conjugate vaccine.	Annual	Annual Health Sector Performance Report/HMIS	MoH
Children under five years with birth registration (Percentage)	Measures the proportion of children under five years of age with birth registration	Annual	Birth register	National Identification Registration Authority
Total number of deaths registered (Percentage)	Measures the proportion of deaths that are registered within the reporting period	Annual	Death register	National Identification Registration Authority
Intermediate Results Indicators				
Indicator Name	**Description (indicator definition etc.)**	**Frequency**	**Data Source / Methodology**	**Responsibility for Data Collection**
Pregnant women receiving ANC during a visit to a health provider (Number)	Measures the cumulative number of pregnant women receiving at least one ANC care visit to a health provider	Annual	HMIS	MoH
RBF health facilities with functional HUMCs with citizen representation	Measures involvement of citizens in the management of the health facilities	Annual	Project Records	MoH

(Percentage)				
HC IVs offering caesarian section (Percentage)	Measures the number of HC IVs able to perform caesarean section	Annual	Annual Health Sector Performance Report	MoH
Health facilities attaining at least 2 star rating under the Quality Assurance Program (Percentage)	Measures the proportion of facilities that attained at least a 2-star rating against number of facilities enrolled in the program.	Annual	Quality Assurance Reports	MoH
Health facilities without stock-outs of any of the six tracer drugs in the previous three months (Percentage)	Measures availability of the six tracer drugs at the facility level in the previous three months.	Annual	Annual Health Sector Performance Report/HMIS	MoH
Health facilities with placed orders that are fully filled by National Medical Stores (Percentage)	Measures the percentage of health facilities whose orders were fully filled by National Medical Stores	Annual	National Medical Stores Records	National Medical Stores/MoH
Health facilities constructed, renovated, and/or equipped (Number)	Measures the cumulative number of health facilities constructed, renovated and/or equipped through the project.	Annual	Project Records	Project Coordination Team
Health personnel receiving training (Number)	Measures the cumulative number of health personnel receiving training through the project	Annual	Project records	Project Coordination Team
Approved posts in public facilities filled by qualified health workers (Percentage)	Measures the proportion of approved (and funded) positions in public facilities filled by qualified health workers	Annual	Annual Health Sector Performance Report/HMIS	MoH
Districts with contracted ambulance and referral system (Percentage)	Measures the number of districts that have contracted ambulance services on a fee for service basis.	Annual	Project records	Project Coordinating Team
Reported maternal deaths that are audited (Percentage)	Measures the proportion of reported maternal deaths for which maternal death audits are conducted.	Annual	Project records	Reproductive Health Division

Note:* This indicator measures the proportion of deliveries conducted in public and private facilities against the estimated total number of deliveries.

Annex 2: Detailed Project Description

UGANDA: Uganda Reproductive, Maternal, and Child Health Services Improvement Project

Component 1: Results-based Financing for Primary Health Care Services (IDA: US$43 million; GFF: US$25 million)

1. The objective of this component is to institutionalize and scale-up RBF with a focus on RMNCAH services. The RBF design of the project draws on the National RBF Framework, and aims at increasing access to quality and cost-effective RMNCAH services provided at both the districts and HCs III and IV. The health facilities include hospitals contracted to provide ambulance and RMNCAH referral services. HCs will be incentivized to promote community-based health care activities through the VHTs. In accordance with the public private partnerships for health, the RBF facilities are drawn from public and private providers. The summary of the essential package for RMNCAH services is described in Table 2.1.

Table 2.1: Essential Package of Reproductive, Maternal, Neonatal, Child and Adolescent Health Services

Category	Interventions
Core package: provided at community and HC II levels	Direct provision: Short-term family planning methods, ICCM, immunization, Misoprostol, KMC, antibiotics for new-born sepsis, pregnancy testing, counselling and birth preparedness, focused ANC (HIV Testing, IPT FP, LLIN distribution, iron/folate) and PNC Service supports: Referral for delivery/PAC/FP/adolescent care, follow up HIV-exposed babies, linkages for adolescent/SGBV/HIV to BCC, sexuality and life skills education, socio-support, BDR, home visits for interpersonal communication on improving household and community RMNCAH practices (including household sanitation and hygiene), compliance support and tracking defaulters, counselling and birth preparedness, demand creation for family planning, adolescent responsive services at facility (adolescent health days), school and community level.
Expanded package at HC III	All the above and the following: Direct provision: Long-term family planning methods, IMNCI, PAC, BEmONC, EMTCT, ART, and adolescent friendly package of health services to include BCC and IEC material distribution. Service supports: Implement health extension and micro-planned integrated outreaches.
Comprehensive Package at HC IV and general hospitals	All the above and the following: Direct provision: CEmONC, inpatient management of severe new-born and child illnesses, permanent contraception. Service supports: Ambulance services, MPDR.

Source: RMNACH Sharpened Plan for Uganda, Ministry of Health, 2016

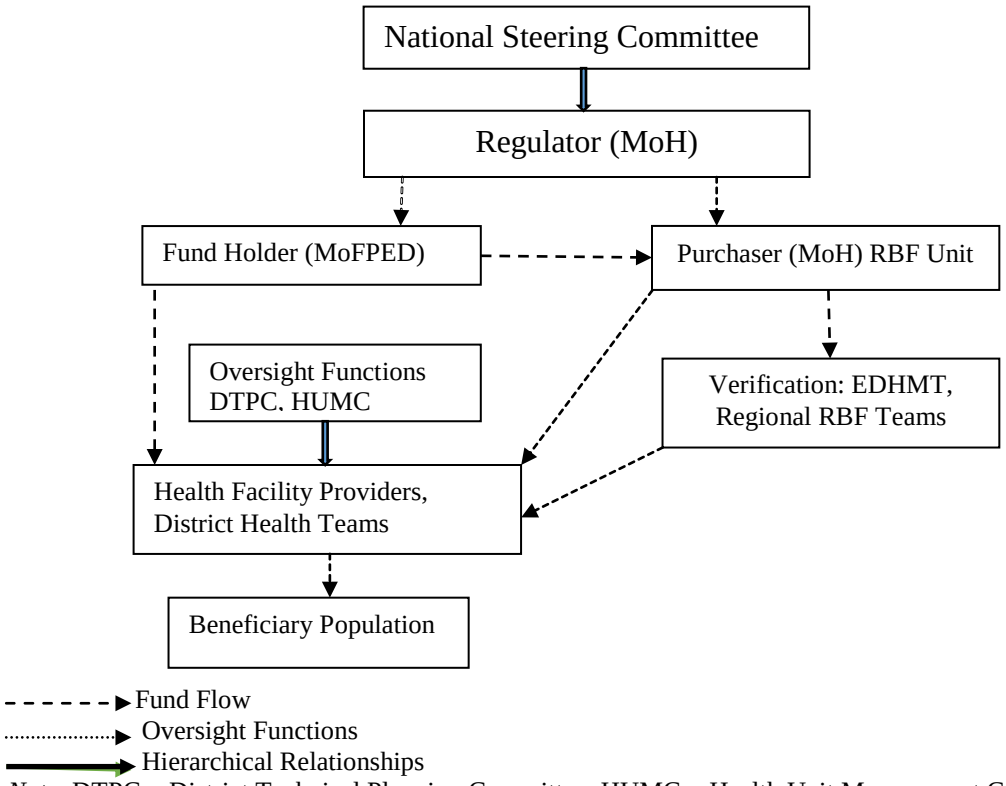
Note: BEmONC = Basic Emergency Obstetric and Neonatal Care; CEmONC = Comprehensive Emergency Obstetric and Neonatal Care; ICCM = integrated community childhood management; KMC = kangaroo mother care; LLIN = long-lasting insecticide treated bednets; PNC = post-natal care; SGBV = sexual and gender based violence; BCC = behavior change communication; IMNCI = integrated management of neonatal and childhood illnesses; EMTCT = elimination of mother to child transmission of HIV; ART = antiretroviral therapy; MPDR = maternal and perinatal death reviews; IEC = information, education, and communication; IPT = Intermittent Presumptive Therapy; FP = Family Planning; PAC = Post Abortal Care; Births, Deaths Registration.

2. Health facilities and the DHTs will be rewarded against performance. Health centres in the RBF scheme will be rewarded for performance based on key quantity and quality indicators derived from the core package of services using a fee-for-service provider payment mechanism embedded with a quality enhancing score. The health centres will also be reimbursed to oversee VHTs within their catchment areas. The DHTs will be rewarded against performance on key health systems governance indicators on a quarterly basis. The regional RBF teams using the district RBF performance framework will assess DHTs with regard to: (a) timeliness in verifying RBF results; (b) provision of technical and supportive supervision to the facilities; (c) functionality of the referral system; (d) availability and maintenance of equipment; (e) distribution and management of human resources; (f) timeliness in submitting complete RBF invoices, HMIS reports, and funding requests; (g) implementation of the medical waste management plan; and (h) drugs logistics and supply management.

3. Figure 2.1 (page 38) shows the RBF organogram for the project. The organogram describes the roles and responsibilities, including: regulation, fund-holding, verification, purchasing, financing arrangement, and service provision. The Ministry of Finance, Planning and Economic Development will serve as the fund holder, while the Directorate of Planning and Development in the MoH is responsible for the purchasing and regulatory functions. As regulator, the MoH is responsible for developing and enforcing policies, standards, guidelines and contracts for the management of the RBF. The MoH will contract the districts, and the districts will contract the health facilities including hospitals. To coordinate execution of the RBF activities, an RBF unit will be created under the MoH. The RBF unit will coordinate the roll-out, technical support, and day-to-day management of RBF activities under the project. The RBF unit will be assisted by five regional RBF teams (north, east, south, west and central) designated to provide oversight and technical support to the districts.

4. RBF payments will be made against verified outputs. The Expanded District Health Management Team (EDHMT) will verify outputs (quantity and quality) at health facilities on a monthly basis. The EDHMT is composed of various stakeholders to avoid collusion between the health facilities and the verification team. Regional RBF teams will validate performance of the EDHMTs every quarter by evaluating performance of a small sample of health facilities based on the verification reports of the EDHMTs and trigger payment. An independent firm will be contracted to carry out external verification of the outputs by the DHTs and health facilities on a semi-annual basis. The purpose of the external verification exercise will be to independently verify the accuracy of reported data, patient tracing, and quality of health services provided. Results obtained from the regional teams and the independent verification firm may trigger penalties and sanctions in the event of misreporting and falsification of data. The Project Implementation Manual will provide details on the selection criteria and contracting process for DHTs and health facilities, list of performance indicators, payment formula, the performance assessment framework and reporting arrangements, internal and external verification, disbursement and utilization of funds, and the sanctions regime.

Figure 2.1: RBF Model and Flow of Funds



Note: DTPC = District Technical Planning Committee; HUMC = Health Unit Management Committee

(Source: National RBF Framework for Uganda, Ministry of Health, 2016)

5. RBF funds will be paid directly to the institutions (districts and health facilities). This permits the institutions to exercise autonomy over the use of the funds within the stipulated financial regulations. To reduce transaction costs, the MoH and MoFPED will synchronize the RBF payment cycle with the disbursement cycle for GoU grants. The RBF funds shall be additional to the other funds that districts and health centers receive from other sources, and shall be accounted for in line with Uganda's PFM Act and financial regulations. Furthermore, within their realm of managerial autonomy, the districts and health centers will use the RBF funds to pay for staff incentives and recurrent operational activities (such as maintenance and repair, drugs and consumables, cleaning materials, office supplies, outreach, transport, strengthening linkages and boosting service delivery at the community level) based on the guidelines issued by the MoH.

6. The operational details regarding the RBF scheme are in the Project Implementation Manual. These shall include: the selection criteria and contracting process for districts and health facilities, performance assessment framework including performance indicators, reporting arrangements, internal and external verification, disbursement and utilization of funds, and the sanctions system. The Project Implementation Manual will also outline capacity building activities for all stakeholders involved in the RBF implementation process particularly the national and regional RBF units, internal and external verification teams, DHTs, and health centers.

7. The project under this component will finance: (a) assessment, selection and strengthening capacity of RBF health providers; (b) performance-based payments to health facilities, hospitals and the DHTs based on verified results; (c) RBF supervision and capacity building; and (d) external verification.

Component 2: Strengthen Health Systems to Deliver RMNCAH Services (IDA: US$54.5 million)

8. The objective of this component is to strengthen institutional capacity to deliver high impact and quality RMNCAH services. The project under the component will support the MoH to address the most critical health systems bottlenecks to RMNCAH service delivery. The six key areas are**:**

(a) **Improving availability of essential drugs and supplies (US$10 million).** The MoH will: (i) procure and distribute essential RMNCAH commodities, including mama kits, ICCM commodities, manual vacuum aspiration kits, and contraceptives; (ii) strengthen district capacity to quantify drug needs and report quarterly on drug availability; and (iii) upgrade the warehousing system in National Medical Stores. The Uganda Health Marketing Group will handle the distribution of reproductive health commodities for private providers, while the National Medical Stores and Joint Medical Stores will store and distribute commodities for public facilities and PNFPs, respectively. In addition, the MoH will support the districts to assign medicines management supervisors to the DHTs, facilitate the roll out of the electronic logistics management system, and issue guidelines for RBF health facilities to procure drugs using the performance based payments.

(b) **Improving availability of human resources for health (US$4.5 million).** The MoH will facilitate remote and understaffed districts to recruit staff and fill vacancies within the available wage bill allocation in a timely manner. In addition, the project will support the MoH to (i) train RMNCAH cadres in short supply (midwives, anaesthetists, and lab technicians); and (ii) support in-service training and mentorship programs targeting RMNCAH services. In-service training and mentorship will be carried out using local institutions in order to build national capacity.[52] The MoH completed the roll out of the human resources for health management information systems to all the districts and established an e-recruitment system under the Health Service Commission (HSC).[53] The two systems are expected to strengthen capacity to manage the health workforce.

(c) **Improving availability and functionality of medical equipment in health facilities (US$9 million).** The MoH will: (i) procure and distribute critical RMNCAH equipment to selected facilities; (ii) redistribute basic medical equipment from districts/health facilities where they are not in use; and (iii) strengthen the

[52] Association of Gynecologists, Pediatricians and Midwives; Marie Stopes Uganda, Reproductive Health and Program for Accessible health Communication and Education (PACE) are training health providers in provision of FP services.

[53] The HSC is responsible for personnel management functions for national level staff and overseeing the District Service Commissions with respect to management of health workers.

inventory management system. In some instances, there are facilities with equipment, which they are not using or are unable to use. This equipment will be redistributed. In addition, guidelines to manage such redistribution arrangements will be prepared to avoid similar occurrence in the future.

(d) **Improving health infrastructure of PHC health facilities (US$22.5 million)**. The project will support the MoH to: (i) construct maternity units in 80 HC IIIs after establishing a clear justification and rationale and (ii) support the districts to undertake simple renovation of health facilities and provision of basic infrastructure (water, power, lighting, remodeling of the facilities to create storage and laboratories, health care waste management, etc.) to enhance their functionality. In supporting the districts, the MoH will issue simple procurement and contract management guidelines for repairs and renovation works, and measures to mitigate environmental and social safeguards during the renovations.

(e) **Improving quality of care and supervision (US$8.5 million).** The project will support the MoH to: (i) effectively supervise and support DHTs in a coordinated and systematic manner through the area supervision teams (comprising the main divisions/units in the MoH: Reproductive Health, Child Health, Health Information, Quality Assurance, Human Resources, and Pharmacy);[54] (ii) roll out the Health Facility Quality of Care Assessment Program (HFQCAP); (iii) issue service standards/protocols including maternal and perinatal death audits, HCWM, client charters, and so on; (iv) develop and issue guidelines for the districts to contract eligible hospitals to provide ambulance and referral services on a fee-for-service basis; and (v) support DHTs to strengthen their community health outreach programs through properly trained, equipped, motivated and supervised VHTs. The HFQCAP is based on a stepwise approach and includes a quality assessment tool with 10 modules, including one on RMNCAH customized to the different levels of health facilities in Uganda.[55] The MoH will coordinate assessments for the hospitals, and build DHT capacity to conduct assessments in lower level health facilities for their respective districts. Health facilities will undergo annual assessments and be expected to develop and implement customized quality improvement plans on the basis of the national quality improvement framework.

Component 3: Strengthen Capacity to Scale-up Delivery of Births and Deaths Registration Services (IDA: US$5 million; GFF: US$5 million)

9. The objective of the component is to strengthen institutional capacity for CRVS and scale-up births and deaths registration services. The development of the component was informed by the proposal prepared by NIRA for the RMNCAH Sharpened Plan, previous work by Uganda Registration Services Bureau and the Registration of Persons Act establishing NIRA.

[54] Area teams comprise central level staff and are responsible for the quarterly supervision of the districts. The Resource Centre is responsible for managing the HMIS.

[55] Leadership and governance; human resources for health; health financing; health information; medicines, health supplies, equipment and vaccines; health infrastructure: RMNCAH; clinical care, surgical care, referral, and emergency services; diagnostic services; and client centered care and safety.

The proposal prioritizes strengthening the principal CRVS institutions; increasing awareness for CRVS; and establishing a CRVS M&E system.

Sub-component 3.1: Strengthen Institutional Capacity to Deliver BDR Services (US$2 million).

10. The objective of this subcomponent is to strengthen the principal CRVS institutions to carry out their mandates in BDR. The project will support NIRA at the national level to enhance its oversight and coordination function and its affiliate offices at the subnational level (district and sub-county) to provide BDR services, giving priority to:

(a) Development and dissemination of a national CRVS policy and strategy to provide the basis and direction for CRVS activities and development of a communication strategy to raise awareness and sustain engagement with major stakeholders over the BDR.

(b) Development of the BDR protocols and manuals, including a community cause-of-death reporting protocol using verbal autopsy; standard pre-service and in-service training curricula on certification of cause of death and ICD coding; norms and standards for cause-of-death reporting and ICD coding; and establishment of a sustainable supply and management of BDR tools.

(c) Establishment and operationalization of a CRVS M&E system, and promotion of the use of CRVS data for planning and accountability purposes. NIRA will establish a quality assurance system to validate the M&E system and spearhead the publication of the annual National CRVS Report. Specific national agencies, including the Uganda Bureau of Statistics will have access to NIRA's database so that they can generate periodic progress reports on vital statistics.

Sub-component 3.2: Scale-up Birth and Death Registration Services (US$8 million)

11. The objective of this sub-component is to support NIRA to scale-up BDR services at the health facilities and the communities. The project under this subcomponent will support NIRA to: (a) establish BDR mobile outreach services for effective coverage within the 63 districts where electronic vital records system[56] is currently operational; (b) scale-up the electronic vital records system for birth registration to the remaining districts; (c) expand birth registration to lower levels of care (218 HC IVs, 1,300 HC IIIs) and private hospitals in all the districts; (d) expand mobile/outreach birth registration services to remote and underserved communities; (e) train facility and community-based registration personnel on BDR; (f) design the death registration module (alongside the birth registration module) within the existing electronic vital records systems that will capture all health facility deaths and train the users on uploading the information; (g) train clinical staff and Maternal and Perinatal Death Audit Committees on cause-of-death reporting according to ICD guidelines; and (h) develop a customized District Health Information System module for reporting cause-of-death and ICD

[56] The electronic vital records system enables the use of a web based application and mobile phones (USSD) to capture the vital events of births (and deaths) in health facilities and communities respectively. It addresses the bottlenecks in a paper-based system and plays a vital role in streamlining and simplifying data capture for births (and deaths) in Uganda. Currently, only the birth registration module is operational.

coding. With the support, NIRA will acquire the necessary materials, tools and equipment for BDR. NIRA is expected to ensure that the necessary staff to carry out registration and notification are in place at all relevant levels and are adequately equipped and facilitated to do their work.

12. A NIRA-appointed registration officer will be responsible for registering all births and deaths occurring within a designated area. NIRA may designate any other person to assist the registration officer of an area to perform his/her functions. Medical facilities will only be notification centers for births and deaths and the administrators of these facilities will be required to file weekly returns with the registration officer of the relevant registration area. In case of events occurring outside medical facilities, a declarant will be required to report the birth or death to the registration officer at the registration center.

Component 4: Enhance Institutional Capacity to Manage Project Supported Activities (US$7.5 million)

13. The objective of the component is to enhance institutional capacity for management of project supported activities. This component will support costs related to overall project management, training, and project operations (safeguards, M&E, citizen engagement) to ensure that the intended objectives are achieved in a sustainable manner. The project will address the skills gaps in project management and build institutional capacity of the relevant units for efficient and effective project implementation. This will include the following:

(a) *Strengthen project management, including fiduciary capacity*. This will entail enhancing capacity for project management, financial management, procurement, and both internal and external audit functions. The project involves many units and needs strong coordination arrangements.

(b) *Strengthen capacity to implement RBF programs*. Special attention will be paid to building capacity of key staff in RBF design and implementation, as well as national coordination of the various RBF programs/schemes. The RBF Unit created in the Health Planning Department will be responsible for coordinating these activities.

(c) *Strengthen capacity for management of environmental and social safeguards related activities*. This is to enable the MoH to plan, coordinate, monitor, and report on implementation of the relevant mitigation activities. The MoH will support the districts to implement as appropriate the ESMF, RPF, IPP and IPPF and provide periodic reports.

(d) *Enhance monitoring and evaluation functions*. The project will support the MoH resource center to generate reliable data to facilitate routine project monitoring, verification of RBF outputs, and coordination and implementation of the mid-term and end-of-project evaluation.

(e) *Support information, education and communication and citizen engagement* through the Health Unit Management Committees (HUMCs), constituency task forces; engaging the media, revising and disseminating appropriate tools, and materials on citizen engagement, and monitoring citizen engagement related activities.

Table 2.2: Proposed List of RBF Districts.

Proposed RBF Districts under the Project		URHVP[57] (implemented by Marie Stopes Uganda)	Belgian Technical Cooperation[58]	USAID Uganda Voucher Plus Activity[59]
1. Wakiso	38. Bukomansimbi	1. Tororo	1. Kibaale	1. Mbale
2. Kampala	39. Ngora	2. Kabale	2. Kasese	2. Gulu
3. Arua	40. Moyo	3. Iganga	3. Hoima	3. Lira
4. Mubende	41. Kiboga	4. Kamuli	4. Kabarole	4. Oyam
5. Mukono	42. Amudat	5. Mayuge	5. Yumbe	5. Pallisa
6. Luwero	43. Nwoya	6. Jinja	6. Kyenjojo	6. Manafwa
7. Buikwe	44. Abim	7. Isingiro	7. Kamwenge	7. Busia
8. Kayunga	45. Moroto	8. Rakai	8. Nebbi	8. Sironko
9. Apac	46. Kapchorwa	9. Ntungamo	9. Zombo	9. Kumi
10. Mityana	47. Buliisa	10. Mbarara	10. Koboko	10. Soroti
11. Rukungiri	48. Butambala	11. Bugiri	11. Maracha	11. Butaleja
12. Masindi	49. Kween	12. Buyende		12. Alebtong
13. Kisoro	50. Lyantonde	13. Kiruhura		13. Serere
14. Amuria	51. Bukwo	14. Sembabule		14. Budaka
15. Kyegegwa	52. Buvuma	15. Masaka		15. Lamwo
16. Kiryandongo	53. Ntoroko	16. Namutumba		16. Otuke
17. Kole	54. Kalangala	17. Luuka		
18. Lwengo	55. Kaberamaido	18. Kanungu		
19. Agago	56. Kitgum	19. Kaliro		
20. Adjumani	57. Bududa	20. Ibanda		
21. Mpigi	58. Kibuku	21. Namayingo		
22. Bundibugyo	59. Bukedea	22. Bushenyi		
23. Amuru		23. Mitooma		
24. Kotido		24. Rubirizi		
25. Kyankwanzi		25. Buhweju		
26. Nakapiripirit		26. Sheema		
27. Pader				
28. Kaabong				
29. Dokolo				
30. Nakaseke				
31. Kalungu				
32. Bulambuli				
33. Nakasongola				
34. Napak				
35. Katakwi				
36. Gombe				
37. Amolatar				

[57] Uganda Reproductive Health Voucher Project, is a grant to Government of Uganda from SIDA/World Bank, Marie Stopes Uganda is a Voucher Management Agent contracted by Ministry of Health

[58] Will implement RMNCAH services using a Results Based Financing mechanism.

[59] Implementing a reproductive health voucher scheme.

Annex 3: Implementation Arrangements

UGANDA: Uganda Reproductive, Maternal, and Child Health Services Improvement Project

A. Project Administration Mechanisms

1. The project will be implemented by the MoH and the NIRA. The MoH will be the main recipient, and NIRA, a sub-recipient under the MoH. While each agency will be responsible for executing specified activities in line with their respective mandates, the MoH as the main recipient will perform FM and procurement functions on behalf of NIRA. The MoH will oversee implementation of activities under Components 1, 2 and 4, while NIRA will be responsible for project activities under Component 3 on civil registration and vital statistics.

2. Project implementation will be mainstreamed within the operations of the MoH and NIRA. This is to ensure that project implementation is aligned with national processes and systems, thus ensuring coordination and sustainability of programs. The following shall be the guiding principles for project implementation consistent with the mainstreaming strategy proposed by the government:

(a) The use of the government structures and systems for project implementation;

(b) The project components will be assigned to and managed by the relevant departments in the MoH and NIRA;

(c) The project components will be supervised by component coordinators who shall be heads of departments whose departmental mandates are consistent with component activities; and

(d) Where there are capacity gaps, the government will source consultant services to support staff within the departments. Such consultants will mentor and train the staff they are attached to. The consultants shall report to the relevant heads of department. Detailed job descriptions of these consultants shall be elaborated in the Project Implementation Manual.

3. The Permanent Secretary (PS) of the Ministry of Health will serve as the accounting officer for the project. The PS will have overall responsibility for the execution of the project and will ensure that project resources are used for their intended purposes and accounted for. The PS will delegate the day-to-day management of the project to a full-time Project Coordinator. Senior officers at the rank of a commissioner or a head of department will be assigned to coordinate implementation of project activities under the respective components. In addition, focal persons, working under the component coordinators will be assigned to coordinate implementation of specific project activities within the components.

4. The Executive Director (ED) of NIRA will provide technical oversight for the execution of project activities under Component 3. The ED will be assisted by the component coordinator assigned to coordinate implementation of component activities.

5. To oversee project implementation, the government will establish a Project Steering Committee. The committee chaired by the PS, MoH will consist of the following members: PS,

MoH; ED, NIRA; senior officials from the two agencies; representatives from the Ministry of Finance, Planning and Economic Development, Ministry of Local Government, Ministry of Public Service and the Local Government Finance Commission; and the Project Coordinator. The Committee will meet biannually and its main roles are to: (a) oversee project implementation, (b) review and approve annual project implementation plans, and (c) provide policy guidance towards project implementation. The Project Steering Committee will be assisted by a Project Implementation Committee, which is responsible for coordinating technical implementation of the project. The Project Implementation Committee will meet quarterly and its main roles are to: (a) monitor implementation of approved workplans, (b) identify and address emerging issues, and (c) review and endorse progress reports. In addition, the MoH will ensure that government officials from the relevant oversight agencies including National Environment Management Authority and Ministry of Gender, Labor and Social Development provide the necessary oversight. In order to coordinate and harmonize financing of RBF projects in the country, the government will establish an Interagency Coordination Committee chaired by the Permanent Secretary/Secretary Treasury MoFPED and composed of the MoH and key RBF development partners.

6. The project will have a secretariat headed by the Project Coordinator. The secretariat will be responsible for coordinating day-to-day implementation of the project, timely project reporting, fiduciary matters, and project M&E. Members of the Secretariat together with the component coordinators and focal persons will be responsible for: (a) identifying critical challenges and proposing solutions, (b) following up implementation of agreed actions, (c) supporting the Project Steering Committee and Project Implementation Committee, and (d) preparing periodic progress reports.

7. As detailed in the National RBF Framework, a dedicated RBF Unit established at the MoH to coordinate RBF implementation in the sector will oversee project RBF activities. This unit will provide technical support and coordinate the rollout and execution of RBF activities under the project. The specific ToR for the RBF unit are contained in the National RBF Framework for Uganda and include supporting the Directorate of Planning and Development in all activities related to RBF such as the selection of facilities that will participate in the RBF program and ensuring that RBF activities are implemented as planned. The RBF unit will also have regional teams within the RBF unit that will be responsible for supervision and coordination of district teams. The Health Sector Budget Working Group (HSBWG) will perform the function of a National RBF Steering Committee with a specific role of ensuring that RBF activities at national, regional, district and facility levels are implemented as planned.

8. At the district level, the District Health Officer will oversee implementation of project activities. The DHO will report to the chief administrative officer and be assisted by the District Health Management Team (DHMT). The DHMT will provide oversight functions including coordination of RBF activities at district level, recommending health facilities for participation in the RBF program, approval of health facility business plans, and internal verification of health facility results. The Expanded District Health Management Team will include staff from the District Community Based Services Department: Labor Officer, Probation and Welfare Officer, the District Community Development and Gender Officer, and PNFPs to support community engagement, mobilization as well as to address project related social and safeguards issues. In addition, the districts where IPs are present shall designate an officer to

oversee the implementation, monitoring and reporting of the IPPs. At the health facility level, the Health Unit Management Committee (HUMC) will oversee all project-related activities executed by the facility.

9. Coordination of policy issues arising from the implementation of Components 1 and 2. This will be through the respective existing technical working groups and respective departments/divisions for onward submission to the Senior Management Committee of the MoH. It will be the responsibility of the Project Coordinator to provide quarterly reports to the senior management and top management committees as well as the Health Policy Advisory Committee, where partners and the Government meet. For Component 3 under NIRA, coordination will also be through the existing technical working groups within NIRA under the supervision of the senior management committee. The PC will also provide quarterly reports to the NIRA Senior Management and top management committee to ensure coordination and harmonization of policy proposals and decisions affecting birth and death registration specifically. This arrangement will ensure coordination and harmonization of policy proposals and decisions which affect the implementation of the project specifically and the health sector generally.

10. To ensure effectiveness of the project's institutional arrangements and smooth flow of communication between the Bank and the Government, the following were agreed upon:

(a) All official communication to the World Bank on the project shall be under signature of the PS/MoH for Components 1 and 2 and the ED/NIRA for Component 3.

(b) All project decisions shall be made by the ministry through the PS/MoH and ED/NIRA, with advice from the PC and component coordinators.

(c) Renewals of TA contracts shall be based on satisfactory performance assessment carried out by the GoU and agreed upon between the MoH, NIRA and the World Bank.

(d) Senior and top management of the MoH and NIRA will be briefed by the PC from time to time regarding the progress of project implementation to ensure transparency and ownership of the project by the Government.

B. Financial Management and Disbursements

11. The MoH is the principal recipient and implementing entity for the project. Being a new entity, NIRA will be a sub-recipient agency under the MoH. The FM assessment covered MoH and NIRA and included a sample of districts and health facilities and reviewed: (a) the adequacy of the FM arrangements in ensuring project funds are used for purposes intended in an efficient and economical way; (b) the capacity to prepare accurate, reliable and timely project financial reports; and (c) the adequacy of the measures in place to safeguard project assets. The assessment was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on March 1, 2010 and retrofitted on February 4, 2015.

12. Actions outlined in the Financial Management Action Plan will be undertaken by MoH, NIRA, districts and health facilities to strengthen the FM system. The government and IDA have agreed on the format of the Interim Financial Report (IFR) and Terms of Reference (ToRs) for external audit. To ensure that the project is effectively implemented, the MoH, NIRA and the districts will ensure that appropriate staffing arrangements are maintained throughout the life of the project.

13. Country issues: Uganda has been undertaking key reforms including in the areas of the public service, decentralization and public financial management with the aim of instilling modern management practices into Uganda's public service and improving service delivery at the local level by bringing services closer to the citizens and empowering local communities in the management and provision of the services.[60]

14. Uganda's performance in PFM is good on transparency but low on budget credibility, controls and compliance, essentially highlighting implementation gaps. The Auditor General's annual reports regularly identify weak compliance with PFM regulations, resulting in avoidable or wasteful expenditure, build-up of arrears, inadequate accountability and, in some cases, the risk of fraud or misappropriation. The June 30, 2015 Annual Audit Report identified the following challenges across government agencies: irregular payments, under absorption of funds, delayed contracts, procurement anomalies, funds not accounted for, under staffing, among others. The new PFM Act 2015 will, if implemented, support faster progress to address these issues, and create the foundation for a good PFM system in terms of macro-fiscal control and stability (macroeconomic management), budget planning and execution (including M&E), procurement, cash and debt management, financial systems and accounting, internal controls and external oversight.

15. The GoU is carrying out the PFM reforms with the support of several donors. The more notable reforms include the enactment of the Public Finance and Management Act, 2015, the upgrade of the Integrated Financial Management System (IFMS), rolling out Donor projects on IFMS, adoption of Treasury Single Account for GoU resources, and many other initiatives some of which are supported by the Financial Management and Accountability Program (FINMAP). In addition, following the ongoing engagement on having donor funded projects on Treasury Single Account, the Government started migrating donor projects to IFMS (Prerequisite for Treasury Single Account) on a pilot basis as from July 1, 2015. Previous cases of fraud and corruption identified by the Auditor General are being addressed in the High Level Action Matrix agreed with the development partners. Mitigation measures have been built into the project design to remedy such shortcomings as appropriate.

16. The following salient features are the main *strengths* of the project's FM system at the MoH: (a) qualified and experienced accounting personnel; (b) use of the enacted Public Finance Management Act, 2015 and updated Financial Management Guidelines developed under Uganda Health Systems Strengthening Project in January 2011 as its accounting policies and procedures; and (c) accounts maintained using the Navision accounting system and the enrollment of the project accounts into the IFMS.

[60] The Public Expenditure and Financial Accountability (PEFA) Report of 2012.

17. The following salient features are the *weaknesses* of the project FM system noted in the past at the MoH: (a) noncompliance with FM arrangements with accounting for staff advances; (b) unsupported expenditures; (c) unaccounted for funds; (d) low absorption of funds; and (e) inefficiencies in procurement, distribution and use of medical equipment. The ministry is in the process of implementing the recommendations to address these issues.

18. The overall residual risk is assessed as Substantial upon the mitigation of identified risks as detailed in the risk assessment and mitigation Table 3.1 below.

Table 3.1: Risk Assessment and Mitigation Measures

Risk	Risk Rating	Risk Mitigation Measures	Risk after Mitigation
Inherent Risk			
Country-level: The 2012 PEFA report identified weaknesses in the government's PFM systems. Challenges in PFM enforcement, corruption, budget performance across MDAs still exist.	**High**	A government-led PFM Reform Program is under implementation. Some of the payroll and pension reforms are addressed through the Ministry of Public Service. Governance and corruption is also being addressed through a high-level action matrix agreed between GoU and development partners which includes: (i) closure of dormant accounts, (ii) enhancement of IFMS security, internal controls as well as electronic funds transfer controls, (iii) strengthening of internal audit, and (iv) successful enactment of the 2015 PFM Act.	**Substantial**
Entity level: MoH's limited capacity in program implementation results in project delays. The annual statutory audits, the World World Bank FM reviews[61] and the GFATM Audit report by the Office of the Inspector General[62] identified several MOH FM weaknesses. Facility-level service delivery is constrained by: (i) facility managers' low management capacity, (ii) inadequate and unmotivated staff and (iii) inadequate funding.	**High**	Experienced fiduciary professionals will be contracted, among others, to support MOH. They will be subjected to performance appraisal for contract renewal. FM training will be conducted for all project teams before roll out. While the project will be eventually integrated with the government's IFMS, Navision will be used in the interim. Unused equipment will be redistributed. Implementation challenges identified in the GFATM Audit report will be mitigated by the use of the existing robust IDA fiduciary arrangements. The project will also support NMS to improve inventory management through strengthening the warehousing system and rolling out the MOH's electronic logistics management system to districts and facilities.	**Substantial**
Project level: Scaling up the RBF program is complex and requires good management	**High**	The lessons from Uganda's various RBF pilots informed the design of the National RBF Framework. The MoH will establish a RBF	**Substantial**

[61] Delayed accounting for advances, unsupported expenditure, low absorption of funds, value for money concerns on medical equipment and delayed submission of reports in implementing Bank projects.

[62] Ineffective supply chain system in distributing and accounting for medicines and commodities, data quality challenge from HMIS, delayed installation of accounting software, weak management of advances, inadequate support documentation for expenditure, inadequacy and effectiveness of current implementation arrangements.

Risk	Risk Rating	Risk Mitigation Measures	Risk after Mitigation
capacity. For any pay-for-performance scheme, over-reporting by service providers is an inherent risk. Delays in verification of results and payments can affect health workers' motivation and the success of a RBF program.		unit to manage the RBF scale-up. There will be robust results verification mechanisms, both internal (to trigger payment) and external (by an independent firm, to trigger possible sanction/penalties to health facilities if over-reporting is found). Fiduciary aspects of the project will have strong linkages with M&E. Finally, the Auditor General Office will be performing annual audits and at least two value-for-money audits during the project life.	
Overall inherent risk			**Substantial**
Control risk			
Planning and budgeting: Poor budget execution results in variances between budgets and actual expenditures. Diversion of GoU project funds is also a risk.	**High**	Project budget plans will be prepared in sufficient details and used as a management tool. The IFRs will be used to monitor budget variances. Project funds under GoU will be ring-fenced.	**Substantial**
Accounting, systems, policies and procedures: MoH's poor management of accounting records and delays in retiring advances may slow down project implementation. Project funds may not be used efficiently and exclusively for purposes intended. There is a shortage of (i) qualified FM staff and FM guidelines at the health facility level and (ii) Chief Finance Officers, Senior Finance Officers and Internal Auditors at the district level.	**High**	The Ministry has qualified staff with experience in implementation of IDA-funded projects. The Ministry installed the Navision Accounting system in 2012 and upgraded it in 2014 to generate project reports including assets and advances registers. While the project will be integrated on IFMS, Navision will be used as an interim arrangement. The FM Guidelines developed under the UHSSP in January 2011 will be updated to complement the Treasury Accounting Instructions. Regulations for the 2015 PFM Act are under preparation. Simplified FM guidelines will be developed and FM training will be conducted for health facilities before disbursement is made to them. The districts will fast-track the ongoing process of filling vacant positions in the finance and internal audit departments. Districts will designate an accountant from the existing departmental accountants to support the project.	**Substantial**
Banking arrangements, funds flow and disbursement. These risks include (i) delays in making payments to contractors, (ii) delays in disbursing funds to health facilities and (iii) slow absorption of project funds.	**Substantial**	The MoH has reviewed its payment procedures and only retained the critical steps. Funds will be disbursed directly to the health facilities without passing through district accounts.	**Moderate**
Financial reporting: These include delays in (i) submission of accurate and reliable quarterly reports and (ii) preparation of annual financial statements for audit.	**Substantial**	Project Accountant has been adequately trained on the preparation of IFRs and use of Navision to ensure accuracy. Project accountant's adherence to reporting deadlines, including for the annual financial reports will be reinforced. Relevant staff at district and	**Moderate**

Risk	Risk Rating	Risk Mitigation Measures	Risk after Mitigation
		health facility levels will be trained on the project reporting formats.	
Internal control and internal audit: There is a risk of over-reporting and delivering of poor quality services by providers. There are currently (i) no advances registers to monitor management of advances, (ii) delays in submitting internal audit reports on ongoing projects, and (iii) weak controls at facility level where most FM functions are carried out by the officer in-charge alone.	**High**	The MoH and stakeholders (EDHMTs and HUMCs) will closely supervise RBF implementation. The MoH will maintain a comprehensive advances register that will be monitored through the quarterly IFR submissions. Submission of internal audit reports will be linked to approval of withdrawal applications for advances to the project. An internal auditor will be recruited to support the project. A finance subcommittee will be established in facilities which have a significant number of staff.	**Substantial**
External Audit The June 30, 2014 audit reports for UHSSP and EAPHLNP were received on time. The reports were unqualified. The Management Letter identified internal control weaknesses and value for money issues on medical equipment.	**Substantial**	The mitigation measures for the identified weaknesses will be incorporated in the project design.	**Moderate**
Overall control risk			**Substantial**
Overall Project Residual Risk Rating			**Substantial**

19. Institutional and implementation arrangements. The project will be managed through the existing FM arrangements established for IDA projects in the MoH. During project execution the MoH shall coordinate project implementation and manage: (a) project monitoring, reporting and evaluation; (b) contractual relationships with IDA and other co-financiers; (c) procurement and (d) FM and record keeping, accounts and disbursements. The Permanent Secretary MoH will be the accounting officer for the project, assuming the overall responsibility for accounting for the project funds.

20. Planning and budgeting arrangements. The project will follow the government planning and budgeting procedures documented in the government's Treasury Accounting Instructions, 2003 (currently under revision in line with the new PFM Act, 2015). These arrangements have been found to be adequate. The health planning department responsible for the budgeting process in the MoH has adequate capacity including a focal person responsible for budgeting.

Accounting System, Policies and Procedures

21. Policies and procedures. The GoU accounting policies and procedures will be supplemented with IDA FM Guidelines as specified in the Financing Agreement and Project Implementation Manual. Simplified FM guidelines will be prepared for the health facilities. Project teams at the MoH, NIRA, districts and health facilities will be trained on the guidelines.

The financial reports of the project will be prepared on a cash basis in accordance with International Public Sector Accounting Standards.

22. Books of accounts. The MoH will maintain similar books of accounts to those for other IDA-funded projects. The books of accounts to be maintained specifically for the project should thus be set up and should include: a cash book, ledgers, journal vouchers, a fixed asset register, an advances ledger, and a contracts register among others.

23. Staffing arrangements. The project will be managed by the project accountant currently handling ongoing World Bank projects. The project accountant will be supervised by the assistant commissioner, accounts. The MoH has one assistant commissioner, a principal accountant, one senior accountant, four accountants and eight accounts assistants. NIRA will also require a project accountant recruited before receiving funds from the MoH. Similarly, the participating districts will be required to fill the key positions of chief finance officers/ senior finance officers who are in charge of accounting and financial reporting. Each district will also nominate an accountant to support the project. For participating health facilities with no accounting staff in the structure, FM training will be offered to nominated existing facility staff to support the function with close supportive supervision from the sub-county and district accountants.

24. Information system. The MoH is connected to the IFMS. The ministry is in the process of piloting the projects in IFMS. The UHSSP and EAPHLNP are on the Navision accounting system. The project accountant is conversant with preparing the accounts using this accounting software. Health facilities and districts without any accounting system will be trained on simplified Excel spreadsheets for their accounting and reporting.

Banking, Funds Flow and Disbursement Arrangements

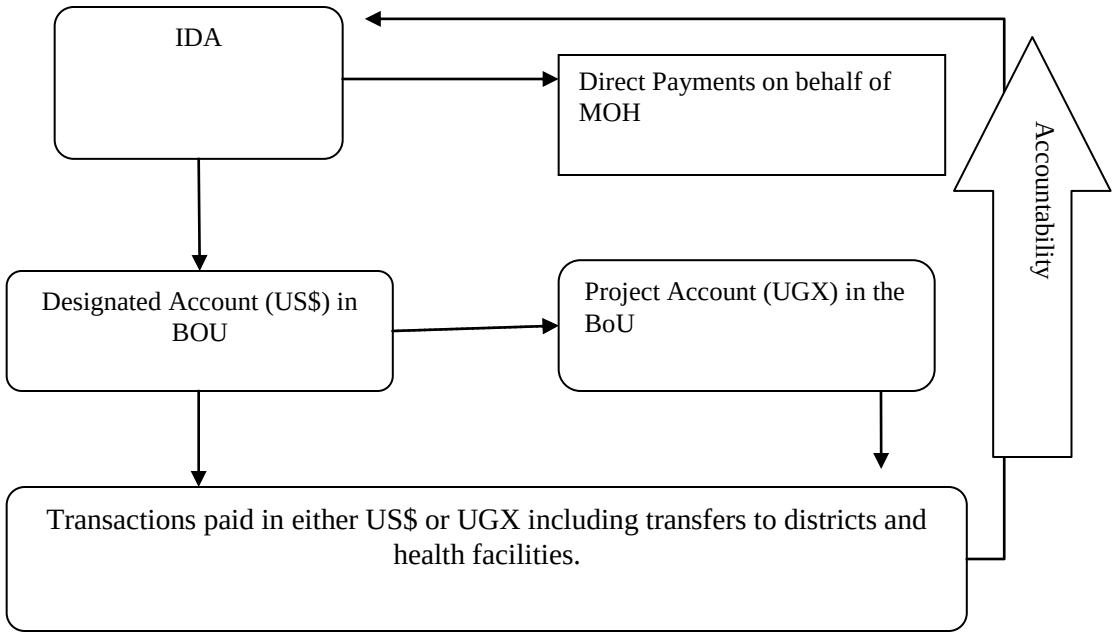
25. Bank accounts. The following bank accounts authorized by the MoFPED will be maintained by the MoH in the Bank of Uganda for purposes of implementing the project: (a) Designated Account denominated in US dollars where disbursements from IDA will be deposited and from which payment in US dollars will be made; and (b) project account, denominated in the local currency. Transfers from the Designated Account (for payment of transactions in local currency) will be deposited into this account in accordance with the project objectives, workplans and budgets. NIRA, districts and health facilities under the project will open project specific bank accounts at Bank of Uganda and acceptable commercial banks into which disbursement from the MoH will be made. Figure 3.1 shows the chart for the flow of funds.

26. The signatories for the project accounts will be in accordance with the treasury accounting instructions. At the MoH, the payments will be approved and signed by the accounting officer (PS) as the principal signatory and the person designated by the Accountant General and project coordinator. At the districts, signatories will be the Chief Administrative Officer, Chief Finance Officer/Senior Finance Officer and project focal person. At the health facilities, the officer in charge, chairman of the HUMC and treasurer will be the signatories.

27. The direct payment method may be used for payments to contractors or service providers upon recommendations of their satisfactory performance by the project authorized officials. Payments may also be made for expenditures against special commitments. The project may also use the reimbursement method. The Accountant General in the MoFPED together with his delegated officials shall be co-signatories for disbursement/withdrawal applications. IDA's Disbursement Letter will stipulate a minimum application value for direct payment and special commitment procedures.

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

FIGURE 3.1: REPRODUCTIVE, MATERNAL AND CHILD HEALTH SERVICES IMPROVEMENT PROJECT - FUNDS FLOW CHART



Note: BoU = Bank of Uganda

29. Financial reporting arrangements: The project will submit a quarterly IFR in an acceptable format to the World Bank within 45 days after the end of each calendar quarter. The report will include: (a) a Statement of Sources and Uses of Funds: and (b) a statement of uses of funds by project activity/component. In addition to the above reports, the MoH will submit to the World Bank: (a) Designated Account Activity Statement; (b) Designated Account and Project Account Bank Statements; (c) Summary Statement of DA expenditures for contracts subject to prior review; and (d) Summary Statement of DA Expenditures for contracts not subject to Prior Review. Simplified reporting formats will be developed for the districts and health facilities as part of the FM guidelines. The annual financial statements should be prepared in accordance

with International Public Sector Accounting Standards (which among others includes the application of the cash basis of recognition of transactions) for external audit.

30. Internal controls: The existing FM Guidelines of January 2011 developed under the UHSSP will be updated together with the FM Manual in the MoH as well as the government's Treasury Accounting Instructions of 2003 to document the internal controls for the management of this project. Similarly, they are contained in the Local Government Act; Local Government (Financial and Accounting) Regulations, 2007; and Local Government FM Manual. To enhance accountability and transparency at the health facilities, finance committees will be formed made up of the heads of sections at the facility. The committee will be chaired by the staff designated as the deputy of the facility in charge.

31. Internal audit. The MoH has qualified and experienced internal auditors (three) and will incorporate the RMNCAH into the internal audit work plan. However, the internal audit has not been conducting the required quarterly internal audit reviews and has not been submitting the reports to the World Bank on time for ongoing projects. To mitigate this, the project will recruit an internal auditor to support the existing team and the submission of the reports will be linked to approval of advances to the project on the relevant quarterly reports. The World Bank will carry out joint review of projects with ministry internal auditors aimed at improving the quality of the internal audit reviews.

32. The audited financial statements for UHSSP and the EAPHLNP were submitted to the World Bank within the submission deadline of December 31, 2015. The auditor issued unqualified opinion on the financial statements and special account statements. The management letter for the UHSSP identified internal control weaknesses, mainly: (a) rejected medical equipment estimated at a cost of US$1,927,194 by two suppliers that had not been fully replaced and (b) low funds absorption rates that led to extension of the project closing date for the UHSSP; and (c) delays in procurement and in civil works. Appropriate mitigation measures have been built into the project design.

33. Financial Management Action Plan. Table 3.2 indicates the actions to be taken for the project to strengthen its financial management system and the due dates for completion.

Table 3.2: Financial Management Action Plan

	Action	**Date Due**	**Responsibility**
1	Agreement on audit ToRs and format of IFR with MoH	Done	MoH/World Bank
2	Recruitment of an accounts assistant and project officer.	Before disbursement by MoH	NIRA
3	Training of project teams on FM	Within three months after project effectiveness	MoH/World Bank
4	Recruitment of internal auditor	Within six months after project effectiveness	MoH
5	Establishment and training of the finance committees at the health facilities	Throughout implementation	Districts / health facilities

34. Effectiveness Conditions:

a. The Recipient shall, not later than six (6) months after the Effective Date, appoint an internal auditor, in accordance with the provisions of Section III of Schedule 2 to the Financing Agreement.

b. The Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled.

c. The Recipient has adopted the Operational Manual in accordance with the provisions of Section I.C.1 of Schedule 2 to the Financing Agreement.

d. The Recipient has, through MoH, established and operationalized an RBF Unit, in accordance with the provisions of the Operational Manual.

35. Disbursement Conditions:

a. No withdrawal shall be made under Category 1, unless and until the Recipient, through MoH, has appointed an IVA in accordance with the provisions of Section I.F.2 of Schedule 2 to the Financing Agreement.

b. No withdrawal shall be made under Category 3, unless and until the Recipient, through NIRA, has appointed an Accounts Assistant and a Project officer, all in accordance with the provisions of Section III of Schedule 2 to the Financing Agreement.

36. Financial Covenants. Financial covenants are the standard ones as stated in the Financing Agreement Schedule 2, Section II (B) on FM, Financial Reports and Audits and Section 4.09 of the General Conditions. In addition, the Recipient shall, not later than three (3) months after the Effective Date, provide financial management training for MoH and NIRA staff involved in financial management under the Project, under terms of reference acceptable to the Association, and, not later than six (6) months after the Effective Date, appoint an internal auditor, in accordance with the provisions of Section III of Schedule 2 to the Financing Agreement.

37. Supervision plan: A supervision mission will be conducted at least twice every year based on the risk assessment of the project. The mission's objectives will include ensuring that strong FM systems are maintained for the project throughout its life. Reviews will be carried out regularly to ensure that expenditures incurred by the project remain eligible for IDA funding.

C. Procurement

38. Procurement for the Project will be implemented at two levels: (a) at the Central Government level – Ministry of Health (MoH), and (b) at the Health Centre III and IV levels.

Applicable Procedures

39. Advance contracting shall apply for this project which allows the Borrower to proceed with the initial steps of procurement before signing the related Bank loan as defined in the

"Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated January 2011 and revised July 2014, paragraph 1.14.[63]

Use of National Procurement System

40. Procurement at the national level. All contracts using National Competitive Bidding (NCB) and Shopping, may follow the national public procurement law (the Procurement and Disposal of Public Assets Authority Act 2003, amended 2014) and attendant regulations. These procedures have been reviewed by the World Bank and found to be acceptable, except for the following provisions, *which will not be applicable under this project:*

a. Domestic preferences shall not apply under NCB;

b. The charging of fees for dealing with bidder complaints at procuring entity level shall not be permitted;

c. Ineligibility shall extend, in addition to firms or individuals suspended by PPDA, to firms or individuals debarred or suspended by the World Bank;

d. Disqualification of bidders for not purchasing bidding documents from the Borrower shall not apply;

e. Paragraph 6(1)(b) of the Fourth Schedule of the PPDA Act, restricting contract amendments to an aggregate amount of 25 percent of the original contract amount, shall not apply;

f. Regulation 53(9) of the PPDA Act, restricting the use of bid securing declarations to restricted domestic bidding and quotations procurement, shall not apply;

g. In accordance with paragraph 1.16(e) of the Procurement Guidelines, each bidding document and contract shall provide for the following: (i) the bidders, suppliers, contractors and subcontractors shall, on request, permit the World Bank to inspect the accounts and records relating to the bid submission and performance of the contract, and shall have the accounts and records audited by auditors appointed by the World Bank; and (ii) any deliberate and/or material violation of such provision by any bidder, supplier, contractor or subcontractor may amount to an obstructive practice provided for in paragraphs 1.16(a) and (v) of the Procurement Guidelines.

h. Procurement under Component 1 at the health facility level shall be conducted by the Health Facility Procurement Committee, as detailed in the Health Facility Procurement Manual.

41. Under the proposed project, procurement shall, in addition to the World Bank guidelines, comply with the national approval system except where the two conflict, in which case the World Bank guidelines will take precedence. Specifically, the Contracts Committees

[63] In such cases, the procurement procedures, including advertising, shall be in accordance with the Consultant Guidelines for the eventual contracts to be eligible for World Bank financing, and the World Bank shall review the process used by the Borrower. A Borrower undertakes such advance contracting at its own risk, and any concurrence by the World Bank with the procedures, documentation, or proposal for award does not commit the World Bank to make a loan for the project in question.

shall perform their oversight functions at every key procurement stage as required by the PPDA Act, and contracts shall be subjected to the Solicitor General's clearance where applicable.

42. Procedure for shopping. Shopping shall follow the Request for Quotation procedures as defined in the PPDA Act and attendant regulations. These procedures have been reviewed by the World Bank and found to be satisfactory subject to the exceptions above in paragraph 40.

43. Use of Framework Agreements. Common supplies, for example, stationery and consumables will be aggregated and procured through framework contracts to enable implementing agencies to place orders for urgently needed supplies at short notice, at a competitive price. Framework Agreements shall not restrict foreign competition, and should be limited to a maximum duration of three years. Framework Agreement procedures applicable to the project are those of the Borrower's that have been deemed acceptable by the World Bank, and shall be described in the Financing Agreement.

44. It has been agreed with the Borrower, that bidding documents under NCB procedures include a clause rendering ineligible for World Bank financing a firm, or an individual, of the Borrower country that is under a sanction of debarment from being awarded a contract by the appropriate judicial authority of the Borrower country and pursuant to its relevant laws, provided that the World Bank has determined that the firm, or the individual, has engaged in fraud or corruption and the judicial proceeding afforded the firm or the individual adequate due process.

Bidding Procedures at Health Facility Level

45. Procurement at the health facility level will follow the shopping method.[64] The procedures shall be described in the Project Operational Manual and the Health Facility Procurement Handbook developed under the project, and whose dissemination as well as procurement training at the health facility level are prerequisites for the health facilities to receive RBF funds.

46. Each facility shall prepare an annual business plan/work plan and a procurement plan which shall be updated quarterly based on the needs/priorities of the facility as identified by the health facility staff through the heads of department, community concerns identified through VHT's, and from the Health Unit Management Committee. A copy of the annual plan and quarterly update, shall be submitted to the district to provide an update, and to ensure alignment of the health facility plans to district plans.

Publication of Opportunities at Health Facility level

47. Upon effectiveness of the project, the DHO shall prepare a general advertisement indicating the menu of possible activities that may be undertaken at the health facilities to notify potential/interested artisans, suppliers and service providers of the available business opportunities using the procedures described in the Project Implementation Manual.

[64] Contracts at PHF level that exceed the shopping threshold shall be referred to MOH for procurement processing.

Solicitation Documents to be Used

48. Goods, works and non-consulting services. The World Bank's standard bidding documents and standard bid evaluation forms will be used for procurement under ICB.

49. Under NCB, the standard tender documents for procurement of supplies prepared and issued by the PPDA may be used subject to modifications acceptable to the World Bank, and to the exceptions in paragraph 40 above.

50. Consulting services. The World Bank's Standard Request for Proposal document and sample form of evaluation report will be used in the selection of consulting firms. The PPDA procedures for selection of Consultants shall not apply.

51. Simplified bidding documents. Procurement planning forms and other documents for use by the health facilities will be developed, and disseminated during the training as a pre-requisite for receipt of RBF funds.

Record Keeping

52. At the MoH level, the procurement and disposal unit will be responsible for record keeping and shall open a procurement file for each contract processed. The file should contain all documents on the procurement process in accordance with the requirements and as described in the PPDA Act. At the health facility level, the Chairperson of the Health Facility procurement committee shall be responsible for record keeping as specified in the simplified implementation manual.

Monitoring

53. Monitoring and evaluation of procurement performance will be carried out through annual *ex-post* procurement and technical audits by (a) procurement consultants with ToR and qualifications acceptable to the PPDA and IDA, (b) World Bank supervision and Post-review missions. At the national level, (a) and (b) will apply, while at the health centers, only (a) will apply.

Scope of Procurement under the Project

Central Government

54. Procurement activities to be financed by the World Bank identified at appraisal are indicated in the Procurement Plan, while other activities will be identified during project implementation.

55. Operating costs. The project will finance costs of MoH and at HC IIIs and IVs that directly relate to project implementation. The project's operating costs include expenditures for maintenance of equipment, facilities and vehicles used for project implementation, fuel, short-term medical and non-medical staff, consumables, travel per diems, accommodation expenses, workshop venues and materials. These will be procured using IDA procedures or the Borrower's procurement, financial and other administrative procedures, acceptable to the World Bank.

Salary top-ups, meeting allowances, sitting/meeting allowances and honoraria to civil/public servants and contracted consultants shall not be financed by the project.

56. Training. The project will formulate an annual training plan and budget which will be submitted to the World Bank for its prior review and approval. The annual training plan will, among others, identify: (a) the training envisaged; (b) the justification for the training, how it will lead to effective performance and implementation of the project and or sectors; (c) the personnel to be trained; (d) the selection methods of institutions or individuals conducting such training; (e) the institutions which will conduct training, if already selected; (f) the duration of proposed training; and (g) the estimated cost of the training. Upon completion of training, the trainee shall be required to prepare and submit a report on the training received. A copy of the training report will be kept for IDA review. Additionally, the MoH's Project Implementation Manual shall specify how candidates eligible for the graduate training shall be selected. These procedures shall ensure equal opportunity to all eligible participants.

Assessment of the MoH Capacity to Implement Procurement

Central Government

57. The capacity assessment of the MoH was carried out on April 12, 2016. The capacity assessment during appraisal excluded NIRA, which at the time did not have any procurement structures and staff in place.

58. The MoH is the implementing agency for three IDA projects: UHSSP, EAPHLNP and the Uganda Reproductive Health Voucher Project, and has established a dedicated unit and a delegated Contracts Committee to manage IDA related procurements. Thus, there is experience in handling IDA funded projects within the MoH. Procurement under the MOH will thus be conducted based on the arrangements provided for the other three projects through a delegated Contracts Committee and a procurement specialist with ToR and qualifications acceptable to the World Bank.

59. The capacity assessment established that procurement processing in the MoH is conducted in accordance with the PPDA Act and IDA guidelines except for the following shortcomings: (a) the Procurement Plan should be updated on time, (b) lack of storage space for procurement records, (c) missing records on invitation for quotations, and (d) delays at evaluation stage.

60. The Health Infrastructure Division[65] is the technical department responsible for construction of health facilities infrastructure, and for supervising the consultants and contractors. A robust contract management mechanism shall be put in place by hiring an architect, quantity surveyor, and clerks of works with ToRs and qualifications acceptable to IDA, to supplement the Health Infrastructure Division staffing and ensure adequate oversight over building works. Based on the lessons learned under the UHSSP, prior to the procurement of the

[65] The Health Infrastructure Division has extensive experience in building works including the 9 hospitals and 26 HCIVs under UHSSP, as well as Government of Uganda, and AfDB financed projects.

civil works MoH shall conduct needs assessment and stakeholder engagement to customize the infrastructure for each HC III to the needs and demand patterns of that HC.

61. Medical equipment. There is a specialized committee in the MoH, the National Advisory Committee on Medical Equipment.[66] Based on the lessons learned under the UHSSP, the MoH shall conduct needs assessment before procurement of equipment to reduce the risk of non-utilization of the equipment acquired, and also put in place a robust mechanism for ensuring that the delivered equipment meets the specifications before distribution to beneficiary health facilities.

62. The risk to project procurement management at the MoH is rated **Substantial.**

Health Facility Level

63. Capacity assessment at the health facility level to inform the arrangements for procurement at health facilities under the RBF was conducted on April 4, 2016 at Buikwe district health office, Namwendwa Health Centre IV (with RBF funding), and the Ngogwe HC III (with no RBF funding) on April 6, 2016. The assessment showed that for HC III and IVs, the facility in-charges, who act as the accounting officers, performed procurement roles without transparency and kept no procurement records. The risk to procurement at the facility level is high as there are no adequate checks and balances in the control mechanisms in place.

64. Procurement under the Project. The PPDA Act provides permissible thresholds for procurement for the different health facility levels. For purposes of this project, each health facility shall conduct its own procurement through the Health Facility Procurement Committee (HPC) made of the health facility staff. The HPC shall be responsible for conducting procurement under the oversight of the in-charge of the health center. Specifically, the HPC shall solicit quotations or prices, compare them and recommend to the officer in-charge: (a) for award and issuance of an order, and (b) for payment after deliveries are made or services executed. Goods/services shall be received in the presence of at least two HPC members and the officer in-charge or his/her designate. The procedures of selection of the PHC and to be followed in procurement processing shall be detailed in a Health Facility Procurement Manual.

Procurement Risk Mitigation Action Plan

65. The proposed corrective measures to mitigate the overall risk and the agreed action plan are indicated in the matrix below:

Risk Factor	**Risk**	**Mitigation Measure**	**Timing /Responsibility**
Internal manuals and clarity of the procurement process	NIRA is still in the formative stages and has to work under the MoH	Prepare project implementation manual to elaborate procurement arrangements and to clarify roles and responsibilities of the stakeholders	Before effectiveness/MoH

[66] The National Advisory Committee on Medical Equipment has prepared the Medical Equipment Policy in three volumes: Volume 1 – Policy, Volume 2 - Guidelines - which contain a list of the different medical equipment required at the different levels of health facilities, and Volume 3 - the detailed technical specifications for the different medical equipment for each level of health facilities

Risk Factor	Risk	Mitigation Measure	Timing /Responsibility
Elite capture at health facility level	Elites interfere with the procurement process leading to losses	Sensitization of procurement committees and other stakeholders about their roles in the process	Throughout implementation
Procurement planning and procurement oversight	Inadequate procurement oversight and delays with procurement. Delay with preparing procurement plans and initiation of procurements leading to delayed procurement	The MoH Top Management will review progress on project implementation including procurement. Maintain a dedicated project procurement Specialist. The project coordinator will monitor procurement progress monthly.	Throughout implementation
	Non-utilisation of acquired equipment	Conduct a Medical Equipment needs assessment prior to procurement processing.	Prior to Bidding process for Equipment
Staffing	Insufficient technical staff numbers and skills mix to support procurement cycle.	Additional technical staff to be hired: architect; quantity surveyors; RBF specialist NIRA: Project Officer and Accounts Assistant	As per the procurement plan Before disbursement to NIRA
Governance, fraud and corruption	Falsification of bidder qualifications and bank guarantees.	Due diligence to be conducted on veracity of bidder qualifications before contract award. Also verify guarantees before release of funds.	Throughout implementation/ MoH.
Procurement oversight at health facility level	Inadequate checks and controls at health facility level.	HC III/HC IV staff will constitute a four-person HPC to manage the procurement cycle and recommend award and payment. Simplified Community procurement manuals shall be developed for the health facilities, and training shall be provided to the staff and HUMC before disbursement of funds.	Throughout Implementation
Transparency of bidding processes	Inadequate publishing of bidding opportunities at health facility level	Publication of available bidding opportunities by districts upon selection under the project;	Within three months after selection of districts to the RBF program.
Record keeping	Inadequate storage for procurement records at MoH and poor procurement filing at health facility level	MoH to avail space for storage of procurement records. Health facility procurement committee to maintain a separate file for record keeping.	During implementation

Frequency of World Bank Supervision

66. In addition to the prior review supervision to be carried out by World Bank offices, the capacity assessment of the Implementing Agency has recommended at least bi-annual supervision missions to visit the field, at least one of which shall include carrying out post review of procurement actions.

Prior Review Thresholds

175. The prior review thresholds are as follows:

Procurement of Goods, Works and Non-consulting Services			
Expenditure Category	Contract Value (Threshold) US$	Procurement Method	Contracts Subject to Prior Review
1. Works	>=10,000,000 < 10,000,000 <200,000	ICB NCB Shopping	All contracts Selected Contracts as indicated on Procurement Plan None
2. Goods and non-consulting services	>=1,000,000 <1,000,000 <100,000	ICB NCB Shopping	All contracts Selected contracts as indicated on Procurement Plan None
All categories	All values	Direct Contracting	All
Selection of Consultants[67]			
Expenditure Category	Contract Value (Threshold) USD	*Selection Method*	Contracts Subject to Prior Review
(a) Firms[68]	>=300,000 <300,000	QCBS, QBS, FBS, LCS Qualifications/Other Selection Methods	All contracts Selected contracts as indicated on Procurement Plan
(b) Individual	<= 5,000	IC	Selected Contracts as indicated on Procurement Plan
Firms and individual	All values	SSS	All contracts

Note: QCBS = Quality- and Cost-Based Selection; QBS = Quality-Based Selection; FBS = Selection under a Fixed Budget; LCS = Least-Cost Selection; IC = Individual Consultant; SSS = Single-Source Selection

Procurement Plan

67. The Procurement Plan was prepared by MOH and approved by IDA on May 17, 2016. The plan will be available with the respective project implementing entities and on the World Bank's external website. The Procurement Plan will be updated in agreement with the Project team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

[67] All Terms of Reference regardless of cost will be subject to clearance by the Bank.

[68] A shortlist of consultants for services estimated to cost less than US$ 300,000 equivalent per contract may consist entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Details of the Procurement Arrangements Involving International Competition

(a) List of contract packages to be procured following ICB and Direct Contracting:

Works:

Ref. No.	**Contract (Description)**	**Estimated Cost ($ thousands)**	**Procurement Method**	**Pre-qualification (yes/no)**	**Domestic Preference (yes/no)**	Review by World Bank (Prior/ Post)	**Expected Bid opening Date**
1	Procurement of contractors for Construction 80 maternity units in selected Health Centers.	20,500	ICB	Post	No	Prior	12-Dec-16

Goods:

Ref. No.	Contract (Description)	Estimated Cost ($ thousands)	Procurement Method	Pre-qualification (yes/no)	Domestic Preference (yes/no)	Review by World Bank (Prior/ Post)	Expected Bid opening Date
1	Procurement of assorted drugs.[69]	8,720	ICB	Yes	No	Prior	16-Mar-17
2	Procurement of equipment) to upgrade the warehouse management system at NMS	1,000	ICB	Yes	No		3-Nov-16
3	Procurement of critical RMNCAH equipment to selected health facilities.[70]	9,640	ICB	Yes	No	Prior	30-Aug-16
4	Procure 34 vehicles.[71]	2,680	ICB	Yes	No	Prior	1-Aug-16
5	Procure BDR equipment to functionalize BDR services in selected Districts	5,500	ICB	Yes	No	Prior	30-Jan-17

[69] Including Oxytocin, Magnesium Sulphate, Anti-biotics for New born, Antenatal Cortico-steroids, Chlorohexidine, Omoxylin Zinc,

[70] critical RMNCAH equipment includes: *Resuscitation tables , Thermometers /temperature monitors, Resuscitation set with ambu-bag, infant resuscitation devices ,mask 0,1, Infant ambu bags size 0, 1, Infant masks 0,1, Baby weighing scale (basin type), Baby oropharyngeal airway, Single use bulb syringes, Glucometers, Penguin suckers, Pulse oximeters, Neonatal inflatable simulators (mannequin), partograph board, MUAC tapes, Mother child health passport, Small wide mouthed cups, Oxygen concentrator, Set for exchange transfusion Blood, transfusion, Nasogastric tubes, cannulas g 22,24, Baby syringe 1 and 2ml ,cord ties, gloves, cord swabs, Timers, MVA Kits, Timers , Delivery beds, Post Natal Beds, Delivery instrument Sets*

[71] Distributed as follows: 5 No. for support supervision and program management, 20 No. for disadvantaged districts, 4 no for Birth & Death registration) and 40 motorcycles for disadvantaged districts

Procurement Packages with Methods and Time Schedule

Selection of Consultants

68. Short list comprising entirely of national consultants: Short list of consultants for services, estimated to cost less than US$200,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Consultancy Assignments with Selection Methods and Time Schedule

1	2	3	4	5	6
Ref No.	**Description of Assignment**	**Estimated Cost** (US$ thousands)	**Selection Method**	**Review by World Bank (Prior / Post)**	**Expected Proposals Submission Date**
1	Procurement of an Independent Verification Agent	1,500	QCBS	Prior	15-Dec -16
2	Procurement of consultants to supervise construction of Maternity units	1,090	QCBS	Prior	17-Jan-17
3	Hire a consultant to develop the national CRVS policy, CRVS strategy and communication strategy for CRVS	300	QCBS	Prior	24-Jan -17
4	Procurement of a consultant to develop BDR protocols and manuals	150	QCBS	Prior	24 -Jan-17
5	Procurement of a consultant to develop and operationalize a CRVs monitoring and evaluation system	500	QCBS	Prior	24-Jan-17
6	Procurement of a Procurement Specialist	450	SSS	Prior	8-Dec-16
7	Procurement of a Monitoring and Evaluation Specialist	413	SSS	Prior	8-Dec-16
9	Procurement of a Project Accountant	375	SSS	Prior	8-Dec-16
10	Procurement of an Internal Auditor	375	IC	Prior	8-Dec-16
11	Procurement of a Project Coordinator	488	IC	Prior	8-Dec-16
12	Procurement of 2 No. RH Advisors	375	IC	Prior	8-Dec-16
13	Procurement of a Child Health Advisor	375	IC	Prior	8-Dec-16
14	Procure a RBF Specialist	375	IC	Prior	8-Dec-16
15	Procure an Architect	375	SSS	Prior	8-Dec-16
16	Procure Quantity Surveyor	375	SSS	Prior	8-Dec-16
17	Procure 10 No. Clerks of works Clerks of works	600	IC	Prior	8-Dec-16
18	TA to operationalize RBF software	107	IC	Prior	15-Dec-16
19	Procure 2 No. Procurement Assistants	300	IC	Prior	8-Dec-16
20	Procure Accounts Assistant	225	IC	Prior	8-Dec-16
21	Hire Project Officer to support NIRA	375	IC	Prior	8-Dec-16

22	Hire Project Accounts Assistant to support NIRA	375	IC	Prior	8-Dec-16
23	Environmental Health Specialist and/or Social Scientist	400	IC	Prior	8-Dec-16

Note: QCBS = Quality and Cost-Based Selection, IC = Individual Consultant

D. Environmental and Social (including safeguards)

69. The project will be implemented through existing health facilities. The activities involve construction of small maternity units in HC-IIIs and minor renovation works in health facilities in HC-IIIs and HC-IVs. The exact locations of the facilities have not yet been determined. In addition to the civil works mentioned above, the interventions supported under the project will generate medical waste in the health facilities. To mitigate any potential impacts, an ESMF and a RPF were prepared in a consultative manner. Site specific environmental assessments and ESMPs shall be undertaken once the specific sites have been identified and the required infrastructure allocations are completed. Each participating site shall develop a HCWM-Plan which shall be reviewed by IDA before implementation. The project's geographical coverage includes districts traditionally occupied by indigenous people. The two communities identified are the IK in Kaabong District and the Batwa in some Districts in south western Uganda. As the inclusion of the specific south western districts in the project has not yet been agreed with the client, an Indigenous Peoples Policy Framework to respond to the needs of Batwa, has been prepared. An Indigenous People's Plan (IPP) for the IK community in Kaabong sub-county in the north was also prepared to respond to the needs of the IK community. Both these documents were approved and disclosed on June 1, 2016.

70. Environmental compliance is the responsibility of the Environmental Health Division (EHD) of the Ministry of Health, which is charged with coordination of health care waste management activities under the overall policy guidance of the National Environment Management Authority. Their capacity to handle environmental and social Safeguards requirements was assessed during preparation of the ESMF and RPF and appropriate remedial measures suggested to address any gaps that may be found. In order to ensure proper implementation and management of the environmental and social aspects of the proposed project, the MoH will designate an officer as part of the project coordination team. The EHD and Health Infrastructure Division will closely coordinate and work with the District Health Management Teams (DHMTs) who in turn will directly interface with the Health Facilities. The respective District Environment Officers (DEOs), District Community Development Officers (CDOs) and District Labor Officers will be part of the DHMTs. The working modalities between the EHD and DHMTs, including with the Health Facilities were assessed and streamlined in the ESMF and RPF. The MoH will liaise with the Ministry of Gender, Labor and Social Development and the National Environment Management Authority to ensure that applicable national policies and procedures are applied during project implementation by the DHMTs, health facilities, supervising consultants and contractors. Contractors will receive appropriate orientation to the national labor laws including on prohibition of child labor and management of workers. All workers will, for instance, be provided job cards/contracts that include the requisite Code of Conduct.

71. The MoH will recruit a consultant or assign a dedicated officer to oversee the implementation of all social safeguards issues including the IPP and IPPF. The officer will

facilitate the DHTs who in turn will support the health facilities in the planning and implementation of the appropriate safeguard measures as outlined in the RBF, ESMF, IPP and IPPF. The project will ensure that the District Community Based Services departments together with local CBOs already supporting the IPs and other social related measures are part of project implementation to support implementation of the IPPF/IPP, RPF/RAP; and other social action plans such as community/stakeholder communication and engagement plans as well as early identification and mitigation of social impacts. The MoH and DHTs will establish an accessible and functional grievance redress mechanisms to address project social- related issues. An agreed mechanism will be defined according to the ESMF/RPF guidance and linked to the client charters.

72. Environment and social safeguards activities will be included in the annual plans prepared by health facilities and districts. This will form the basis of implementation. Project supported health facilities and districts will report on a regular basis on the status of implementation.

E. Monitoring & Evaluation

73. The MoH will have overall responsibility for project monitoring and evaluation. While the MoH will collect health related data, NIRA will collect data on BDR. The data will be collected from three main sources: HMIS under the MoH, civil registration database under NIRA, and the project's specific database. In addition, project implementation agencies will collect key information specific to the project for measuring and verifying agreed results for the RBF. The Resource Center in the MoH and the M&E Unit under NIRA will be responsible for coordinating M&E activities under the project. An M&E specialist will be recruited to support the process in the MoH.

74. The project will rely mostly on data collected by the District Health Teams from health facility data. Assessment[72] of the quality of Uganda's health facility data collected through the Health Management Information System (HMIS) for the period July 2010 to June 2011 concluded that the health facility reporting produces data of good quality for most indicators of intervention coverage. Completeness of reporting was good while accuracy of reporting was found to be partly adequate in that there were substantial discrepancies between the annual totals and the sum of the monthly reports. It was also noted that there was no independent external verification conducted. As part of the project, the MoH will support the districts in data collection. The independent verification agent will also be expected to conduct regular assessment of the facility records.

75. Every quarter, the MoH will provide quarterly progress reports and quarterly Interim Financial Reports for onward submission to the World Bank in accordance with the reporting requirements set out in the Operations Manual. For reimbursement purposes, the DHMTs will on a quarterly basis submit verified reports to the MoH for payment after certification by the RBF unit. The independent verification agent will prepare semiannual verification reports against which disbursements for components 2 and 3 are made. Furthermore, a

[72] Assessment of health facility data quality: Data quality report card – Uganda, 2010–2011

mid-term review will provide the opportunity to assess progress and make appropriate mid-course corrections.

F. Role of Partners

76. The project will be implemented in close collaboration and coordination with other RMNCAH programs in the country. This is to ensure alignment of the programs to the RMNCAH Sharpened Plan and to allow for synergy and complementarity in the implementation of the RMNCAH programs within the districts. Under the sector wide approach, the compact signed between the government and partners provides the framework for collaboration and implementation of programs by partners. The project will be implemented under this framework. To determine the status of RMNCAH implementation and provide the necessary information to guide the parties, the government and partners have agreed to institutionalize the mapping of RMNCAH programs on an annual basis within the health planning department.

77. A large number of partners are supporting the delivery of RMNCAH services (Table 3.2). The World Bank is currently supporting a reproductive voucher program in 26 districts, while USAID is also supporting an additional 24 districts. In addition, the BTC is implementing a supply-side RBF in 10 districts. The USAID has further indicated that it will implement an integrated and comprehensive RMNCAH program in 61 districts, and is currently holding discussions with the government. DFID is preparing a new country program, but is envisaged to continue support for family planning services using a combination of approaches. As part of the H4+, the UN agencies are supporting government through various mechanisms to deliver RMNCAH services. While the United Nations Population Fund is focusing its RMNCAH support to 25 districts, UNICEF is also in the process of focusing its support to 20 districts.

Table 3.2: Ongoing RMNCAH Support by the Development Partners

Development Partner	Description of Project Supported
Belgian Technical Cooperation	The BTC is implementing a € 5 million Institutional Capacity Building (ICB) Project II which is supporting capacity of the central level, districts and health facilities to provide health services using Results Based Financing approaches. BTC is also implementing an € 8 million project supporting results based financing interventions in PNFP health facilities. Both projects are implemented in 15 districts.
USAID	The USAID/Uganda Voucher Plus Activity Project is US$24 million project financing subsidized vouchers for safe delivery. The project target is to support 250,000 safe deliveries. The project is implemented in 34 districts mainly in private and private not for profit health facilities. Building on the HIV/AIDS programs, USAID intends to consolidate their support to 61 districts to deliver an integrated and comprehensive package of RMNCAH services, including selected health systems strengthening actions.
Uganda Reproductive Health Voucher Project (URHVP)	SIDA through the World Bank is financing implementation of a US$13.3 million Uganda Reproductive Health Voucher Project. The project target is to support 132,400 pregnant women to access a defined package of safe delivery services from contracted private and public providers.
UNFPA	UNFPA has committed US$1 million for scale-up of RMNCAH voucher services under the URHVP. In addition, UNFPA has consolidated its support to 25 districts, where the focus is on delivering a comprehensive package of reproductive health services.
UNICEF	UNICEF has consolidated its support to 20 districts to provide a full RMNCAH package.

Annex 4: Implementation Support Plan

UGANDA: Uganda Reproductive, Maternal and Child Health Services Improvement Project

Strategy and Approach for Implementation Support

1. The World Bank team will provide support during implementation support missions as appropriate. The missions will assess the progress with implementation, including the status with regard to risk mitigation measures, fiduciary and environmental and social safeguards, compliance with the provisions of the legal covenants as well as agreed actions during the previous implementation support missions. The World Bank technical implementation support will include, but not be limited to, building capacity of the government on RBF, providing relevant sample ToRs, bid documents, and specifications for equipment to be procured under the project. The current practice of monthly meetings between the World Bank team and coordinators of World Bank funded projects/program will continue, to be able to respond to issues promptly as they emerge.

2. A majority of the World Bank's implementation support team members (fiduciary, environmental and social safeguards), including the Task Team Leader, are based in the Uganda Country Office. This will ensure timely, efficient and effective implementation support to the MoH. Formal implementation support missions and field visits will be carried out semi-annually. In addition, because they are based in the country, the majority of the World Bank's implementation support team will be available to provide assistance at any time over the life of the project.

Table 4.1: Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate Staff Weeks	Partner Role
First twelve months	Procurement support	Procurement specialist	6	na
	FM support	FM specialist	6	
	Social development support	Social development specialist	4	
	Environmental management support	Environmental specialist	4	
	Task team leadership	Task team leader	8	
	Technical support	Consultant	8	
	RBF	Health specialist	6	Joint missions
12-60 months	Financial management, disbursement and reporting	FM specialist	12	na
	Procurement and contract monitoring	Procurement specialist	12	
	Environment/social monitoring	Environment specialist Social development specialist	12 12	
	Operational support	Operations analyst	16	
	Technical support	Consultant	40	
	Task Team leadership	Task team leader	32	

Table 4.2: Staff Skills Mix Required

Skills Needed	Number of Staff Weeks per Year	Number of Trips	Comments
Task team leader	8	2-3	Country office based
Procurement	5	Field trips required	Country office based
Financial management specialist	4	Field trips required	Country office based
Environment specialist	4	Field trips required	Country office based
Social specialist	4	Field trips required	Country office based
Consultant	8	Field trips required	Consultant
Operations analyst support	4	One trip per year	Washington DC

Annex 5: Economic and Financial Analysis

UGANDA: Uganda Reproductive, Maternal and Child Health Services Improvement Project

Economic Analysis

3. The World Health Organization estimates that annually 42 percent of women who give birth experience at least mild complications during pregnancy, and 15 million women annually develop long-term disabilities attributable to pregnancy related complications. About 50 to 80 percent of pregnant women in developing countries develop acute health problems, and between 8 and 29 percent develop chronic health problems as a result of pregnancy.[73] About 830 die from preventable causes related to pregnancy and child birth every day. Approximately 99 percent of maternal deaths occur in developing countries and more than half occur in Sub-Saharan Africa.

4. In Uganda, close to 6,000 women die during pregnancy and child birth each year and 45 in 1,000 babies die before their first birthday.[74] Neonatal mortality accounts for 21 percent of mortality in children under five years of age. The contrast between and within regions is stark. About 79 percent of women in urban areas delivered in a health facility compared to only 36 percent of women in rural areas.[75] Moreover, women in the highest quintile are three times more likely to deliver in a health facility compared to women in the lowest quintile. Under-five mortality rates range from 65 deaths per 1,000 live births in Kampala to 153 deaths in Karamoja. Cost-effective interventions to reduce maternal and childhood deaths exist but they are not always available to those who need them most.

Project Development Impact

5. The proposed project will potentially contribute to Uganda's economic development through reducing maternal and child deaths, reducing chronic morbidity for mothers and children, lowering the incidence of non-communicable diseases later in life, saving health care costs, and increasing economic growth. The potential pathways of the project's development impact are described in more detail in this section.

6. Maternal deaths lead to losses in current and future production, income and consumption of non-health goods. The project will reduce maternal mortality by supporting a wide range of cost-effective interventions highlighted in Uganda's RMNCAH Sharpened Plan. These include increasing the number of women attending the recommended ANC visits, promoting delivery for women under the care of skilled birth attendants, increasing uptake of family planning and lowering the fertility rate, which is currently very high in Uganda compared to other countries with similar levels of development.

[73] Estimates by World Health Organization, United Nations Children's Emergency Fund and United Nations Population Fund.
[74] UNICEF, 2015
[75] Uganda Demographic Health Survey, 2011

7. The project will contribute to improved child survival by supporting a wide range of cost-effective high impact interventions to address the major causes of childhood mortality and morbidity in Uganda. These include- but are not limited to- increasing vaccination coverage, kangaroo mother care, neonatal resuscitation, intermittent prophylaxis therapy for malaria and antenatal corticosteroids for prematurity. Child survival will also increase by saving the lives of mothers, as mothers are intricately involved in the lives of their children through adolescence to adulthood.[76]

8. The project will contribute to saving health care costs related to maternal and child morbidity. Many RMNCAH conditions, not only cause death but disability too. For every death, there are a number of women and children with the same condition who survived many with a long-term disability and needing constant medical care. In Uganda, 75 percent of total reproductive health expenditure comes from households through out-of-pocket payments. These payments are not only a barrier to access, but they can potentially push or trap households into poverty. Only 21 percent of married women used any modern method of contraceptive and 34 percent of married women had an unmet need for contraception. This high level of unmet need for contraception leads to a high incidence of unintended pregnancy. Post-abortion care costs the Ugandan health sector US$14 million per annum.[77] Reducing unplanned births will save on public sector spending on social services including education, water, and sanitation, and reduce pressure on scarce natural resources, which indirectly contributes to social and economic development.[78]

9. The Project will contribute toward long-term economic growth in the form of high GDP, arising from increased labor force participation and productivity. Healthier communities give rise to increased investment in human and physical capital generating higher rates of economic growth. Potential pathways through which the project will contribute towards Uganda's economic development include the following:

(a) By reducing maternal mortality and morbidity, women will be more productive in the labor force, will support their children through the critical development stages and contribute to other non-income generating activities that are critical for economic growth. One maternal death reduces GDP by US$0.42 per capita per year (in 2015 prices)[79] in the African region. In addition, indirect costs of maternal deaths in Africa amounted to US$4.5 billion in 2010.[80] With 16 women dying in Uganda each day, the costs of maternal deaths to the Ugandan economy can be

[76] Moucheraud C, A. Worku, M. Molla, J.E. Finlay, L. Leaning, and E. Yamin, (2015). "Consequences of Maternal Mortality on Infant and Child Survival: a 25 year Longitudinal Analysis in Butajia Ethiopia" (1987-2011). *Reproductive Health*, 2015; 12 (Supp 1): S1.

[77] Vlassoff M, F. Mugisha, A. Sundaram, A. Bankole, S. Singh, L. Amanya, C. Kiggundu, and F. Mirembe. "The Health System Cost of Post-Abortion Care in Uganda", *Health Policy and Planning*, 2012, doi: 10.1093/heapol/czs133.

[78] Singh, S and L. Darroch, 2012. Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012.

[79] Kirigia J.M, D. Oluwole, G.M. Mwabo, D. Gatwiri, L.H Kainyu, (2006). "Effects of Maternal Mortality on Gross Domestic Product in WHO African Region". *African Journal of Health Services* (13): 86-95.

[80] Kirigia J.M, G.M. Mwabu, J.N. Orem, and M. Muthuri., (2014). Indirect Costs of Maternal Deaths in the WHO African Region in 2010. *BMC Pregnancy and Childbirth* (14): 299.

substantial.

(b) By addressing causes of childhood mortality, more children will survive into adulthood, will be healthier, have higher cognitive development, complete education and actively participate in the labor force.

(c) Uganda has a TFR of 6.2 children. High fertility significantly contributes to maternal and child mortality, leads to higher health care and education costs, and potentially results in delayed economic growth. The project will support scale-up of the provision of long-term and permanent family planning services.

10. Other potential benefits to the health sector and societies that are not quantifiable but play a critical role in a country's development include the following:

(a) Mothers play a very important role in their families and communities, and evidence shows that maternal deaths have significant effects on the welfare of children and other family members. In Kenya for example, 25 percent of the babies born to a mother who died of maternal causes did not survive the first seven days of life compared to only 1 percent of babies whose mothers were still living,[81] while in Bangladesh children who lost their mother had lower probability of surviving to their 10th birthday compared to children whose mothers are still alive.[82]

(b) Early childhood development affects adult health and human capital. Poor health due to under-nutrition of children whose mothers are dead or suffer from chronic morbidity contributes to stunting, poor cognitive development, and poor performance at school and- for women-lower birth weight for their children.[83] [84]

(c) Women experiencing maternal morbidity (for example, obstetric fistula) have low quality of life and are likely to be stigmatized in their communities. By improving access to RMNCAH services, the project will potentially improve the quality of life among women through reduction in maternal associated morbidities.

11. The project will promote equity, shared prosperity and efficiency by allocating resources to lower levels of care. The performance based payment will be based on indicators that promote equity (for example, population, poverty levels and burden of disease). By re-directing resources towards lower levels of care through RBF, the proposed project addresses allocative efficiency and has high potential to reach the poorest population with high impact interventions. In addition, the project will address technical efficiency, by rewarding performance, which is known to increase utilization of services.

[81] Ministry of Health (2014). A Price too High to Bear: *The Costs of Maternal Mortality to Families and Communities*.
[82] Ronsmans C, M. Chowdhury, S. Dasgupta, A. Ahmed, M. Koblinsky, (2010). Effects of Parent's Death on Child Survival in Rural Bangladesh. *The Lancet* (375): 2024-2031.
[83] J. P. Shonkoff, L. Richter, J. Gaag, and Z. A. Bhutta. 2012. An Integrated Scientific Framework for Child Survival and Early Childhood Development. *Pediatrics* (29), no 2.
[84] Victora C.G, L. Adair, C. Fall, P.C. Hallal, R. Martorell, L. Richter, H.S. Sachdev. (2008). Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital. *The Lancet* (371): 340-357.

12. CBA is a technique that relates the costs of a program to its key outcomes or benefits. It compares the costs with the dollar value of all (or most) of a program's benefits. A major difficulty with the CBA analytical approach is that it is difficult to value all benefits in monetary terms. Indirect benefits arise from mothers' contribution towards their families through social relations, nutrition of the infants and other children, up-bringing and socialization of children, education and health and contribution to wider communities. Such benefits play a critical role in economic development, but they are difficult to measure quantitatively.

13. The CBA of the proposed project was based on a combination of interventions and not on specific interventions (that is, it was assumed that all interventions supported in this project will contribute to reduced maternal and child mortality). Due to its complex design, and lack of clarity on which districts will benefit from the intervention, it is neither possible to conduct a CBA of specific interventions nor limit the analysis to only the regions where project funds will be targeted. Thus, the CBA presented here adopts the approach of economic evaluation of complex interventions. Together, the combined set of interventions will contribute towards the reduction in morbidity and mortality in the population group of interest. Moreover, it has been shown that packages of RMNCAH interventions are more cost-effective than individual interventions, due to synergies on costs. This highlights the importance of considering effective integration of services and implementation of RMNCAH interventions in parallel, particularly those interventions with common delivery modes. The CBA focuses only on interventions to address maternal and child mortality and uses a five-year time frame, consistent with the project implementation period. The assumptions informing the analysis are summarized in Table 5.1.

Table 5.1: Assumptions guiding the CBA

Assumptions	Rate
Median age of children cohort saved	3
Median age of mothers saved	22
Age of onset of productivity	22
Number of productive years	35
Annual per capita productivity (GDP per capita in US$)	715
Annual rate of increase in productivity	0.05
Discount rate (costs and benefits)	0.03

14. The results presented in Table 5.2 show that the proposed project is a sound economic investment. The present value of the project's benefits is US$2515 million, while the present value of the cost invested is US$128.2 million, assuming 100 percent disbursement rate. This investment gives rise to a net present benefit (i.e. benefits-costs) of US$2386.8 million and a benefit-cost ratio of 19.6, meaning that for every US$1 invested in the project, a return of US$ 19.6 will be achieved.

15. This analysis only focused on economic benefits related to saving lives. There are many other benefits arising from saved lives and reduced morbidity. As decisions on the

allocation of resources are not based solely on considerations of cost effectiveness, the results presented here should be considered alongside other health system goals and feasibility of implementing the interventions.

Table 5.2: Cost Benefit Analysis

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Child Health Benefits						
Number of under five deaths averted	4,618	4,730	4,878	5,032	5,192	24,450
Number of productive years saved	161,616	165,553	170,733	176,120	181,714	855,736
Present value of productive years gained (US$ Millions)	463.7	475.0	489.9	505.3	521.5	2455.4
Maternal Health Benefits						
Maternal deaths averted	283	290	299	309	319	1500
Number of productive years gained	9,915	10,157	10,457	10,805	11,148	52,501
Present value of productive years gained (US$ millions)	11.3	11.5	11.8	12.3	12.7	59.6
Total Health Benefits (US$ millions)	475.0	486.6	501.8	517.6	534.1	2515.0

Rationale for Public Sector Financing

16. The use of public resources to address the objectives outlined in this project is justified for the following reasons:

a. The Constitution of Uganda gives all Ugandans the right to health and the Vision 2040 recognizes good health as essential in transforming the country into middle-income status. The Government of Uganda has demonstrated its commitment towards ensuring that all citizens realize these through removing user fees in all public health facilities. The project thus supports the Government of Uganda in achieving this noble objective.

b. The public sector is the main health care provider for the majority of Ugandans, but these facilities are severely underfunded and often understaffed. Wide inequities in access to RMNCAH services exist between and within regions, which cannot be addressed through the private sector. Investing in RMNCAH is not only of sound economic value (as demonstrated by the CBA) but also a moral issue that cannot be left to the private sector.

c. Although there is a vibrant private sector in Uganda, the sector is still underdeveloped, poorly regulated and mainly consists of small clinics, drug shops,

and informal "social enterprises" (traditional healers) which offer basic curative care of dubious quality. The project will, therefore, seek to provide quality RMNCAH services primarily through the public sector with complementary services through the private sector.

d. Interventions proposed under this project such as vaccination and intermittent prophylaxis therapy for malaria have positive externalities.

Value added of Bank's support

17. The Bank has been a key supporter of Uganda's health sector through existing operations (UHSSP and EAPHLNP) which focus on improving the health system. It has established a constructive and evidence-based dialogue with the Government through various analytical and advisory activities. Building on the lessons of past investments and studies, the proposed Project would continue to deepen the World Bank's engagement in the sector for better results. With its regional and global experiences in supporting client countries in health system strengthening (particularly health financing), including a large number of results-based financing programs, the World Bank is in a good position to assist the Government in translating global best practice into context specific solutions for Uganda. At the global level, the World Bank and the key partners launched a global financing facility (GFF) for Every Woman Every Child initiative in September 2014 in order to mobilize and channel additional resources to scale-up delivery of effective and efficient RMNCAH services. Since the World Bank is leading the operationalization of the GFF and overseeing all front-runner countries, the World Bank is well placed to support Uganda to harmonize funding for RMNCAH services, to mobilize domestic and donor resources, and contribute with best practices from the GFF front-runner countries.

Financial Analysis

Macroeconomic Situation

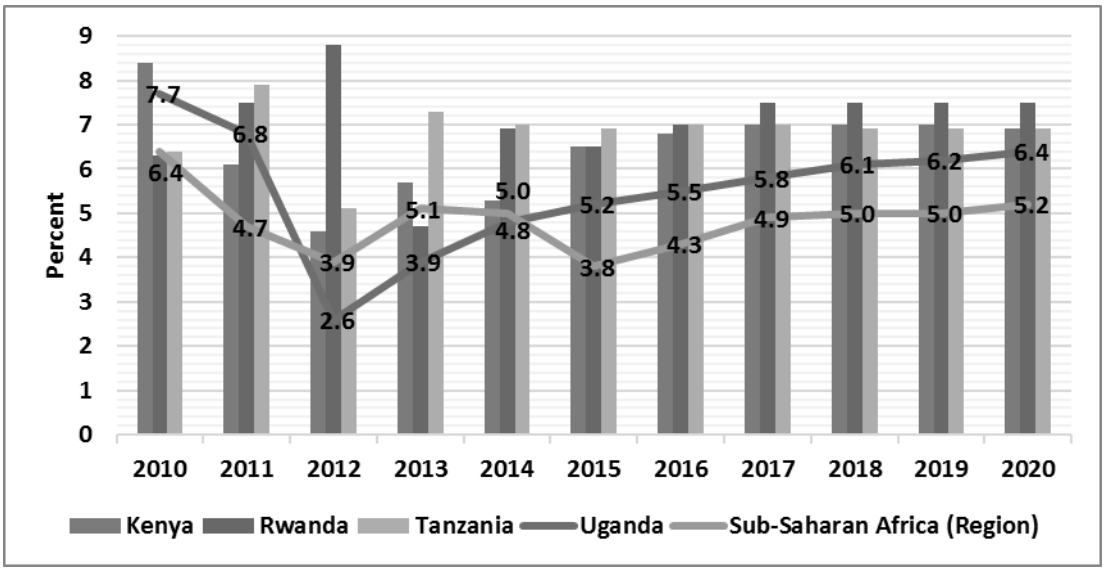
18. Economic growth in Uganda declined from an annual average of 7.7 percent in 2010 to 2.6 percent in 2012 (Figure 5.1). Thereafter, the economy grew consistently between 2012 and 2014, but this growth was below three other countries in East Africa (Kenya, Rwanda, and Tanzania) and the Sub-Saharan Africa (SSA) regional average. However, between 2014 and 2015, economic growth in SSA countries dropped from 5 percent in 2014 to 3.8 percent in 2015 but the growth in Uganda increased slightly from 4.8 percent in 2014 to 5.2 percent in 2015. As a result, the GNI per capita[85] grew marginally from US$630 in 2012 to US$670 in 2014. Nonetheless, economic growth in Uganda was still below that of Kenya, Rwanda, and Tanzania in 2015. This can be attributed to both domestic and external factors, particularly inconsistent fiscal and monetary policies and civil unrest in South Sudan and the Democratic Republic of Congo[86]. Economic growth in Uganda is also constrained by inadequate access to finance, a poor road network, underdeveloped infrastructure, limited availability of electricity, and an inefficient business environment. Furthermore, at 11.9 percent of GDP in 2014,[87] tax revenue in Uganda is

[85] GNI per capita, Atlas method (current US$) from http://data.worldbank.org/indicator/NY.GNP.PCAP.CD
[86] World Bank (2015). Uganda Systematic Country Diagnostic Report.
[87] Ibid.

by far lower than the commonly used yardstick of 20 percent. And due to low regional trade, contribution of the external sector to GDP growth has also been limited.

19. Despite the challenges, Uganda has been transforming rapidly since 2012. The World Bank's Systematic Country Diagnostic suggests that the discovery of oil, regional integration, information, communication and technology innovation, and urbanization present the best opportunities for accelerating development in Uganda in the coming years. Estimates show that real GDP growth is expected to average 8.8 percent annually between 2016 and 2025,[88] which is about 2.2 percentage points higher than the scenario without oil shown in Figure 5.1. In other words, real GDP in Uganda is expected to grow consistently from 2016 onwards even without oil revenues. On the other hand, progress has been made on tax administration by removing tax exemptions and increasing excise duty on some products. International Monetary Fund estimates also show that increasing tax compliance (focused on VAT) to 40 percent in Uganda would lead to an annual growth in tax revenue of about 0.5 percent of GDP.[89] Ultimately, increasing overall tax revenues from the current 11.9 percent of GDP to 20 percent would yield an additional tax revenue of US$38 per capita.[90] Furthermore, Uganda's total public debt estimated at 28.9 percent of GDP, is less than the macroeconomic convergence criteria (that is, less than 50 percent of GDP), and this suggests that Uganda has a low risk of debt distress. The fiscal deficit (average 3.3 percent of GDP during 2011-14) is also lower than most of the countries in Sub-Saharan Africa.

Figure 5.1: Real GDP growth (Annual percent change) in Uganda, East Africa and Sub-Saharan Africa



Source: World Economic Outlook http://www.imf.org/external/datamapper/index.php

Health Sector Expenditure and Financial Sustainability Analysis

[88] Ibid.
[89] Hutton Eric, Mick Thackray, and Philippe Wingender. 2014. Revenue Administration Gap Analysis Program—The Value-Added Tax Gap.
[90] Background paper: First Universal Health Care Financing Forum. World Bank/USAID, April 14-15, 2016

20. Uganda spends a total of US$50.1 per capita on health.[91] While this is higher than the spending levels in other low-income countries around the world which spend an average of US$34.2 per capita, it is lower than the spending levels in Sub Saharan Africa which are estimated at US$94.2 per capita.[92] Uganda's US$50.1 total per capita health expenditure is also below the recommended US$86 per capita per annum (expressed in 2012 US dollar terms)[93] for low-income countries such as Uganda to provide a basic package of health services and for the health system to function effectively. This suggests that there is a financing gap of US$35.9 per capita per year in the health sector in Uganda. The underlying problem with health financing in Uganda is that the elasticity of growth of health funding is mostly dependent on growth in external funding and not increased domestic resources.[94] For example, the proportion of donor resources contributing to the total government health budget increased from 14 percent to 42 percent between 2010/11 and 2014/15. As such, development partners are the main financiers of health care in Uganda and contribute about 46.3 percent to the total health expenditure followed by households at 38.4 percent, and the government at 15.3 percent.

21. Notwithstanding the above, Uganda has potential to increase its fiscal space in the short to medium term as articulated in the World Bank's Systematic Country Diagnostic and the Health Financing Strategy for Uganda. This will be achieved by improving allocative and technical efficiency in all sectors of the economy, improved tax compliance and revenue collections, development of the oil industry, and expanding regional trade and investment. However, even with the predicted increase in domestic resources, external resources are expected to remain important for Uganda in the short to medium term because an increase in domestic resources alone will not guarantee significant increases in resource availability for Uganda's health sector.

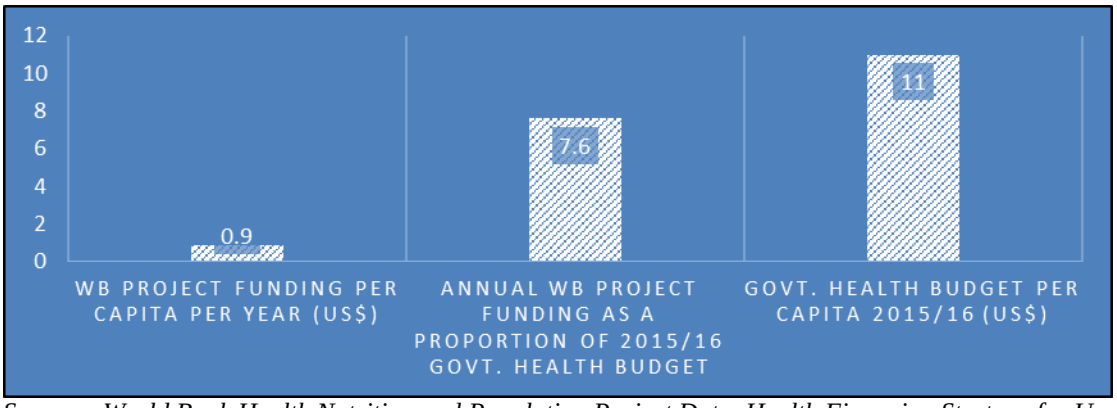
22. To determine the ability of the Government of Uganda to sustain the project when it comes to an end, a financial sustainability analysis was conducted. The project investment of US$140 million (estimated at US$28 million per year) was compared to the 2015/16 government health budget as expressed in per capita and proportional terms (Figure 5.2). The data shows that the project funding per capita per year will be US$0.8, which is lower than the 2015/16 government health per capita budget of US$11. The annual per capita project funding is also lower than the total health expenditure per capita and the GNI per capita which are estimated at US$50.1[95] and US$670[96], respectively. However, while the annual project funding as a proportion of the total 2015/2016 government budget is estimated at 7.1 percent, the government non-wage budget at district level is only 23 percent of the annual project recurrent funds.[97] The

[91] Estimates based on the Uganda 2011/12 National Health Accounts. US$50.1 represents the total per capita health expenditure.
[92] http://apps.who.int/nha/database/Regional_Averages/Index/en
[93] McIntyre D., and F. Meheus. 2014. Fiscal Space for Domestic Funding of Health and Other Social Services. A paper prepared for the Centre on Global Health Security Working Group. London: Chatham House
[94] Health Financing Strategy for Uganda 2015/16-2024/25
[95] Uganda 2011/12 National Health Accounts
[96] 2014 GNI per capita, Atlas method (current US dollars) from http://data.worldbank.org/indicator/NY.GNP.PCAP.CD
[97] The US$70 million that has been allocated for RBF RMNCAH frontline services under the project was compared to the 2016/17 domestic non-wage budget at district and PHC facilities

project's contribution to the US$1018 million that has been committed/pledged in the RMNCAH Sharpened Plan is estimated at 14 percent.

23. Because of the above, the project is a potentially financially sustainable investment. This is in light of the historical growth in the government health budget, which grew by 93 percent (annual average of 15 percent) in nominal terms during the period 2011-16, and expectations of increased fiscal space in future due to: (a) projected increase in GDP with and without oil revenues (8.8 percent and 6.4 percent, respectively); (b) growth in tax revenue of about 0.5 percent of GDP due to increased VAT compliance, and a potential increase in tax revenue by US$38 per capita[98] if the tax to GDP ratio rises from 11.9 percent to 20 percent; and (c) efficiency improvements in the health sector. Under the optimistic scenario (20 percent annual growth in the government health budget), government per capita health expenditure is projected to double between 2015 and 2020 (from US$11 to US$24). If the prevailing 15 percent annual growth in the Government health budget is maintained, Government per capita health expenditure is anticipated to increase to US$20. Consequently, the annual project financing as a proportion of the total government (domestic) budget for health is expected to diminish overtime as government (domestic) financing increases.

Figure 5.2: Project Financing versus 2015/16 Government Health Budget



Sources: World Bank Health Nutrition and Population Project Data, Health Financing Strategy for Uganda, Uganda National Health Accounts, National Population and Housing Census 2014 Provisional Results

24. While the total project amount is a potentially financially sustainable investment, there is need for more commitment by government if the project's benefits and those of the other development partners are to be sustained beyond the project's five-year life span. As shown above, development partners are the main financiers of health care in Uganda (46.3 percent of total health expenditure), and they are also expected to contribute about 77 percent of the US$1,018 million that has been committed/pledged in the RMNCAH Sharpened Plan for Uganda. While appreciating that development partner support is necessary for Uganda in the short to medium term, the current large volume of external funding will require consistently large annual increases in government expenditure (in real terms) over a number of years to overturn the trend. If this is not achieved, the government will fail to absorb the project's costs (and that of other development partners). Consequently, regardless of how much revenue the

[98] Background paper: First Universal Health Care Financing Forum. World Bank/USAID, April 14-15, 2016

government raises, the critical decision is to allocate a considerable amount of these funds to the health sector particularly for non-wage RMNCAH recurrent expenditures. Increased government financing for non-wage RMNCAH services will increase income at district and health facility levels, and help reduce the high levels of out of pocket expenditures among poor households.

25. The World Bank has a long history supporting the health sector in Uganda and will continue to support the government as it moves towards increasing its own financing for RMNCAH. The project builds on the ongoing multisectoral IDA portfolio, and will continue to deepen the World Bank's engagement in the sector and country. The project will complement on-going operations including the Uganda Multisectoral Food Security and Nutrition Project (P149286). The lessons from the project on using the RBF approach are expected to inform the government's broader plans to adopt performance-based financing in key sectors as well as inform the World Bank's proposed Program for Results on decentralization. With its regional and global experience in supporting client countries to accelerate action toward achievement of universal health coverage, the World Bank is in a good position to assist the government in translating global best practice into context-specific solutions for Uganda.