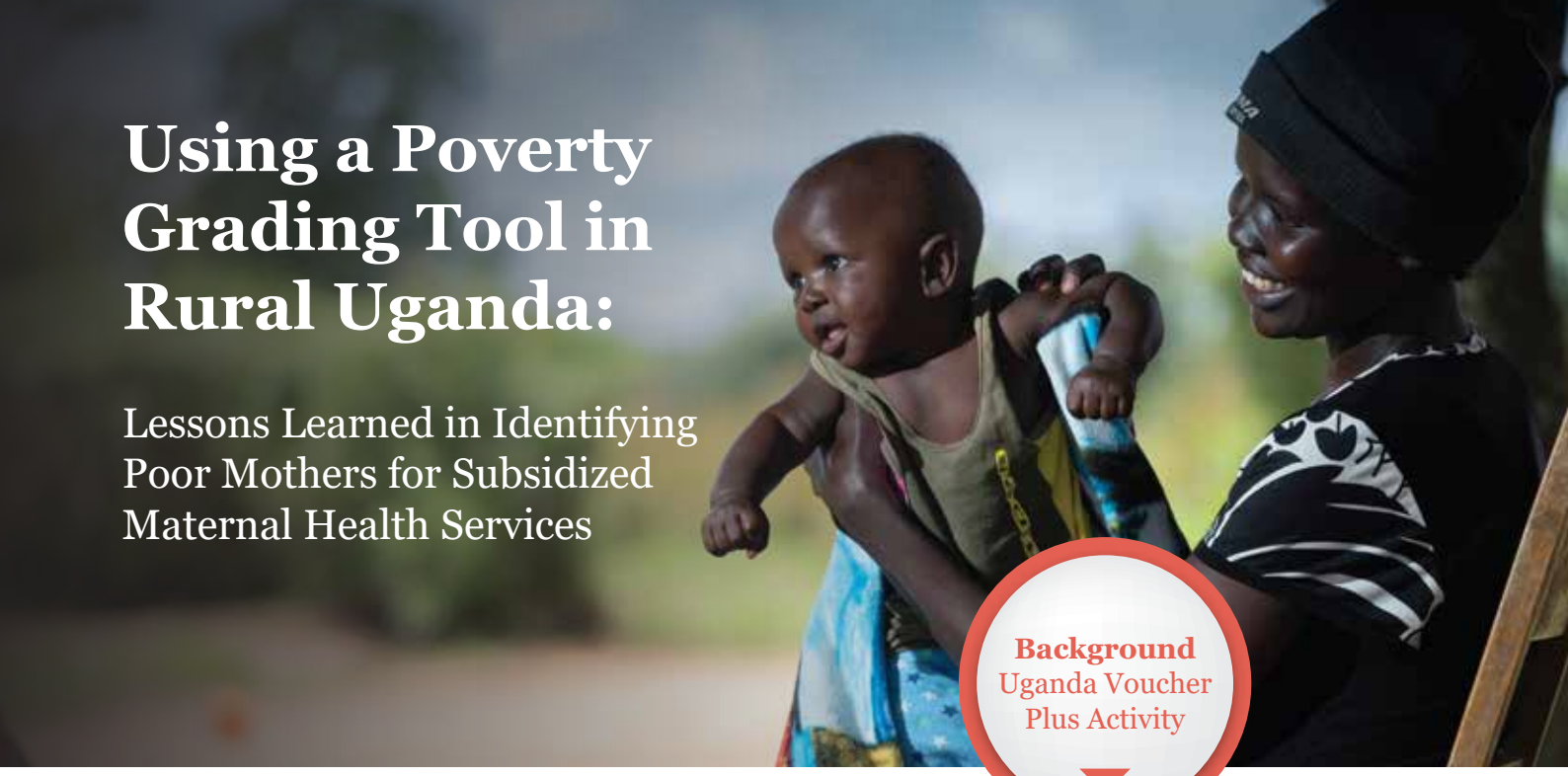
Using a Poverty Grading Tool in Rural Uganda:

Lessons Learned in Identifying Poor Mothers for Subsidized Maternal Health Services



Background
Uganda Voucher Plus Activity

The Uganda Voucher Plus Activity, led by Abt Associates, provides quality obstetric, newborn, and postpartum family planning services to poor women in Northern and Eastern Uganda. The Activity uses a Poverty Grading Tool (PGT) to identify women who are eligible to receive vouchers for critical maternal health services.

Applying the PGT correctly and capturing accurate information are essential to ensure resources reach the most vulnerable women.

In August 2018, the Activity conducted a rapid-cycle learning review to evaluate its effectiveness in reaching the target population. The findings will inform programming adaptations and future efforts for long-term health financing that will target specific populations in Uganda.

The Activity aims to improve health equity by protecting poor women from large out-of-pocket payments. The Activity works with community volunteers, including Village Health Teams, who provide safe motherhood information to target populations and sell vouchers to eligible women to support healthy pregnancies and deliveries in 35 districts. The voucher package includes four antenatal care (ANC) visits; services to eliminate mother-to-child transmission of HIV; delivery with a skilled birth attendant and referral for complications; postnatal care; and postpartum family planning. The Activity also identifies and accredits private providers and it reimburses them for delivery of the service package. The Activity strengthens the capacity of participating private providers through clinical and administrative mentoring, supervision, and auditing and ensures they contribute to the district health management information system. Finally, the Activity contributes evidence that supports the Ministry of Health as it implements output-based financing programs in Uganda.

Uganda Voucher Plus Activity: key findings from a rapid review of using a Poverty Grading Tool to identify poor mothers:

- The Activity is successfully reaching its target population.
- Community-based distributors are using the PGT correctly to collect accurate information.
- Community workers need to be trained in the tool and apply it in local languages.
- Criteria for selecting poor women should include the level of control a woman has over financial resources and her ability to use them for her own health.

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Poverty Grading Tool

One of the Activity's primary objectives is to expand obstetric, newborn, and postpartum family planning services to poor, hard-to-reach populations. Critical to this effort is identifying poor mothers who cannot afford the full cost of a quality maternal, newborn, and child health service package. The Activity uses the PGT to assess the eligibility of pregnant women based on their level of poverty, a common approach among voucher programs targeting the poor. An alternative would be targeting geographic areas with high rates of poverty and enrolling all interested pregnant women. This approach is cheaper, but it requires access to poverty maps from the Uganda Bureau of Statistics. Updated Poverty maps (based on 2016/2017 household survey) were not readily available at the time of method selection.

The PGT features seven questions identified as standard poverty assessment criteria covering access to health services, drinking water, farmland, shelter, livestock, sanitation, and daily food intake.

Trained voucher community-based distributors (VCBDs) interview mothers in their homes and validate their responses with direct observation. Depending on the response, mothers can score 1–3 points on each question, leading to a total score of 7–21 points. Women scoring less than or equal to 12 are considered eligible to purchase a voucher for 4,000 UGX; women scoring above 12 are encouraged to purchase services from their nearest private health facility or seek freely available public sector services.

Methods

The monitoring, evaluation, and learning (MEL) team conducted two focus group discussions to capture implementer perspectives on application of the PGT. The first group included social and behavior change communication (SBCC) officers, and the second SBCC management personnel. These groups were selected because they oversee VCBD activities and are the first to receive reports of challenges in voucher distribution. A team of field researchers also conducted qualitative interviews with 15 VCBDs representing 15 of the 35 districts served by the Activity. The VCBDs were interviewed to capture their first-hand experience implementing the PGT and working directly with potential voucher clients. The MEL team organized the transcribed data by survey question, coded the narrative segments, grouped emergent codes by overarching themes, and analyzed themes across different respondents.

QUALITATIVE DATA SOURCES

Focus group discussions with social and behavior change communication officers and managers

Key informant interviews with 15 voucher community-based distributors

QUANTITATIVE DATA SOURCES

Structured questionnaire administered to 399 voucher clients

In addition to qualitative data, the MEL team collected quantitative data from voucher clients. The MEL team added a subset of PGT questions to a client satisfaction survey instrument for 399 voucher clients from 26 districts. A multistage (districts, facilities, clients) sampling approach was used to select clients from five socio-linguistic sub regions based on criteria established for the client satisfaction study. The study included clients who had attended at least three ANC visits and clients who had used services within the four months prior to the study. Field researchers interviewed voucher clients using a structured questionnaire and mobile data collection software. The MEL team used descriptive analysis of the quantitative, PGT-specific client data, applying sampling weights to adjust for the probability of client selection.

[1] See for example a recent review of voucher programs in 11 countries: doi 10.1016/j.ijgo.2015.06.023.

Limitations

For the quantitative data used in this study, the team interviewed only existing voucher clients, i.e., those who were rated as poor by the PGT. We did not interview women who were interested in vouchers but were rated as not poor by the tool and thus did not become clients. Therefore, we cannot assess the incidence of false exclusions (poor women who were erroneously scored as not poor). This may be a topic for future study.

Although the study aimed to capture the implementer's perspective, the health service providers who deliver voucher services were not included, as they do not work directly with the PGT. Future studies could include this group to capture their insights on the socio-economic status of the women who redeem vouchers for health services. Finally, this study sought to assess VCBD adherence to PGT implementation, but it did not conduct comprehension assessments to further verify VCBD skill level.

Findings

Findings from the qualitative and quantitative data answered two overarching questions: how effectively is the PGT enabling the Activity to reach the target population and how competently are the VCBDs implementing the PGT? These findings are presented below.

Reaching the Target Population

Based on the demographic characteristics of the 399 sampled clients, the Activity has been successful in reaching poor, rural women. More than 77 percent lived in rural areas (Table 1). Clients had limited education, with 73 percent having either no education or primary school as their highest level. Nearly 90 percent had no employment or relied on small-scale, food-crop farming. Clients' spouses fit the same pattern: possessing no education or primary education (55%) and 61 percent were either unemployed or relying on small-scale agriculture.

Table 1: Client Demographics

Characteristic (N = 399)	Frequency (n)	Percentage (%)
Residence		
Urban	89	22.3
Rural	310	77.7
Education level of client		
No education	10	2.4
Primary	284	71.2
Secondary	98	24.4
Tertiary	8	2.0
Occupation		
Unemployed/housewife	84	21.1
Agriculture	274	68.6
Skilled manual	10	2.5
Business	19	4.8
Professional technical/managerial	3	0.9
Student	7	1.6
Declined to answer	2	0.5

Characteristic (N = 399)	Frequency (n)	Percentage (%)
Partner's highest level of education attained		
No partner	35	8.7
No education	14	3.6
Primary	206	51.6
Secondary	114	28.5
Tertiary	30	7.6
Partner's occupation		
No partner	39	10.8
Unemployed	19	4.8
Agriculture	225	56.4
Unskilled manual	17	4.1
Skilled manual	36	9.0
Business	33	8.2
Professional technical/managerial	25	6.3
Student	7	1.8
Declined to answer	1	0.2

87 percent of clients purchased the voucher because they could not afford to pay out of pocket for the services covered (Table 2). This indicates that the Activity reaches women who would otherwise incur potential financial hardship by accessing maternal health services.

Table 2: Client's Primary Reason for Purchasing Voucher

Reason (N = 399)	n	%
Could not afford to pay services by myself	346	87.1
Friend/family member bought one for me	4	0.9
VCBD said I should	4	0.9
Some of my friends had bought it	2	0.4
Other	43	10.7

Overall, focus group participants and VCBD interviewees agreed that the PGT was effective in identifying poor clients. When asked to rate the effectiveness of the PGT in identifying eligible women on a scale of one to five, participants on average rated the tool as four (very effective).[2]

> *The tool is very detailed and really captures all the information* – **SBCCO**

> *In my view, it is very effective because most questions are there and I understand them*– **VCBD Sironko**

[1] The scale was 1. Not at all effective, 2. Slightly effective, 3. Moderately effective, 4. Very effective, 5. Extremely effective

However, two key challenges regarding use of PGT emerged in the focus group discussions and the VCBD interviews: 1) accurately scoring teen mothers and 2) capturing nuances that might qualify women who scored above 12 and were therefore considered ineligible. Both challenges relate to women residing in homes that may appear better off, but where women lack the authority to use household resources for maternal health services. In such a case, VCBDs are instructed to notify their SBCCO and request a case-by-case review to determine if an exception could be considered. This is illustrated by the following quotes.

> *Some of the questions need adjustments, e.g., even if she is a [teen mother] staying at her relatives' home where she only spends a few days, this would make her not qualify. I see such a [teenager] needs a voucher herself.* – **VCBD Kapchorwa**

> *I recommend they put another option in the tool to cater for these [teenagers] who look for shelter from relatives or good Samaritans [during pregnancy].* – **VCBD Kapchorwa**

> *Sometimes there are certain mothers who are poor but when it comes to the PGT they score more, yet they have nothing…. Even meals per day could be misleading because some mothers are able to eat two to four meals per day, but when it comes to getting money for visiting the hospital, it's a big problem to them.* – **VCBD Lira**

> *The livestock question is a problem because the livestock does not always belong to the woman. If I'm a married woman and my husband has two cows, he would never sell them and I could never touch them.*– **SBCC management staff**

PGT Implementation

Proper implementation of the PGT requires VCBDs to interview all potential clients before selling the vouchers. The interviews are required to take place at the clients' homes to allow the VCBDs to observe household conditions and verify the responses. VCBDs are then required to leave copies of the completed PGTs with the mothers. To assess whether VCBDs were implementing the PGT correctly, quantitative data were collected from beneficiaries to confirm the location of the interview and assess their level of understanding of the purpose of the poverty grading process, their understanding of the questions, whether they felt that the interviewer had adequately captured their responses, and whether they retained copies of the PGT.

Nearly 90 percent of respondents reported having been screened using the PGT (Table 3). Of this group, 17 percent were unsure of the purpose of the poverty grading exercise, while 56 percent understood it was to determine poverty levels. Eighty-four percent reported that the interview took place at home. Nearly all of the screened clients felt the interviewers had adequately captured their answers. Finally, 87 percent of screened clients retained a copy of the completed PGT assessment form. Overall, these findings indicate that the poverty grading assessments was being implemented properly by Activity staff and client information was perceived to be captured accurately in the PGT.

Table 3: Client Perspectives on the PGT

Client screened with PGT (N = 399)	Percentage (%)
Yes	87.5
No	12.5
Understood purpose of PGT (N=349)	
Unsure	16.8
To determine poverty level	56.2
To determine if I could purchase the voucher	6.9
To collect information about me/my household	3.3
Requirement of the project	10.1
Cannot access services without completing screening	3.2
Other	3.5
Client retained a copy of completed PGT (N = 349)	
Yes	87.3
No	12.7
Interviewer adequately captured PGT responses (N = 349)	
Yes	98.7
No	1.3
Location of PGT interview (N = 349)	
Home	84.8
Health facility	8.7
Market	1.6
Community event	1.2
Other	3.7

The MEL team collected qualitative data from the implementers (VCBDs and SBBC staff) to verify their understanding of, and adherence to proper application of the PGT. Implementers were also asked how well they believed potential clients understood the overall purpose of the poverty grading assessments and the questions themselves.

Findings from the qualitative data identified three key themes that affect the ability of the VCBDs to implement the PGT in the field: 1) the ability to conduct the interviews in the mothers' local languages, 2) VCBD training, and 3) verifying responses through direct observation.

Theme 1: Local Language

In a country like Uganda with many different spoken languages and literacy levels that vary significantly in rural areas, the Activity deemed it important to recruit VCBDs from the villages where they would serve in part to ensure they could communicate with mothers in their local languages. When asked if they believed that mothers understood the PGT questions and purpose, both VCBDs and SBCC staff agreed that mothers understood due to the ability of the VCBDs to communicate in the local languages.

> *Usually we translate the questions in the local language and explain the questions; that's when she understands the question and gives you a response* – **VCBD Manafwa**

> ***The only challenge is the language sometimes. In some places you find the person doesn't understand your language, like if [she] only speaks Swahili or Alugbara. In such instances, I use the Village Health Team [member] to interpret*** – **VCBD Kitgum**

Theme 2: Training

The first group of recruited VCBDs were trained in a classroom setting on how to implement the PGT. However, following poor VCBD performance in post-training testing, the Activity adapted the training model from classroom-based to on-the-job training, which was selected to 1) provide more opportunity for supervised hands-on experience, 2) accommodate individual learning styles and literacy levels, and 3) reduce the logistical burden of scheduling training sessions for a large cadre of VCBDs across 35 districts. On-the-job training took place in the field under direct supervision of SBCCOs and peer VCBDs. Despite programmatic data showing poor comprehension of the PGT following classroom-based training, perceptions of the two training models among interviewed SBCC staff and VCBDs favored classroom-based over on-the-job training. VCBDs who had received classroom training indicated feeling more confident using the tool, whereas VCBDs who had received on-the-job training felt less prepared. A limitation to this finding is that these perceptions were not verified with any quantifiable performance assessment data. SBCCOs and VCBDs also expressed the need for frequent refresher training on using the PGT, with a focus on identifying probing skills.

> *We trained the first set much better than the second set. We should bring them together. [We] changed the training from classroom-based to on-the-job training."* – **SBCCO**

> *On-the-job training is rushed and [VCBDs] cannot learn from their peers or get background on the Activity.* – **SBCCO**

> *Our colleagues trained three years back [classroom-based], but for us, we trained on the job by the coordinator of [the] Eastern region. Now we understand it [the PGT], but it took some time. It was not easy for the first two weeks, but after about one month it became easy.* – **VCBD Pallisa**

> *We went for training for three days in Lira and every day we could talk about the tool. I understand it very well* – **VCBD Manafwa**

> *We were trained for three days at Kumi and I felt I had grasped it well after the training* – **VCBD Bukedea**

> *I had training in Gulu [classroom-based] before starting work as [a] VCBD; I felt I was ready after the training I received. However, I need refresher training because now in the facility I remain alone, and so I don't have anyone to consult because the other lady [VCBD] didn't continue…. They brought other people [VCBDs] in the system and they want me to mentor them; I need more refresher training for that reason.* – **VCBD Amuru**

> *[There is need to] strengthen [VCBDs'] ability to interpret answers; during refresher training, teach them to probe* – **SBCCO**

Theme 3: Verifying Client Responses through Direct Observation

SBCC management staff, SBCCOs, and VCBDs all referenced the ability to observe the living conditions of potential clients as a key factor in ensuring the PGT captured accurate information. In some cases, verification included speaking with other members of the family and community. For this reason, screening clients in their homes is critical.

> *It's administered at the client's home, meaning you can observe the reality* – **SBCC management staff**

> *They [mothers] tell me the truth because I ask about the things in the grading tool—water, shelter, and tick accordingly. If you think they are not telling the truth, you can check with the children* – **VCBD Amuru**

> *There are some [mothers] who…like to deceive [the VCBDs], but I disqualify them when I get to their home [to apply the PGT], for instance, and I find cows* – **VCBD Sironko**

Discussion and Implications

Quantitative data collected from clients indicate that the PGT is an effective mechanism for identifying poor, rural women to participate in the voucher program. Both quantitative and qualitative data indicate that VCBDs are implementing the PGT in accordance with Activity policies. These policies include:

- Screening all potential clients prior to selling vouchers,
- Conducting the PGT interviews at the homes of the mothers,
- Effectively communicating with women in their local languages (to the extent feasible), and
- Sharing copies of the completed PGT with mothers after the screening process.

In addition to these findings, the study identified the following successes and challenges to address in PGT implementation:

Realizing Successes

- Implementing a poverty screening tool that uses criteria recognized by local institutions as accurate assessments of poverty was an effective mechanism to target vulnerable populations for specific services.

- Recruiting VCBDs from the villages where they live to ensure that they are able to communicate in mothers' local languages enabled women to understand the purpose and questions of the PGT. This is significant in contexts similar to Uganda where many different languages are spoken and suggests that implementing a screening mechanism in one language risks excluding a large portion of the target population.

Addressing Challenges

- Training on how to apply the screening tool is critical. Training-of-trainers should be used to identify the most talented staff to employ as on-the-job trainers. Training should include tailored mentorship to accommodate individual learning styles and literacy levels, as well as a strong monitoring system to identify implementation problems quickly and adapt training when necessary.

- Activities seeking to reach young expecting mothers should explore developing and implementing a youth-specific eligibility screening tool to accurately capture the unique socio-economic situation of this vulnerable group. Questions should consider vulnerability as a criterion in lieu of, or in addition to, the current measures related to household income. This should also be considered as a strategy to more accurately screen women with limited control over household resources.